

Health insurance
that rewards you for looking after yourself



Important information

August 2011

Important information

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Before you join or transfer your health cover to FIT Health Insurance we recommend you read the following important information.

If you have any questions call 1300 FIT 111 (1300 348 111).

We recommend you contact us for a benefit estimate before commencing any treatment just to confirm the benefit payable. Please retain this member guide with any other FIT Health Insurance documents.

Fit Health Insurance, brought to you by GMHBA Limited ABN: 98 004 417 092

Application for membership with FIT Health Insurance

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

When you complete a membership application it's important that you provide us with all the information requested to allow us to maintain an accurate record of your membership. It is also important that the information you provide is true and correct.

FIT Health Insurance will consider your membership void if you provide false or incorrect information on your membership application and premiums received in advance for coverage beyond the termination date will be refunded. Like most health funds, FIT Health Insurance uses the terms 'fund member', 'spouse/partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'fund member' can authorise changes to the membership unless the fund member has previously authorised the spouse/partner to make such changes.

Similarly, correspondence issued by FIT Health Insurance will be addressed to the fund member and it is the fund member's responsibility to notify FIT Health Insurance of any change of address. The signing of the membership application and the payment of any premium constitutes an acceptance of any conditions laid down in the regulations of the fund in force at that time or as they may be amended from time to time.

FIT Health Insurance reserves the right to refuse admission to membership of any level of health insurance except Base and Base Sport Hospital cover.

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

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

Arrears

FIT Health Insurance fund members are responsible for ensuring their premiums are up to date. Membership will cease when premiums fall into arrears of more than 2 months after the premium due date. To claim benefits a fund member must be financial at the time of incurring the expense for the service or treatment.

Audits

FIT Health Insurance undertakes audit activities in order to protect members' assets and contain costs. From time to time, in the general interest of members, a FIT Health Insurance representative may contact you with a request for assistance to monitor costs - whether relating to benefits paid or charges raised by health care providers. Your co-operation with such requests is critical to our cost containment efforts, and will be treated in a completely confidential manner.

Check your cover

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

How to claim with FIT

1. Hospital Claims - are paid from FIT direct to the hospital. You will need to present your membership card upon admission, and you will not need to contact us in most cases. For claims paid direct to the hospital on your behalf, you will receive a statement of benefit for your records.
2. Extras Claims - When you have extras cover you can use your membership card to claim electronically on the spot when this facility is available at your health care provider. After the service has been provided, your membership card will be swiped through the terminal, your claim details entered and your claim will usually be processed electronically within seconds. Once your claim is authorised you simply pay any difference between the full fee for the treatment and the amount paid by us. If there is an unexpected rejection of your claim at the point of service, your provider should call 1300 FIT 111 (1300 348 111) to clarify the issue at the time of the service taking place.
3. If your service provider does not have an electronic terminal, you will need to pay your account with your service provider in full. Once the services have been paid for, you can claim your benefit online through the Member Services area on our website. To support your claim, you will need to submit a scanned copy of your original receipt by email to

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service@fithealthinsurance.com.au. Alternatively, after you have submitted your claim online, you can send the original receipt by mail to: FIT Health Insurance Claims, PO Box 90, Geelong VIC 3220.

4. In some situations you may not be able to claim online and you will need to submit your claim via mail. You will need to submit your claim via mail if the service occurred more than 6 months before the date of claiming or the services was for orthodontic treatment.

Claiming

Claims may be made by post or by the assignment of your benefit entitlement to a hospital or health care provider. In order to assess your claim and calculate your benefit, FIT Health Insurance needs the following information:

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

You'll also be required to provide an orthodontic treatment plan certificate, completed by the treating orthodontist/dentist is required before orthodontic benefits can commence. You can obtain an orthodontic treatment plan certificate by calling our customer service centre on 1300 FIT 111 (1300 348 111). 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.

- FIT Health Insurance reserves the right to take the following actions against any policy holder or persons where improper, fraudulent or indiscretion occurs whilst making claims against the fund. Actions that may be taken are:
 - Suspension of electronic claiming with the period of time determined by the fund depending on the severity of the incident
 - Restitution (voluntary or negotiated)
 - Prosecution
- No extras benefit will be payable unless a medical reason/condition is present.
- Services for both ancillary and hospital benefits must be validated by clinical notes.

