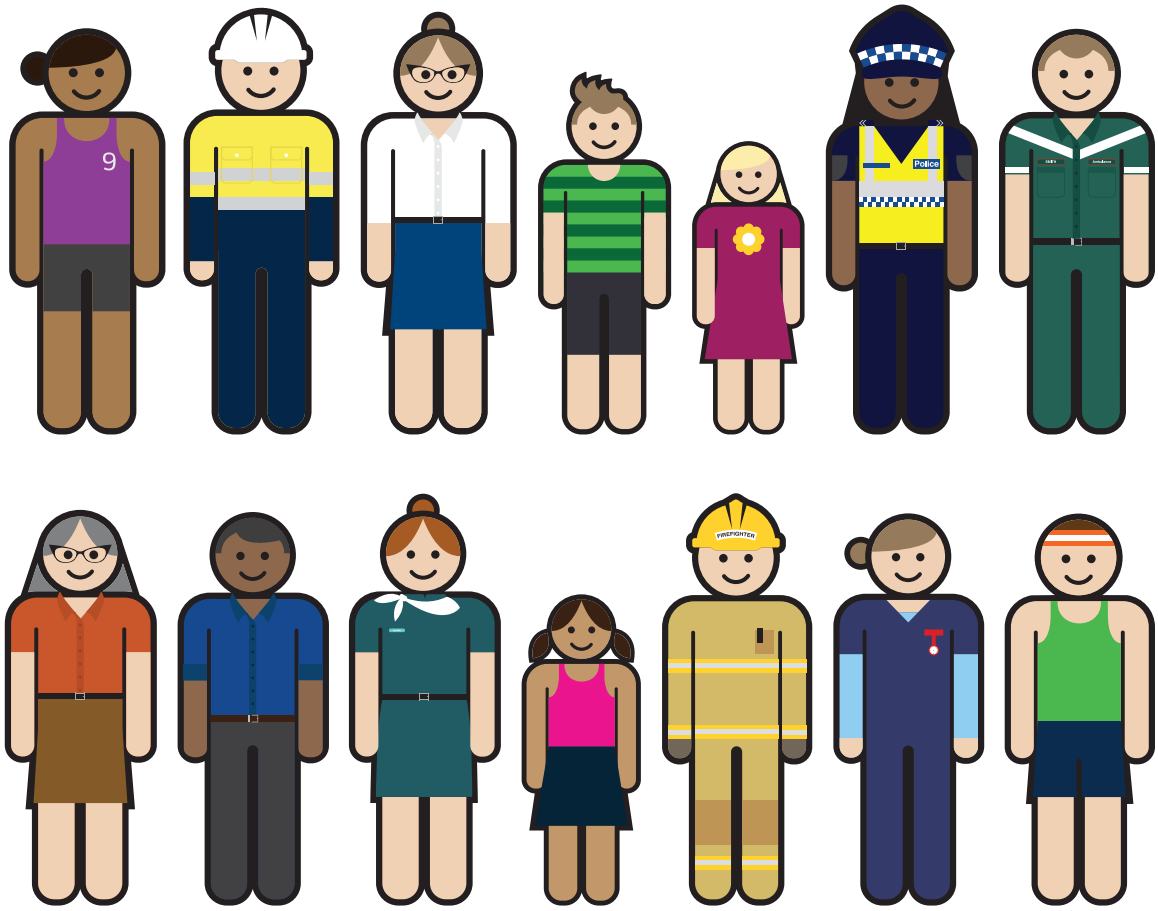
TUH Health Fund

MEMBERS OWN HEALTH FUND

Important Information Guide



Effective 1 January 2018

Please carefully read and retain this brochure.
Refer to your relevant product brochure for specific information about your cover.

This publication gives an outline of the general information you'll need to understand your health insurance and make informed choices about your cover. Terms that are underlined are explained further in the Definitions, terms and conditions section.

For details about our rules and conditions, please contact us for a copy of our Fund Rules.

All together better.

Contents

Icons explained

Contact us

Refer to product brochure

See our website

Information in this brochure is correct at time of printing and may be subject to change. TUH may change the premiums for any cover. We will advise any affected members if this occurs.

Here are a few things you should know about your private health insurance policy.

Membership

Your membership starts on your join date and you may be eligible to claim once you have paid a premium. Your membership card may be needed to claim, so keep it handy. If you lose it, contact us and we'll replace it. You'll be unable to use your old card, once it has been replaced.

Membership categories

Single membership covers one adult only.

Single parent membership covers one adult and their dependants.

Couple Membership covers one adult and their partner or two adults living in the same household.

Family membership covers one adult and their partner or two adults living in the same household; and their dependants.

Who is the "policy holder"

The policy holder is the person in whose name the membership is held and the person who holds the legal responsibility for the membership. Only the policy holder can terminate the membership or remove dependants. See Spouse/partner authority.

How to claim

You can make claims or other transactions once your first premium payment has been received.

There are waiting periods on your cover, which means that you may have to be a member for a period of time before you can make a claim. Waiting periods can vary between different services so refer to your product brochure for details. For further details see Claiming.

Payments

Your health insurance premiums are payable in advance. Your membership payments must be up to date to enable you to make claims. Your membership will automatically cease if your payments are more than two months in arrears. If you are experiencing difficulty in making regular payments, please contact us to discuss payment options.

