Member Information Brochure

EFFECTIVE: JANUARY 2025

Your health, Your future

Mildura HEALTH Fund

WELCOME

As a valued existing member or potential new member of Mildura Health Fund, this Member Information Brochure is full of information about what our health insurance has to offer. Outlined in this brochure, you will find easy to read information about our range of hospital cover, extras cover and other important information you need to know.

We are very proud of our health fund and the service we provide to our members. Since 1929, our focus has never changed and that is to offer our members a quality health insurance product to ensure that when they need us, we are here in their time of need.

As a not for profit health fund we focus on our members, rather than profits. This means we offer our members lower premiums, greater benefits and an award-winning health insurance product.

If you have further questions, please contact our Member Experience Team and they will be more than happy to assist you.

Gerard Op de Coul
Chief Executive Officer

SWITCHING IS EASY...

- ✓ We will contact your current insurer and organise your transfer
- ✓ We will honour any waiting periods served for an equivalent level of cover
- ✓ We offer a 30 day cooling-off period

Contact us today to find out more information

OUR MEMBERS ARE AT THE HEART OF EVERYTHING WE DO...

Operating since 1929 Mildura Health Fund is a regional health insurance fund existing purely to serve more than 37,500 members nationwide.

99%

Our staff provide consistently high levels of member service. An independent member survey shows that 99% of our members are 'satisfied' with their membership, equal to the best in the industry.

We are a not-for-profit member owned fund, this means that our members get more benefits and competitive premiums, where dividends are not paid to shareholders.

We own the Mildura Health Private Hospital where no excess is payable for same day procedures and management of costs assist to provide lower premiums for all of our members.

You can find us at three locations in Mildura, Swan Hill and Broken Hill.

2.5%

We offer a 2.5% discount for members who pay by direct debit (Cheque and savings accounts only).

21-25

Your single children remain covered to age 21 and if they are full time students they remain covered to age 25. Single parent plus and family plus cover options are available for single adult dependents to remain on a family policy up to age 25.

We have agreements with more than 445 private hospitals across Australia which is highly comparable to our competitors. Members can claim anywhere in Australia for both hospital and extras cover.

You can access your membership anytime, anywhere with our online membership services at www.mildurahealthfund.com.au

WELCOME TO MILDURA HEALTH FUND

We take pride in the fact we have been operating regionally for over 90 years providing valued service and peace of mind to our members. This brochure provides an overview of the features and benefits of our range of comprehensive health insurance products.

CONTENTS

IMPORTANT: The information contained in this brochure is current at the time of issue 1 January 2025 and supersedes all previously published material. It is subject to change at any time. Membership of Mildura Health Fund, including entitlement to and payment of benefits, is subject to the Fund Rules which are available for inspection at 79 Deakin Avenue, Mildura. Ensure you read this brochure thoroughly before any decision is made to purchase a health insurance product and retain a copy for future reference. If you anticipate undergoing any medical treatment for which you are expecting a benefit from the Mildura Health Fund, contact us before treatment or being admitted to a hospital to confirm your benefit entitlements. It is also important to remember to review your health insurance cover regularly to ensure it continues to meet your health needs.

Note: This brochure provides all the necessary information you'll require to decide which level of cover best suits you. Should you require more detailed information on any of our services or benefits, please come into to our office or call us on (03) 5023 0269

WHY DO I NEED PRIVATE HEALTH INSURANCE?

Peace of mind - you get health care options and benefits not available in the public health care system.

Own choice of doctor - private hospital cover generally lets you choose your own doctor.

Choice where you are treated - decide whether you stay in a public or private hospital.

Avoid public hospital waiting times - if you are a private patient, you can choose when you are treated.

Gap Medical benefits - payable on doctor's services rendered whilst you are an inpatient in a public or private hospital when you have hospital cover. Please see more information on page 11.

You can lock in your Lifetime Health Cover entry age - avoid paying higher hospital cover premiums by joining at a younger age.

Avoid the Medicare Levy Surcharge - by joining hospital cover, higher income earners can avoid the surcharge.

You can claim on services not covered by Medicare - benefits include dental treatment, glasses, physiotherapy and health aids and appliances, and many more.

On the spot claiming if you hold extras cover - use your Mildura Health Fund membership card at over 100,000 participating providers nationally!

Gap free preventative dental cover - available on our Dental and Five Star Extras covers.

"I just changed over to Mildura Health Fund, it was extremely easy and the staff there are very friendly and helpful" **Shaun - member.**

HOSPITAL COVER

FIVE STAR GOLD HOSPITAL COVER

Our top, comprehensive cover gives you Australia wide cover in a contracted private hospital or private day facility.

If you would prefer to pay a lower premium and still have the most comprehensive cover, our Five Star Gold cover has a choice of three different excess amounts that you can choose to pay.

It is the same top cover with no exclusions or restrictions but with a known upfront excess amount to pay. The higher the excess, the lower the premium.

We have contracts with more than 445 private hospitals Australia wide, to give you peace of mind knowing that you will be covered. Using a contracted private hospital will provide you with the maximum cover for your accommodation and theatre fees. A current list of contracted private hospitals can be found on our website, along with our 'Going to Hospital' brochure.

BASIC PLUS

The Basic Plus hospital cover will give you shared room accommodation in a public hospital with your choice of doctor.

The choice is yours. Both types of hospital cover can be taken on their own or combined with an extras cover depending on your needs and budget.

Compare our hospital covers to find the option that best suits your circumstances using the table below.

HOSPITAL COVER	FIVE STAR GOLD	BASIC PLUS
Choice of Doctor	✓	✓
Choice of Hospital	✓	✗
Excess options available	✓	✓
Private Room, Public* or Private Hospital	✓ *out of pocket costs could apply	✗
Shared Room, Public or Private Hospital	✓	✓ out of pocket costs could apply
Theatre Fees	✓	✗
Gap Medical Benefits	✓	✓
Prosthesis	✓	✓

COVER OVERVIEW BY CLINICAL CATEGORIES

COVER	FIVE STAR GOLD	BASIC PLUS
EXCESS OPTION	$250, $500, $750	$750
Rehabilitation	✓	R
Hospital psychiatric services	✓	R
Palliative care	✓	R
Brain and nervous system	✓	R
Eye (not cataracts)	✓	R
Ear, nose and throat	✓	R
Tonsils, adenoids and grommets	✓	R
Bone, joint and muscle	✓	R
Joint reconstructions	✓	R
Kidney and bladder	✓	R
Male reproductive system	✓	R
Digestive system	✓	R
Hernia and appendix	✓	R
Gastrointestinal endoscopy	✓	R
Gynecology	✓	R
Miscarriage and termination of pregnancy	✓	R
Chemotherapy, radiotherapy and immunotherapy for cancer	✓	R
Pain management	✓	R
Skin	✓	R
Breast surgery (medically necessary)	✓	R
Diabetes management (excluding insulin pumps)	✓	R
Heart and vascular system	✓	R
Lung and Chest	✓	R
Blood	✓	R
Back, neck and spine	✓	R
Plastic and reconstructive surgery (medically necessary)	✓	R
Dental surgery	✓	R
Podiatric surgery* (provided by an accredited podiatric surgeon - limited benefits)	✓	R
Implantation of hearing devices	✓	R
Cataracts	✓	R
Joint replacements	✓	R
Dialysis for chronic kidney failure	✓	R
Pregnancy and birth	✓	R
Assisted reproductive services	✓	R
Weight loss surgery	✓	R
Insulin pumps	✓	R
Pain management with device	✓	R
Sleep studies	✓	R

* *Limited benefits apply - contact the Fund for information.*

✓ ***No restrictions or exclusions:*** *This level of cover has no restrictions on services covered. You will be fully covered in a shared or private room in a private hospital or private day facility. For private room accommodation in a public hospital the Fund will pay an additional benefit of $80 above the shared ward accommodation rate.*

R ***Restricted benefits:*** *You will be covered in a shared ward in a public hospital only. If you are admitted to a private or private day facility to be treated, it is likely to result in large out of pocket expenses. Some specialists may not operate in a public hospital, this should be taken into consideration when choosing your hospital cover.*

HOSPITAL COVER EXCESS

WHAT IS AN EXCESS

An excess is the amount you agree to pay upfront if you go into a public hospital, private hospital or private day facility. It is that simple!

The higher your excess amount, the less you pay in your regular premiums. Just decide the excess amount that suits your individual circumstances and you are on your way to lower premiums.

