1 April 2017

Value Extras

Value Extras is our lowest level extras cover, which gives you benefits on a range of services for your health and wellbeing. The cost of this cover is reduced by excluding a number of different treatment types, offering a lower level of benefits than our other extras covers, and applying maximum 'per membership' annual limits. If you are interested in a higher level of cover, please speak with our team about the options available.

What does Value Extras cover you for?

Over the page, you'll find a comprehensive list of the products, services and treatments you can claim under your Value Extras cover. For most items shown, you will also see:

- the maximum benefit you can receive each time you make a claim
- the maximum benefit you can receive each year for the different things you are covered for
- information about whether the maximum annual benefits apply across your whole membership or to each person covered by the membership
- the waiting periods that apply before you can make a claim.

Because your Value Extras cover pays you benefits on a vast number of different products, services and treatments, it's not possible to list them all, particularly when it comes to individual dental items. Every dental procedure has an item number associated with it, and every item number has a set benefit – there are thousands of different dental item numbers. The best way to find out how much you're going to get back on a dental claim 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.

If you're planning to use your extras cover and you would like to know in advance how much you'll get back when you make your claim, please feel free to ask our team.

There are a few important things to understand about how your Value Extras cover works

1. Annual limits

Each type of product, service or treatment has an 'annual limit.' This is the total amount that can be claimed for that particular item in a calendar year.

With Value Extras, most annual limits are shown 'per person' and 'per membership.' This means that any one person covered by the membership can claim up to the 'per person' limit, however, together, everyone covered by the membership can only claim up to the 'per membership' amount. This is relevant for people with family memberships who may wish to claim for a particular type of health care service for multiple people, because not everyone covered will be entitled to claim the 'per person' limit. Please speak with our team if you have any questions about how 'per membership' benefit limits are applied, and if you are interested in a higher level of cover that imposes fewer 'per membership' limits.

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

2. Registered providers

Benefits are only paid for products, services or treatments provided to you by appropriately qualified practitioners. These are called 'registered providers.'

As a general rule, registered providers include:
Dentists registered with AHPRA (Australian Health Practitioner Regulation Agency)
Registered optometrists or ophthalmologists
Licensed optical dispensers
Natural therapists registered with the Australian Regional Health Group.

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 on services you receive from registered providers, we help to ensure that you receive care from properly qualified people.

3. Products, services or treatments purchased in Australia

Health funds are only permitted to pay benefits for products, services or treatments that are purchased in Australia. If you purchase something overseas; order it online and the transaction takes place overseas; or have a treatment or procedure overseas, you are not able to claim benefits for it under your extras cover.

Please be aware that some overseas online providers may appear to be based in Australia. If you contact us with the name of the provider and the provider number before ordering products online, we can let you know if your purchase will be eligible for a benefit.

4. Claiming costs through Medicare and your extras cover

A limited number of extras treatment types can be provided by practitioners with a Medicare provider number, and costs for these services can be claimed under Medicare. You are not able to claim costs for the same treatment from both Medicare and your extras cover.

How do you make an extras cover claim?

1. Make sure that the product, service or treatment you're planning to claim is covered

If you're not 100% certain, please ask us. If it's something you've claimed before, but it's been a while since your last claim, check with us to make sure nothing has changed. We can let you know how much you're going to get back, so there'll be no surprises.

2. Make sure that the person you are going to for treatment is a 'registered provider'

You can do that by asking them, or by giving us a call. Any appropriately qualified natural therapist can apply to the Australian Regional Health Group, and if they meet the criteria, can become a registered provider.

3. Make sure that you have served your waiting periods

When you take out extras cover for the first time, 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 must have the cover for a certain period of time before you can claim for some services. All the waiting periods that apply to your Value Extras cover are shown over the page. If you're not sure whether you've served your waiting periods or not, please ask our team.

4. When you're ready to make a claim, there are two different ways you can go about it

On the spot

If your practitioner offers the HICAPS or iSOFT claiming facilities, you can use your rt membership card to make an on-the-spot claim. You'll swipe your rt card through a special terminal when you're about to pay your bill. The information will be sent directly to us, and your claim will be lodged right there on the spot. All you pay is any difference between the amount of your rt benefit and the cost of the treatment.