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

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

Unpaid accounts (other than hospital accounts)

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

Paid accounts

Benefits for paid accounts will be paid:

- by cheque, made payable to the fund member for larger claims, and mail claims,
- directly into the members' financial institution account where these arrangements are in place,
- to FIT Health Insurance, where the member requests that the benefit refund is, either in part or full, used to pay FIT Health Insurance premiums.

Medical benefits

Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except in the case of claims made through FIT Health Insurance's medical gap cover) and your claim for hospital benefits has been assessed and paid. FIT Health Insurance benefits are not payable for services rendered when the patient is not a hospital inpatient.

Code of Conduct

FIT Health Insurance is brought to you by GMHBA, a fully compliant member of the private health insurance code of conduct.

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

Development of the codes commenced in 2003 with a committee formed by AHIA and HIRMAA. That committee had broad representation from funds, so the development has had detailed and expert input from a cross-section of the industry and from stakeholders. The Minister for Health and Ageing and the Treasurer have endorsed the Code. The Code is designed to sit beside the current Government acts and regulations within which the industry operates and underlines the intent of the industry to show its commitment to consumers.

The Private Health Insurance Code of Conduct is designed to help you by providing clear information and transparency in your relationships with health insurers. The Code covers four main areas of conduct in private health insurance ensuring:

- You receive the correct information on private health insurance from appropriately trained staff;
- You are aware of the internal and external dispute resolution procedures with 1300 FIT 111 (1300 348 111);
- Policy documentation contains all the information you require to make a fully informed decision about your purchase and all communications between you and 1300 FIT 111 (1300 348 111) are conducted in a way that ensures appropriate information flows between the parties; and
- All information between you and FIT Health Insurance is protected in accordance with national and state privacy principles.

You can download the Code at
“<http://www.privatehealth.com.au/codeofconduct.php>”

Community Rating

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

When making decisions in relation to members, FIT Health Insurance will disregard the following:

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

FIT Rewards

FIT Rewards gives you the chance to earn program exclusive rewards for doing what comes naturally to you... being fit and active. From participating in a fun run or competing in a triathlon to playing your favourite team sport or getting a proper health check, you can earn points through a variety of activities.

Once you have earned points, you can redeem them for some incredible rewards including exclusive access to the AFL, Netball Australia and other national sporting bodies. In addition there will be limited specials and promotions for Money Can't Buy Experiences, like the right to walk on the ground pre matches, attendance at official matchday functions, or even an appearance by an elite player at your local club.

The more points you earn, the quicker you gain access to our fantastic range of sporting rewards.

Damages or compensation

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

Dependants

1. FIT Health Insurance membership

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

Child dependants that do not meet the criteria (of a student dependant) will be terminated off the membership from the date they turned 21. They have 2 months to organise health insurance from this date, however their new membership will commence from the date they turned 21. They won't have to serve waiting periods when transferring to an equivalent or lower level of health insurance.

Student dependants: are covered up until they turn 25 years of age. They have 2 months to organise health insurance from this date however, their new membership will commence from the date they turned 25. They will not be required to serve waiting periods when transferring to an equivalent or lower level of health insurance.

Important information

Student dependants - mid year school/ apprenticeship & traineeship leavers: who transfer from their parent’s FIT Health Insurance membership within 2 months of leaving school or finishing an eligible apprenticeship or traineeship through a registered training group are not required to serve waiting periods when transferring to an equivalent or lower level of cover. A letter from their school or registered training group confirming the date of completion is required.

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

Group Training is an employment and training arrangement whereby an organisation employs apprentices and trainees under an Apprenticeship/ Traineeship Training Contract and places them with host employers. A registered Group Training Organisation undertakes the employer responsibilities for the quality and continuity of the apprentices’ and trainees’ employment and training. To qualify as a traineeship and be eligible to attract Commonwealth Government incentives, there must be a registered training contract between the trainee and the employer. Please contact us on 1300 FIT 111 (1300 348 111).

2. Other funds

Student dependants whose parents are fund members of another registered health fund may join FIT Health Insurance within 2 months of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without serving waiting periods. An acceptable transfer certificate and claims history must be received.

3. Previously uninsured

Previously uninsured dependants may join FIT Health Insurance within 2 months of leaving school or on completion of a full-time apprenticeship/traineeship, and receive immediate Base and Base Sport Hospital cover benefits, except for any pre-existing condition/illness (other than for psychiatric, rehabilitation and palliative care) and maternity cases for which a waiting period of 12 months will apply.