Your excess is only payable should you be admitted to a private hospital, private day facility, or a public hospital as a private patient. For singles, couples and family type covers, the per person excess is only payable once per calendar year, 1 January to 31 December, to the maximums shown in the table below, irrespective of the length of stay or the number of admissions that year.

The excess is waived for all persons under 21 years of age.

NOTE: The excess is payable for all overnight admissions in all public and private hospitals. The excess is also payable for same day patients in all public and private hospitals and private day facilities with the exception of Mildura Health Private Hospital where members do not pay an excess for day surgery.

COVER	PRODUCT CODE	EXCESS AMOUNT	MAXIMUM YEARLY EXCESS	
			SINGLE	COUPLE / FAMILY
Five Star Gold $250 Excess	F2	$250	$250	$500
Five Star Gold $500 Excess	F3	$500	$500	$1000
Five Star Gold $750 Excess	F4	$750	$750	$1500
Basic Plus $750	H1	$750	$750	$1500

HOSPITAL COVER IMPORTANT INFORMATION

Benefits are payable for treatment received in a recognised hospital or facility in Australia only.

Benefits will not be payable unless all applicable waiting periods have been completed. See page 12 for details.

Restricted benefits will be payable at the Minimum Benefit Payable (MBP), this is the minimum benefit the Private Health Insurance Act requires health funds to pay for treatment under a hospital cover. If you hold the Basic Plus cover and are admitted to a private hospital or day facility, benefits will be payable at the MBP which may leave you with large out of pocket expenses to pay.

Treatment where no Medicare benefit is payable will not be covered by your hospital cover. However, limited benefits are payable towards the cost of hospital inpatient treatment for Podiatric surgery provided by an accredited podiatric surgeon depending on level of hospital cover. Cosmetic surgery is specifically excluded where there is no Medicare benefit payable

Benefits are payable for 365 days of the year provided your doctor certifies your need for ongoing acute care. If after 35 days, your doctor doesn't provide certification you will be classified as a long term 'nursing home type' patient. We will cover you for the minimum benefit amount as determined by the Department of Health (DoH) leaving you with a daily co-payment to pay. Depending on your length of stay your co-payment amount may be significant.

Gap Medical benefits are payable on all inpatient services where a Medicare benefit is payable. See page 11 for details. If you, or your family, are being admitted to hospital always contact us first to confirm your cover.

Our 'Going to Hospital' brochure can be downloaded from our website or forwarded to you on request.

WHAT ARE MY OPTIONS IF I AM ADMITTED TO A PUBLIC HOSPITAL?

When you are admitted to a public hospital, you can to choose whether to be treated as a public patient or as a private patient. If you choose to be a public patient, you will be treated by a doctor appointed by the hospital and not be charged for your care.

You can choose to be treated as a private patient in a public hospital to have your choice of treating doctor, or to have a private room. However, this may not necessarily guarantee the doctor of your choosing or that a private room will be available, nor does it guarantee a higher level of care.

There is no difference in the level of care you receive at a public hospital if you elect to be a private patient, you may however be charged some out-of-pocket costs.

BENEFITS ARE PAYABLE FOR TREATMENT RECEIVED IN A RECOGNISED HOSPITAL OR FACILITY IN AUSTRALIA ONLY

WE RECOMMEND THAT YOU CONTACT US PRIOR TO ANY PLANNED HOSPITALISATION WITH THE MBS ITEM NUMBERS, AND FEES THE DOCTOR WILL BE CHARGING, TO DISCUSS THE LEVEL OF BENEFIT YOUR POLICY PROVIDES TO YOU.

HOSPITAL COVER WHAT ELSE IS COVERED?

GAP MEDICAL BENEFITS

When you are admitted to hospital you will be charged separately for medical fees by your doctor, medical specialist, surgeon, anaesthetist, radiologist or pathologist.

These fees will be in addition to your accommodation and theatre fees, and are always negotiable between you and your health care provider. You will receive 100% of the Medicare Benefit Schedule (MBS) fee, the Medicare benefit plus the Fund Benefit, for inpatient services. If your specialist chooses to charge above the MBS fee, we will pay a further benefit towards this amount, known as the gap, which may result in a gap payment or no out of pocket cost to you. If your doctor has an agreement in place with us, they will bill us direct. Otherwise you can submit your unpaid account to us for claiming.

Please contact the Fund prior to any planned hospitalisation with the MBS item numbers, and fees the doctor will be charging, so that we can ensure that you will be covered and advise you of any out of pocket amounts you may need to pay.

NO GAP MEDICAL BENEFITS AT MHPH

Mildura Health Fund has no gap medical agreements with a number of medical specialists, doctors and surgeons who operate at Mildura Health Private Hospital (MHPH).

Your doctor will bill us direct and you will have no out of pocket costs if treated at MHPH by a no gap provider.

The current list of no gap medical providers can be found on our website mildurahealthfund.com.au

PROSTHESES

A prosthesis is a surgically implanted medical device or artificial body part, such as a hip, knee joints or a cardiac pacemaker.

If you are having a procedure that involves implantation of a prosthesis, we will pay a benefit up to the minimum benefit as defined on the Government approved prosthesis list. You will be responsible for the gap where the prosthesis charge is above the defined minimum benefit.

OTHER COSTS YOU MAY INCUR

Depending on the procedure you are having whilst an inpatient in hospital, your doctor may need to use high cost items that are not normally covered.

When this occurs, long term Mildura Health Fund members may qualify for an ex-gratia benefit to be paid to the hospital, on their behalf, towards the cost.

This can include items such as high cost disposables associated with certain procedures, and high cost drugs.

HOSPITAL COVER WHAT IS NOT COVERED?

There are hospital costs we do not cover, these include:

- Treatment received whilst serving a waiting period
- Treatment that relates to a pre-existing condition whilst serving a waiting period
- Treatment provided at the emergency department of a public or a private hospital
- Pharmaceuticals and other supplies not directly associated or essential to your admission
- Take home items such as crutches and pharmacy items
- Boarder accommodation for a partner or dependent
- Personal expenses such as TV hire, phone calls, newspapers and parking

MEDICAL COST FINDER

The Department of Health's Medical Cost Finder online tool can be used to help you understand the cost of common medical procedures provided by medical specialists in Australia.

The Medical Cost Finder can be found at https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder

WAITING PERIODS

HOSPITAL	
Pre-existing conditions*	12 Months
Pregnancy and Birth related services	
All other hospital treatment including Rehabilitation, Psychiatric Services and Palliative Care	2 Months
Accidental Injury **	Immediate
Newborns***	

EXTRAS	
Newborns***	Immediate
Accidental injury**	
Ambulance subscription refund	
Extras therapies - Acupuncture - Chiropractic - Mental Health - Dietician - Visiting nurse - Eye therapy - Exercise physiology - Myotherapy - Nutritionist - Occupational therapy - Osteopathic - Pharmaceutical - Physiotherapy - Podiatry - Remedial massage - Speech therapy	2 Months
Dental - General & Major (excluding orthodontics & dentures)	2 Months
Five Star Health Management	6 Months
Optical	
Dentures	12 Months
Foot Orthotics	
Orthodontics	24 Months
Health aids & appliances - Braces & splints - CAM boot - Artificial limbs & prosthesis - Crutches, walking frame & walking stick - Wigs - Compression garments	12 Months
- Blood glucose monitor - Blood pressure monitor - Tens machine - Nebuliser - CPAP (machine only) - Hearing aid	36 Months

Pre-existing Conditions* A pre-existing condition is where the signs or symptoms of your ailment, condition or illness, in the opinion of MHF's appointed independent medical adviser (not your own doctor), existed at any time in the 6 months preceding the day you joined hospital cover or the date you upgraded to a higher level of cover. It is not necessary that you, or your doctor knew what the condition was or that the condition had been diagnosed.

Decisions on whether or not an illness is pre-existing can only be made by MHF's appointed independent medical adviser. In forming an opinion, the Fund's practitioner must take into account information provided by your own doctor.

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

Accidental Injury** An accident is an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object requiring treatment from a Medical Practitioner. You are covered for accidental injury treatment immediately after you join, providing that there is no right to claim compensation or damages from another source. Not classed as an accident are injuries arising out of: surgical procedures; unforeseen illness; pregnancy; drug use; and aggravation of an underlying condition or injury.

Newborn*** We understand that it is a busy and exciting time when a baby is born. It is important that you contact us as soon as possible after your baby's birth to ensure that they are added to your membership.

If you currently hold a single policy with us, you will have 2 months to upgrade to a single parent, or a family type policy, after baby arrives. The applicable premium will be payable from baby's date of birth and they will inherit your waiting period status.