The following payment methods are available:

Direct debit - Payments can be debited fortnightly, monthly, quarterly and half-yearly.

Credit card - Payments can be charged monthly, quarterly and half-yearly.

Accounts - Accounts are sent monthly, quarterly and half-yearly.

Payment methods include:

- BPAY;
- Member Services Online (credit card only);
- in person (at our Health Hub);
- by telephone; and
- by mail (cheque).

Want to change your membership?

We recommend you check your cover carefully to ensure it meets your current needs and review it periodically. When your circumstances change you may need to update your membership category (single, family etc.) or level of cover, or add/remove persons from your membership.
You can update most of these details via Member Services Online or download a *Change to Membership Details form* from our website. In the unfortunate event a person on your membership dies, please let us know as soon as possible—we'll advise you if you need to move to a different category of cover.

Changing your level of cover

Waiting periods and Benefit Limitation Periods will apply to any increases/upgrades in cover for existing TUH members or those transferring from a lower level of cover at another fund. The previous level of cover will apply until all appropriate waiting periods have been served. Please contact us to discuss your individual circumstances.

Years of membership with your previous fund are not recognised.

Changing to a cover with a lower excess is considered to be an upgrade of cover.

If you reduce your level of cover, the lower benefits on your new cover will apply immediately if you have served your current waiting periods.

Changing your contact details

Only you, or your authorised partner listed on the membership, are permitted to change the address details. You can update and access your account details via Member Services Online or download a *Change to Membership Details form* from our website or call us.

Changing your payment method/frequency

You can change your payment method or frequency by giving us a call, using our Member Services Online portal on our website, or our smart phone app. See Payments.

About hospital cover

What is covered?

With hospital cover, you are covered for medically necessary treatment in Australian private hospitals that TUH has a contract with. For eligible private inpatient services, Medicare will cover 75% of the Medicare Benefit Schedule (MBS) fee set by the Government for doctor's charges. TUH will cover the remaining 25%.

Your cover includes accommodation, theatre fees, intensive care, coronary care, industry approved prostheses (see Surgically implanted prostheses) and hospital medication allowed under law.

You can also choose your own doctor and get quick access into almost all private hospitals in Australia. An updated list of these hospitals is available on our website.

What is not covered?

We pay benefits in accordance with the law and TUH Fund Rules and policies. The items that we do not pay benefits for include, but are not limited to:

- hospital treatment that is not medically necessary or treatment which is not eligible for Medicare benefits;
- cosmetic surgery;
- outpatient treatment;
- charges above the Medicare Benefits Schedule (MBS) fee;
- some pharmacy items;
- personal incidentals;
- experimental procedures/therapies;
- high cost medications;*
- robotic surgery consumables;*
- medical devices not included in hospital theatre fee charges as determined by law;
- emergency department;
- procedures or services that are excluded on your cover; and
- treatment while you are serving a waiting period.

*Special consideration for benefits toward high cost medications, exceptional medical procedures or other extraordinary costs related to the health care of a TUH member may be given at the discretion of TUH in accordance with the hospital contract. Requests are considered on a case by case basis.

Hospital types

Contracted hospitals:

TUH has contracts with an extensive network of hospitals. These contracts enable us to pay in line with the Private Health Insurance Act for services included on your cover (less any applicable excess). Benefits are paid in accordance with each individual hospital contract. Please visit our website to search for contracted hospitals, or call us prior

to hospital admission.

Non-contracted hospitals:

If you choose to be admitted to one of these hospitals you will receive a default benefit.

Private or public hospitals:

You can choose to be treated as a private patient in either a private or a public hospital. We have agreed rates with our large network of contracted hospitals, which don't include public hospitals. Therefore if you choose to stay as a private patient in a public hospital it may result in higher costs to TUH which, in the long term, may affect your premiums. You can confirm the costs with the hospital prior to admission. See Informed financial consent.

You have the option of being treated as a public patient in a public hospital at no charge, even if you have private health insurance.

Hospital excess

See Excess.

Inpatient/outpatient

You're an 'inpatient', when you have been admitted into a hospital for treatment. There are many occasions, such as follow-up consultations after surgery, pre-natal visits, x-rays and the emergency department, where you may receive medical services but not be admitted. In these cases, you're known as an 'outpatient'.

Hospital benefits will only apply for medically necessary inpatient treatment as determined by law.

For medical services not related to inpatient treatments (outpatient treatment), such as a specialist appointment or a pathology test, Medicare will cover 85% of the Medicare Benefit Schedule fee. However, the law does not allow for any remaining cost to be paid by TUH.

About extras cover

What is covered?

You can choose to be covered for a large range of extras services, including dental, optical and other health care services such as physiotherapy, chiropractic, remedial massage, etc. See your product brochure for a full list of benefits and limits. Your annual limits are reset on 1 January. You can check your limits via Member Services Online on our website.

Benefits are paid for treatment by registered practitioners in private practice and recognised natural therapists approved by TUH. Please contact us to check if your provider or natural therapist is recognised by TUH.

What is not covered?

We pay benefits in accordance with the law and TUH Fund Rules and policies. The items that we do not pay benefits for include, but are not limited to:

- services where a benefit is payable by Medicare;
- treatments by providers not recognised by us for benefit purposes;
- services which took place two years or more before the date of lodgement of the claim;
- overseas products, treatments or services;
- telephone and email consultations or letters of advice by providers;
- treatment by a provider who is a family member including (but not restricted to) partner, brother, sister, father, mother, son, daughter or self treatment; and
- vitamins and supplements.