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

Dental

For new memberships with no previous cover or where 12 months continuous cover has not been held, all dental benefits on extras will be limited to \$200 per single or \$400 per couple/family membership during the first 12 months of membership, or \$300 per single or \$600 per couple/family membership on Max Sport Extras.

Item numbers included under Preventative Dental

Item #	ADA Schedule	Simplified definition
011	Comprehensive oral examination	Evaluation of all teeth, also includes recording medical history
012	Periodic oral examination	Follow up consult, records all changes to patients teeth since previous consult
013	Oral examination - limited	A “problem focused” consult done immediately prior to required treatment
014	Consultation	A consult to seek advice/ discuss treatment regarding a specific condition
015	Consultation - extended (30 minutes or more)	A consult to seek advice/ discuss treatment regarding a specific condition which goes for 30 minutes or more
016	Consultation by referral	A consult with a patient referred by a dental or medical practitioner for the management/opinion of a specific dental condition
017	Consultation by referral - extended (30 minutes or more)	A consult with a patient referred by a dental or medical practitioner for the management/ opinion of a specific dental condition which goes for 30 minutes or more
018	Written report (not elsewhere included)	A written report of the patients care
111	Removal of plaque and/or stain	Removal of plaque/stain from all surfaces of the teeth
113	Recontouring of pre-existing restoration(s)	Reshaping/repolishing of existing fillings
114	Removal of calculus - first visit	Removal of tartar from the surfaces of the teeth

Item #	ADA Schedule	Simplified definition
115	Removal of calculus - subsequent visit	Is the follow up consult to remove all tartar from the surfaces of the teeth
121	Topical application of remineralizing and/or cariostatic agents, one treatment	An application of an agent to the surfaces of the teeth eg: calcium salts, fluoride

Excess

FIT Health Insurance's range of hospital covers often feature an excess to let FIT Health Insurance members share some of the cost of hospital admissions in return for lower premiums.

Child dependant excess

No excess applies for child dependants under 21 on FIT Health Insurance's Max and Max Sport Family Single Parents hospital covers listed in the member guide.

Excess - Hospital only

An excess is deducted from the benefit paid by FIT Health Insurance. For example, if FIT Health Insurance's full benefit for a hospital stay was \$5,000 and the member has a \$250 excess on their hospital cover, the benefit would reduce by the amount of the excess and an adjusted benefit of \$4,750 would be paid.

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

No excess applies for child dependants under 21 on FIT Health Insurance's Max and Max Sport Family and Single Parents hospital covers listed in the member guide.

Exclusions

You cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Account/s which have been altered in any way will not be accepted. Providers are required to re-issue any account/s or endorse any alterations.
- Natural remedies (includes Modifast & Optifast).
- Food supplements.
- Dental procedures carried out and charged direct to the fund member/dependant by a dental mechanic, other than an advanced dental technician.

- A range of dental procedures when provided on the same day e.g. a filling on a tooth that has been removed.
- Dental procedures where a limit on the number you can have has been exceeded.
- Dental procedures unless tooth identifications (ID) are supplied by the provider.
- Services/treatment for which the member and/or dependant has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act.
- Services/treatment rendered more than 2 years prior to the date of claiming.
- Where more than one consultation and/or treatment type per day has been claimed regardless of provider within the group of chiropractor (excluding x-ray), naturopath, homeopath and osteopath.
- Where more than one consultation and/or treatment type per day has been claimed regardless of provider within the group of physiotherapy, myotherapy and remedial massage.
- Services/treatment which is not covered by your membership and/or is rendered while the membership is in arrears or is suspended.
- Services/treatment rendered by a practitioner not in private practice and/or not recognised by bodies approved by FIT Health Insurance.
- Services not rendered face to face (e.g. remotely over the phone).
- Foot orthotics provided by a physiotherapist or chiropractor.
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- Treatment is provided to themselves, a member of the providers family and/or to a providers business partner and their family members or any other people not independent from the practice. Family members include: wife/husband, brother/sister, children, parents, grandparents, grandchildren of the provider/business partners' and their spouse/partner.
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment.
- Fund benefits, payable under a hospital or extras cover shall not exceed the fees and/or charges raised for any treatment and/or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source.
- Benefits for services on treatment received overseas.

Important information

Extras services purchased over the internet Benefits will be paid for optical services purchased over the internet from Australian providers where a script is provided. Consistent with current FIT Health Insurance rules, benefits for services on treatment received overseas are excluded.

If things go wrong

Our mission to be your trusted partner in the provision of private health insurance goes beyond providing quality affordable products and high levels of customer service.

