member guide

Health Insurance

Effective April 2018

Information for non-Australian residents

The Hospital covers that this Guide applies to are generally not suitable for non-Australian residents, including visitors from countries with which the Australian government has Reciprocal Health Care Arrangements. If you're a non-Australian resident, please contact us for information about health covers that may be more appropriate for you.

Our Member Guide

This Guide is a summary of Medibank's Fund Rules and policies as at the date of this Guide. It's designed to help you understand how your Medibank membership works, and should be read together with the Cover Summary you receive when joining or changing your cover. Your Cover Summary is a summary of the services and treatments provided by your particular health insurance cover. You can download a copy of your Cover Summary and our Fund Rules from **www.medibank.com.au**

- Please read this Guide and your Cover Summary carefully and keep them for your reference.
- If you need further information about your cover or anything in this Guide, please contact us.
- We'll send correspondence to your email address, or your postal address where you have opted out of email communication. It's important that you let us know if your contact details change.
- It's also important to contact us if you, or anyone else on the membership, are going to need treatment, to check what services and treatments we pay benefits towards and what out-of-pocket expenses you may have. Our contact details are on page 34 of this Guide.
- This Guide only applies to Medibank Australian resident covers. The information in this Guide is only relevant to these covers. If you hold a cover other than an Australian resident cover, please contact us for details of the services covered and membership conditions.

Before you get started...

Here is an explanation of some of the terms commonly used in this Guide:

'We', 'us' and **'our'** is Medibank Private.

'You' is any member of Medibank to whom this Guide applies.

'Member' is any person covered under a Medibank membership.

'Membership' is made up of one or more members.

'Policy holder' is the person who is responsible for the membership. This is the person we contact when we need to communicate about the membership.

To help you make the most of this Guide and understand the services and treatments under your cover, we've also prepared a glossary of useful terms that you can access online at **www.medibank.com.au/health-insurance/glossary**

Medibank Joining Statement

By joining Medibank, you (if you are the Policy holder) have agreed that you:

- will ensure that all information supplied to Medibank is true and correct
- will keep your membership information up to date and notify us of any changes as soon as possible
- will ensure that all members on the membership are aware of and abide by Medibank's Fund Rules, the information in this Guide and Medibank's policies including its Privacy Policy
- have the authority to provide the personal information of other members on the membership
- will make, or authorise the making of, all claims under the membership and ensure that any claim that includes sensitive information of a member aged 16 years and over is made having first obtained the consent of that member
- authorise any health service provider to supply to Medibank any information Medibank considers necessary for the assessment of any claim on the membership, and will ensure that members aged 16 years and over have provided the relevant consent
- authorise Medibank to supply to any health service provider any information Medibank considers necessary for the assessment of any claim on the membership, and will ensure that members aged 16 years and over have provided the relevant consent
- will make the minimum advance premium payments required
- are aware that Medibank may terminate your membership in accordance with Medibank's Fund Rules.

What's Inside

What's Inside

Welcome to Medibank

Your welcome pack

If you've just joined Medibank, you'll receive a welcome pack which includes:

- this Guide
- a Cover Summary, which is a summary of the services and treatments under your cover
- a Standard Information Statement (SIS), which is a high-level summary and isn't intended to be a comprehensive description of your cover. We are required by law to give you a SIS when you join, and then at least once every 12 months. It's important that you read the SIS with your Cover Summary and this Guide to fully understand your cover.

You'll also receive a membership card (sometimes referred to as a policy card), either with your welcome pack or shortly after. Use your membership card to make a claim or arrange admission to hospital. You should also keep it handy if you need to make an enquiry about your membership.

Make sure you keep your card safe and advise us immediately if it's lost or stolen. Medibank won't accept liability for any loss to you resulting from the misuse of a lost or stolen membership card.

Transferring from another Australian health fund

Provided that you join Medibank within two months of leaving your previous private health insurance fund, you generally won't need to re-serve any waiting periods you have already served. This means you'll generally only need to serve waiting periods for any treatments or items:

- that were not included under your previous cover
- that have an increased benefit (e.g. upgrading from a Limited to an Included hospital service or increasing an annual limit on an Extras cover). If you've served the waiting periods for the lower benefits on your previous equivalent cover, benefits will be paid at that level until you've served your new waiting periods
- for which you have not fully served the waiting period.

When you transfer to Medibank, we'll use our nearest equivalent cover (to the cover you held with your previous fund) to determine benefit entitlements. It's important to be aware that:

- extras benefits paid by your previous fund/s will be counted towards:
  - annual limits in your first calendar year of Medibank membership
  - lifetime limits
  - benefit replacement periods (refer to page 25).
- any loyalty bonus or other similar entitlements (e.g. increased annual limits on Extras cover for orthodontics) built up with your previous fund/s won't apply to your Medibank cover.
- if you choose a Medibank Hospital cover with a lower excess, the excess of the equivalent cover will apply until you have served the relevant waiting period.
- any excess or per-day payment paid to your previous fund won't be deducted from any excess or per-day payment payable under your Medibank Hospital cover (where applicable).

We need a Transfer Certificate from your previous fund to confirm your level of cover, waiting periods served and benefits paid. You may not be able to claim benefits for certain services until we have received your Transfer Certificate. We also need a Transfer Certificate to check whether a Lifetime Health Cover loading applies to anyone on the membership, as this can affect premiums payable (refer to page 31).

Where you join Medibank with a break in cover of more than two months, you'll be treated as a new member and all waiting periods relevant to your cover will apply.

Cooling off period

We give you 30 days from the date you join or change your cover to review and make sure you're happy with it. If you change your mind during that period, and no claims have been made, we'll either give you a full refund or transfer you to a more appropriate cover.

During the cooling off period, you cannot generally return to a cover that Medibank has closed.

Types of cover

Medibank offers a range of health insurance covers. A person may be a member of:

- a Hospital cover, Extras cover or both; or
- a packaged cover which is made up of both Hospital and Extras.

Some Hospital covers must be taken with an Extras cover and some Extras covers must be taken with a Hospital cover.

Changes to the Terms and Conditions of your membership

All members of Medibank are subject to our Fund Rules, which set out the terms and conditions of cover, as well as the services we pay benefits for. We may change the Fund Rules from time to time. If any changes to our Fund Rules will have a detrimental effect on a member's entitlement to benefits under their cover, we'll provide the Policy holder with reasonable notice in writing before the changes are due to take effect.

Any changes will apply regardless of whether premiums have been paid in advance and may include:

- Closing a cover. If we close a cover that you're on:
  - we may permit you to stay on the cover, but not make any changes to your membership (e.g. adding or removing a member or component of cover). If you want to make a change to your membership, you'll need to select a new cover; or
  - we may not permit you to stay on this cover and will move you to a cover as similar as possible.
- Removing a service or item from a cover.
- Reducing or removing a benefit or benefits under a cover.

If we make a change and you choose to continue your membership (under the new or changed cover) you'll be bound by its terms and conditions. If you do not wish to continue under the new or changed cover you have the option of transferring to a different cover or cancelling the membership.

Medicare eligibility

Your Medicare Card indicates your eligibility for Medicare. Holding a reciprocal (yellow) Medicare card or no Medicare card at all, will affect the benefits you're entitled to receive under Hospital cover. As a result, you could be left with very large out-of-pocket expenses if you receive hospital treatment.

If you, or any member on the membership, have limited or no access to Medicare, you should call us to discuss whether the cover you've chosen is the most suitable. Medibank offers a range of non-resident covers that may be better suited to your needs.

Managing your Membership

My Medibank

My Medibank is a convenient way of managing your membership online. You can sign up at **www.medibank.com.au**. Once you have signed up you'll be able to:

- View membership details
- Update contact details
- Manage premium payments
- Register bank account details to receive benefits for extras claims by EFT
- Order a replacement membership card

All Medibank members aged 16 years and over can use My Medibank; however, access to some functions may be limited to the Policy holder.