Restrictions may apply for multiple treatments on the same day.

Definitions, terms and conditions

Access Gap Cover

TUH aims to close the gap on out-of-pocket in-hospital medical expenses for our members. Access Gap Cover is available with any level of hospital cover. Participation in this scheme is the personal choice of your medical practitioner, so check this before commencing treatment. Also ask your specialist to confirm that any assisting specialist/s use Access Gap Cover for billing services.

How Access Gap Cover works

For eligible inpatient services, Medicare will cover 75% of the Medicare Benefit Schedule (MBS) fee set by the Government for doctor's charges. TUH will cover the remaining 25%.

Prior to treatment request an estimate of costs from your doctor. See Informed Financial Consent.

If your doctor charges above the MBS fee, this is an out-of-pocket cost. If your doctor uses the Access Gap Cover scheme you will either:

- have lower out-of-pocket costs; or
- have no out-of-pocket costs.

If your doctor participates in the Access Gap scheme, in most cases, you will not receive an account as TUH receives the bill and makes any claims on your behalf from Medicare and pays the doctor directly. You can download an Access Gap checklist on our website. See also Medical Gap cover.

Accidents

You are immediately covered for hospital treatment for accidents with no waiting periods to serve, providing you joined TUH prior to the accident and have the appropriate level of cover for that treatment.

If you have been involved in an accident and received compensation or damages from a third party, additional benefits cannot be claimed in relation to this accident.

Any benefits and any associated costs already paid by TUH must be repaid if you receive compensation. See Emergency departments.

Active Health Bonus

The Active Health Bonus is a reward available to members with eligible levels of cover, when one adult member completes our online health assessment, Health-e-Profile. You may use the bonus to pay the out-of-pocket costs for extras treatments (up to the annual limit).

- participation requires the completion of one questionnaire in each consecutive twelve month period.
- the Active Health Bonus limit is per policy per calendar year.
- a six month waiting period to receive the bonus applies from your join date.

The following are not claimable under the Active Health Bonus:

- co-payments for Pharmaceutical Benefit Scheme (PBS) prescriptions;
- any difference between the Medicare Benefits Schedule fee and the doctor's charge for medical expenses;
- any medical expense our Fund Rules or legislation prevents us from paying; and
- hospital excesses.

If you decrease/change your level of cover, you may receive a reduced or no Active Health Bonus.

Australian Government Rebate on Private Health Insurance

See Rebate.

Ambulance transport

Emergency ambulance transport is covered when it results from an event that is unplanned, non-routine and which requires transport to hospital for immediate medical attention.

You are not covered for transportation from a hospital to: your home, a nursing home, or another hospital (if you have been admitted to the transferring [first] hospital). You are also not covered for transportation from your home, a nursing home or hospital for ongoing medical treatment, e.g. chemotherapy or dialysis. No benefit will be paid in respect of air ambulance services.

QLD residents

All Queensland residents are covered by Queensland Ambulance Service (QAS) arrangements, including interstate travel. Any claims are to be submitted directly to QAS.

NSW and ACT residents

If you live in ACT or NSW an ambulance levy to cover transportation by NSW ambulance is included in your hospital cover. If you receive a NSW Ambulance account, send it to us. If you require transportation in another State you will be covered if you have combined hospital and extras cover.

When a dependant resides in NSW or the ACT, but the main member's residential address is in another state ambulance transport is only covered on combined hospital and extras covers.

TAS residents

All Tasmanian residents are covered by Ambulance Tasmania. If a Tasmanian resident requires services in QLD or SA, they're not covered by the state scheme and can only claim if they are on combined hospital and extras cover.

All other states and territories (for members who have combined hospital and extras policies)

You are entitled to full cover for emergency ambulance transportations if you have combined hospital and extras cover. If you receive an ambulance account, send it to us for payment.

Benefit

The amount you receive from TUH when you make a claim. See your product brochure for a list of benefits payable under your cover or please call us.

Benefit Limitation Period (BLP)

A benefit limitation period of the first 24 months of membership* applies for members who are new to private health insurance and those upgrading from a hospital cover which excludes or restricts benefits for the below services.

Easy Choice, Total Care Hospital ($0 excess or $300 excess)

- Psychiatric services
- Gastric banding and bariatric/ obesity surgery, including reversal

Total Care Hospital ($500 excess)

- Psychiatric services
- Gastric banding and bariatric/ obesity surgery, including reversal
- Obstetrics (pregnancy and birth-related treatment)
- Newborn/neonatal care

During the BLP, we pay the public hospital default benefits as per the law, which means you may have significant out-of-pocket costs to pay for the treatment. Waiting periods still apply for services with a BLP. For example, after serving the 2 months waiting period for psychiatric services, your benefit will be limited to a default benefit for the following 22 months. After 24 months, you are entitled to the full benefit claimable for the treatment.

* Members who joined Easy Choice or Total Care Hospital between 1 November 2016 and 3 October 2017 have a BLP of the first 12 months of membership on psychiatric services only.

Calendar year

A 12-month period commencing 1 January and ending 31 December.