While we receive many letters of praise about our products and customer service advisors like any organisation we aren't perfect and on occasions we also receive complaints. We believe that your complaints are of equal or greater importance than praise.

As such we have stringent guidelines in place to ensure we acknowledge you in the most efficient and timely manner.

So, in the unfortunate circumstance that you have a concern or complaint you can contact us through the following channels and can expect an acknowledgement as indicated below:

1. Talk to a FIT Health Insurance representative
You can talk to a representative by calling 1300 FIT 111 (1300 348 111) or emailing service@fithealthinsurance.com.au. We respond to all our phone calls immediately, and will follow up all e-mail and telephone messages within 24 hours.
2. Write to us
We will provide an acknowledgement within 5 working days for written correspondence.
Where the matter is complex we will attempt to finalise within a month. However where the difficulty of the matter precludes this, we will inform you of the progress.
3. Write to the Member Services Review Committee (MSRC)
If after receiving our response you are still not satisfied you can write to the Member Services Review Committee (MSRC). We have appointed a panel of highly experienced employees including Subject Matter Experts, First Line Leaders, a Senior and Executive Manager who meet regularly to discuss any issues received from members. The aim of the MSRC is to listen to you and provide decisions that are fair and equitable for all our members.
You will receive an acknowledgement of your

correspondence within 5 working days of the committee's weekly meeting.
You're welcome to write to the MSRC at PO Box 90 Geelong VIC 3220.

4. Contact our Member Satisfaction Manager
If you require further clarification about the decision made at the MSRC please write to the Member Satisfaction Manager at PO Box 90, Geelong VIC 3220. We will acknowledge your correspondence within 5 days of receipt. Where the matter is complex we will attempt to finalise within a month, however where the complexity of the matter precludes this, we will keep you informed of the progress.

If you're still dissatisfied with the outcome, free independent advice is available from the Private Health Insurance Ombudsman. You can contact the Ombudsman on freecall 1800 640 695 or Suite 2, Level 22, 580 George Street, SYDNEY NSW 2000.

Insure? Not sure?

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

Liabilities of fund members to FIT Health Insurance

A fund member can be liable to FIT Health Insurance for unpaid premiums and for overpayments. Overpayments can be made by FIT Health Insurance 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 FIT Health Insurance on demand.

If a fund member is liable to FIT Health Insurance for unpaid premiums or overpayments then FIT Health Insurance has the right to deduct the amount of that liability from any monies due by FIT Health Insurance to the fund member on any account.

Medicare levy surcharge

The Medicare levy surcharge is a surcharge on individuals and families on higher incomes who don't have eligible private patient hospital cover (eligible cover).

The surcharge is 1% of taxable income in addition to the normal 1.5% Medicare Levy. People may have to pay the Medicare levy surcharge if they or any of their dependants do not have eligible cover and they are:

- A single person - without dependent children - with a taxable income (including any reportable fringe benefits of \$1,000 or more) greater than \$80,000.
- A family - including a couple and single parent - with a combined taxable income (including any reportable fringe benefits of \$1,000 or more) greater than \$160,000 (increasing by \$1,500 per dependent child, after the first child).

Contact your tax adviser or FIT Health Insurance for further details about the Medicare levy surcharge.

Membership card

When you join FIT Health Insurance, you'll receive a membership card that identifies you as a member. The card shows your membership number and who is covered. FIT Health Insurance's contact details are listed on the card. Have your membership card on hand when you arrange admission to hospital, visit a participating provider or when you call FIT Health Insurance with any questions.

A new card may be issued when you make changes to your membership. Please note that an existing card will become invalid whenever a new membership card is issued. Keep your card safe and please advise FIT Health Insurance if your card is lost or stolen.

Membership for non-residents of Australia

FIT Health Insurance hospital covers are designed for people who have full Medicare eligibility. These covers will not meet the cost of public hospital treatment, medical treatment or diagnostic services for people who do not have full Medicare eligibility. Temporary residents of Australia who do not have full Medicare eligibility should contact FIT Health Insurance on 1300 FIT 111 (1300 348 111) to discuss appropriate health insurance arrangements.

Migrants

Migrants who join FIT Health Insurance within 2 months of arriving in Australia shall receive the following concessions:

- No 2 month waiting period for any level of hospital cover.
- No 12 month waiting period for pre-existing conditions/illnesses will apply to Base and Base Sport Hospital cover.

All other waiting periods for hospital and extras will apply.