Partner authority

If the Policy holder adds their partner they'll be given authority to manage most aspects of the membership, unless the Policy holder tells us otherwise. This means Medibank may disclose membership details to both the Policy holder and their partner.

Partner authority includes:

- Making claims
- Adding or removing dependants
- Changing cover
- Suspending and reactivating the membership
- Changing contact and bank account details
- Changing payment methods
- Requesting and receiving premium refunds

Only the Policy holder can remove themselves or cancel the membership entirely.

Third party authority

Anyone on the membership can nominate a third party to deal with Medibank on their behalf.

There are three ways a member can nominate someone as their authorised third party:

- Verbally over the phone;
- By completing a Medibank Authority form – the form can be downloaded at **www.medibank.com.au**; or
- By giving Medibank a valid Power of Attorney.

A third party can be nominated for a specific timeframe or for the duration of the membership.

Managing your Premiums

Generally you cannot pay more than 12 months in advance for any cover. However, if you join Standalone Ambulance cover you'll need to pay either six or 12 months in advance.

Premium payment options

We offer a range of options for premium payments, including:

- Financial institution direct debit
- Credit card direct debit
- Manually through direct payment. If you pay using this method, we'll send you a Health Cover Account which has instructions on all the ways you can make a payment.

Premium protection

Premiums can change from time to time subject to approval by the Minister for Health. Where this occurs we'll write to the Policy holder to let them know what the new premium will be.

If you've paid your premiums in advance, the new premium won't apply until your next payment is due. This is known as premium protection. For example, if your premium increases on 1 April and you have paid your current premiums until 1 August, the new premium will apply from 2 August.

However, if you make one of the following changes your premium protection will be lost and the new premium will apply from the date of the change:

- Change your level of cover
- Change your membership category or state of membership
- Add or remove a component of your cover (e.g. Hospital or Extras)
- Reactivate your membership after a period of suspension.

Where you have paid in advance, the date you have paid up to will be adjusted accordingly.

Premium protection doesn't protect you against any other changes made to the terms and conditions of your membership.

Premium arrears

A membership is in arrears whenever the premiums aren't paid up to date. You won't receive any benefits for services provided or items purchased while your membership is in arrears.

If your premiums remain in arrears for more than two consecutive months, your membership will be closed and you'll no longer be eligible to receive any benefits from us.

It's your responsibility to ensure that your premium payments are up to date.

Premium refunds

If you cancel your membership, you can apply for a refund of premiums paid in advance. Your refund will generally be calculated from the date of application. An administration fee may apply.

Changing your Membership

As your circumstances change you may need to add or remove members on your cover. The following people can be on a Medibank membership:

Policy holder – this is the person who is responsible for the membership. Unless approved by us, the Policy holder must be 16 years of age or older.

Partner – a person who lives with the Policy holder in a marital or de facto relationship.

Child dependant – a child of the Policy holder or their partner who isn't married or living in a de facto relationship and is under the age of 21.

Student dependant – a child of the Policy holder or their partner isn't married or living in a de facto relationship, has reached the age of 21 but is under 25 and is undertaking full-time education at an approved educational institution.

Adult dependant – a child of the Policy holder or their Partner who isn't married or living in a de facto relationship, has reached the age of 21 but is under 25 and isn't undertaking full-time education.

If the status of anyone on the membership changes, for example a student dependant ceases to be a student or defers their study, you must notify us immediately as it may mean they're no longer eligible to remain on the membership.

Categories of membership

Adding or removing a member may mean the category of your membership needs to change. This type of change can also affect the premiums you'll need to pay.

We offer the following membership categories:

Single membership – covers the Policy holder.

Couple membership – covers the Policy holder and their partner.

Single parent family membership – covers the Policy holder and any of their child dependants and/or student dependants.

Family membership – covers the Policy holder, their partner and any of their child dependants and/or student dependants.

We also provide an option for families with adult dependants, where, for an additional cost, some covers can be extended to also include an adult dependant/s.

Not all membership categories are available for all covers. Contact us to find out more.

Adding a child dependant

To cover your child dependant from their date of birth or inclusion in your family unit (e.g. through marriage, adoption or fostering) you'll need to have commenced your Medibank membership no later than that date and add them within the timeframes below.

- For a single membership – **two months**. This change *must* be backdated to the child's date of birth/inclusion in the family unit and means you'll need to change to a family or single parent family cover and pay higher premiums. Where a child is added outside two months, they'll have to serve all waiting periods applicable to the cover.
- For a couple or family membership – **12 months**. This change *can* be backdated to the child's date of birth/inclusion in the family unit, or commence from the date of application or any future date you choose. Where a child is added outside 12 months, their cover will commence from the date of application or any future date you nominate.

Where a child is added within the above timeframes and the membership commenced no later than the child's date of birth they'll only have to serve the waiting periods that haven't been served by the Policy holder.

Moving interstate?

Premiums and some benefits vary from state to state. When moving interstate, you need to advise us of your new address within two months so that we can adjust your premiums and ensure you receive the benefits applicable to your state.

Receiving treatment interstate

If you receive treatment interstate, Medibank will pay benefits in accordance with our provider agreements in that state (our agreement providers are referred to as Members' Choice providers, see pages 15 and 24 for more details).

Where you receive treatment by a Non-Members' Choice provider, benefits are payable as follows:

- For hospital treatment, benefits are payable at the level applicable to the state in which treatment is provided.
- For extras treatment, benefits are payable at the level of benefits applicable to your state of membership, regardless of the state in which the service was provided.

Suspending your membership

Members can apply to suspend their membership if they are travelling overseas, receiving some types of Centrelink assistance or have been given a custodial sentence.

If you're considering suspending your membership you should note:

- Benefits are not payable for treatment received, services provided or items purchased during a period of suspension.
- You may be subject to the Medicare Levy Surcharge for the period you're suspended (refer page 30).
- Any period of suspension won't count towards waiting periods or benefit replacement periods.
- Any period of suspension can affect your entitlement to an increase in annual benefit limits for extras items and services.
- Members with both Hospital and Extras cover cannot suspend one without the other.
- Standalone Ambulance cover cannot be suspended.
- The maximum suspension periods are two years for eligible Centrelink benefits and four years for overseas travel and custodial sentencing.
- The minimum period between reactivation and suspension for the same reason is six months for overseas travel and 12 months for eligible Centrelink benefits and custodial sentencing.

If you're considering suspending your membership for overseas travel, you should also note:

- Premiums must be paid two weeks in advance of your suspension date.
- The suspension application must be made prior to your departure date.
- The minimum period for overseas travel suspension is two months. This means you must be absent from Australia for at least two months to be eligible to suspend your membership on this basis.

From time to time Medibank may close covers. If your cover is closed while your membership is suspended, you may be transferred to a similar cover. The premium applicable to the new cover will apply from the date your membership reactivates.

Depending on the reason for requesting a suspension, you may need to provide supporting documentation.

Going to Hospital

It's important to be aware that Hospital cover may not pay all of the costs associated with hospital treatment. You may still incur out-of-pocket expenses above the benefits we pay.

To help understand your potential out-of-pocket expenses, you should contact us prior to any hospital admission. You should also speak to your doctors and hospital to confirm any out-of-pocket expenses you may incur.

Inpatient vs outpatient

Hospital cover provides benefits when a member is treated as a private inpatient. An inpatient is someone who is admitted to hospital to receive medical care or treatment. Services that are provided where a member isn't admitted to hospital are called outpatient services. Outpatient services also include things such as visits to an emergency department, a general practitioner (GP) or a specialist.

Under government legislation, Medibank isn't allowed to pay benefits for outpatient services. This is why we won't pay any benefits when a member isn't admitted to hospital. A rebate may be claimable from Medicare for outpatient services.

Informed financial consent

Before going to hospital it's important to ask your doctor/s and the hospital about any potential out-of-pocket expenses you might incur. This information should be provided in writing before your treatment or hospital admission and is known as informed financial consent.