Claiming

If a benefit is payable to you, it will be paid directly into your nominated bank account.

We offer five easy ways to claim:

- **via HICAPS/iSoft** at your participating health care provider - just swipe your membership card and your benefit is applied immediately;
- **online claiming** for eligible services through Member Services Online on our website. Please retain your original accounts/ receipts for 12 months after your claim has been paid, as they may be subject to audits;
- **to claim on your smart device**, download the TUH smart phone app, then photograph your receipts and submit your claim;
- **to claim in person or by mail**, download the *Claim form* from our website, complete the form and mail or bring it into our Health Hub with the original accounts/receipts.

For inpatient Medical Gap Cover treatment the Medicare statement of benefits is required to process your entitlements.

We will retain all documents unless you indicate otherwise.

Any account or receipt submitted must be on an official receipt or account form, and bear the provider's official stamp. It must be legible and display the provider's name, provider number, practice address, ABN/ACN, the date of service, a description of the service, the name of the patient and the cost. Cash register dockets will not be accepted.

All claims are subject to Private Health Insurance legislation, Fund Rules and policies and procedures.

Cooling off period

You have the right to a 30-day cooling off period if you change your mind about joining TUH or changing your level of cover. There are to be no claims made during the cooling off period. The 30-day period commences from:

i. the joining date;
ii. the date the level of cover increases; or
iii. the date the level of cover decreases.

For ii and iii the cover reverts back to the previous level of cover.

Cosmetic surgery

"Cosmetic surgery" refers to procedures performed for non-medically necessary reasons. We are unable to pay benefits for these procedures or the hospital costs associated with them.

To help us determine if your treatment is medically necessary, we may ask for further information from your treating practitioner before we can confirm your correct benefit entitlements. If in doubt, talk to your doctor and call us before committing to any treatment. See Plastic and reconstructive surgery.

Default benefit

This benefit is determined by the Government and is the minimum amount funds must pay for accommodation costs in hospitals. Default benefits do not provide any benefit for labour ward or theatre fees. The default benefit covers the cost of:

- shared accommodation as a private patient at a public hospital;
- a reduced level of accommodation benefits as a private patient at a private hospital;
- Access Gap/Medical Gap Cover with participating doctors; and
- surgically implanted prostheses – we will cover the full cost of any Government approved (no gap) prostheses and the minimum benefit for gap permitted prostheses.

Significant out-of-pocket costs may result if the treatment can only be claimed at default benefit rates so remember to check whether your level of cover suits your needs.

Dental

The dental treatments you're covered for depend on the item number for that treatment. Some covers exclude certain procedures. Contact us for a quote on the item number or use the benefit quote function in Member Services Online.

Dental prosthetists

Benefits are paid for treatment by registered dental prosthetists at 75% of the benefit which would be payable for treatment provided by registered dentists.

Mouthguards are also covered under this category of treatments with a limit of one per person per calendar year.

Major dental

Major dental includes all dental services relating to dentures, crowns, bridges, inlays, onlays, facings, dental implants, endodontia, periodontia, anti-snore devices and orthodontia. Conditions apply for Active Choice, Young Choice and Mid Range Extras. Major dental is not covered on Basic Extras.

Orthodontics

Benefits are paid for active treatment and annual limits apply. To be eligible you must submit an orthodontic treatment plan from your orthodontist at the commencement of treatment. TUH will advise the benefits available in writing, taking into account

previous orthodontic benefits paid by TUH or any previous fund and length of active treatment. For more information please contact us.

Dependant

- A natural child, stepchild, legally adopted child or child to whom the policy holder is the legal guardian or who is in the policy holder's legal custody.
- The policy holder's adult children, who are not married or in a de facto relationship and who are under 21 years of age.

Extended dependant cover

TUH offers single parents and families with non-student children (including apprentices) the opportunity to purchase extended dependant cover. This allows young adults who are single, not covered as a student dependant and earning less than $50,000 (taxable income) a year, to be covered on their parents'/ guardians' policy until the age of 25.

Extended dependant cover is available for Ultimate Choice, Easy Choice and Total Care Hospital with $300 excess combined with Comprehensive Extras.

Student dependants

A policy holder's student dependent child who is:

- a full time student at a recognised education facility for the whole of the academic year;
- under age 25;
- unmarried and not in a de facto relationship; and
- earning a taxable income under $50,000.

A policy holder must complete and return to TUH a Student Dependant Registration form (available on our website) upon commencement of study.

Students are not covered if they cease or defer study during the year.

Emergency departments

Visits to public or private hospital emergency departments or other hospital treatments where you are not admitted as an inpatient (as determined by law), are not covered by private health insurance.

Excess

An excess is an amount you elect to contribute towards the cost of your hospital treatment (including same day surgery and procedures, such as chemotherapy and dialysis). Agreeing to pay an excess if you need hospitalisation reduces the amount of premium you pay.

The hospital excess is not charged for dependants.

Note: Reducing your excess is considered to be upgrading your membership. We will charge your previous excess within the first 2 months of the upgrade for pre-existing ailments or conditions.

Excluded services

These are services for which no benefit is payable under some levels of cover. Examples of excluded services for some covers include:

- obstetrics (pregnancy and birth related treatment);
- labour ward;
- infertility investigations and assisted reproductive services;
- sterility reversals;
- hip, knee and joint replacements;
- eye surgery, including cataracts; and
- dialysis for chronic renal failure.