If you already hold a family type policy, you simply need to let us know baby's details, within 2 months of their birth and they will inherit your waiting period status.

If you are expecting a multiple birth, you will need to have a family type policy as the 2nd, or subsequent birth, will be admitted to hospital in their own right. This will mean that if you hold an excess cover, and you haven't already met your excess liability for the calendar year, the excess will be payable for your 2nd baby.

REFER A FRIEND AND WE WILL REWARD YOU

Refer your family and friends to us and if they join any new policy, we will thank you with a $50 Eftpos gift card. We encourage you to spend this within your local community. Please ensure that the person you refer lets us know your name at the time they join. No limits apply, the more members you refer to us the more you will receive in gift cards^.

^Refer a friend campaign is bound by terms and conditions. You can find the terms and conditions at http://www.mildurahealthfund.com.au/About-Us/Promotions or you can contact us for a copy.

HOSPITAL PREMIUMS

SINGLE MEMBERSHIP	WITH BASE TIER REBATE*		WITHOUT REBATE	
HOSPITAL COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
F2 Five Star Gold $250 Excess	$193.55	$2322.85	$256.75	$3081.00
F3 Five Star Gold $500 Excess	$181.65	$2179.90	$240.95	$2891.40
F4 Five Star Gold $750 Excess	$169.95	$2039.65	$225.45	$2705.40
H1 Basic Plus $750 Excess	$111.45	$1337.60	$147.85	$1774.20

COUPLES / FAMILY MEMBERSHIP	WITH BASE TIER REBATE*		WITHOUT REBATE	
HOSPITAL COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
F2 Five Star Gold $250 Excess	$387.10	$4645.65	$513.50	$6162.05
F3 Five Star Gold $500 Excess	$363.30	$4359.80	$481.90	$5782.80
F4 Five Star Gold $750 Excess	$339.90	$4079.30	$450.90	$5410.80
H1 Basic Plus $750 Excess	$222.90	$2675.20	$295.70	$3548.40

**The Rebate is the percentage amount that the government pays towards your health insurance depending on your age and income. The premiums above in the 'With Base Tier Rebate' column, are calculated using the maximum Rebate for under 65 year olds.*

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

INCOME THRESHOLD 2024/2025 FINANCIAL YEAR		WITH BASE TIER REBATE*			MEDICARE LEVY SURCHARGE
		UNDER 65 YEARS OLD	65-69 YEARS OLD	70+ YEARS OLD	
Base Tier	**SINGLE** UP TO $97,000 **FAMILY*** UP TO $194,000	24.608%	28.710%	32.812%	0%
Tier 1	**SINGLE** $97,001 TO $113,000 **FAMILY*** $194,001 TO $226,000	16.405%	20.507%	24.608%	1%
Tier 2	**SINGLE** $113,001 TO $151,000 **FAMILY*** $226,001 TO $302,000	8.202%	12.303%	16.405%	1.25%
Tier 3	**SINGLE** $151,001 AND ABOVE **FAMILY*** $302,001 AND ABOVE	0%	0%	0%	1.5%

** The family income threshold is increased by $1,500 for each Medicare levy surcharge dependent child after the first child. A family includes couples and single parent families. Further information can be found at privatehealth.gov.au. Income threshold is subject to change and is valid until 30 June 2025.*

SINGLE PARENT PLUS OR EXTENDED FAMILY PLUS

If your dependants reach 21 and are no longer studying full-time, you can keep them covered on your membership until they reach 25 for an extra 25% of your current premium.

If you have a family membership you can upgrade to our Family Plus cover or if you are a Single Parent you can upgrade to our Single Parent Plus cover.

There is no limit to the number of adult dependents aged 21-24 you can cover, as long as they are unmarried and not a student.

Contact us for a quote on Single Parent, Single Parent Plus or Family Plus cover, on 03 5023 0269 or visit our website.

See pages 27 - 28 for types of cover and dependents.

SINGLE PARENT COVER

You can cover your child and/or student dependent/s on single parent hospital cover for an extra 60% of the single membership premium.

There is no limit to the number of child/student dependents you can cover.

VISIT MILDURAHEALTHFUND.COM.AU FOR A GREATER CHOICE OF PRODUCT PRICING OPTIONS. OR, ALTERNATIVELY, YOU CAN CONTACT OUR TEAM TODAY.

EXTRAS AT A GLANCE

SERVICE		FIVE STAR EXTRAS	MID EXTRAS	BASE EXTRAS
Physiotherapy & Other Therapies	Physiotherapy	✓	✓	✓
	Exercise Physiology			
	Occupational Therapy			
Podiatry	Podiatry	✓	✓	✓
	Foot Orthotics			
Dietician	Dietician	✓	✓	✓
Therapies	Remedial massage	✓	✓	✗
	Acupuncture			
	Myotherapy			
	Nutritionist			
Chiropractic & Oesteopathic	Chiropractic	✓	✓	✓
	Osteopathic			
Mental Health	Clinical Psychology	✓	✓	✗
	Counselling	✓	✗	✗
Optical	Prescription Glasses & Contact Lenses	✓	✓	✓
Ambulance Subscription	Ambulance subscription refund	✓	✓	✓
Eye Therapy	Eye Therapy	✓	✓	✓
Speech Therapy	Speech Therapy	✓	✓	✓
Home Nursing	Visiting Nurse (excludes midwifery services)	✓	✓	✓
Pharmacy	Non PBS Prescriptions (after standard pbs amount has been deducted)	✓	✓	✗
Health Aids & Appliances	Blood Glucose Monitor	✓	✓	✓
	Blood Pressure Monitor	✓	✓	✓
	Tens Machine	✓	✓	✓
	Nebuliser	✓	✓	✓
	CPAP (machine only)	✓	✓	✓
	Hearing Aid	✓	✓	✓
	Braces & Splints	✓	✓	✓
	CAM Boot	✓	✓	✓
	Artificial Limbs & Prosthesis	✓	✓	✓
	Crutches, Walking Frame & Walking Stick	✓	✓	✓
	Wigs	✓	✓	✓
	Compression Garments	✓	✓	✓
Five Star Health Management Benefits	Approved Programs*	✓	✗	✗

**See page 17 for the complete list of approved programs*

FIVE STAR HEALTH MANAGEMENT BENEFITS		
MHF APPROVED PROGRAMS		
HEALTH SCREENINGS #	FITNESS AND PREVENTION PROGRAMS	IMPROVEMENT & WEIGHT MANAGEMENT PROGRAMS*
	MHF BENEFIT APPROVAL REQUIRED**	
Mole Mapping Removal of sun spots MRI, CT & PET scans Bowel cancer test kits Lung function tests	Swimming Lessons Personal training programs Group training	Quit Smoking Nicotine replacement Weight Watchers Tony Ferguson Jenny Craig Cohen's Weight Loss Metabolic Balance

*# Fund Benefits not payable where a Medicare benefit is applicable, * Benefits payable for weight loss membership fees only*

***A MHF benefit approval form can be downloaded from our website mildurahealthfund.com.au or emailed to you on request.*

"SWAPPED FROM MEDIBANK YEARS AGO AND HAVE NEVER REGRETTED IT. FRIENDLY HELPFUL STAFF AND I SAVED SO MUCH MONEY ON MY PREMIUMS." - ANNA (HAPPY MILDURA HEALTH FUND MEMBER)

