Your Guide to Extras Cover

This is an important document. Please read it carefully and retain for future reference.

Effective: 1 July 2017
Getting the most from your extras cover

Extras cover includes healthcare services not covered by Medicare such as dental, optical and physiotherapy.

Depending on your level of cover, we pay benefits on a wide range of services and treatments including:

- general dental
- major dental
- optical appliances
- remedial massage
- myotherapy
- physiotherapy
- mental health
- health management
- pregnancy care
- audiology

Your extras benefits are paid per calendar year, except for optical, orthodontic and aids/appliances benefits.

Our most popular extras benefits on our Essential and Total Extras Cover

- 100% cover on general dental checkups
  up to twice a year on Essential Extras

- Mental health benefits across all levels of cover

- $500 optical limit
  over 2 years

- No preferred provider arrangements

Did you know?

You can view your claim history and remaining benefits through Online Member Services.

Register at www.doctorshealthfund.com.au/OMS

The next few pages of this guide provide the detail you need to understand for your choice of extras including what waiting periods may apply before you can make a claim.

Take the time to go through this guide and call us on 1800 226 126 or email at info@doctorshealthfund.com.au if you have any questions or wish to review your cover.
Total Extras Cover

This is a comprehensive extras cover including a range of major dental services benefits and high annual claim limits per person.

Waiting periods apply if you are new to extras cover or if you are switching from a lower level of extras cover

- 24 months for hearing aids
- 12 months for major dental services, aids and appliances
- 2 months for all other services

Limits:
- Limits apply per person per calendar year except where otherwise stated

<table>
<thead>
<tr>
<th>Included Services and Treatments</th>
<th>Annual Limits Per Person</th>
<th>Benefits Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>General dental services</td>
<td>No limits</td>
<td>100% of the cost of check-ups, fissure sealings and bitewing x-rays where the fees are within the range of usual, customary and reasonable charges. Fixed benefits paid for all other items. Check-ups limited to an examination, fluoride and a scale and clean.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examination items 011 to 017, Fluoride treatment item 121, Scale &amp; Clean items 111, 114 and 115</td>
</tr>
<tr>
<td>Major dental services</td>
<td>$1,000</td>
<td>Fixed benefits paid per item</td>
</tr>
<tr>
<td>Endodontic/periodontics</td>
<td>$1,000</td>
<td>100% of the cost of orthodontics</td>
</tr>
<tr>
<td>Crowns &amp; bridges</td>
<td>$1,200</td>
<td>With a lifetime limit of $3,000 accrued at $600 per year of membership</td>
</tr>
<tr>
<td>Dentures &amp; prosthodontics</td>
<td>$1,000</td>
<td>$500 limit over any 2 consecutive calendar years i.e. claims made in the current and prior year cannot exceed $500</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>$1,000</td>
<td>No sub-limits apply. Use the full $500 for your choice of frames, lenses or contact lenses. 100% of the cost of optical appliances</td>
</tr>
<tr>
<td>Optical appliances</td>
<td>$500</td>
<td>Included in $500 optical limit</td>
</tr>
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<tr>
<td>Non-PBS pharmaceuticals, immunisations, mammograms, ThinPrep tests, bone density tests</td>
<td>$600</td>
<td>85% of the cost covered above the PBS $60 per test</td>
</tr>
<tr>
<td>One hearing aid</td>
<td>$800</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Two hearing aids</td>
<td>$1,600</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Hearing aid repairs</td>
<td>$50</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Audiology test</td>
<td>$60</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Total service limit of $700</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Occupational &amp; speech therapy</td>
<td>$600</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Podiatry, dietetics &amp; orthoptics</td>
<td>$45 per visit</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Remedial massage &amp; myotherapy</td>
<td>$40 per visit</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Mental health services (with a registered mental health practitioner)</td>
<td>$100 per visit</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Podiatry, dietetics &amp; orthoptics</td>
<td>$40 per visit</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Home nursing</td>
<td>$30 per visit of up to 6 hrs $60 per visit exceeding 6 hrs</td>
<td></td>
</tr>
<tr>
<td>Aids &amp; appliances</td>
<td>$1,000</td>
<td>75% of the cost where the use of the item was prescribed by a registered health practitioner for a health condition</td>
</tr>
<tr>
<td>Health management programs</td>
<td>$200 per person per calendar year up to $400 per policy for family/couple/single parent policies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of the cost</td>
<td></td>
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</tbody>
</table>
Essential Extras Cover

This is a mid level cover with a substantial range of benefits including optical cover that is exceptional for extras insurance at this level.