Please contact us or refer to your product brochure for exclusions and restrictions that might apply to your level of cover.

Informed financial consent

Before you receive treatment as a private patient in hospital, you are entitled to ask your doctor, your health fund and your hospital about any out-of-pocket costs you may incur.

Ask your treating doctor or specialist, wherever practical, how much their fee will be and if you will need to pay a gap. For major treatment, this information should preferably be provided in writing. It is your right to ask for this information before you agree to a proposed treatment. In some circumstances, such as emergency admissions, it will not be possible for your doctor to obtain informed financial consent before the service is provided.

You may have more than one doctor involved in your treatment, such as a surgeon and anaesthetist. Your surgeon should be able to advise who else will be treating you and how you can contact the other doctors to seek fee information from them. See also Access Gap Cover.

Law/legislation

The main law governing private health insurance is the Private Health Insurance Act 2007 and associated Rules. TUH must also comply with its Fund Rules.

Lifetime Health Cover

Lifetime Health Cover is a Government initiative designed to encourage people to join a private health fund early in life and to maintain membership. If you take out hospital cover after the 1st July following your 31st birthday, your base premium will increase by 2% for each year you are over the age of 30 up to a maximum of 70%. This surcharge also applies to your partner if over 30. If you were born on or before 1 July 1934 you will not be affected by the Lifetime Health Cover surcharge.

Any loading you pay is removed once you have paid the higher premium for a continuous period of 10 years.

IMPORTANT: Having extras cover only will not exempt you from paying the Lifetime Health Cover loading.

Limit

Annual limit

The maximum amount payable per calendar year for an extras benefit. The annual limit is renewed on 1 January each year.

Sub limit

A limit which is applied annually (or another specified period of time) on the benefit paid for a particular item or service within an overall category limit.

For example:

With our Easy Choice cover, you have an annual overall major dental limit of $2000. Crowns and bridges have a sub-limit of $650 for your first year, so this is the maximum you can claim for this item. Your overall annual limit will then be reduced to $1350 which you can use for other treatments within the major dental category.

Maternity

See Obstetrics (pregnancy and birth related treatment).

Medical Gap

For eligible inpatient services, Medicare will cover 75% of the Medicare Benefit Schedule (MBS) fee set by the Government for doctor's charges. TUH will cover the remaining 25%. If your doctor charges above the MBS fee, this is an out-of-pocket cost.

Medical practitioner

Means a medical practitioner within the meaning of the Health Insurance Act 1973.

Membership eligibility

You must be aged over 18 and meet the eligibility criteria set out below to qualify for membership with TUH:

- current or former member of any Australian union, or
- a family member of a current or former union member, or a TUH member. This includes parent, partner or former partner, dependent child, adult child (and their partner), grandchild, brother or sister (and their partner and dependent children).

Medicare Benefits Schedule

The benefits you receive from Medicare are based on a schedule of fees for medical services set by the Australian Government. The Medicare Benefits Schedule (MBS) lists a wide range of consultations, procedures and tests, and the schedule fee for each of these items. Benefits are only payable for hospital procedures that are listed in the MBS and/or meet the eligibility criteria for Medicare benefits. You can look up a service or item number via www.mbsonline.gov.au or ask your medical practitioner.

Nursing Home Type Patients

Non-acute certified admissions exceeding 35 days may be defined as Nursing Home Type Patient. A co-payment may apply, please contact TUH for more information.

Out-of-pocket costs

Hospital

Possible hospital out-of-pocket costs include:

- hospital treatment that is not medically necessary or treatment which is not eligible for Medicare benefits;
- charges in excess of the public hospital default benefit during a relevant benefit limitation period;
- cosmetic surgery;
- outpatient treatment;
- charges above the Medicare Benefits Schedule (MBS) fee;
- some pharmacy items;
- personal incidentals (e.g. toiletries, newspapers, tv, etc.);
- experimental procedures/therapies;
- high cost medications;*
- robotic surgery consumables;* and
- medical devices not included in hospital theatre fee charges as determined by law.

*Special consideration for benefits toward high cost medications, exceptional medical procedures or other extraordinary costs related to the health care of a TUH member may be given at the discretion of TUH in accordance with the hospital contract. Requests are considered on a case-by-case basis.

Access/Medical Gap Cover is limited to treatment provided during inpatient hospital admission.

For more information please refer to the Commonwealth Ombudsman's brochure 'Doctor's Bills' which you can download from its website **www.ombudsman.org.au**. Alternatively you can contact us and we'll send you a copy.

Extras

An extras out-of-pocket cost is the difference between the amount a service provider charges and the benefit TUH pays. For example, if a physiotherapist charges $70 for a visit and TUH pays a benefit of $32, the out-of-pocket cost would be $38.

Visiting a preferred service provider may reduce the out-of-pocket costs you are required to pay. For a list of TUH's preferred dental and optical providers, please refer to our website.

Overseas products, treatments and services

We do not pay benefits for services provided or products purchased overseas, including internet purchases where the goods are provided from an overseas supplier. This is to ensure you receive the high level of consumer protection and quality of service that is provided under Australian standards and health conditions.