Proof of residency must be presented to FIT Health Insurance. Lifetime health cover regulations also apply to migrants. Contact FIT Health Insurance for details.

Overseas travel

FIT Health Insurance does not provide benefits for services or treatment received overseas.

FIT Health Insurance 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.

Exclusions – hospital

Exclusions are treatments for a particular condition that are not covered by the policy. Any treatment as a private patient in a public or private hospital will not incur benefits toward hospital or medical costs.

Restricted Benefits

Restricted benefits are benefits paid on treatment as a private patient in a public hospital. Any benefits paid will be at the public hospital rate and will incur considerable out-of-pocket costs if treated in a private hospital for these services.

Benefit Limitation Period

A Benefit Limitation Period (BLP) is a restriction on benefit entitlements for a particular condition or treatment for a set period of time. After that period of time has elapsed you would normally be entitled to full benefits for that condition or treatment. The BLP commences from the date of joining the hospital cover. Hospital claims during the BLP will attract public hospital benefits in a shared room only, providing the appropriate waiting period has been served. Higher benefits will be available after the BLP has been served and the condition or treatment is not excluded or restricted.

Package Cover

Combining FIT Extras and hospital products not only gives you complete peace of mind, but brings with it some great extra benefits along the way. For example, by purchasing a combined product, you'll get up to 80% back on your extras instead of 50% (with all Mid, Max and Max Sport product ranges).

You'll also receive a further 10% on the Physio cost when provided by a Sports Titled or Sports Specialist member of the Australian Physiotherapy Association.

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Benefits	BASE		MID		MAX	
	Benefit	Annual Limits (single)	Benefit	Annual Limits (Single)	Benefit	Annual Limits (Single)
Physiotherapy / Hydrotherapy	50% of cost	\$400	50% of cost 80% of cost if packaged cover.	year 1 \$500 year 2-3 \$520 year 4-5 \$540 year 6-7 \$560 year 8-9 \$580 year 10+ \$600	50% of cost 80% of cost if packaged cover.	year 1 \$700 year 2-3 \$720 year 4-5 \$740 year 6-7 \$760 year 8-9 \$780 year 10+ \$800
Osteopathy Chiropractic Massage Podiatry	50% of cost	\$400	50% of cost 80% of cost if packaged cover.	year 1 \$500 year 2-3 \$520 year 4-5 \$540 year 6-7 \$560 year 8-9 \$580 year 10+ \$600	50% of cost 80% of cost if packaged cover.	year 1 \$700 year 2-3 \$720 year 4-5 \$740 year 6-7 \$760 year 8-9 \$780 year 10+ \$800
Sports Psychology (inc. clinical) Dietitian Exercise Physiology	50% of cost	\$200	50% of cost 80% of cost if packaged cover.	year 1 \$400 year 2-3 \$410 year 4-5 \$420 year 6-7 \$430 year 8-9 \$440 year 10+ \$450	50% of cost 80% of cost if packaged cover.	year 1 \$450 year 2-3 \$460 year 4-5 \$470 year 6-7 \$480 year 8-9 \$490 year 10+ \$500
Acupuncture Naturopathy Myotherapy Homeopathy	50% of cost	\$200	50% of cost 80% of cost if packaged cover.	\$400	50% of cost 80% of cost if packaged cover.	\$450
Preventive Health Assessment ¹	nil	nil	100% of cost	\$100	100% of cost	\$150
Orthotics	nil	nil	80% of cost	\$480	80% of cost	\$480
Optical	50% of cost	\$250	80% of cost	\$250	80% of cost	\$250
Ambulance	50% of cost	\$75	80% of cost	\$75	100% of cost	\$75
Mouth Guards	50% of cost	\$50	80% of cost	\$200	100% of cost	\$250

All calendar year limits shown are based on single membership. These are double for couple, single parent and family. Unless otherwise stated.

1. When provided by either member of AFLMOA (AFL Medical Officers Association), a Sports Titled or Sports Specialist member of the Australian Physiotherapy Association, or other FIT preferred provider. One benefit per person.

Participating providers

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

Details of participating private hospitals can be obtained by calling 1300 FIT 111 (1300 348 111) or from www.fithealthinsurance.com.au

a) Participating private hospitals

1. Max Hospital covers

Members of FIT Health Insurance's Max Hospital covers, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods are entitled to cover for accommodation, theatre, delivery suite, intensive and coronary care and other agreed hospital charges - less any excess (if applicable).

Members should present their FIT Health Insurance membership card when attending a participating private hospital.

