

# Extras Cover

*(When you don't have an rt hospital cover)*

Read more about your extras cover in our online A to Z guide  
[www.rthealthfund.com.au/atozofrt.html](http://www.rthealthfund.com.au/atozofrt.html).

## Our top-level extras cover

Our Extras Cover comes in two slightly different varieties – if you have Extras together with our Private or Basic Hospital Cover, then you get our top level of benefits. If you have Extras on its own, then you have restrictions on a couple of different benefits for dental and specialist therapies, please make sure you understand what these benefit restrictions are.

## Your Extras Cover pays benefits when:

- the service is provided in Australia,
- by a recognised provider,
- after all applicable waiting periods have been served, and
- where the treatment is necessary or appropriate to the condition.

## What are you covered for?

Over the page we've listed most things you can claim under your Extras Cover, including your annual limits and how much you'll get back for each product, service or treatment. Please be aware that some additional benefit limitations apply when you have Extras Cover without an rt hospital cover, these apply to dental and specialist therapies – higher benefits are available when you have both hospital and extras together.

**Annual limits** – an annual limit is the total amount that can be claimed for a particular item in a calendar year. Most limits are 'per person' (which means each person on the membership can claim up to that amount), but there are one or two 'family limits' (which are combined limits shared by everyone on the membership). The table over the page shows what the limits are and whether they apply per person or per family.

On 31 December each year any unused annual limits expire, and they reset again on 1 January. It is not possible to rollover any unused limits, or to transfer limits between people covered by the membership.

**Registered providers** – benefits are only paid for healthcare services provided by appropriately qualified practitioners, we refer to these as 'registered providers'. As a general guide, we will pay benefits for healthcare services provided by:

- Dentists registered with the Australian Dental Association
- Registered optometrists or ophthalmologists
- Licensed optical dispensers
- Natural therapists registered with the Australian Regional Health Group

The reason we have registered providers is to ensure that our members are receiving healthcare from appropriately qualified practitioners. Unlike doctors and hospitals, which are monitored by Medicare, there is no one body that ensures only qualified, skilled and experienced practitioners provide the types of treatments covered by Extras. By only paying benefits for services provided by registered providers we help to ensure that our members are receiving care from properly qualified people.

Unlike some health funds, we don't think it's our role to tell our members who can and can't treat them, so we don't try to encourage you to only go to our favourite providers. With us, as long as your provider is registered (which simply means that they have been able to demonstrate the appropriate credentials), then you're covered for the services they provide.

**Dental benefits** – this is a particularly tricky area as every dental procedure and part has an item number associated with it, and every item number has a set benefit – and there are hundreds and hundreds of different dental item numbers. The best way to find out how much you're covered for is to ask your dentist for the item numbers of the services you'll be receiving and then give our member care team a call to have them calculate the benefit for you.

## How does it work?

First, make sure that the product, service or treatment you're planning to claim is covered. If you're not 100% certain, please ask us. We can also let you know how much you're likely to get back too, so there'll be no surprises.

When you're ready to make a claim, there are a couple of different ways you can go about it:

**Use your rt membership card for on-the-spot claiming with HICAPS or iSOFT.** If your practitioner offers this service, they'll swipe your card through a special terminal when you're about to pay your bill. The information gets sent directly to us, and the claim is lodged right there on the spot. All you pay is any difference between the amount of your rt rebate and the cost of the treatment.

This type of claiming is often available through dentists, optometrists, physiotherapists, chiropractors, osteopaths, podiatrists, speech pathologists, occupational therapists, psychologists, dietitians, remedial massage therapists, naturopaths and acupuncturists. Ask your practitioner when you make your appointment if they offer electronic claiming, and visit the HICAPS and iSOFT websites for more information, [www.hicaps.com.au](http://www.hicaps.com.au) and [www.ibahealth.com](http://www.ibahealth.com).

**Send us a claim form.** If on-the-spot claiming is not available, then you do it the old fashioned way: fill in a claim form, send us your receipts or account, and we'll send you a cheque – or even better – drop the money straight into your bank account. You can nominate a bank account for payments to be made into when you complete your claim form, or online anytime through our online member centre.

You have up to two years from the date of service to lodge your claim.

## Waiting periods

When you first take out extras cover, rejoin after letting your cover lapse, or when you upgrade to a higher level of cover, you are required to serve waiting periods. This means you have to be a member for a certain period of time before you can claim for some services.