Overseas travel

Private health insurance does not cover you for medical/hospital/extras treatment received while travelling overseas or while on a cruise ship in Australian waters. We recommend you obtain travel insurance for all overseas travel.

Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) is run by the Australian Government to subsidise prescription medicines for Australians who have a Medicare card. If a medicine is subsidised under the PBS, you pay a lower price for the medicine, and the Government pays the rest. For more information, see **www.pbs.gov.au**.

If your cover includes pharmaceutical, you are able to claim the amount above the PBS fee up to the benefit amount.

Plastic and reconstructive surgery

Plastic and reconstructive surgery refers to the evaluation and treatment to correct functional impairments caused by trauma and congenital abnormalities. Plastic surgery can be performed to approximate a normal appearance, for example, a breast reconstruction following a mastectomy or skin grafting following burns. Plastic and reconstructive surgery is a restricted service on some levels of cover so please check your level of cover if you believe you may require this benefit. Plastic and reconstructive surgery is not cosmetic surgery. Cosmetic surgery is performed for non-therapeutic purposes and no benefit is paid by TUH.

Pre-existing ailments or conditions

All hospital claims in the first twelve months of membership for new members, members upgrading to a higher level of hospital cover or transferring from another fund are subject to the pre-existing ailment or condition rule. This rule refers to an ailment, condition or illness, the signs or symptoms of which existed at any time during the six months before a member joined the Fund or upgraded to a higher level of cover, even though a diagnosis may not have been made.

Our appointed medical adviser will decide if a condition is pre-existing based on medical notes and standard medical practice. If your claim is deemed pre-existing you will receive the benefits relating to your previous lower level of cover or will not be paid if no previous hospital cover was held.

Please allow five days for all the information to be received and assessed by the medical advisor.

A waiting period of twelve months is standard practice within the private health insurance industry to receive benefits for a pre-existing ailment. Two months apply to palliative care, psychiatric services and rehabilitation.

Premium payment options

Direct debit

Payments can be debited fortnightly, monthly, quarterly and half-yearly.

Credit card

Payments can be charged monthly, quarterly and half-yearly.

Accounts

Accounts are sent out monthly, quarterly or half yearly.

Payment options include:

- BPAY;
- Member Services Online (credit card only);
- in person (at our Health Hub);
- by telephone; and
- by mail.

Obstetrics (pregnancy and birth related treatment)

While most of our covers include cover for obstetrics, some don't. Please refer to the relevant product brochure to see if you have the correct level of cover. Please be aware a twelve month waiting period applies.

By law, TUH is unable to pay any expenses relating to visits to your obstetrician, gynaecologist or other doctors (including scans and doctor's management fees) either before or after you are hospitalised. Medicare will usually pay a benefit on these services.

To ensure your baby is covered from birth, members on single and couple cover must transfer to family or single parent membership within three months of your child's birth and ensure the additional premium is paid from the date of the baby's birth.

Visit our website or contact us for detailed information about pregnancy and pregnancy related benefits.

Paediatric services provided to your baby in hospital are only claimable if the hospital deems it medically necessary and admits your baby as an inpatient.

Rate protection

You may pay your membership for up to six months in advance at the rate that applies at that time. This means that you will not have to pay extra if premiums increase during the period for which you have paid. Rate protection will cease if you change your level of cover or suspend membership; any amount paid in advance of the date of the cover change or suspension will be applied at the rate that is current at that time.

Rebate

The Government provides a rebate on private health insurance premiums. The rebate you receive depends on your age (persons aged 65 and over receive a higher rebate) and your household income. You must be eligible for Medicare benefits to qualify for the rebate.

You can claim the rebate as a reduction of your premiums, or as a tax rebate when you lodge your annual tax return.

To have the rebate deducted from the premium you pay, just complete the application form for the Australian Government Rebate on Private Health Insurance when you join TUH.

Please visit **www.privatehealth.gov.au** for more information.

Restricted services

For services listed as restricted (for specific levels of cover) we will pay the default benefit for hospital accommodation as determined by the Government for restricted services. Examples of restricted services for some covers include:

- psychiatric services;
- rehabilitation;
- obstetrics (pregnancy and birth related treatment;
- podiatric surgery;
- gastric banding and obesity surgery; and
- plastic and reconstructive surgery.

Refer to individual covers for services with restricted benefits. Any excess applicable to your cover will be charged even where a default benefit only is paid.

The default benefit does not cover theatre or labour ward fee benefits.

School accident cover

This cover is available for Ultimate Choice, Easy Choice and Family Extras covers only. It covers your dependent child for accidents occurring while attending, or travelling to or from school or an organised school activity. Benefits are limited to single parent and family cover.

Services covered under the school accident cover include:

- travel expenses;
- parking expenses; and
- physiotherapy (in addition to other physiotherapy benefit entitlements).

Spouse/partner authority

A policy holder can request that their spouse/partner (on the same policy) be authorised to operate the policy on the same level as the policy holder (excluding joining/terminating membership and removing dependants). This can be done by contacting us or by downloading the *Spouse/Partner Authority form* on our website. The policy holder may withdraw the authority at any time by notifying us, in writing or over the phone. See Transaction authority.

Surgically implanted prostheses

A surgically implanted prosthesis is a piece of equipment that is implanted into the body during a hospital procedure, such as artificial hip, a pacemaker, a cardiac stent, screws and plates. Most Government approved surgically implanted prostheses are covered by your hospital cover. However some will require a patient contribution to be paid if the supplier charges above the listed benefit. If a gap amount applies to your prosthesis your surgeon/hospital will arrange for you to complete an *Informed financial consent form*.