MILDURA HEALTH FUND

COMPARE OUR EXTRAS BENEFITS

EXTRAS BENEFIT TABLE			FIVE STAR EXTRAS		MID EXTRAS		BASE EXTRAS	
SERVICE		WAITING PERIOD	BENEFIT	CALENDAR YEAR LIMIT	BENEFIT	CALENDAR YEAR LIMIT	BENEFIT	CALENDAR YEAR LIMIT
Physiotherapy & Other Therapies	Physiotherapy	2 months	Initial - $50 Standard - $45 Group* - $10 (Group sub limit $100*)	$650 person $1300 family	Initial - $36 Standard - $32 Group* - $9 (Group sub limit $90*)	$540 person $1080 family	Initial - $27 Standard - $24 Group* - $8 (Group sub limit $80*)	$390 person $780 family
	Exercise Physiology	2 months						
	Occupational Therapy	2 months						
Podiatry	Podiatry	2 months	Initial - $46 Standard - $42	$650 person $1300 family	Initial - $40 Standard - $35	$540 person $1080 family	Initial - $30 Standard - $26	$390 person $780 family
	Foot Orthotics	12 months	Set benefit per item		Set benefit per item		Set benefit per item	
Dietician	Dietician	2 months	Initial - $42 Standard - $38	$650 person $1300 family	Initial - $36 Standard - $32	$540 person $1080 family	Initial - $27 Standard - $24	$390 person $780 family
Therapies	Remedial Massage	2 months	Initial - $36 Standard - $34	$600 person $1200 family	Initial - $29 Standard - $27	$540 person $1080 family	No benefit	No benefit
	Acupuncture	2 months						
	Myotherapy	2 months						
	Nutritionist	2 months						
Chiropractic & Osteopathic	Chiropractic	2 months	Initial - $40 Standard - $34	$600 person $1200 family	Initial - $32 Standard - $27	$540 person $1080 family	Initial - $25 Standard - $21	$390 person $780 family
	Osteopathic	2 months	Initial - $50 Standard - $45		Initial - $36 Standard - $32		Initial - $27 Standard - $24	
Mental Health	Clinical Psychology	2 months	Initial - $70 Standard - $60 Group - $12	$650 person $1300 family	Initial - $50 Standard - $45 Group - $10	$540 person $1080 family	No benefit	No benefit
	Counselling^	2 months	Initial - $32 Standard - $32		No benefit	No benefit	No benefit	No benefit
Optical	Prescription Glasses & Contact Lenses	6 months	$270 Per Person	$270 Per Person	$235 Per Person	$235 Per Person	$180 Per Person	$180 Per Person
Ambulance Subscription	Ambulance subscription refund	0 months	Family - $97 Single - $48.50	Equal to benefit	Family - $87 Single - $43.50	Equal to benefit	Family - $72 Single - $36	Equal to benefit
Eye Therapy	Eye Therapy	2 months	Initial - $42 Standard - $38	$650 person $1300 family	Initial - $36 Standard - $32	$540 person $1080 family	Initial - $27 Standard - $24	$390 person $780 family
Speech Pathology	Speech Therapy	2 months	Initial - $50 Standard - $45	$650 person $1300 family	Initial - $36 Standard - $32	$540 person $1080 policy	Initial - $27 Standard - $24	$390 person $780 policy
Home Nursing	Visiting Nurse (Excludes midwifery services)	2 months	$12	$600 person $1200 family	$12	$500 person $1000 policy	$12	$350 person $700 policy
Pharmacy	Non PBS prescriptions	2 months	$40	$300 person $600 family	$30	$200 person $400 family	No benefit	No benefit

All benefits subject to Waiting Periods and Benefit Limitations – see pages 12 and 25.

Sub-limits apply to these services - see page 25, explaining your claim limits. Group benefits not payable for Occupational Therapy – see page 26, group therapy. Refer to page 12 for a full list of waiting periods.

^Counsellor must be accredited with Australian Regional Health Group (ARHG)

MILDURA HEALTH FUND

COMPARE OUR EXTRAS BENEFITS

EXTRAS BENEFIT TABLE CONTINUED			FIVE STAR EXTRAS		MID EXTRAS		BASE EXTRAS	
SERVICE		WAITING PERIOD	BENEFIT	CALENDAR YEAR LIMIT	BENEFIT	CALENDAR YEAR LIMIT	BENEFIT	CALENDAR YEAR LIMIT
Health Aids & Appliances ^	Blood Glucose Monitor	36 months	$260 (every 3 years)	$1200 person $2400 family	$200 (every 3 years)	$1000 person $2000 family	$150 (every 3 years)	$600 person $1200 family
	Blood Pressure Monitor	36 months	$200 (every 3 years)		$150 (every 3 years)		$125 (every 3 years)	
	TENS Machine	36 months	$200 (every 3 years)		$150 (every 3 years)		$125 (every 3 years)	
	Nebuliser	36 months	$200 (every 3 years)		$150 (every 3 years)		$125 (every 3 years)	
	CPAP (Machine only)	36 months	$520 (every 3 years)		$400 (every 3 years)		$230 (every 3 years)	
	Hearing Aid	36 months	$1100 (every 5 years)		$770 (every 5 years)		$500 (every 5 years)	
	Braces & Splints	12 months	85% up to $600 (every 3 years)		75% up to $500 (every 3 years)		65% up to $300 (every 3 years)	
	CAM Boot	12 months	85% up to $600 (every 3 years)		75% up to $500 (every 3 years)		65% up to $300 (every 3 years)	
	Artificial limbs & prosthesis	12 months	85% up to $600 (every 2 years)		75% up to $500 (every 2 years)		65% up to $300 (every 2 years)	
	Crutches, walking frame & walking stick	12 months	85% up to $50 (every 2 years)		75% up to $35 (every 2 years)		65% up to $25 (every 2 years)	
	Wigs +	12 months	85% up to $300 (every 2 years)		75% up to $250 (every 2 years)		65% up to $150 (every 2 years)	
	Compression Garments +	12 months	85% up to $300 (every 2 years)		75% up to $250 (every 2 years)		65% up to $150 (every 2 years)	
Five Star Health Management Benefits	Approved Programs**	6 months	70%	$150 person $300 family	No benefit	No benefit	No benefit	No benefit

All benefits subject to Waiting Periods and Benefit Limitations – see pages 12 and 25. ^ Health Aids and Appliances must be medically necessary and for the treatment of specific conditions.
*+ Conditions apply, sport related garments are excluded. Contact the Fund for further information. **See page 17 for complete list of approved programs and conditions.*

DENTAL / EXTRAS BENEFIT TABLE			FIVE STAR EXTRAS					DENTAL				
SERVICE		WAITING PERIOD	BENEFIT	SUB-LIMIT	FIRST YEAR MEMBERSHIP	LIFETIME LIMIT	CALENDAR YEAR LIMIT	BENEFIT	SUB-LIMIT	FIRST YEAR MEMBERSHIP	LIFETIME LIMIT	CALENDAR YEAR LIMIT
General & Major Dental	Preventative Dental	2 months	100% ^	x	$450 Maximum benefit payable per person	x	$1,500 Maximum benefit payable per person once first year is completed	100%^	x	$350 Maximum benefit payable per person	x	$1,050 Maximum benefit payable per person once first year is completed
	General & Major Dental	2 months	85%^^					70%^^				
	Inlay/Onlay, Crown & Bridge, Implants, Indirect Restorations	2 months	As per MHF dental schedule	1st calendar year of membership $440				As per MHF dental schedule	1st calendar year of membership $350			
				2nd calendar year of membership $560					2nd calendar year of membership $450			
				3rd calendar year of membership $620					3rd calendar year of membership $500			
				4th calendar year of membership $680					4th calendar year of membership $550			
				5th calendar year of membership $740					5th calendar year of membership $600			
				6th calendar year of membership $800					6th calendar year of membership $650			
	Dentures	12 months	(every 3yrs^^^)	x				(every 3yrs^^^)	x			
	Orthodontics	24 months	50% up to $800	$800 Per person per calendar year		$2,400 Per person		50% up to $600	$600 Per person per calendar year		$1,500 Per person	

^ Dental 100% benefit available at super dental providers ^^Percentage based on MHF dental schedule ^^^Full set of dentures claimable every 3 years

EXTRAS AND DENTAL COVERS

BENEFITS ON A WHOLE RANGE OF HEALTH CARE SERVICES

With our Extras cover you'll get great benefits on a whole range of health care services and treatments that are not covered by your hospital cover or by Medicare.

Not only will you be able to claim on your regular dental check-up, you can also claim benefits for glasses, physiotherapy and remedial massage. For the full list of services covered, along with the benefits that are payable, see our benefits tables.

There are six levels of Extras to choose from depending on the services you use and your budget. These can be taken on their own or combined with your choice of hospital cover.

COVER	PRODUCT CODE	DESCRIPTION
COMPREHENSIVE EXTRAS		
Five Star Extras	E1	Our most comprehensive level of extras cover includes Dental benefits and offers the highest benefits and yearly limits of our extras and dental covers. The Five Star Health Management benefit is exclusive to the Five Star Extras cover. This includes benefits for Fitness and Prevention programs including Swimming Lessons, Personal Training, Group Training and Aqua Aerobics. Health Screening tests not covered by Medicare such as Mole Mapping and Lung function testing and Weight Management and Quit Smoking programs. A detailed fact sheet can be found at mildurahealthfund.com.au
Mid Extras & Dental	A1D	Our mid-ranged extras and dental cover combined, includes benefits for Remedial Massage, Physiotherapy, Chiropractic and Health Aids & Appliances. Gap free preventative dental is included in this cover along with the full range of dental services, all at a reasonable premium.
Base Extras & Dental	AD	Our base extras cover, combined with our dental cover offers lower extras benefits and limits at an affordable price, while still covering a great range of services our members use. This includes our popular mid-range dental cover.
STAND ALONE EXTRAS		
Mid Extras	A1	Our mid-range extras cover offering benefits for Remedial Massage, Physiotherapy, Chiropractic and Health Aids & Appliances. This is a stand-alone extras cover that does not include dental cover. Mid Extras can be taken on its own or combined with dental and/or hospital cover for greater flexibility.
Base Extras	A	Our base extras cover offers lower benefits and limits at a lower cost whilst still covering a great range of services our members use. Base Extras can be taken out with dental and/or hospital cover, or on its own.
Dental	D	Our popular mid-range dental offers a full range of dental benefits, including gap free preventative dental cover. Dental can be taken out on its own or can be combined with an extras cover and/or hospital cover.