If you're admitted in an emergency, there may not be time for the hospital or doctor/s to seek your informed financial consent. Information about your out-of-pocket expenses should be provided by the hospital or doctor/s as soon as possible after you receive treatment.

Hospital accommodation benefits

The benefits we pay for hospital accommodation will depend on whether the hospital admission is for an Included, Limited or Excluded service (refer to your Cover Summary), and the type of hospital you're admitted to as explained below.

- Included services – we pay benefits towards same day and overnight hospital accommodation and intensive care; however, out-of-pocket expenses may still apply.
- Limited services (also known as Restricted services) – we pay the minimum benefits for hospital accommodation set by the Australian government (also known as default benefits) towards same day and overnight hospital accommodation and intensive care. The benefits we pay won't be enough to cover all hospital costs. This means you could incur substantial out-of-pocket expenses. For Limited services in a public hospital we'll pay minimum shared room benefits.
- Excluded services – no benefits are payable.

Hospital accommodation benefits do not include other things such as TV hire, telephone calls, newspapers, parking and take-home items, e.g. crutches. Medibank won't pay benefits for these (or similar) items and services. The hospital should discuss any charges with you.

Choice of hospital

Hospital cover allows you to choose whether you're treated as a private patient at either a private or public hospital. While we pay benefits regardless of where you're treated (if the treatment is Included or Limited under your cover) the benefits we pay and the out-of-pocket expenses you may incur for your hospital stay can vary depending on the hospital you choose.

When making a decision about which hospital you'll be treated at, you should be aware that not all doctors have admitting rights to all hospitals and this may affect where your doctor can treat you. Your doctor will be able to tell you at which hospitals they have admitting rights.

Regardless of whether you're treated at a Members' Choice, non-Members' Choice or public hospital, the hospital should seek your informed financial consent about any out-of-pocket expenses you'll need to pay. It's also important to be aware that if you have a Hospital cover with an excess or per-day payment, it will apply regardless of the type of hospital you choose (refer to page 22 for more information about how an excess and/or per-day payment will apply).

Members' Choice hospitals

Medibank has agreements with most private hospitals and day surgeries in Australia. We refer to our agreement hospitals as Members' Choice hospitals. For an Included service in a Members' Choice hospital, we'll pay an agreed rate for your treatment, which includes the cost of a private room (where available) or shared room and any theatre or procedure room costs. Generally this means any out-of-pocket expenses you incur for accommodation charges will be limited to any excess and/or per-day payment applicable to your cover.

By visiting a Members' Choice hospital, you'll generally get better value for money compared to a non-Members' Choice hospital as long as the service you receive is included in our agreement with the hospital and isn't Excluded or Limited under your cover.

Our agreements with Members' Choice hospitals are subject to change. You should confirm prior to receiving treatment whether your hospital provider is part of our Members' Choice network as this may affect your out-of-pocket expenses.

To find a Members' Choice provider, visit **www.medibank.com.au**

Non-Members' Choice hospitals

Non-Members' Choice hospitals are private hospitals and day surgeries Medibank doesn't have agreements with. The benefits we pay towards accommodation in these hospitals are generally lower than those in a Members' Choice hospital and you may incur significant out-of-pocket expenses (in addition to any applicable excess and/or per-day payment).

Public hospitals

All eligible Australian residents are entitled to be treated as a public patient in a public hospital. If you elect to be treated as a private patient in a public hospital we'll pay the minimum benefits for accommodation for a shared room only. You'll be required to pay any difference between the benefit we pay and the amount the hospital charges (in addition to any applicable excess and/or per-day payment).

Medicare Benefit Schedule (MBS) and medical services

The Medicare Benefit Schedule (MBS) lists all of the medical services subsidised by the Australian government through Medicare. These medical services include:

- doctors' services, e.g. GPs and specialists
- diagnostic services, e.g. blood tests, x-rays and ultrasounds provided by pathologists and radiologists.

Each service listed in the schedule has an item number and a corresponding fee that's been set by the government. Medibank pays benefits towards in-hospital medical services based on the Medicare Benefits Schedule (MBS). If a service is listed in the MBS and Included or Limited under your cover, Medicare will pay 75% and we'll pay 25% of the MBS fee. This means where the provider charges you no more than the MBS fee, you won't have an out-of-pocket expense for those inpatient medical services.

Doctors and providers are not restricted to charging the MBS fee and may choose to charge more for a particular service. Where this occurs you'll have an out-of-pocket expense unless:

- your doctor participates in Medibank's GapCover; and
- the service provided is eligible for GapCover.

The MBS is available at: **www.mbsonline.gov.au**

Items on the MBS are subject to change from time to time in accordance with changes made by the Department of Health.

Doctors' fees and GapCover

Where your doctor/s elects to charge more than the MBS fee, you'll be left with an out-of-pocket expense you'll need to pay. This is commonly referred to as the 'gap'. To help you reduce or eliminate the gap, GapCover is available on all Medibank Hospital covers in relation to eligible services (excluding Public Hospital covers).

If your doctor/s chooses to participate in our GapCover for the claim forming part of your treatment, we pay an amount higher than 25% of the MBS fee. Where they participate, there are two possible scenarios:

Scenario 1 'No Gap'

Your doctor participates in GapCover and charges you no out-of-pocket for the claim forming part of your treatment you receive as an inpatient.

OR

Scenario 2 'Known Gap'

Your doctor participates in GapCover and charges you a limited out-of-pocket of no more than $500 for the claim forming part of your treatment you receive as an inpatient.

If your doctor/s chooses not to participate in Medibank's GapCover, the amount we pay will be limited to 25% of the MBS fee. This means that where the doctor elects to charge more than the MBS fee you'll need to pay the gap yourself, which could result in very large out-of-pocket expenses.

It's important to be aware that:

- It's entirely up to your doctor whether they'll participate in GapCover.
- Doctors can decide to participate in GapCover on a per claim, per treatment, and per patient basis.
- If you're being treated by more than one doctor (e.g. surgeon and anaesthetist), participation is at each individual doctor's discretion.
- GapCover doesn't eliminate amounts that you have agreed to pay under the terms of your policy, e.g. excess and/or per-day payment.
- GapCover doesn't apply to diagnostic services (e.g. blood tests, x-rays and ultrasounds). This means where you're charged more than the MBS fee for in-hospital diagnostic services, you'll have an out-of-pocket expense for the difference between the charge and the MBS fee.
- GapCover doesn't apply to any doctors' charges for outpatient medical services.

You should always confirm upfront with your doctor/s prior to each claim forming part of your treatment whether they'll participate in Medibank's GapCover.

Contact us to find out more about GapCover.

Surgically implanted prostheses

If you need to be hospitalised for a procedure requiring a surgically implanted prosthesis (e.g. a pacemaker or cardiac stent), we'll pay the minimum benefit set out in the government's Prostheses List. The Prostheses List includes over 10,000 items together with a minimum benefit and, in some cases, a maximum benefit that can be charged for each item.

You'll have an out-of-pocket expense where (in consultation with your doctor) you choose a prosthesis that:

- is included in the government's list but costs more than the minimum benefit. In that case you'll have to pay the difference between the minimum benefit we'll pay and the cost of the item; or
- isn't included in the government's list at all. In that case, we won't pay any benefits and you'll be responsible for the full cost of the item.

Your doctor should discuss your prosthesis options with you and seek your informed financial consent regarding additional costs you may have to pay.

Benefits are not payable for any prosthesis associated with an Excluded service under your cover.

The Prostheses List is available at **www.health.gov.au**

Pharmaceutical Benefit Scheme (PBS)

The Pharmaceutical Benefit Scheme (PBS) is funded by the government and makes subsidised prescription medicines available to Australian residents. Residents eligible for the PBS contribute to the cost of subsidised medicines by paying a co-payment for each item set by the government.

Government legislation prevents health insurers from paying benefits for medications covered by the PBS unless provided under an agreement with the hospital.

