1 April 2022

Deluxe Extras

Want extra Extras? Our deluxe-level Extras cover offers high limits on a wide range of the most popular services, including optical, dental and physio. The best option for singles, couples and growing families who expect to be high claimers.

What does Deluxe Extras cover you for?

Over the page, you'll find a comprehensive list of the products, services and treatments you can claim under your Deluxe 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 benefit applies 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 Deluxe 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, every item number has a set benefit – there are hundreds 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 Deluxe 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 Deluxe Extras, most annual limits apply 'per person', which means that each person covered by the membership can claim up to that amount. However, there are a few 'membership' limits, which are maximum amounts shared by everyone covered by the membership.

On 31 December of each year, any unused annual limits expire, and they reset again on 1 January. It's not possible to roll over 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 Deluxe Extras cover are shown over the page. If you're not sure whether you've served your waiting periods, 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 Transport Health membership card to make an on-the-spot claim. You'll swipe your Transport Health 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 Transport Health 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 YOUR CLAIM

If on-the-spot claiming is not available, you have two options.

1. Download our free Transport Health Mobile Claims app from the App Store or Play Store.

OR

2. Fill out 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 years are not payable.

DELUXE EXTRAS 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
General dental	Includes x-rays, surgical items, preventive dentistry, restorations (fillings), scaling and cleaning, extractions, mouthguard, fluoride application and more	60% of the fee charged		$800 per person	2 months
Major dental	Periodontics, endodontics, crowns and bridges, dentures and occlusal therapies			*$800 per person 1-3 years* *$1,000 per person 3-5 years* *$1,200 per person 5 years+* **Dentures claimable every three calendar years*	12 months
Orthodontics	All orthodontic treatment *(treatment plan required)*	100% of the fee charged		$500 per person 1st year $850 per person 2-4 years $1,000 per person 5 years+ $2,500 lifetime limit	12 months
Optical	All prescription frames, lenses and contact lenses, including Irlen lenses	100% of the fee charged		$300 per person	6 months
Therapies **Physiotherapy, myotherapy, chiropractic, osteopathy and podiatry**	Initial consultation Subsequent consultation	$42 $32		$850 per person $1,700 per membership	2 months
Acupuncture, remedial massage, Chinese herbalism, speech therapy, eye therapy (orthoptics), occupational therapy and dietetics	Initial consultation Subsequent consultation	$37 $27		$600 per person $1,200 per membership	
Psychology	Initial consultation Subsequent consultation	$70 $50		$500 per person $800 per membership	
Pharmaceuticals	Up to	$50 per script	Per non-PBS prescription payable after you have paid the equivalent of the PBS patient copayment amount for each item. A letter from a medical practitioner is required for some claims.	$400 per person $800 per membership	
Home Surgical Nursing		$22 per visit	Itemised account required including provider details.	$400 per person $800 per membership	
Health Aids **Orthotics**	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.	80% of the cost		$200 per person	12 months
Artificial eye/limb, blood glucose monitor, blood pressure monitor, nebuliser kit, asthma pump, peak flow meters and compression garments (non-sports)		80% of the cost to a maximum of $200 per aid		$400 per person $800 per membership	
Health First **Approved programs; MRI scans (where no Medicare benefit is payable), specialist skin testing, quit smoking programs, weight-loss and stress management programs (consultations only)**		70% of the cost per program to a maximum of: $200 per person $400 per membership		$300 per person $600 per membership	2 months
Membership Fees **(registered organisations e.g. Diabetes Australia)**		$20 per person			
Laser Eye Correction Surgery				$300 per person 3-5 years $500 per person 5 years+ $500 lifetime limit	36 months
Hearing Aids	Claimable every 3 years	100% of the charge		$1,000 per person	24 months
Audiology	Initial consultation Subsequent consultation	$32 $22			2 months

Read more about your Extras cover in online A to Z guide which can be found under 'Your Cover' on our website. You can find a copy of the Private Health Information Statement by visiting PrivateHealth.gov.au

Effective 1 April 2022. 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 Pulse Newsletter. While you are making your decision about whether to join Transport 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.

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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.

Transport Health