Ask your practitioner when you make your appointment if they offer electronic claiming, or visit the HICAPS website (hicaps.com.au) for more information about practitioners that offer these facilities.

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 drop the money straight into your bank account. You can nominate a bank account when you complete your claim form.

You have up to two years from the date of service to lodge an extras cover claim. Claims with a service date older than two

VALUE EXTRAS COVER

Here's what you're covered for:

Service		Benefit for each purchase, service or treatment	Annual limit	Waiting period
General dental	X-rays and surgical items Preventive dentistry Restorations (fillings) Scaling and cleaning Extractions Mouthguard Fluoride application And many more	Each general 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.	$500 person $1,000 membership	2 months
Major dental **Orthodontics**	Not covered			
Optical	All prescription frames, lenses and contact lenses, including Irlen lenses	100% of cost	$200 person	3 months
Specialist therapies **Physiotherapy**	Initial consultation Subsequent consultation Group consultation	$35 $30 $25	$350 person $700 membership	2 months
Chiropractic | Osteopathy	Initial consultation Subsequent consultation X-ray	$35 $25 $60	$300 person $600 membership	
Occupational therapy	Initial consultation Subsequent consultation	$30 $25	$300 person $600 membership	
Orthoptics	Initial consultation Subsequent consultation	$30 $25	$300 person $600 membership	
Dietetics	All consultations	$30	$300 person $600 membership	
Alternative therapies *(Consultations only)* **Acupuncture**	Initial consultation Subsequent consultation	$30 $25	$300 person $600 membership	
Remedial massage	All consultations	$20	$200 person $400 membership	
Pharmaceuticals	Up to	$35 per non-PBS prescription payable after you have paid the equivalent of the PBS patient copayment amount for each item.	$300 person $600 membership	
Vaccines	Up to	$50 per injection	$150 person	
Health services **Travel expenses**	Please speak with our member care team for details about when these benefits are payable, **1300 886 123**.	Up to $50 per round trip (over 200km)	$200 person $400 membership	
Health aids *(Purchase only)* **Artificial eye/limb, blood glucose monitor, blood pressure monitor, braces/splints, BPAP and CPAP machine, compression garments (non-sports), crutches (hire or purchase), external breast prosthesis, nebuliser, oral appliance (983 and 984), oxygen concentrator/cylinder, TENS machine (excluding circulation boosters/massagers/reflexology devices), wheelchair, wig**	A letter from a medical practitioner is required with all 'Health aids' claims. No benefits are payable for consumables used in conjunction with any of these items. CPAP and BPAP machine benefits may only be claimed once every three calendar years.	80% of the cost	up to $300 per item	$300 person $600 membership 12 months
Wheelchair hire		$30	$30 membership	
Low vision aids for ARMD *(Age-related macular degeneration)*		Up to 100% of the cost per non-electronic optical aid	$70 person	
Repairs to health aids	Up to	100% of the cost	$100 person $200 membership	
Over-the-counter nicotine replacement therapy	A specific list of products is covered. Please check with us prior to purchasing.	50% of the cost	$100 person $200 membership	2 months

Read more about your hospital cover in our online A to Z guide in the forms and publications section of our website rthealth.com.au/publications.

Effective 1 April 2017. 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*. While you are making your decision about whether to join rt health, and which cover is best for you, it is important that you read (and retain for future reference) this cover guide and any other materials that we might send to you or refer you to.

1300 886 123
help@rthealthfund.com.au rthealth.com.au

Private Health Insurance Code of Conduct

Our industry code of conduct The Private Health Insurance Code of Conduct is a voluntary industry code aimed at delivering better service to health members through clear and complete communication, whether in writing or in person. As a signatory to the code, we are committed to ensuring that our members receive accurate information from properly trained staff, including clear and complete policy documentation, and information on internal and external dispute resolution processes. You can read more about the code at www.privatehealthcareaustralia.org.au.

We make it simpler