SUPER DENTAL AGREEMENTS

The Fund has entered into agreements with dental providers, known as super dental agreements, to limit the out of pocket expenses our members have to pay.

All dental providers receive the same benefit per service, whether they have an agreement with us or not. Our agreement dental providers will only charge the agreed amount for the service they provide.

You still have a choice of who you receive treatment with, we do not reduce the benefits paid if you see a provider who doesn't have an agreement with us.

We are unlike other health funds, who have preferred providers, we give you choice! Other health funds with preferred providers restrict who you can see, how much you can claim and generally pay a lower benefit for the same service to dentists who are not one of their preferred providers.

GAP FREE PREVENTATIVE DENTAL

A popular feature of our Dental and Five Star Extras covers is Gap Free Preventative Dental.

We will pay 100% of the fee for each eligible preventative service provided by one of our agreed dentists.

The same benefit amount will be paid whether you see an agreed dentist or not. (A balance may be payable for treatment provided by a non-agreement dentist).

Regular visits to the dentist are essential for the maintenance of healthy teeth and gums. MHF and Dentists recommend that you, and your family, visit every six months to ensure overall good oral health.

Benefits apply to adults and children who have served their waiting period. All limits and benefit conditions apply to these services. See 'Explaining your claim limits' on page 25 for full details.

DENTAL SERVICE BENEFITS		FIVE STAR EXTRAS	DENTAL
SERVICE		**BENEFIT**	**BENEFIT**
Preventative Treatment	Periodical oral examination	$55.75	$55.75
	Emergency consultation	$35.05	$35.05
	X-Ray	$47.20	$47.20
	Scale & Clean	$114.20	$114.20
	Fluoride Treatment	$47.65	$47.65
General & Major Dental	Surgical Extraction	$230.30	$189.90
	Filling - Adhesive one surface	$124.85	$102.95
	Filling of one root canal	$225.50	$185.95
	Full crown veneer	$800	$650
	Full denture	$1,500	$1,050

Benefits subject to dental limits – see page 20-21

NOT ONLY DOES REGULAR DENTAL CARE HELP KEEP YOUR TEETH AND GUMS HEALTHY, IT WILL HELP PREVENT THE NEED FOR MORE EXTENSIVE TREATMENT LATER ON.

EXTRAS PREMIUMS

COMPREHENSIVE EXTRAS

SINGLE MEMBERSHIP	WITH BASE TIER REBATE*		NO REBATE DEDUCTED	
EXTRAS COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
E1 Five Star Extras	$78.35	$940.45	$103.95	$1247.40
A1D Mid Extras & Dental	$51.90	$622.90	$68.85	$826.20
AD Base Extras & Dental	$39.35	$472.25	$52.20	$626.40

COUPLE / SINGLE PARENT / FAMILY MEMBERSHIP	WITH BASE TIER REBATE*		NO REBATE DEDUCTED	
EXTRAS COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
E1 Five Star Extras	$156.70	$1880.85	$207.90	$2494.80
A1D Mid Extras & Dental	$103.80	$1245.75	$137.70	$1652.40
AD Base Extras & Dental	$78.70	$944.50	$104.40	$1252.80

STAND ALONE EXTRAS

SINGLE MEMBERSHIP	WITH BASE TIER REBATE*		NO REBATE DEDUCTED	
EXTRAS COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
A1 Mid Extras	$24.25	$291.30	$32.20	$386.40
A Base Extras	$11.70	$140.65	$15.55	$186.60
D Dental	$27.60	$331.55	$36.65	$439.80

COUPLE / SINGLE PARENT / FAMILY MEMBERSHIP	WITH BASE TIER REBATE*		NO REBATE DEDUCTED	
EXTRAS COVER	MONTHLY	YEARLY	MONTHLY	YEARLY
A1 Mid Extras	$48.55	$582.60	$64.40	$772.80
A Base Extras	$23.45	$281.35	$31.10	$373.20
D Dental	$55.25	$663.15	$73.30	$879.60

**The Rebate is the percentage amount that the government pays towards your health insurance depending on your age and income. The premiums above in the 'With Base Tier Rebate' column, are calculated using the maximum Rebate for under 65 year olds. See page 14 or 31 for further information and for the table to work out your income tier.*

EXPLAINING YOUR CLAIM LIMITS

YEARLY LIMIT

This is the maximum amount you can claim for a service in a calendar year, from 1 January to 31 December.

If you don't claim your full limit for the year it does not roll over to the next year – it will reset 1 January. If you claim your full limit in a calendar year, no further benefits will be payable until 1 January the next year.

See page's 18-21 for a full list of yearly limits that relate to each service type.

SUB LIMIT

This is a limit within a limit. It applies to a specific service, per person, per calendar year.

For example if you have Dental Cover, there is a yearly limit for all dental treatment. A sub limit applies to orthodontic of $600 per person, so once you reach that limit you can no longer claim orthodontic for that year. However, you could claim a further $400 in claims for other dental services.

PERSON LIMIT

This is the maximum limit each person on a membership can claim in a calendar year.

If you are on a policy that includes more than one person, each of you have your own individual limit.

MEMBERSHIP LIMIT

This is the maximum amount that can be claimed collectively, by everyone covered by a membership within a calendar year, for a specific service.

Remember that these limits apply in addition to your individual per person limits. This limit may not be high enough for all of the family members to claim their full individual limits. For example, you may have a person limit of $540 with a membership limit of $1080. If there are more than 2 persons on your membership, they may not all be able to claim their full person limit.

LIFETIME LIMIT

A lifetime limit applies to orthodontic treatment and applies to an individual.

Once this limit has been reached, no further benefits will be payable by MHF. This limit does not reset, even if you leave us and start your cover again at a later date.

SERVICE LIMIT

Limitations apply to some types of extras services, in particular dental services.

For example, you can only claim a periodic consultation with your dentist every six months. These limits apply from the date you receive the treatment not from the date you submit the claim.

IMPORTANT INFORMATION

Benefits are not payable for the following:

- Extras treatment or services covered by Medicare
- Treatment or services received within your waiting periods (see page 12)
- Treatment received at a hospital emergency department
- Care and accommodation in an aged care facility
- Treatment or services that are not medically necessary nor clinically relevant
- Treatment or services received from a provider who is not recognised with Mildura Health Fund i.e. not registered with the Department of Health or the Australian Regional Health Group
- Treatment or services covered by Work Cover, damages legislation or any type of insurance (i.e. third party or sports club insurance)
- Treatment, goods or services received or sourced outside of Australia
- Treatment that has been provided by a family member, relative, business partner, or yourself
- Treatment or services that have been paid for but not yet received
- Services that you haven't been charged for
- Surcharges, delivery costs and credit card processing fees
- Services provided for sport, recreation or entertainment
- Non-Prescription glasses, sunglasses or contact lenses
- Hire of Health Aids and Appliances with the exception of crutches
- Purchase of replacement parts or components in relation to Health Aids and Appliances i.e. CPAP mask replacement
- Purchase of second-hand, pre-owned goods or equipment
- Health Aids must have 100% manufacture warranty from new purchase date
- Cosmetic treatment or services
- Counselling must be provided by an accredited by Australian Regional Health Group (ARHG)
- All Health Management programs require an approval
- Pilates are not covered

EXTRAS AND DENTAL COVER WHAT YOU NEED TO KNOW

OPTICAL BENEFIT

Covers your prescription glasses and contact lenses that have been prescribed by a registered optometrist.

Non-prescription sunglasses are specifically excluded. Your claim for benefits will be processed as at the date you collect or receive your glasses or contact lenses, not the date that they are ordered. Glasses and contact lens maximums apply per calendar year. See page 18-19 for further information.

AMBULANCE SUBSCRIPTION

Ambulance subscription benefits are payable on the subscription paid to an Ambulance service provider only.