This means Medibank will only pay benefits towards PBS medications where:

- you're admitted to a Members' Choice hospital for an Included service (refer to your Cover Summary)
- the pharmaceutical is directly related to the treatment of the condition for which you're admitted; and
- the pharmaceutical isn't prescribed for cosmetic purposes.

No benefits are payable for PBS pharmaceuticals that do not meet the above requirements, including pharmaceuticals provided on discharge from hospital and pharmaceuticals provided at a non-Members' Choice hospital.

Under Hospital cover, benefits are not payable for non-PBS pharmaceuticals.

Further details about the PBS are available at **www.pbs.gov.au**

Emergency department facility fees

Some private and public hospitals charge an Emergency Department facility fee to outpatients. Unless benefits are specifically provided under your cover (refer to your Cover Summary), Medibank won't pay towards those fees. Additionally, if you're treated in an Emergency Department and you're not admitted to hospital, you'll be an outpatient and we won't pay any benefits for treatment you receive.

Hospital benefits table

We've prepared this table to help you understand what benefits Medibank pays under Hospital covers (for Included and Limited services) and where potential out-of-pocket expenses may arise. Medibank doesn't pay any benefits for Excluded services (refer to your Cover Summary).

		Members' Choice Hospital	Non-Members' Choice Hospital	Public Hospital
Accommodation and Intensive Care Unit (ICU) charges	Included service	• **Medibank will pay** the cost of shared or private room accommodation in hospital or same day facility. • **Your potential out-of-pocket expense** is limited to any hospital excess and/or per-day payment applicable to your cover.	• **Medibank will pay** the minimum hospital benefit set by the Australian government for shared room only. • **Your potential out-of-pocket expense** will be any charge above the minimum benefit set by the government and any excess and/or per-day payment applicable to your cover.	
	Limited service	• **Medibank will pay** the minimum hospital benefit set by the Australian government. • **Your potential out-of-pocket expense** is any charge above the minimum benefit set by the Australian government in addition to any excess and/or per-day payment applicable to your cover.		
Theatre fees	Included service	• **Medibank will pay** costs as per our agreement with the hospital. • **Your potential out-of-pocket expense** is limited to any hospital excess and/or per-day payment applicable to your cover.	• **Medibank will pay** no benefits. • **Your potential out-of-pocket expense** will be any charge raised by the hospital and any excess and/or per-day payment applicable to your cover.	
	Limited service	• **Medibank will pay** no benefits. • **Your potential out-of-pocket expense** will be any charge raised by the hospital and any excess and/or per-day payment applicable to your cover.		
Surgically implanted prostheses	Included or Limited service	• **Medibank will pay** the minimum benefit set out in the government's Prostheses List. • **Your potential out-of-pocket expense** – if the prosthesis is: – included in the Prostheses List and costs up to the minimum benefit – no out-of-pocket expense. – included in the Prostheses List and costs more than the minimum benefit – any charge above the minimum benefit. – not included in the Prostheses List – the full cost of the prosthesis.		
In-hospital doctors' medical services	Included or Limited service	• **Medibank will pay** 25% of the MBS fee. • **Your potential out-of-pocket expense** – where your doctor/s charges more than the MBS fee and: – participates in Medibank's GapCover – either no out-of-pocket expense or limited out-of-pocket expense of no more than $500 per doctor. – doesn't participate in Medibank's GapCover – any difference between the MBS fee and the amount the doctor charges.		
In-hospital diagnostics (e.g. bloods tests, scans etc.)	Included or Limited service	• **Medibank will pay** 25% of the MBS fee. • **Your potential out-of-pocket expense** – any difference between the MBS fee and the amount you're charged.		

Hospital Cover

Hospital cover pays benefits towards hospital accommodation, intensive care and medical services that you receive when you're treated in hospital as a private inpatient.

How hospital benefits are assessed

In assessing benefits for hospital charges, Medibank takes the following into account:

- The cover you held at the date the service was provided. This includes whether the service was Included or Limited and any excess and/or per-day payment applicable to your cover (refer to your Cover Summary)
- The type of hospital to which you were admitted (Members' Choice, non-Members' Choice or public hospital)
- Whether all relevant waiting periods had been served by the member requiring treatment
- Whether a Medicare benefit is payable for the treatment
- Whether the premiums were paid up to date
- Any legislative requirements governing hospital treatment
- Whether any other exclusions or assessing rules apply.

Benefits for certain same day procedures specified by the Department of Health may not be payable unless your doctor certifies your need to be admitted to hospital.

Long stay hospital patients (nursing home type patients)

If you're admitted to hospital as an inpatient for a period of continuous hospitalisation exceeding 35 days, you'll be regarded as a long stay or nursing home type patient. If your doctor doesn't certify your need for ongoing acute care after 35 days, we'll pay a lower benefit towards the daily accommodation hospital charge and you'll need to pay the difference as an out-of-pocket expense. These charges could be significant depending on your length of stay.

Treatments where no Medicare benefit is payable

Hospital cover benefits are generally payable only for treatment for which a Medicare benefit is payable. However, under some Hospital covers we pay limited benefits towards the following treatments when provided to a hospital inpatient, even though no Medicare benefit is payable (refer to your Cover Summary):

- Surgical removal of wisdom teeth. We'll pay benefits towards hospital accommodation charges. We don't pay any benefits towards the dentist's fees under Hospital cover. This means you could incur out-of-pocket expenses for those charges. Some benefits (up to applicable limits) may be claimable for the dentist's fees if you hold an appropriate level of Extras cover.
- Podiatric surgery. We pay limited benefits towards hospital accommodation charges for podiatric surgery performed by an accredited podiatrist. This means you could incur significant out-of-pocket expenses.

Waiting periods

A waiting period is a set amount of time each member must wait before they can receive benefits under their cover. No benefits are payable for items and services obtained while serving a waiting period.

It's important to know that waiting periods apply when each member:

- first takes out cover, is added to an existing membership, or changes cover prior to serving all applicable waiting periods
- resumes cover after a break of two months or more (having previously held cover with another Australian health fund)
- changes their cover to include new or upgraded services or items, or to reduce their excess or per-day payment.

Check your Cover Summary for waiting periods that apply.

Mental Health Waiver

The Mental Health Waiver allows members who have served their two month waiting period for Limited in-hospital psychiatric treatment to upgrade to a cover with Included in-hospital psychiatric treatment and elect to have the two month waiting period for those higher benefits waived.

Members can elect to use their waiver at the point of upgrading or after upgrading, prior to serving the two month waiting period for Included psychiatric treatment. Members need to have held Hospital cover without a break of more than two months to be eligible to use the waiver.

The waiver only applies to the two month waiting period for the higher Included benefits for in-hospital psychiatric treatment. All other applicable waiting periods will continue to apply.

Members will only be able to use the Mental Health Waiver once in their lifetime.

Pre-existing conditions (PEC)

Most hospital treatments have a two month waiting period, unless we determine the condition to be pre-existing. Treatment of a pre-existing condition (PEC) has a 12 month waiting period. The only hospital treatments that aren't subject to the PEC waiting period are psychiatric care, rehabilitation and palliative care (a two month waiting period applies to these services). Obstetrics-related services are also not subject to PEC, as they always have a 12 month waiting period (refer to page 21).

What is a PEC?

An ailment, illness or condition that, in the opinion of a Medical Practitioner appointed by Medibank, the signs or symptoms of which existed at any time in the six month period prior to the day on which the member became insured under the policy or changed their cover.

The PEC waiting period will apply even if an ailment, illness or condition was not diagnosed before the date of commencing membership or changing cover.

Where a member requires hospital treatment, their condition will be assessed for a PEC if:

- they have held their cover for less than 12 months; or
- they have changed their cover to include a new or upgraded service and they haven't been covered for that service for 12 months.

Medibank's Medical Practitioner is the only person authorised to determine if an ailment, illness or condition is pre-existing. To have a determination made, the member will be required to provide two PEC certificates completed by their treating practitioners (e.g. their GP and their admitting specialist).