Suspension of cover

Financial hardship

If you are experiencing financial hardship and have been a financial member of TUH for at least six months, we may allow you to suspend your membership for a minimum period of one month to a maximum period of 12 months. Multiple suspensions are allowed, however twelve months must be served between consecutive suspensions. No claims can be made while your membership is suspended or for treatment that occurred while your membership was suspended.

Overseas travel

If you are travelling overseas and have been a financial member of TUH for at least twelve months, you may suspend your membership for a minimum period of two calendar months to a maximum period of three years. One month's premium must be paid in advance of the suspension date. Two suspensions are allowed per calendar year. The second suspension can commence after you have resumed the policy for a period equal to the length of your previous absence or nine months, whichever is shorter. Please contact us to request an *Application for Suspension of Membership form*, or download the form from our website. No claims can be made while your membership is suspended.

Application to suspend membership must be made prior to the date of overseas departure.

Documentation to verify departure and return dates will be required at time of suspension.

Please refer to the conditions that apply to suspension of membership, which are listed on the *Application for Suspension of Membership form* and the accompanying information sheet.

The remainder of any waiting periods or Benefit Limitation Periods not completed prior to departure will continue when membership is resumed.

Transaction authority

For any persons, other than your spouse/partner, to make transactions on your policy a Power of Attorney is required. For enquiries about the policy a *Third Party Enquiry form* must be completed. See also Spouse/partner authority.

Transferring to TUH

Hospital cover

When you transfer to TUH from another fund you will receive continuity of equivalent cover providing you join TUH within two months of leaving your former health fund. If any waiting periods have not been served (at all or in part) with your former fund you will be required to serve the balance of the waiting period before you can claim any benefits from TUH. Where your new cover has higher benefits (including a lower excess or fewer excluded/restricted services) waiting periods will apply.

In the case of a lower excess, you'll need to pay the previous higher excess for a hospitalisation in the first two months of cover.

Extras cover

When you transfer to an equivalent level of cover with TUH you will receive the year-one benefits for covers that have annual limits that increase with years of membership and limits with TUH for all services, where applicable, provided all waiting periods have been served with the previous fund.

Credit will be given for waiting periods partially served with your previous fund or on a previous level of cover if you are upgrading. If you transfer to a TUH level of cover that provides services not covered by your previous fund, all relevant waiting periods for these services must be served with TUH.

Any benefits paid by your previous fund will be deducted from the TUH limits within the first twelve months of membership. Continuity of membership will only be taken into account if you join TUH within two months of ceasing membership with your previous health fund.

Travel insurance

Your health insurance does not cover you if you are travelling overseas. As a TUH member you can save up to 30% on travel insurance with QBE Insurance (Australia) Ltd. This offer is only available if you book through our website.
See Overseas travel.

Waiting periods

For all new memberships and upgrades of cover (where your new cover has higher benefits, lower excess or more services), including transfers from another fund, the following conditions will apply:

- **two months** for all hospital and extras services unless specified otherwise;
- **two months** for palliative care, psychiatric services (BLP apply for some covers), rehabilitation and Home Care Programs;
- **six months** for Active Health Bonus, outpatient midwife services, Disease Management Programs, Optical (Young Choice, Family Extras, Healthy Options Extras and Mid Range Extras);
- **twelve months** for pre-existing ailments or conditions (excluding palliative care, psychiatric services and rehabilitation), obstetrics/ pregnancy and birth-related treatment (BLP apply for some covers); and prostheses;
- **twelve months** for major dental, orthodontia; orthotics, hearing aids and mechanical/health appliances; and
- **two years** for refractive laser eye surgery.

There are no waiting periods for accidents that occur after you join TUH.

Some services do not apply to all levels of cover. See your product brochure for details on services available on your specific level of cover.

Workers Compensation

Claims for work related injuries must be submitted directly to WorkCover or the Workers Compensation authority in your state. In the event that WorkCover rejects your claim, TUH may make payment relevant to your level of cover. We require fully itemised accounts/ receipts with a copy of WorkCover's letter stating that you are not entitled to WorkCover benefits.

Our commitment to you

Code of Conduct

TUH is accredited under the Private Health Insurance Code of Conduct. This industry code stipulates a standard of service to promote communication and understanding between private health insurers and their members.

The code ensures we:

- continually work towards improving the standards of service we offer to our members;
- provide information in plain language about our products and services;
- provide easy access to our internal dispute resolution procedures; and
- keep your information confidential in accordance with privacy principles.

Accreditation is a significant achievement and confirms TUH's commitment to excellence in delivering quality products and services to our members.

For further information visit the Code of Conduct website: **www.privatehealthcareaustralia.org.au/codeofconduct/**

Resolution of problems

TUH has a resolution process to ensure your concerns are dealt with in a timely, professional and consistent manner to our mutual satisfaction where possible. When we receive a complaint, we'll look into the matter and get back to you within five working days. If we need more time to investigate the matter further, we'll get back to you and let you know how long it will take.