Public hospitals: Max Hospital cover provides cover for hospital accommodation costs when you are admitted to a single or shared room (subject to bed availability) as a private patient in a recognised public hospital.

A Benefit Limitation Period (BLP) of 24 months applies to Psychiatric Services and Dialysis for chronic renal failure. Max Hospital can only be purchased with an Extras component (Hospital and Extras).

2. Mid with OBS Hospital cover

This cover has benefit restrictions for a range of services below:

Hospital cover	Benefit exclusions and restrictions
Mid with OBS Hospital	Joint replacement, cataract surgery and corneal transplants, gastric banding, haemodialysis and cosmetic surgery (excluded).
Mid SPORT Hospital	Obstetrics, IVF and related services, joint replacement, cosmetic surgery, cataract surgery and corneal transplants, Haemodialysis, Gastric Banding and Cochlear Ears.

For these services benefits are paid at Public Hospital shared room only.

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

b) Non-participating hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Please contact FIT Health Insurance on 1300 FIT 111 (1300 348 111) for further details.

Members of Max Hospital who are to be admitted to a non-participating private hospital should contact FIT Health Insurance at least 3 business days before admission. FIT Health Insurance will then contact the hospital and negotiate fee and benefit arrangements on the members' behalf with the aim of minimising out-of-pocket costs.

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

3. Base hospital cover

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

This cover has the benefit exclusions for a range of services below:

Hospital cover	Benefit exclusions
Base Hospital	Gastric banding, haemodialysis
Base SPORT Hospital	Obstetrics, IVF and related services, joint replacement, cosmetic surgery, cataract surgery and corneal transplants, Haemodialysis, Gastric Banding and Cochlear Ears.

These services do not attract any benefits.

Please note: Benefits for a single room in a public hospital or for treatment in a private hospital when using Base Hospital cover will result in significant out-of-pocket expenses. For further information on private patient benefits on Base Hospital cover, please call 1300 FIT 111 (1300 348 111) or visit a branch.

Quick hospital cover comparison



Legend

<input checked="" type="checkbox"/>	Public hospital cover as a private patient only (not recommended for private hospital treatment)	<input checked="" type="checkbox"/>	For selected services at participating private hospitals	<input checked="" type="checkbox"/>	Cover provided in participating private hospital	<input checked="" type="checkbox"/>	* 24 month Benefit Limitation Period applies	<input checked="" type="checkbox"/>	No benefits payable
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Out of pocket costs may apply for admissions to non-participating private hospitals. Contact us for details.

Hospital Cover	Base	Base Sport	Mid OBS	Mid Sport	Max	Max Sport
EXCESS OPTIONS	\$250 or \$500	\$250 or \$500	\$250 or \$500	\$250 or \$500	No excess, \$250 or \$500	No excess, \$250 or \$500
Medical Gap Cover (up to 120% of MBS fee and 100% off MBS fee for pathology/radiology)	✓	✓	✓	✓	✓	✓
Higher Medical Benefits for injuries more likely to occur playing sport	✗	✗	✗	✗	✗	✓
Higher Medical Benefits when referred by a member of the AFLMOA	✗	✗	✗	✓	✗	✓
Accident	☑	☑	✓	☑	✓	✓
Private Hospital Accommodation - Private Room	✗	☑	✓	☑	✓	✓
Private Hospital Accommodation - Shared Room	✗	☑	✓	☑	✓	✓
Public Hospital Accommodation - Private Room	✗	☑	✓	☑	✓	✓
Public Hospital Accommodation - Shared Room	☑	✓	✓	☑	✓	✓
Private Hospital Accommodation - Day Stay	✗	☑	✓	✓	✓	✓
Admission excess waiver for child dependents	✗	✗	✗	✗	✓	✓
Cataract Surgery	☑	✗	✗	☑	✓	✓
Cosmetic Surgery (where MBS item applies)	☑	✗	✗	☑	✓	✓
Delivery Suite	☑	✗	✓	☑	✓	✓
Intensive & Coronary Care	☑	✓	✓	☑	✓	✓
IVF & related services	☑	✗	✓	☑	✓	✓
Joint Reconstruction	☑	✓	✓	☑	✓	✓
Joint Replacement	☑	✗	✗	☑	✓	✓
Nursing Home Cover	☑	✓	✓	☑	✓	✓
Obstetrics	☑	✗	✓	☑	✓	✓
Psychiatric	☑	☑	✓*	☑	✓*	✓*
Rehabilitation	☑	✓	✓	☑	✓	✓
Same Day Treatment	☑	☑	✓	✓	✓	✓
Surgically implanted prosthesis	✓	✓	✓	✓	✓	✓
Theatre	☑	✓	✓	☑	✓	✓
Corneal Surgery	☑	✗	✗	☑	✓	✓
Haemodialysis	✗	✗	✗	☑	✓	✓
Gastric banding	✗	✗	✗	☑	✓	✓
Cochlear ears	☑	✗	✓	☑	✓	✓