Medibank won't pay for the member or a provider to supply this information.

Medibank will apply the PEC waiting period if:

- the member doesn't authorise the release of medical or paramedical evidence relating to their claim; or
- despite the member's authorisation, their provider doesn't release that evidence.

We need up to 10 working days after receiving all required information to make a PEC assessment. Members should allow time for a determination to be made before agreeing to a hospital admission date. However, it's important to be aware that a condition requiring hospitalisation will still be assessed for a PEC (and the 12 month waiting period may still apply), even where a member is admitted to hospital in an emergency.

If a member:

- is admitted to hospital and chooses to be treated as a private patient
- has been covered for the required service or treatment for less than 12 months; and
- our Medical Practitioner determines (either prior or subsequent to the admission) the member's condition to be a PEC.

Medibank won't pay any benefits. This means the member will be required to pay **all** hospital and medical charges.

Medibank reserves the right to apply, or not to apply, the PEC waiting period to individual claims. This means we can refuse or reduce benefits on later claims even if the PEC waiting period hasn't been applied to any earlier claims for that ailment, illness or condition.

You can download the PEC certificates at **www.medibank.com.au**

Having a baby?

If you're considering having a baby we recommend you contact us to ensure your cover includes obstetrics-related services. This is because there is a 12 month waiting period for those services that the mother will need to have served before the baby is born.

This waiting period applies regardless of the baby's due date or whether the member was pregnant at the time of taking out or upgrading their cover to include obstetrics-related services.

What are obstetrics-related services?

Services and treatment provided in hospital that deal with the care of women during pregnancy, childbirth and following delivery.

In addition, once the baby is born, it's important to ensure they're added to your cover from birth, in case they require hospital treatment immediately.

Ensuring your newborn is added to your membership

Generally, a healthy newborn isn't separately admitted to hospital as an inpatient (this is because the baby comes under the mother's admission). Because the baby isn't an inpatient, it's important to be aware that any treatment, tests or doctor's visits (e.g. a pre-release check-up by a paediatrician) are outpatient services, for which Medibank doesn't pay any benefits. This means you'll only be eligible to claim a Medicare rebate for those services and may have out-of-pocket expenses.

In some cases a newborn may need to be admitted to hospital in their own right, for example where they require treatment in a special care nursery or an intensive care unit. This type of admission can be very expensive. To ensure your newborn will be entitled to receive benefits in the event they need these services, we strongly advise you to add them to your membership from their date of birth. If a newborn isn't added within Medibank's required timeframes (refer page 12), you'll be responsible for any costs associated with their admission.

You should also be aware that if you're expecting a multiple birth (e.g. twins) your second or subsequent babies will always be separately admitted to hospital as inpatients. This means that an accommodation charge will be raised by the hospital, so it's important to make sure they're added to your membership.

Contact us to add your baby to your membership.

Accident waiting period waiver and Accidental Injury Benefit

What is an accident?

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

Accident doesn't include any unforeseen conditions the onset of which is due to medical causes, nor does it include pre-existing conditions, falling pregnant or accidents arising from surgical procedures. Condition means a state of health for which treatment is sought.

Accident waiting period waiver

Where a one day or two month waiting period applies to a Limited or Included service or treatment on your hospital cover (refer to your Cover Summary), it may be waived for claims resulting from an accident. All other waiting periods will continue to apply.

Accidental Injury Benefit (also known as Accident override)

Under some Hospital covers, benefits are payable for services which would normally be Excluded or Limited, where treatment is required for injuries sustained in an accident. This is known as Accidental Injury Benefit (refer to your Cover Summary to check if Accidental Injury Benefit applies).

The following conditions apply to Accidental Injury Benefit on all applicable covers:

- It's limited to hospital treatment and doesn't give you coverage for any services or items under any level of Extras cover you may hold.
- It only applies to treatment for which a Medicare benefit is payable.
- It doesn't apply to Standalone Ambulance cover.

Some Hospital covers have additional eligibility requirements (e.g. you must see a medical practitioner within seven days of the Accident occurring). Please see your Cover Summary for details.

To make a claim under Accidental Injury Benefit, you'll need to submit the Accident form for assessment. The form can be downloaded at **www.medibank.com.au**.

Hospital covers with an excess

Medibank offers a range of Hospital covers, some of which have an excess. The SIS sent to you in your welcome pack will confirm whether you've chosen a cover with an excess and how much that excess is. Alternatively, you can contact us to check whether an excess applies to your cover.

What is an excess?

An amount that you must contribute towards your hospital treatment. It's deducted from the benefits we pay when you make a hospital claim, separate to any per-day payment applicable. Some hospitals may require you to pay this amount at the time of admission.

If your cover has an excess, the excess will apply:

- per hospital admission, including same day admissions and overnight admissions
- only where the Policy holder or partner is hospitalised – it won't apply to hospital admissions for child dependants, student dependants or adult dependants on family memberships
- regardless of the type of hospital you're admitted to (e.g. Members' Choice, non-Members' Choice or public hospital).

For most covers the excess will apply per member per calendar year. For some other covers the excess will apply to each episode of hospital treatment up to an annual maximum. Refer to your Cover Summary for details.

Where a member is re-admitted to hospital for the same or a related condition within seven days of discharge, the excess won't be applied to the second admission, even if the admissions stretch across two calendar years.

Hospital covers with a per-day payment

Medibank offers a range of Hospital covers, some of which have a per-day payment (also known as co-payment). You can check your Cover Summary, SIS or contact us to check whether a per-day payment applies to your cover.

What is a per-day payment?

A daily amount that a member contributes towards their accommodation costs when admitted to hospital, separate to any excess applicable. The amount payable is determined by the cover held and is payable directly to the hospital.

If your cover has a per-day payment, it will apply:

- per day per hospital admission, including same day admissions and overnight admissions
- only where the Policy holder or partner is hospitalised – it won't apply to hospital admissions for child dependants, student dependants or adult dependants on family memberships
- regardless of the type of hospital you're admitted to (Members' Choice, non-Members' Choice or public hospital).

Claiming for a CPAP-type device

Benefits are payable under some of our Hospital covers for CPAP-type devices (refer to your Cover Summary to see if you're entitled to benefits).

What is a CPAP-type device?

These devices include Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP) or similar devices, as approved by Medibank.

Benefits for a CPAP-type device are only payable when:

- the member has served the 12 month waiting period
- the member has undergone an overnight investigation for sleep apnoea (sleep study) for which a Medicare benefit is payable
- the member has been prescribed or recommended CPAP therapy (the member must supply either a letter from a Medical Practitioner or the results of the study itself); and
- the device is purchased or hired within 12 months of undergoing the study.

If the CPAP-type device costs more than the benefit we pay, you'll be responsible for paying the remaining amount. A benefit replacement period of five years applies (refer to page 25 for details about benefit replacement periods).