The waiting periods that apply to your Extras Cover are all listed on the table over the page.

**Australian Financial Review's *Smart Investor* magazine has named our Private Hospital + Extras Cover among the best-value health cover packages offered by any health fund in the country for two years running (2008 and 2009).**

## Extras Cover Only (when not taken together with either Private or Basic Hospital Cover)

Here's what you're covered for:

Service	Benefit for each purchase, service or treatment		Annual limit (limits are per person unless otherwise shown)	Waiting Period
<b>General dental</b>			max 6 extractions and 8 fillings	2 months
<b>Major dental – endodontics</b>	Each general and major dental item has a set benefit. Please call our member care team with the item number of the service you're having and we'll let you know how much you'll be getting back.		\$600	\$625 combined limit (\$1,250 combined family limit) sub-limits apply for major dental
– crowns and bridges			\$1,200	
– dentures			\$800 every three years	
– periodontics			\$500	
– occlusal therapy			\$300	
<b>Orthodontics – all orthodontic treatment</b>	70% of the cost		\$1,000 (\$3,000 lifetime limit)	12 months
<b>Optical – all prescription frames, lenses and contact lenses, including prescription sunglasses and Irlen lenses</b>	length of time extras cover held	1-4 years 75% of cost 5+ years 100% of cost	\$300	3 months
<b>Specialist therapies – physiotherapy, occupational therapy, speech therapy, orthoptics, chiropractic, osteopathic, podiatry</b>	Initial consultation \$40 Subsequent consultations \$35		\$500 combined limit (\$1,000 combined family limit) sub-limits apply	2 months
– psychology	Initial consultation \$60 Subsequent consultations \$35		\$500	2 months
– hypnotherapy	Initial consultation \$50 Subsequent consultations \$35			
– audiology	\$80 per consultation		\$160	
– dietetics	\$35 per consultation		\$500	
– pharmaceuticals	Up to \$70 per prescription		\$600	
– vaccines	Up to \$50 per vaccine		\$150	
<b>Alternative therapies – acupuncture</b>	Initial consultation \$40 Subsequent consultations \$35 Note: if acupuncture is performed by a general practitioner, and you are given a receipt with the item number 173 on it, you can claim this service through Medicare.		\$750 combined limit	2 months
– aromatherapy, bower therapy, reflexology, remedial massage, shiatsu, swedish massage	Initial consultation \$25 Subsequent consultations \$25			
– chinese medicine, herbal medicine, homeopathy, iridology, myotherapy, naturopathy	Initial consultation \$35 Subsequent consultations \$30 Note: benefits for chinese medicine and herbal medicine are for consultations only. No benefits are payable for any medicines or remedies purchased.			
<b>Health services – home nursing</b>	\$30 per visit		\$700	\$1,400 combined limit
	\$80 per day			
– midwife	\$30 per visit		\$300	
	\$330 per delivery		\$330	
– hearing aid repairs	100% of the cost		\$100	2 months
– school accidents	100% of the cost		\$750	Please speak with our member care team for details about when these benefits are payable, 1300 886 123.
– travel expenses	Up to \$60 per round trip		\$250 (\$500 family limit)	
– accommodation expenses	Up to \$40 per night		\$300 (\$600 family limit)	
<b>Health aids – orthotics – custom-made</b>			\$150	\$1,600 combined limit
– orthopaedic shoes – custom-made			\$250	
– orthopaedic shoes – non custom-made (with a referral from a podiatrist)	100% of the cost		\$200 every 2 years	
– artificial eyes, artificial limbs, crutches (hire or purchase), wheelchairs, wigs, blood glucose monitors, nebulisers, braces and splints, blood pressure monitors, external breast prostheses, CPAP and BPAP machines, compression garments, oral appliance (dental item numbers 983 and 984), TENS machine, oxygen cylinders	80% of the cost Please note: no benefits are payable for consumables used in conjunction with any of these items.		\$600 per item	
– hearing aids	100% of the cost		\$1,200, every 3 years max \$600 per hearing aid	24 months



Effective 1 April 2010. Fund rules and policies are subject to change without notice. If a change will adversely affect your membership and/or benefits, we will notify you in writing. Depending on the issue, this may be through a personally addressed letter, via email or through our member magazine, *be well*.