Important information

Payment in advance

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

Pre-existing conditions (PEC)

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

The only person authorised to decide that a condition is pre-existing is the medical practitioner appointed by FIT Health Insurance. However, the fund medical practitioner must consider any information regarding signs and symptoms provided by your treating medical practitioner/s.

The pre-existing condition rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital cover.

The only test is whether or not, in the 6 months prior to joining your current hospital table signs and symptoms:

- were evident to you or,
- would have been evident to a reasonable general practitioner if a general practitioner had been consulted.

When to contact FIT Health Insurance

If you have less than 12 months membership on your current hospital cover, make sure you contact us before you are admitted to hospital and find out whether the pre-existing condition waiting period applies to you. We need about 5 working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioner/s. Make sure you allow for this time frame when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and we subsequently determine your condition to be pre-existing, you'll have to pay all outstanding hospital charges and medical charges not covered by Medicare.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently if you have less than 12 months membership on your current hospital cover you might have to pay for some or all of the hospital and medical charges if:

- you are admitted to hospital and you choose to be treated as a private patient; and

- we later determine that your condition was pre-existing.

Privacy

We value the relationship between FIT Health Insurance and our members. An important part of this relationship is our commitment to protecting the personal information entrusted to us by our members.

This commitment is documented in our privacy policy and summarised in our privacy brochure. You can pick up a copy of our privacy brochure by calling 1300 FIT 111 (1300 348 111) or by visiting www.fithealthinsurance.com.au

Proof of age

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

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

Recommendation or endorsement

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

Refunds

You may cancel your FIT Health Insurance membership from:

- the date you notify FIT Health Insurance, in writing of the cancellation (a transfer certificate will be provided to the insured person within 14 days of request) or your current premium due date, whichever is earlier
- within 60 days of joining and get a full refund of any premiums received provided you have not made a claim.

Replacement rule

A benefit replacement rule applies to items/services covered by FIT Health Insurance's extras covers. The rule requires that after you claim for such an item, you must wait a specified period of time before you can lodge another claim for the same type of item. The replacement rule applies to dentures only.

Restrictions

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

- you have already claimed the maximum allowable benefits during a specified period.
- you have transferred to FIT Health Insurance from another fund and have previously claimed for the service/treatment.
- the health care account has been incompletely, incorrectly or inappropriately itemised.
- you have an excess to pay on your chosen level of cover.
- the fund believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care after 35 days continuous hospitalisation, FIT Health Insurance benefits will be reduced to Nursing Home Type Patients benefits and will be paid in accordance with the default benefit determined by the Health Department. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.
- the service/s is subject to a waiting period or other limit.
- surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact FIT Health Insurance for details.
- when no MBS item number is provided by the GP/specialist e.g. cosmetic surgery.
- where professional services are provided to themselves, the provider or members of the provider's family or to a provider's business partner's family members or any other people not independent from the practice, only wholesale material costs involved in the provision of the service are subject to benefits.
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.

Standard Information Statements

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

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

A newly insured member will be given an up to date copy of the relevant SIS, details about what the policy covers and how benefits are provided and a statement identifying the referable health benefits funds when they join.

State of the health funds report

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

A copy of this report can be downloaded from www.phio.org.au

Suspension

You can suspend your FIT Health Insurance membership for periods of overseas travel provided you:

- have at least 12 months continuous unsuspended membership with FIT Health Insurance prior to departure, and,
- plan to be overseas for at least 2 months, and,
- have paid premiums to the date of departure, and
- apply for suspension of your membership prior to departure.

You'll be required to resume your suspended membership within 2 months of returning to Australia and premiums must be paid from the date of re-entry. Your passport, boarding pass or a statutory declaration may be required to be presented to FIT Health Insurance as proof of travel.

A 3 year maximum cover suspension period for overseas travel applies. Only the balance of outstanding waiting and benefit limitation periods need to be served upon resumption of your membership.