Hospital benefit exclusions

Benefits are not payable:

- for any treatments or services that are:
  - Excluded under your cover (refer to your Cover Summary)
  - subject to a PEC or other waiting period or benefit replacement period
  - rendered while premiums are in arrears or the membership is suspended
  - rendered, or items purchased, outside Australia (including medical appliances, pharmaceuticals and other items purchased by mail order or over the Internet direct from a supplier outside Australia) or prior to joining
  - provided in an aged care service
- for any claims:
  - submitted more than two years after the date of service
  - for services in respect of which you have received, or are entitled to receive, compensation (refer to page 32)
  - that are fully covered by a third party (refer to page 32)
  - containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
  - for charges by your doctor in excess of the Medibank benefit payable under your cover
- where the treatment is rendered by providers who are not recognised by Medibank for the purpose of paying benefits (refer to page 32)
- for procedures not recognised for Medicare benefit purposes
- for cosmetic treatment
- for podiatric surgery performed by a non-accredited podiatrist
- for pharmaceuticals that are:
  - prescribed for cosmetic purposes
  - provided on discharge from hospital
  - not covered by Medibank's agreement (if any) with the hospital, including any PBS co-payment the member may be required to pay
  - non-PBS pharmaceuticals
- for surgically implanted prostheses and other items not included on the government's Prostheses List, or for any charge that exceeds the minimum benefit set out in the government's Prostheses List
- for items such as newspapers, TV hire, etc. not covered by Medibank's agreement (if any) with the hospital
- for the cost of treatment as an outpatient (unless specifically approved by Medibank)
- accident and emergency department fees, unless included under your cover (refer to your Cover Summary)
- for charges by a doctor in excess of the MBS fee, unless they participate in Medibank's GapCover
- for same-day procedures determined by the Australian government as not requiring hospitalisation where the doctor hasn't provided suitable certification that treatment is required as an admitted inpatient in hospital
- where we consider that one service forms part of another service
- where the number of services performed or items provided exceeds a pre-determined number of services or items over a certain period or course of treatment
- where a provider has charged for two or more consultations on the same day, except where it can be shown that two separate attendances took place, and that these attendances are clearly identifiable on the member's account as separate consultations
- where the service is performed in stages and a separate benefit cannot be claimed for each stage
- where the member has reached their annual limit, sub-limit or lifetime limit for the particular item or service, or a group of items or services
- where the treatment is rendered by a provider to their partner, dependant, business partner or business partner's partner or dependant
- where the treatment is otherwise excluded by the operation of a Fund Rule.

Extras Cover

Extras cover pays benefits towards the cost of services and items that are generally not covered by Medicare, including physiotherapy, dental and prescription glasses. The services and items included in your cover, and benefits paid, will depend on your Extras cover. You should refer to your Cover Summary for details.

How extras benefits are assessed

In assessing benefits for extras items or services, Medibank takes the following into account:

- The cover you held at the date the service was provided or item purchased. This includes whether the service or item was included under your cover.
- Whether the service or item is subject to a waiting period or benefit replacement period.
- Whether any annual limit, sub-limit or lifetime limit (where applicable) has been reached.
- Whether the item is purchased from, or the service is provided by, a Medibank recognised provider. This includes whether you received the service from a Members' Choice extras provider. Refer to page 32 for more information.
- Whether there is an entitlement to a Medicare benefit.
- Whether the premiums were paid up to date.
- Whether any other exclusions or assessing rules apply.

Item numbers for which benefits are payable are subject to change in accordance with third parties, such as professional associations.

Members' Choice extras providers

Medibank has agreements with a number of extras providers, including dentists, physiotherapists, chiropractors, podiatrists, acupuncturists and more. We refer to our agreement providers as Members' Choice providers.

With a Members' Choice provider you'll generally get better value for money, as we have negotiated the maximum amount you can be charged for their services.

It's important to be aware that Medibank's Members' Choice Extras providers are subject to change without notice, and are not available in all areas, so please check if they're a Members' Choice provider before your treatment or service.

Find your nearest Members' Choice provider, at **medibank.com.au/memberschoice**

Non-Members' Choice extras providers

Non-Members' Choice providers are providers we don't have an agreement with. As long as the provider is a Medibank recognised provider, benefits are still payable for services or items included under your cover and you'll get a fixed amount for that service regardless of the provider's charge.

Waiting periods

A waiting period is a set amount of time each member must wait before they can receive benefits under their cover. No benefits are payable for any items purchased, or services you have received while you're serving a waiting period, or before you joined Medibank.

It's important to be aware that waiting periods apply when each member:

- first takes out cover, is added to an existing membership, or changes cover prior to serving all applicable waiting periods
- resumes cover after a break of two months or more (having previously held cover with another Australian health fund)
- changes their cover to include new items or services or higher annual limits.

Check your Cover Summary for waiting periods that apply.

Benefit replacement periods

A benefit replacement period applies to some extras items payable under Extras cover.

What is a benefit replacement period?

A set period of time you need to wait from the date of purchase for an item included under your cover before you can receive another benefit to replace the item. This is separate to the waiting period for the item.

The following benefit replacement periods apply (refer to your Cover Summary to check whether any of these items are included under your Extras cover). Benefit Replacement Periods can apply per member or per membership, depending on your cover. Refer to your Cover Summary for more information.

12 months	• external mammary prostheses and repairs of external prostheses and health appliances
2 years	• wigs • hip protectors • insulin delivery pens • pregnancy compression garments
3 years	• blood glucose monitors • blood pressure monitors • breathing appliances – nebulisers – peak flow meters (per member or per membership, depending on your cover) – spacing devices • mouthguards (a benefit may be payable for a replacement mouthguard each calendar year for members under 18 years of age) • dentures, crowns and bridges • other health appliances and external prostheses • TENS machines
5 years	• hearing aids • CPAP-type devices (claimable under some Hospital covers)

Applicable limits

The benefits we pay towards items and services under Extras cover will generally be subject to one or more of the following limits:

- Annual limits
- Sub-limit
- Lifetime limits.

In most cases the benefits we pay for a particular claim will be less than the applicable limits and less than your provider's charge. This means you may have out-of-pocket expenses.

You should refer to your Cover Summary and SIS to confirm what limits apply to your cover.

Please contact us if you would like to confirm the benefit payable for an item or service.

Annual limit

An annual limit is the maximum amount of benefits we pay towards particular items or services, or a group of services and/or items within a calendar year (1 January to 31 December).

In most cases the limit will apply per member, but it can apply per membership.

Some covers have increasing annual limits that apply for particular services or groups of services. Refer to your Cover Summary to confirm if your cover has increasing annual limits.

Sub-limit

A sub-limit is the maximum amount of benefits you can receive for a particular item or service within the overall annual limit. Sub-limits generally apply per calendar year. For example, an Extras cover may have an annual limit of $400 for Health Appliances, with a $100 sub-limit for breathing appliances.

Lifetime limit

A lifetime limit is the maximum cumulative benefit we pay over your lifetime towards an item or service, or a group of items or services.

When you reach this limit, you can no longer claim that benefit again, even if you change your cover.

Refer to your Cover Summary to confirm if a lifetime limit applies.

Consultations

Benefits are payable towards initial and subsequent consultations for services included under your Extras cover. The following requirements apply:

- The consultation must be with a Medibank recognised provider.
- Benefits are payable for the consultation only, unless otherwise stated.
- In most cases the consultation must be face to face (telephone, internet or video consultations are generally ineligible for benefits).
- Generally benefits are only payable once per day for the same provider.

Prescription pharmaceuticals – non-PBS

Non-PBS pharmaceuticals are drugs that aren't subsidised by the Australian government under the Pharmaceutical Benefit Scheme (PBS). If your Extras cover includes benefits for non-PBS pharmaceuticals (refer to your Cover Summary), we'll pay benefits for pharmaceuticals that:

- aren't covered by the PBS
- legally require a prescription in order to be dispensed and are supplied by a registered pharmacist, medical practitioner or dentist; and
- aren't prescribed for oral contraceptive or cosmetic purposes.

Where eligible, benefits are paid up to a fixed amount for each prescription pharmaceutical. Before paying any benefits, we'll deduct an amount equivalent to the current non-concessional PBS co-payment amount. This means that you'll have out-of-pocket expenses for the co-payment amount plus any cost above the fixed amount we'll pay for the pharmaceutical. Where your prescription pharmaceutical costs less than the co-payment amount, we won't pay any benefits.

Appliances requiring referrals

A referral is required to claim benefits for the following items (where included under your Extras cover – refer to your Cover Summary). The referral must be in writing and provided by a medical practitioner unless otherwise indicated below:

- blood glucose monitors
- blood pressure monitors
- breathing appliances
  - nebulisers
  - peak flow meters
  - spacing devices
- orthotic appliances for shoes (can also be referred by podiatrists, physiotherapists and chiropractors)
- wigs
- pressure therapy garments (can also be referred by physiotherapists)
- pressure stockings
- pregnancy compression garments
- braces, splints and orthoses (can also be referred by orthotists, physiotherapists, occupational therapists and podiatrists)
- custom-made footwear (can also be referred by podiatrists and physiotherapists)
- TENS machines
- modifications to footwear (can also be referred by podiatrists)
- external prostheses and health appliances
- hip protectors
- insulin delivery pens.