Contact us

438 St Pauls Terrace,
Fortitude Valley QLD, 4006

PO Box 265,
Fortitude Valley QLD 4006

Phone: 1300 360 701

Email: enquiries@tuh.com.au

TUH Complaints Officer:
Phone: 1300 360 701
Email: enquiries@tuh.com.au

TUH Dental Manager:
Phone: (07) 3259 5863;
Email: dental.enquiries@tuh.com.au

If you remain dissatisfied with the way we've managed your concern, you may contact the Commonwealth Ombudsman.

Commonwealth Ombudsman

The Commonwealth Ombudsman's role is to assist with enquiries and complaints about any aspect of private health insurance. The Ombudsman is independent of private health funds, private and public hospitals. For information or complaints about health insurance please contact the Ombudsman's office.

Phone: 1300 362 072

Web: **www.ombudsman.gov.au**

Email: **phio.info@ombudsman.gov.au**

Online: **http://www.ombudsman.gov.au/making-a-complaint/contact-us**

Post: GPO Box 442, Canberra ACT 2601

Fax: 02 6276 0123

Privacy policy

We are committed to protecting any personal information entrusted to or obtained by us. We comply with the *Privacy Act 1988*, including the Australian Privacy Principles.

This section is a guide to our Privacy Policy. A copy of the latest, complete Policy can be obtained from **tuh.com.au** or by calling us on 1300 360 701.

What is personal information?

Personal information is any information or opinion about you that could reasonably be expected to identify you, regardless of whether the information or opinion is true, or whether it is recorded in a hard or electronic or any other material form.

Sensitive information is a subset of personal information which is subject to greater controls. It includes health information and union membership details. Reference to personal information below includes sensitive information.

Why do we collect and use personal information?

We collect personal information primarily to enable us to provide private health insurance benefits and health care services and programs.

We will only use or disclose your personal information for direct marketing purposes about our own products and services, or those from other providers that you may reasonably expect us to communicate with you about. You may opt out of marketing communications at any time by letting us know.

Policy holder and membership

The private health insurance policy holder is the person in whose name the membership is held and holds the legal responsibility for the membership. We will direct correspondence to the policy holder unless we are responding to a request from another person covered by that policy, or a suitable alternative authority or direction is in place.

What personal information do we collect?

The personal information we collect and hold depends on the nature of the relationship we have with you and the extent to which you have used our services or made claims. Information will only be collected with your consent or as permitted by law.

How do I provide consent?

By making an enquiry about our products or services, becoming a member or client, making a claim for benefits or otherwise making use of services offered by TUH (including where the services are provided by organisations contracted by us), you are regarded as having consented to:

- The collection of personal information by us, including from third parties; and
- The use and disclosure of personal information.

If the policy held by you includes anyone aged 18 and over, it is important that you obtain their approval to provide their personal information to us. If you provide such information we will consider that you have obtained this consent. We will also assume that you have authority to provide us with the personal information of anyone covered by the policy who is aged under 18.

You can deal with us anonymously where it is lawful and practicable to do so. For example, for quotes, some general enquiries about membership and benefits we pay for a particular procedure, there will usually be no need for you to provide your personal details. If you wish to deal with us anonymously, we may not be able to provide you with many of the benefits or services that we offer.

How do we collect personal information?

Where it is reasonable and practicable to do so we will collect personal information directly from you. We may collect information about you from another person or organisation, such as other persons on your policy, your hospital or a health provider or your current insurer if you are transferring your membership.

If you use our website, we collect cookies data to help us understand which pages are viewed the most, which helps us improve content and make navigation easier.

We may also use Google Analytics and similar tools from other organisations such as Facebook and YouTube to better understand how our website is used. The information is aggregated and does not identify individuals.

When do we disclose personal information?

We will only disclose information to third parties when you have authorised, or would reasonably expect us to provide information.

How can you correct personal information?

We will take reasonable steps to ensure the personal information collected, used or disclosed is accurate, complete and up to date. If you believe that your personal information is not accurate, please advise us and we will amend your records promptly unless we disagree with the change requested. If that occurs, we will explain the reason and document it on your records.

How do we communicate with you?

Where you have provided us with an email address, including by using one of our Apps, we will use that as the main method of communicating with you, unless you have nominated another preferred method. We may also contact you by phone, mail or SMS.

You can choose how we communicate with you by letting our Customer Contact Centre know.

Who do I contact if I want more information or to make a complaint?

If you have a question on this Privacy Policy or would like further details of how we may collect, use, store and disclose your personal information please contact the TUH Privacy Officer.

You should also contact our Privacy Officer if you have any concerns or a complaint about how we have handled your personal information or have complied with the Australian Privacy Principles. We will acknowledge receipt within three working days and aim to resolve any complaint as soon as possible.

Privacy Officer

Email: privacy.officer@tuh.com.au or enquiries@tuh.com.au

Phone: 1300 360 701


Police

438 St Pauls Terrace
Fortitude Valley
Queensland 4006

PO Box 265
Fortitude Valley
Queensland 4006

Phone: 1300 360 701

Email: enquiries@tuh.com.au

For more information about:

- Products and services
- Government initiatives
- Privacy Policy
- Complaints process
- Private Health Insurance Code of Conduct
- Fund Rules

... please visit **tuh.com.au**
or contact us on 1300 360 701.

QUEENSLAND TEACHERS' UNION HEALTH FUND LIMITED
ABN 38 085 150 376