Subscription costs and conditions vary from state to state. See page 32 for ambulance provider information - 'Ambulance Cover Explained.'

FOOT ORTHOTICS

Foot Orthotics must be prepared for the member by a registered podiatrist or a registered orthotist.

Pursuant to a referral from a registered podiatrist or doctor in the course of private practice. Benefits are not payable on
pre-fabricated orthotics.

GROUP THERAPY

Group Therapy benefits are only payable when treatment is provided by a registered Physiotherapist, Exercise Physiologist or Clinical Psychologist.

Group treatment is defined as when a patient does not have the provider's exclusive attention for the entire therapy session (e.g. more than one patient).

DENTURES

Subject to waiting periods, benefits are limited to one full set of dentures per person every 3 year service years.

PHARMACY

Pharmacy benefits are payable on our Five Star Extras (E1) and Mid Extras (A1) covers.

Benefits include Non-Pharmaceutical Benefit Scheme (PBS) drugs and medicines dispensed by a pharmacist and /or vaccines, including travel vaccines, dispensed by a pharmacist or doctor.

To be eligible items need to be prescribed by your doctor, be a Schedule 4 or Schedule 8 item and not be a Pharmaceutical Benefit Scheme (PBS) subsidised prescription.

The benefit is calculated after deducting the current general patient contribution as defined by the PBS.

TYPES OF COVER

THE MEMBER

The member is the name of the person the health insurance policy, or membership, is held under.

The member is:
- The primary point of contact for MHF
- Responsible for payment of premiums
- Advises MHF of any changes to membership details
- Nominates who is covered on the membership

SINGLES COVER

As a single membership covers the one person only, this person is referred to as the member.

SINGLE PARENT COVER

A single parent cover includes:

- The member
- The members child dependents
- The members student dependents

SINGLE PARENT PLUS COVER

This is an extended cover to include:

- The member
- The members child dependents
- The members student dependents
- The members adult dependents aged 21-24 inclusive

COUPLES COVER

The following people can be covered on a couple membership:

- The member
- The member's spouse or partner

FAMILY COVER

The following people can be covered on a family cover:

- The member
- The members spouse or partner
- Child dependents of the member and/or the members spouse or partner
- Student dependents of the member and/or the members spouse or partner

FAMILY PLUS COVER

The following people can be covered on an extended family cover:

- The member
- The members spouse or partner
- Child dependents of the member and/or the members spouse or partner
- Student dependents of the member and/or the members spouse or partner
- Adult dependents of the member and/or the members spouse or partner aged 21-24 inclusive

FAMILY TYPE COVER

This term refers to the following membership types or covers:

- Single Parent cover
- Single Parent Plus Cover
- Family Cover
- Family Plus Cover

SWITCHING IS EASY

Our membership team will do all the work for you...

From helping you to compare products, providing a quote and requesting your details from your previous health fund.

Provided that you have served your waiting periods with your previous fund, you will not have to re-serve them on the equivalent level of cover with MHF. Should you decide to upgrade your level of cover, you will only have to serve the new cover waiting periods, not the ones you have already served.

You will be able to start claiming as soon as your previous health fund provides us with the details of your cover (a Transfer Certificate), this can take up to 14 days. Any claims you may have while we are waiting on these details, will be honoured as soon we receive the required information.

If you have used your claim limits with your previous fund, they will be taken into account by us. With the exception of orthodontic limits, your claim limits will renew in the next calendar year so you will not miss out on any benefits.

Contact our membership team today.

DEPENDENTS

CHILD DEPENDENT

Child dependents are automatically covered on a family type membership until they reach 21 years old regardless of their student or employment status.

When a child dependent turns 21, their dependent status will change and the following will need to be considered:

If they are still a full time student, and meet the Student Dependent criteria, they can remain on the family's membership until age 25.

They can continue on the family's membership as an Adult Dependent if the criteria is met and the families membership is upgraded to an extended cover.

They can join their own membership from their 21st birthday. Benefits will continue automatically provided all waiting periods have been served and the new membership is commenced within 2 months of turning 21.

Continuation of cover will require dating and payment of this membership from the date of their 21st birthday.

STUDENT DEPENDENT CRITERIA

Student dependents aged 21-24 inclusive can remain on the family's membership, until they turn 25, as a full-time student provided that:

They complete a minimum of 75% of a full-time course load as defined by the student's educational institution.

They are not married or in a de-facto relationship.

Note: Apprenticeships and traineeships do not qualify as full-time study.

A dependant registration form must be signed when they turn 21 and then again in February each year.

When they turn 25, they must join their own membership to have continued coverage.

They will not be required to serve waiting periods if joining an equivalent, or lower, level of cover to the cover you hold.

Continuation of cover will require dating and payment of this membership from the date of their 25th birthday.

ADULT DEPENDENT CRITERIA

Your non-student dependents aged 21-24 inclusive who are not married, can remain on your membership until age 25 at an extra cost of 25% of your current premium.

This will require an upgrade of your membership to an extended cover – either Single Parent Plus or Family Plus depending on your circumstances. There is no limit to the number of adult dependents included, the cost will be the same for one or more.

When they turn 25, they must join their own membership to have continued coverage. They will not be required to serve waiting periods if joining an equivalent, or lower, level of cover! Continuation of cover will require dating and payment of membership from the date of their 25th birthday. See page 31 to find out how to receive the Youth Discount for 18-29 year olds.

Continuation of cover will require dating and payment of this membership from the date of their 25th birthday.

CHILD DEPENDENTS ARE AUTOMATICALLY COVERED ON A FAMILY TYPE MEMBERSHIP UNTIL THEY REACH 21 YEARS OLD

MANAGING YOUR MEMBERSHIP

MEMBERSHIP CARD

When you join Mildura Health Fund, you will receive a membership card identifying you as a member. Your card will show all persons covered, along with your membership number. Additional cards can be requested at any time. Have your membership card on hand when you arrange an admission to hospital, visit a service provider, contact the Fund or come into our office.

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 card is issued. Keep your card safe and please notify the Fund if your card is lost or stolen.

CHANGING YOUR CONTACT DETAILS

Always make sure that we have your up to date contact details. You can make changes at any time by logging in to Online Member Services (OMS) via our website, mildurahealthfund.com.au.

SUSPENDING YOUR COVER

If you are traveling overseas you can apply to suspend your membership provided that you:

Have been a member for at least 12 months

Have paid your premiums up to your date of departure

Have had at least 6 months active cover since any previous suspension

Are going overseas for a minimum of 2 weeks

Suspend your membership for a period no greater than 2 years

Lodge your application for membership suspension prior to the date of your departure from Australia

Members must provide documentary evidence of departure and return dates when lodging their application.

Suspension of membership due to overseas travel does not affect your Lifetime Health Cover (LHC) loading as you are still considered to be maintaining your membership.

Depending on income level, suspension of hospital cover may result in the Medicare Levy Surcharge (MLS) being applied by the ATO.

CHANGING YOUR COVER

You can change your level of cover at any time. Waiting periods will apply if you are upgrading your level of cover or reducing your hospital cover excess amount. If you are upgrading your level of cover, your previous level of cover will apply during the waiting period.

CANCELLATION OF MEMBERSHIP

You can cancel your membership at any time. Cancellation will be effective from the date you notify the Fund or from your current premium due date, whichever is earlier.

We require something in writing from you, a signed cancellation form or an email will suffice, before a cancellation takes effect.

Prior to cancelling, we encourage you to call our customer service team. Our specialised team will be able to assist you to review your current cover or answer any questions you may have.

PAYING YOUR PREMIUMS

We offer a variety of different payment methods for you to choose from. Along with different frequency options to suit every budget, you can choose from fortnightly, monthly, quarterly, half yearly and yearly.

If you elect to pay quarterly, half yearly or yearly, a reminder notice will be sent to you. Note that if you are paying by Direct Debit on one of these frequencies, you will receive an SMS or email reminder but will not receive a detailed account.

It is your responsibility to ensure that your payments are for the correct amount and that they are in advance. This avoids the embarrassment of your claims being rejected due to your membership being unfinancial at the time you claim.

If your premiums are in arrears by more than two consecutive months, your cover will lapse and your membership will be closed. Every attempt will be made to contact you if this occurs.

PAYMENT OPTIONS:

DIRECT DEBIT Pay by direct debit from your nominated cheque or savings account. You will receive a 2.5% discount if you use this option. A reminder will be sent via SMS or email prior to your due date if you elect to pay quarterly, half yearly or yearly.