Generally a letter of referral is valid for 12 months. Where a member requires another item after 12 months, they'll need a new referral.

Extras benefit exclusions

Benefits are not payable:

- for any items or services that are:
  - not included under your cover (refer to your Cover Summary)
  - subject to a waiting period or benefit replacement period
  - purchased or provided while premiums are in arrears or the membership is suspended
  - rendered, or items purchased, outside Australia (including medical appliances, pharmaceuticals and other items purchased by mail order or over the Internet direct from a supplier outside Australia) or prior to joining
- for any claims:
  - submitted more than two years after the date of service
  - for services in respect of which you have received, or are entitled to receive, compensation (see page 32)
  - that are fully covered by a third party
  - where there is an entitlement to a Medicare benefit
  - containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
- for treatment rendered by a provider who isn't recognised by Medibank for the purpose of paying benefits (see page 32)
- for pharmaceuticals that are:
  - oral contraceptives
  - prescribed for cosmetic purposes
  - supplied under the PBS
- for services provided at a public hospital or publicly funded facility
- where the treatment is rendered by a provider to their partner, dependant, business partner or business partner's partner or dependant
- where the service is provided in an aged care service
- where we consider that one service forms part of another service
- where the number of services performed or items provided exceeds a pre-determined number of services or items over a certain period or course of treatment
- where a provider has charged for two or more consultations on the same day, except where it can be shown that two separate attendances took place, and that these attendances are clearly identifiable on the member's account as separate consultations
- where the service is performed in stages and a separate benefit cannot be claimed for each stage
- where the member has reached their annual limit, sub-limit or lifetime limit for the particular item or service, or a group of items or services
- where treatment is otherwise excluded by the operation of a Fund Rule.

Ambulance Services

We pay benefits towards ambulance services under all of our Hospital and Extras covers (refer to your Cover Summary).

When are benefits payable?

Where you need an ambulance and your medical condition is such that you can't be transported any other way, you'll be covered for services provided by a Medibank approved ambulance provider:

- when ambulance transportation to a hospital or other approved facility is required to receive immediate professional attention
- when an ambulance is called to provide immediate professional attention but transport by ambulance isn't needed
- when, as an admitted patient, the hospital requires you to be transferred from one hospital to another (excluding transfers between public hospitals)
- for transport by air ambulance, where pre-approval has been obtained from Medibank by the air ambulance provider.

When are benefits not payable?

Medibank doesn't pay benefits for any ambulance service not described under 'When are benefits payable?'. This includes:

- ambulance services where immediate professional attention isn't required (e.g. general patient transportation)
- any ambulance transport required after discharge from hospital (e.g. transport from hospital to home)
- inter-hospital transfers when, as an admitted patient, you're transferred from one public hospital to another public hospital
- any ambulance costs that are fully covered by a third party arrangement, such as an ambulance subscription or federal/state/territory ambulance transportation scheme, WorkCover or the Transport Accident Commission
- any air ambulance services that are fully subsidised, such as South Care or LifeFlight.

State Ambulance Schemes

If your principal place of residence is in Queensland or Tasmania, your ambulance services are provided under the relevant state ambulance schemes operating in those states.

In Western Australia, aged pensioners are entitled to free primary ambulance services provided by St John Ambulance Australia. All other Western Australian senior citizens aged 65 or over are entitled to receive a 50% subsidy on the cost of ambulance transport provided by St John Ambulance Australia. The remaining 50% of the cost may be claimable from Medibank if the member is entitled to ambulance benefits under their cover. Please visit the Western Australian Department of Health for more information **www.health.wa.gov.au**

NSW and ACT members with Hospital cover

In New South Wales and the Australian Capital Territory, when you have Hospital cover you pay a government-imposed ambulance levy as part of your health insurance premium.

This entitles you to ambulance services provided under your state/territory ambulance transport schemes. This means that, if you receive an account for ambulance services, you should send it to Medibank for endorsement and we'll then forward your claim to the appropriate state/territory ambulance service provider for payment.

If you hold a New South Wales or Australian Capital Territory Hospital cover and also a Commonwealth concession card, you may be entitled to an exemption from paying the ambulance levy and to free ambulance services. Please contact us for more information.

Standalone Ambulance cover

Medibank also offers Standalone Ambulance cover which provides benefits for the cost of ambulance services (as outlined under 'When are benefits payable?').

Standalone Ambulance cover isn't available in Queensland and Tasmania. For members in Western Australia, a co-payment of $100 per trip applies to non-emergency transport, as classified by the ambulance service provider.

Making a Claim

There are a number of ways you can make a claim with Medibank for in-hospital and extras services.

Hospital claims

Medibank has arrangements with most hospitals for benefits to be paid direct to the hospital on a member's behalf. This means generally it won't be necessary for you to submit a separate claim for hospital benefits. If needed, hospital claims can be submitted via post with a completed claim form or at a Medibank store. Where claims are submitted in store, we'll assess them separately (at a later date) and pay benefits to you or the hospital, as appropriate.

Extras claims

Most extras providers offer the convenience of electronic claiming using your membership card. Where available, the claim will be processed automatically and you'll just need to pay the remaining balance to the provider.

If electronic claiming isn't available, one of the following options can be used:

- **My Medibank**

A claim can be submitted online for most extras services using a My Medibank account.

- **Post**

Fill in and submit a claim form – the form can be downloaded at **www.medibank.com.au** Make sure to attach the original invoices or receipts. As these won't be returned, we recommend you keep a copy for your records.

For extras claims, we'll pay the benefit to you, and if your claim relates to an unpaid invoice, you'll need to pay the service provider in full.

Claims documentation

Medibank retains all account and receipt documentation for the period required by law.

Benefit payments are accompanied by a statement that contains all information relevant to each service claimed. This statement should be retained for taxation purposes.

Medibank will, on request, provide a financial year consolidated Statement of Benefits which may assist you for taxation purposes.

For online claims, members are required to retain receipts for a specified period for verification purposes.

Time limit for submitting a claim

A claim for benefits must be submitted within two years of the date of service or the date the item was purchased. No benefits will be paid for any claims submitted outside that timeframe.

Government Initiatives

Australian Government Rebate on private health insurance

The Australian Government Rebate (AGR) on private health insurance can help reduce the cost of your premiums. It applies to Hospital and Extras cover but won't reduce any Lifetime Health Cover loading that may apply to your premiums.

To claim the AGR you must be eligible for Medicare. The percentage of the rebate you're entitled to (also known as your rebate tier) is determined by the age of the oldest person on your membership and your income for tax purposes (single and couple/family income thresholds apply).

You can choose to nominate your AGR tier in one of two ways:

- as an automatic reduction in your premiums – to use this option you'll need to download a copy of the AGR form at **www.medibank.com.au**
- as a tax offset in your tax return.

Nominating a rebate tier helps ensure you receive the correct rebate based on your circumstances. If you don't nominate a rebate tier we'll generally apply the base tier. If a tier has been nominated (either by us or you) that results in a higher rebate than your income entitles you to, you may incur a tax liability.

For more information about the AGR visit the Australian Taxation Office website at **www.ato.gov.au**

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is applied to Australian taxpayers who do not hold an appropriate level of private hospital cover and who earn above a certain income (individual and couple/family income tiers apply).

For more information about the MLS visit the Australian Taxation Office at **www.ato.gov.au**

Lifetime Health Cover loading

Lifetime Health Cover (LHC) is an Australian government initiative designed to encourage people to take out Hospital cover before the age of 31.

An LHC loading is applied to people who haven't taken out and maintained private hospital cover by 1 July following their 31st birthday. This is known as their LHC base day.