**Waiting periods apply**
- 24 months for hearing aids
- 12 months for major dental services, aids and appliances
- 2 months for all other services

**Limits**
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<tr>
<td>General dental services</td>
<td>Combined limit with Major Dental of $800</td>
<td>100% of the cost of check-ups, up to two times per year, and fissure sealings where the fees are within the range of usual, customary and reasonable charges. Fixed benefits apply to additional check-ups and all other items. Check-ups limited to an examination, fluoride and a scale and clean. Examination items 011 to 017, Fluoride treatment item 121, Scale &amp; Clean items 111, 114 and 115</td>
</tr>
<tr>
<td>Major dental services</td>
<td>Combined limit with General dental services of $800 Orthodontic services to a lifetime limit of $1,250 accrued at $250 per year of membership</td>
<td>100% of the cost of orthodontics Fixed benefits paid per item</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>$500 limit over any 2 consecutive calendar years. Claims made in the current and prior year cannot exceed $500</td>
<td>No sub-limits apply. Use the full $500 for your choice of frames, lenses or contact lenses. 100% of the cost of optical appliances</td>
</tr>
<tr>
<td>Optical appliances</td>
<td>Included in $500 optical limit</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Included Services and Treatments**

- Non-PBS pharmaceuticals, immunisations, mammograms, Thinprep tests, bone density tests: $300 limit One of each test per person per year 85% of the cost covered above the PBS. $60 per test
- Mental health services
- Occupational & speech therapy
- Physiotherapy - Individual - Group - Hydrotherapy
- Podiatry, Dietetics & orthoptics
- Pregnancy care services, remedial massage & myotherapy: Total service limit of $900 Sub-limits of $500 per type of therapy
- Aids & appliances including hearing aids: $500 One set of hearing aids every 3 calendar years For Fund approved consumable items, benefit paid twice per calendar year For Fund approved non-consumable items, benefits paid once every 2 years 75% of the cost where the use of the item was prescribed by a registered health practitioner for a health condition (except hearing aids) One hearing aid $200 Two hearing aids $400 Hearing aid repairs $50
Basic Extras Cover

This is an entry level cover for those starting out in health insurance. It is only available to singles and couples in combination with Smart Starter hospital cover.

Waiting periods apply
- 12 months for aids and appliances
- 2 months for all other services

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<tr>
<td>General dental services (excludes tooth whitening and oral surgery)</td>
<td>$500</td>
<td>100% of the cost for the first check-up, 50% of the cost for subsequent check-ups and other dental services, where the fees are within the range of usual, customary and reasonable charges. Check-ups limited to an examination, fluoride and a scale and clean</td>
</tr>
<tr>
<td>Optical appliances</td>
<td>$150</td>
<td>No sub-limits apply Use the full $150 for your choice of frames, lenses or contact lenses. 100% of the cost of optical appliances</td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td>$80 per visit</td>
</tr>
<tr>
<td>Physiotherapy - Individual</td>
<td></td>
<td>$35 per visit</td>
</tr>
<tr>
<td>- Group</td>
<td></td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Speech &amp; occupational therapy</td>
<td>Total service limit of $400</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Podiatry, dietetics &amp; orthoptics</td>
<td></td>
<td>$30 per visit</td>
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<tr>
<td>Remedial massage &amp; myotherapy</td>
<td></td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Aids &amp; appliances</td>
<td>Combined limit with Non PBS pharmaceuticals of $150</td>
<td>75% of the cost of the item where the use of the item was prescribed by a registered health practitioner for a health condition</td>
</tr>
<tr>
<td>Non-PBS pharmaceuticals</td>
<td>Combined limit with aids &amp; appliances of $150</td>
<td>85% of the cost covered above the PBS</td>
</tr>
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Health Management Programs

Health Management Programs are only available under Total Extras. They are treatments intended to manage a member’s specific health condition.

This is a condition that’s been diagnosed by your ordinary registered medical practitioner, who is not related to you.

Examples of specific health conditions are asthma, arthritis, unhealthy BMI, high blood pressure and muscular skeletal disorders. Core strengthening, flexibility and wellness are not examples of a specific health condition.

There are strict legal requirements about what can, and cannot, be a Health Management Program under a health insurance product. For example, personal training to reduce an obese member’s BMI would likely be considered a Health Management Program, while a member with a healthy BMI (and no other specific health condition) would be ineligible to claim.