BPAY Our biller code reference is 228080, the reference number that is specific to your membership can be provided on request.

EFTPOS payments can be made in person at the Mildura, Swan Hill or Broken Hill branches. Or alternatively, over the phone.

ONLINE MEMBER SERVICES (OMS) You can make payments online by logging into OMS via our website, and accessing 'Make a Payment'. You have the option of using your credit card or internet banking.

IN PERSON You can pay at one of our branches:
Mildura branch 79 Deakin Avenue, Mildura
Swan Hill branch 28a McCrae Street, Swan Hill
Broken Hill branch 2 Chloride Street, Broken Hill

GOVERNMENT INITIATIVES

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

The Private Health Insurance Rebate is the amount the Government contributes towards the cost of eligible Australians health insurance premiums.

Your eligibility to receive the rebate is based on your income and the age of the oldest person on your membership. See the table on page 31 to help work out your rebate tier.

The rebate only applies to the standard (base) amount of your premium before any discount or Lifetime Health Cover (LHC) amount is applied.

If you select the wrong rebate tier, any difference will be reconciled when you lodge your tax return.

You don't have to claim your rebate as a reduced premium, you can pay the full premium cost and claim the rebate back at tax time.

Calculation of the rebate percentage is based on a complex formula and the Consumer Price Index (CPI). The rebate percentage is reduced each year.

MEDICARE LEVY SURCHARGE

The Medicare Levy Surcharge (MLS) is levied on Australian taxpayers who are high income earners and who do not hold hospital cover.

The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private hospital system to reduce demand on the public Medicare system.

The surcharge is between 1% and 1.5% (depending on your household income) and is in addition to the 2% Medicare Levy paid by most Australian taxpayers.

LIFETIME HEALTH COVER

Lifetime Health Cover (LHC) is a government initiative designed to encourage people to take out private hospital cover earlier in life and maintain this cover throughout their lifetime.

If you join private hospital cover before July 1 immediately following your 31st birthday and keep it, you will not incur an extra cost for LHC loading.

If you decide to take out cover later in your life, you will pay an extra 2% more for cover every year that you are over the age of 30. This is called Lifetime Health Cover loading.

LHC loading applies to the hospital portion of your cover only. The Australian Government Rebate is not payable on any LHC loading amount that may apply to your cover.

OTHER INFORMATION:

The maximum loading you will ever pay is 70%.

If you were born before 1 July 1934 you are exempt from the loading.

You can drop your hospital cover for up to 1,094 days throughout your lifetime without incurring penalty loading when re-joining. Waiting periods will apply when you re-join.

You can vary your level of hospital cover without affecting your LHC loading.

LHC loading remains on your membership for 10 years. After 10 straight years the loading will be removed. However, the loading may be reapplied if you cease your hospital cover and then take it up again at a later date.

END OF FINANCIAL YEAR TAX STATEMENTS

The Fund no longer issues members with a paper copy of their health insurance tax statement at the end of the financial year.

If you lodge your tax return online with myTax or a registered tax agent, your health insurance tax information should be automatically populated in your tax return by 8 July each year. You will not need to add this information.

You can access your end of financial year statement by logging on to your Online Member Service. Alternatively, you can contact our Customer Service team who will be able to supply you with a copy.

YOUTH DISCOUNTS

The Youth Discount is an age-based discount designed to encourage people to join hospital cover early in life and to then maintain their cover throughout their lifetime.

To receive the discount a person must be aged 18-29 inclusive and join an eligible level of hospital cover. Eligible hospital covers are our Five Star Gold suite of products.

A person can transfer between eligible covers and still retain their discount. If transferring a Gold cover from another health fund that offers age-based discounts, the discount will be retained when joining a Five Star Gold cover with MHF.

The discount amount starts at 10%, for persons aged 18 to 25 inclusive and will reduce by 2% for each year you put off joining hospital cover after you turn 25 until you reach age 30.

For example, if you join a Five Star Gold cover at age 28, you will be entitled to a 4% discount. 28 will become your age* at assessment date.

As long as you remain on an eligible hospital cover, you will continue to receive your full discount entitlement until you turn 41.

At the age of 41, your discount will start to reduce by 2% every year until it reaches zero.

See the table below for the applicable discount percentage by age:

*AGE	%
18-25	10%
26	8%
27	6%
28	4%
29	2%
30	0%

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

INCOME THRESHOLD 2024/2025 FINANCIAL YEAR		WITH BASE TIER REBATE*			MEDICARE LEVY SURCHARGE
		UNDER 65 YEARS OLD	65-69 YEARS OLD	70+ YEARS OLD	
Base Tier	**SINGLE** UP TO $97,000 **FAMILY*** UP TO $194,000	24.608%	28.710%	32.812%	0%
Tier 1	**SINGLE** $97,001 TO $113,000 **FAMILY*** $194,001 TO $226,000	16.405%	20.507%	24.608%	1%
Tier 2	**SINGLE** $113,001 TO $151,000 **FAMILY*** $226,001 TO $302,000	8.202%	12.303%	16.405%	1.25%
Tier 3	**SINGLE** $151,001 AND ABOVE **FAMILY*** $302,001 AND ABOVE	0%	0%	0%	1.5%

** The family income threshold is increased by $1,500 for each Medicare levy surcharge dependent child after the first child. A family includes couples and single parent families. Further information can be found at privatehealth.gov.au. Income threshold is subject to change and is valid until 30 June 2025.*

AMBULANCE COVER EXPLAINED

Ambulance cover is important as you never know when an emergency may happen. Ambulance coverage in Australia is different from state to state, so we encourage you to read below to find out what you need to do to be fully covered. Generally emergency ambulance transport is covered but non-emergency ambulance transport will not be.

VICTORIA

To be fully covered in Victoria for emergency transport, you need to take out an Ambulance Victoria subscription. Visit the Ambulance Victoria website for joining options. When you've signed up, MHF will pay a benefit towards your ambulance subscription each year if you hold an *eligible extras cover, to help offset the cost of your comprehensive ambulance cover. With an Ambulance Victoria Subscription, you are covered in full for emergency ambulance transport, paramedic care and treatment, including air ambulance throughout Australia. Visit the Ambulance Victoria website: www.ambulance.vic.gov.au/membership/ to join.

NEW SOUTH WALES (NSW) AND THE ACT

If you reside in NSW or the ACT and have joined hospital cover, you are automatically covered for Australia-wide road and air emergency ambulance transportation provided by a State or Territory ambulance service.

MHF pays a levy on behalf of members who reside in NSW or the ACT to cover the cost of ambulance transportation. If an ambulance is called, you will receive an invoice from the ambulance service that provided the transport. Just send the invoice on to us and we'll let them know you're covered.

If you hold Extras only, MHF does not provide benefits against the cost of ambulance travel and does not offer 'ambulance only' insurance. To be covered for comprehensive ambulance services Australia wide, you will need to purchase a standalone ambulance subscription.

Members who hold *eligible extras cover with the Fund can claim a benefit on their ambulance subscription fee. Benefit amounts vary depending on the level of cover held.

For further information about NSW or ACT ambulance, visit www.ambulance.nsw.gov.au for NSW residents and www.esa.act.gov.au for ACT residents.

SOUTH AUSTRALIA

MHF does not provide benefits against the cost of ambulance travel and does not offer 'ambulance only' insurance. To be covered for comprehensive ambulance services Australia wide, you will need to take out a Standard Plus interstate subscription with the South Australian Ambulance Service (SAAS).

Members who hold an appropriate level of extras cover with the Fund can claim a benefit on their ambulance subscription fee. Benefit amounts vary depending on the level of cover held.

TASMANIA

Tasmanian residents are covered by a State based scheme.

For more information check out the Ambulance Tasmania website www.dhhs.tas.gov.au/ambulance

WESTERN AUSTRALIA

If you reside outside of metropolitan Perth, you need to contact your local St John Ambulance company to take out an Ambulance subscription.

Residents in Metropolitan Perth need to take out a standalone Ambulance Transport cover

If you hold an *eligible extras cover with MHF, we will pay a benefit towards the cost of your subscription each year.

Contact St John Ambulance directly for information on 08 9334 1284, as your postcode will determine how you can purchase your St John Ambulance subscription

QUEENSLAND

All Queensland residents are automatically covered for the cost of emergency services Australia wide. This is paid for by the QLD state government. You don't have to do anything. For more information visit the Queensland Ambulance Service website www.ambulance.qld.gov.au

NORTHERN TERRITORY

If you take out a subscription with St Johns Ambulance Service NT you will be covered Australia wide. When you've signed up, MHF will pay a benefit towards your ambulance subscription each year if you hold an *eligible extras cover, to help offset the cost of your comprehensive ambulance cover. For more information visit the St John Ambulance NT website www.stjohnnt.org.au

DO YOU STILL HAVE QUESTIONS?
Contact our Ambulance cover specialist who can discuss your options with you.