If a person doesn't hold hospital cover on their LHC base day, they'll pay a 2% loading on their hospital premium, up to a maximum of 70%, for each year (or part year) they are aged over 30.

Example: Maegan took out Hospital cover at age 55 for the first time. Because she didn't hold hospital cover on her LHC base day (1 July following her 31st birthday), Maegan pays an LHC loading of 50% on top of her Hospital cover premium. This equates to 2% for each year Maegan is aged over 30.

The LHC loading is removed once a person has held hospital cover and paid the loading for 10 continuous years.

Permitted days without Hospital cover

In most cases a person needs to have held Hospital cover on and/or after their LHC base day to be eligible to access their permitted days without Hospital cover.

The following are considered permitted days without Hospital cover and won't affect a person's LHC loading:

- Days where a person's Hospital cover is suspended under our Fund Rules
- Days when the person is overseas for a continuous period of more than one year (which can include periods of return to Australia of less than 90 days each time)
- The first 1,094 days of not having hospital cover.

LHC loading exemptions

People who were born on or before 1 July 1934 can take out hospital cover at any time and not have an LHC loading imposed.

In some other cases, you may be eligible to apply for an exemption from any LHC loading that may otherwise apply. To check whether you're eligible and to apply for an exemption, download our LHC exemption form at **www.medibank.com.au**. The form sets out the exemption categories, criteria and documentation required.

For more information about LHC and to use the LHC calculator to find out whether you'll need to pay a loading, visit **www.privatehealth.gov.au**

Other Important Information

Members' Choice Network

Medibank has entered into agreements with most private hospitals and many extras providers. These agreement providers form our Members' Choice Network. Visiting a Members' Choice provider means you may be able to access services at a capped fee and/or receive higher benefits.

It's important to be aware that Medibank's Members' Choice providers and/or agreements are subject to change without notice. Members' Choice providers are not available in all areas, so please check if they're a Members' Choice provider before your treatment or service.

To find a Members' Choice provider visit **www.medibank.com.au**

Recognised providers

To be eligible for benefits, a service or treatment must have been rendered by a provider recognised by Medibank. Medibank recognised providers include hospitals and extras providers and are not limited to providers in our Members' Choice Network. Recognition of providers is at Medibank's discretion. Recognised providers must meet criteria set by Medibank and Medibank may at its discretion cease to recognise a provider it has previously paid benefits for. You should check whether your provider is recognised by Medibank prior to treatment. To do this, please contact us.

Disclaimer

Medibank encourages providers to offer high quality products and services at competitive prices to members.

However, where Medibank recognises a provider, advertises on behalf of a provider, or appears (by reference to its logo or otherwise) in an advertisement of any provider, to the fullest extent allowed by law such advertising or reference should not be construed as:

- an endorsement by Medibank; or
- an acknowledgment or representation by Medibank as to fitness for purpose; or
- a recommendation or warranty by Medibank of, for or in relation to the provider's products and/or services. Accordingly, Medibank neither takes nor assumes any responsibility for the product and/or service provided. Members should rely on their own enquiries and seek any assurance or warranties directly from the provider in relation to the service or product, or from the relevant registration body (e.g. AHPRA) regarding any conditions or restrictions associated with the provider's registration.

The health care providers who participate in our Members' Choice Network, and the providers whose services we pay benefits for, may change from time to time.

Members' Choice providers may not be available in all areas. Benefits and other arrangements with those providers may vary depending on their location.

To check if your provider is a Medibank recognised provider, contact us.

Compensation and damages

Benefits are not payable for expenses relating to treatment of a condition for which you have received, or are entitled to receive, compensation or damages from a third party (e.g. your state's Workers' Compensation authority, motor vehicle accident authority or other third party insurance). This includes treatment of a condition caused by an accident.

In some circumstances, we may agree to make provisional payment of benefits to you, subject to the terms of your cover, and other conditions.

Where you appear to have a right to make a claim for third party compensation in relation to a condition (including where it's caused by an accident), Medibank expects you to make reasonable enquiries to pursue the compensation claim. Medibank may elect not to assess your claim for benefits until you have done so.

You must provide Medibank with timely information and copies of documents relating to any claim you make for compensation from a third party.

If you are paid any Medibank benefits, for a medical condition in respect of which you subsequently receive compensation, you must reimburse Medibank for the benefits paid in relation to that condition.

Medibank Privacy Statement

We collect and use your personal and sensitive information to enable us, other Medibank Group Companies and our third party suppliers and partners to provide you with products and services, including insurance, health-related services and partner offerings, and to give you information on other products and services.

If we do not collect this information, we may not be able to provide you with these services.

We may collect your information from you, another person on your membership, a person authorised to provide us this information on your behalf, another Medibank Group company or a third party.

Where you give us personal information about others, you must ensure that you let them know what information you're giving us and that you have their consent to do so. You should also let them know about this Statement.

We may disclose your personal information to persons or organisations in Australia or overseas, including other Medibank Group Companies, our service providers and professional advisers, health service providers, our suppliers and partners, government agencies, financial institutions, your employer (if you have a corporate product) and your educational institution, migration agent or broker (if you have overseas student health cover or a visitors cover). We may also disclose your information to other persons covered under your policy or your agents and advisers.

We may disclose your personal information overseas to other Medibank Group Companies or third parties who provide services to us including the United States.

Our Privacy Policy contains more information about our privacy practices, including how we use your information and how you may opt-out of receiving promotional material from us. The Policy also details how you may request access to, or correction of, personal information we hold about you, how you can lodge a privacy complaint and how we manage such complaints. You can obtain the latest version of our Privacy Policy by contacting us or by visiting **www.medibank.com.au**

You can also write to our Privacy Officer at: Privacy Officer, Medibank Private Limited, GPO Box 9999 (your capital city) or email **privacy@medibank.com.au**

Private Health Insurance Code of Conduct

Medibank is a signatory to the Private Health Insurance Code of Conduct. The code was developed by the health insurance industry and aims to promote the standards of service to be applied throughout the industry. The code is designed to help you by ensuring that:

- information we provide to you is written in plain language
- Medibank employees are competently trained to deal with your enquiries
- Medibank protects the privacy of your information in line with the Australian Privacy Principles
- you have access to a reliable and free system of addressing complaints with Medibank.

A copy of the code is available online at **www.privatehealth.com.au/codeofconduct**

Private Patients' Hospital Charter

The Private Patients' Hospital Charter is a guide to what it means to be treated as a private patient in hospital. It sets out what you can expect from your doctors, the hospital and your private health insurer.

To download a factsheet about the charter please visit **www.health.gov.au**

Contact Us

At Medibank we value your comments on our products and services. If you have any feedback for us or require further explanation of any matter affecting your membership, you can contact us by:

Phone **132 331**

Mail Medibank Private, GPO Box 9999
in your capital city

In person visiting one of our stores. Visit our website at **www.medibank.com.au/locations/** to find a store near you.

Complaints

At Medibank we aim to resolve all enquiries and concerns the first time you talk to us. If your concern is still unresolved, our Customer Care team is here to help. You'll need to provide us with sufficient information to enable us to investigate your concern.

You can contact our Customer Care team by:

Phone **132 331**

Mail Medibank Private Customer Care,
GPO Box 9999, Melbourne, VIC 3000

If you're still dissatisfied with the outcome of your complaint, or if you have a general question about private health insurance, you can receive free, independent advice from the Private Health Insurance Ombudsman:

Phone **Health Insurance complaints:**
1300 362 072

Health Insurance advice:
1300 737 299

Online **www.ombudsman.gov.au/about/private-health-insurance**

Notes

Talk to us today

132 331

Visit a store today

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call +61 3 8622 5780 if outside Australia

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For Better Health

Private Health Insurance Code of Conduct

Medibank Private is a signatory to the Private Health Insurance Code of Conduct.

The information contained in this guide is current at the time of issue, April 2018. It applies only to Medibank branded products and supersedes all previously published material.

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