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

Transferring from another health fund

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

- have served all waiting periods with your previous fund and,
- transfer to any equivalent or lower level of cover providing you transfer within 30 days of your membership ceasing with your previous fund and,
- provide FIT Health Insurance with an acceptable transfer certificate and claims history issued by your previous fund within 7 days of transferring your cover.

FIT Health Insurance recommends that your cover starts immediately after your previous cover ends. If your new cover with FIT Health Insurance provides higher benefits or benefits for services not covered by your previous fund, you'll be regarded as a new member for those higher benefits, and/or additional services and will be required to serve the waiting periods - but only for the higher benefits/additional services.

If you transfer to FIT Health Insurance from another fund before completing the waiting and benefit limitation periods with your previous fund, you'll need to serve the balance of the waiting and benefit limitation periods with FIT Health Insurance.

When you transfer to FIT Health Insurance your benefit entitlements may be adjusted by benefits already paid by your previous fund. Under lifetime health cover, continuity of a member's/partner's certified age at entry (CAE) is possible when transferring from another Australian registered health fund.

Waiting periods

Waiting periods exist to protect members from claims made by those who join the fund or increase their level of cover because they have a condition or illness that may require treatment.

Waiting periods will apply to:

- New memberships (previously uninsured),
- Additions to a membership (unless the addition/s has already served all waiting periods with FIT Health Insurance or another fund) except newborns, adopted and permanent foster children where the family membership has been in existence for at least 2 months, and where the addition/s has already served all waiting periods with FIT Health Insurance or another fund,
- Existing FIT Health Insurance memberships, and transfers to FIT Health Insurance from another fund where:
 - i the level of cover and/or benefit entitlement is upgraded or increased;
 - ii any hospital or extras service was not covered by the previous fund and/or;
 - iii the waiting and benefit limitation periods have not been completed.

For new extras memberships (no previous extras cover) or where a member has not had 12 months continuous dental cover prior to joining FIT Health Insurance, all dental benefits on Base Sport and Mid Sport Extras will be limited to: \$200 per person/single membership and \$400 per family membership and Max Sport Extras: \$300 per person/single membership and \$600 per family membership, during the first 12 months of membership with FIT Health Insurance.

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

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

- 12 months - obstetric or pre-existing condition (other than for psychiatric, rehabilitation or palliative care).
- 2 months - Psychiatric, rehabilitation or palliative care.
- 2 months - Any other benefit for hospital (or hospital substitution) treatment.
- 12 months - Major dental and orthotic appliances
- 6 months - Optical benefits
- 2 months - Any other extras benefit.



Important information

The above waiting periods also apply to previously uninsured members.

For treatment that was covered under the old policy, at the same or higher level than the new policy, waiting periods are no longer than the balance of any unexpired waiting period for the benefit that applied to the person under the policy.

For treatment that was covered under the old policy but at a lower level, the member is entitled to the lower benefits on their old cover during the waiting period. Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover during the waiting period.

Waiting periods – Pre-existing condition (PEC)

A special waiting period applies to obtain benefits for hospital treatment for new members who have pre-existing conditions. The waiting period also applies to existing members who have recently upgraded their level of hospital cover.

If the ailment, illness or condition is considered pre-existing:

- new members must wait 12 months for any hospital benefits (other than psychiatric, rehabilitation and palliative care).
- members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits (other than psychiatric, rehabilitation and palliative care).

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover.

Planning a child

If you are preparing to start a family and your hospital cover does not include obstetrics, you will need to ensure you upgrade your hospital cover to include obstetrics at least 12 months before you have a child to ensure all waiting periods have been served.

If all goes well, a new born baby is not admitted as a patient in hospital, but if you have complications and your baby requires any accommodation or medical attention, you will not be covered for accommodation or medical services unless your child has served the waiting period. So, if you are currently on a singles membership, you will need to change to a family

membership at least two months before your baby is born. FIT Health Insurance recommends that you change to family membership three months before your baby is due, (you can add an unborn child as an additional person) in case your baby arrives prematurely.

Contact us

If you need to chat to us about anything you're not sure of, it's easy. Call 1300 FIT 111 (1300 348 111) to speak with one of our friendly customer service reps, email service@fithealthinsurance.com.au or visit us at www.fithealthinsurance.com.au

FIT is easy to join. There are no waiting periods if you switch to FIT from another health fund as long as you are on an equivalent level of cover and served all your waiting periods. Fill in the application form following on and send it to:

FIT Health Insurance

PO Box 90

GEELONG VIC 3220