**Eligible extras – Five Star Extras, Mid Extras and Base Extras*

MEMBERSHIP APPLICATION /CHANGE OF DETAILS FORM

☐ Application to join Mildura Health Fund
☐ Change level of cover
☐ Add/Remove person(s) from this membership
☐ Transfer to Mildura Health Fund- Complete Transfer Certificate Request
☐ Change of contact details
☐ Add Delegated Authority
☐ Add Direct Debit/Credit details- change payment option
☐ Register for Rebate/Change Rebate Tier
☐ Other

I would like my Application/Change of details to take effect from: __ __ / __ __ / __ __ __ __

MEMBER'S DETAILS		
Title:	**M / F / X**	**Membership Number:**
First name:	**Second name:**	**Last name:**
Home Address:		**Date of Birth:**
Postal Address:		**Phone:**
Email Address:		**Mobile:**
Medicare card no:		**Expiry date:**

* By giving us your email address you are consenting to receive correspondence via email

Please tick your level of cover ☐ Single ☐ Single Parent ☐ Single Parent Plus ☐ Family ☐ Family Plus

OTHER PEOPLE ON YOUR MEMBERSHIP (family type policy)			
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**

HOSPITAL COVER		EXTRAS COVER	
Five Star Gold	**Basic Plus Hospital**	**Combined Extras**	**Stand Alone Extras**
☐ F2- $250/$500 Excess	☐ H1- Basic Plus $750/$1500 Excess	☐ E1- Five Star Extras	☐ A1- Mid Extras
☐ F3- $500/$1000 Excess		☐ A1D- Mid Extras & Dental Cover	☐ A- Base Extras
☐ F4- $750/$1500 Excess		☐ AD- Base Extras & Dental Cover	☐ D- Dental Only Cover

This space is for office use only:

Mildura Health Fund
ABN 13 078 202 089 / ACN 078 202 089
79 Deakin Ave Mildura Vic 3500
PO Box 5046 Mildura Vic 3502
T 03 5023 0269
F 03 5023 7732
E mhf@mildurahealthfund.com.au
www.mildurahealthfund.com.au

TRANSFER CERTIFICATE REQUEST FORM

Member name:	**Date of Birth:**
Partner Name:	**Date of Birth:**
Name of existing health fund:	**Member No:**
Date of cancellation:	
Have you been with this Health Fund for more than 12 months? If no, please supply your previous health fund name and membership number:	

DELEGATED AUTHORITY

For your convenience, you may wish to nominate someone else (not covered by this membership) to act on your behalf when dealing with Mildura Health Fund. An authorised person is able to make claims on your behalf and has access to your personal information.

Nominated Person:	**Surname**	**Given Names**	**Relationship to Member**
Title			
Phone		**Email**	

DIRECT DEBIT REQUEST (DDR)

☐ **Direct Debit** **(Note: This account will also be used for any refunds or benefits payable to you)**

Name of Financial Institution
Name of Account Holder/s

BSB | | | | | | | **Account Number** |

Please debit my Mildura Health Fund contributions from the above account on **Date:**

☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ 6 Monthly ☐ Yearly

Or Receive Account ☐ Quarterly ☐ 6 Monthly ☐ Yearly

I Request and authorise Mildura Health Fund (18530), until further notice to arrange, through its own financial institution, a debit to your nominated account any amount payable under my selected Mildura Health Fund cover.

This debit will be made through the Bulk Electronic Clearing System (BECS) from your account held at the financial institution you have nominated and will be subject to the terms and conditions of the Direct Debit Request Service Agreement'.

Acknowledgment: By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between you and Mildura Health Fund as set out in this Request and in your Direct Debit Request Service Agreement

Account Signature:	**Date:**

APPLICATION FOR THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

This section must be completed to receive the Australian Government Rebate on Private Health Insurance as a reduced premium.

If you do not complete this section, full rate membership fees will apply.

You need to notify Mildura Health Fund as soon as possible should you want to nominate a new income tier or stop receiving the Rebate.

Are you covered by this policy? ☐ Yes ☐ No

Are all people on the policy eligible for Medicare? ☐ Yes ☐ No

Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Rebate Tier: The Rebate you receive depends on your household income, the age of the oldest person on your membership, inflation (CPI) and average health fund industry increases. Refer to the Rebate table in our current brochure to determine your Rebate Tier. For more information about the Australian Government Rebate on Private Health Insurance, go to www.humanservices.gov.au/privatehealth

Rebate Tier: ☐ **Base Tier** ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 3**

Privacy Notice: Your information may be provided to the Australian Government Department of Human Services. The Department of Human Services uses this information for administering the Australian Government Rebate on private health insurance as a reduced premium. The collection of this information is permitted by the Privacy Act 1988. The Department of Human Services may disclose this information to other Commonwealth departments or agencies, anyone who you have agreed to have your information or other parties where the release is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the Department of Human Services will manage your personal information, including its privacy policy, at humanservices.gov.au/privacy.

If your Medicare Card is a Reciprocal ☐ **or Interim card** ☐ Please tick appropriate box

DECLARATION

I agree to the collection and storage of private/sensitive information by Mildura Health Fund for private health insurance purposes, and accept the rules, Privacy Policy, and Disclosure Statement of Mildura Health Fund, and undertake to inform all persons of consent age covered by this policy of the above. I understand the conditions of membership, waiting periods and Pre-Existing Conditions (please refer to the Pre-Existing Conditions rule in the brochure). I also agree to become a member of Mildura Health Fund and to be bound by the constitution and rules of the Company.

I declare that the information I have provided in this form is complete and correct and understand that giving false or misleading information is a serious offence.

Signature:	**Date:**

YOUR RIGHTS AS A MEMBER OF MILDURA HEALTH FUND

COMPLAINTS OR DISPUTES

At Mildura Health Fund, we are continually looking for ways to serve you better and member satisfaction is extremely important to us.

If you ever have a complaint or dispute relating in any way to your membership, contact us directly as quickly as possible at memberexperience@mildurahealthfund.com.au or phone 03 5023 0269.

Making a complaint to the Commonwealth Ombudsman

If we have done all we can to rectify the situation and you are still not satisfied with the outcome, you have the right to request an independent review from the Commonwealth Ombudsman, whose duty it is to provide advice and information and attempt to resolve complaints about health insurance.

To make a complaint, contact the Commonwealth Ombudsman at www.ombudsman.gov.au or phone 1300 362 072.

For general information about private health insurance, see www.privatehealth.gov.au

COOLING OFF PERIOD

Our 30 day cooling off period applies to new members, and existing members, who upgrade or downgrade their level of cover.

Just let us know in writing, within the 30 days of joining, or changing your cover if you have changed your mind. As long as no claims have been made against your membership, we can either transfer you to a more suitable cover or refund your premiums in full.

PRIVACY

To provide our services to you, we need to hold certain personal information about you.

We will respect your privacy. We are committed to ensuring that any personal information you entrust us with is protected against misuse. A copy of our privacy policy is available on our website: mildurahealthfund.com.au Alternatively, contact our office and we will provide you with a copy.

REPORTING FRAUD IF YOU SUSPECT THAT A PERSON OR GROUP IS ENGAGING IN HEALTH INSURANCE FRAUD, PLEASE CONTACT OUR INVESTIGATIONS TEAM ON (03) 5021 7010 OR EMAIL INVESTIGATIONS@MILDURAHEALTHFUND.COM.AU

IT'S EASY TO JOIN MILDURA HEALTH FUND

CALL
03 5023 0269

VISIT
one of our three locations

ONLINE
mildurahealthfund.com.au

TRANSFER
from another health fund

Head Office: Mildura Health Fund
79 Deakin Avenue, Mildura Vic 3500
Open: Weekdays 8:30am - 5pm

PO Box 5046, Mildura Vic 3502
T 03 5023 0269
E mhf@mildurahealthfund.com.au
ABN 13 078 202 089
www.mildurahealthfund.com.au
Follow us on:

Swan Hill branch
175 - 177 Beveridge St, Swan Hill
Open: Monday to Friday 8:30am - 5pm

Broken Hill branch
320 Argent St, Broken Hill
Open: Monday to Friday 8.30am - 5pm
T 08 8005 8700

Mildura HEALTH Fund