The current treatments recognised by Doctors’ Health Fund as Health Management Program services (not goods) are:

- Exercise physiology
- Quit Smoking
- Acupuncture
- Weight loss classes
- Exercise classes conducted at a gym or by a personal trainer
- Class physiotherapy

Health Management Programs must be delivered by appropriately trained individuals with current registration, with a national association, to perform the treatment. Exercise physiologists and Royal Australian College of General Practitioner acupuncturists must have a current Medicare provider number before we can provide a benefit.

Health Management Programs are not claimable through HICAPS but can be claimed through our mobile app.

Remedial Massage and Myotherapy

For us to pay benefits for remedial massage and myotherapy services the provider must either be a registered physiotherapist or have accreditation in remedial massage therapy or myotherapy with an organisation that adheres to the Private Health Insurance (Accreditation) Rules 2011.

Doctors’ Health Fund recognises remedial massage therapists & myotherapists limited to

- ATMS (Australian Traditional Medicine Society)
- AMT (Association of Massage Therapists)
- AAMT (Australian Association of Massage Therapists)
- ANTA (Australian Naturopathic Practitioners’ Association)
- IRMA (Institute of Registered Myotherapists of Australia)
- ARM (Association of Remedial Masseurs)

If you are unsure whether your provider is covered, please call our Member Service Team on 1800 226 126.
Aids and Appliances

All our extras covers have benefits for aids and appliances which includes items like a CPAP machine or a blood glucose monitor. The aid or appliance you want to claim must be approved by us.

Aids and appliances are only eligible to be claimed when a registered health professional provides written support of your claim.

Orthodontics

Orthodontics is a branch of dentistry concerned with the diagnosis, prevention and treatment of problems with the alignment of the teeth and jaws. Orthodontic services are available on Total and Essential Extras only and are subject to a lifetime limit, annual limits and annual sub limits which vary depending on your level of cover.

A Lifetime Limit is the maximum benefit payable for a particular service for the lifetime of the member. Any orthodontic claims you have made, even if you have transferred to a new insurer, will be deducted from your policy’s lifetime limit.

Orthodontic treatment may involve:
- Custom made appliances e.g. to change the jaw shape
- Braces or aligners to straighten the teeth
- The fitting of a retainer to maintain the position of the teeth once the braces are removed

To receive the correct benefit, you need to provide us with the dental item numbers from the Australian Schedule of Dental Services and Glossary – your dentist can provide these to you.

Please note that no benefit is paid before the treatment takes place, even if you choose to pay for your orthodontic treatments in advance or via a treatment plan. Benefits for braces and aligners can only be paid once the braces or aligners are in place.

If you are planning orthodontic work please contact us and we can help you determine what you’re covered for.

How to claim

The most popular and convenient way to submit your extras claim is through HICAPS. Ask your extras providers if they are connected to HICAPS. If they are, they can process your claim on the spot, and you only pay them any difference between the amount of the claim and the amount of their bill.

There are a range of other ways you can make a valid claim for extras:

- Doctors’ Health Fund mobile app;
- Email to info@doctorshealthfund.com.au; or
- Post (PO Box Q1749, Queen Victoria Building, Sydney NSW 1230).

Claims that are submitted by email or post must include a valid claim form which can be downloaded from www.doctorshealthfund.com.au

Doctors’ Health Fund does not provide benefits on any level of extras cover for services that are not medically proven. This includes chiropractic, natural therapies or exercise physiology and acupuncture when it is not part of a health management program.
Claims for extras are **not** payable where:

- they are submitted more than 2 years after the date of service of the claimed treatment;
- the provider is not qualified to supply the treatment under the Fund Rules;
- more than one ‘like’ treatment is claimed for the same date of service (e.g. massage and physiotherapy are not payable on the same day);
- the patient and the treating practitioner are related;
- the policy is unfinancial or suspended at the date of service;
- the relevant waiting periods have not been served at the date of service;
- an amount is, or a right exists for an amount to be, paid or payable from a third party;
- the service was for health screening, superannuation entry or employer requested health check;
- false or inaccurate information is supplied;
- the service is excluded or restricted on your cover;
- you have exceeded the relevant claims limits on your cover;
- the date of service was prior to the patient joining the fund, or after the patient left the fund;
- the treatment or appliance was supplied outside of Australia;
- aids, appliances, glasses, contacts, pharmaceuticals or hearing aids are not accompanied by a prescription from the patient’s ordinary practitioner;
- the treatment does not meet the standards and requirements of the Private Health Insurance Act 2007 or its associated instruments;
- the treatment was not delivered in person;
- a treatment was supplied whilst an in-patient in hospital;
- an ailment, illness or condition is not being treated, managed or cured;
- the treatment has not yet been supplied;
- there was no legally enforceable debt for the supply of the treatment.