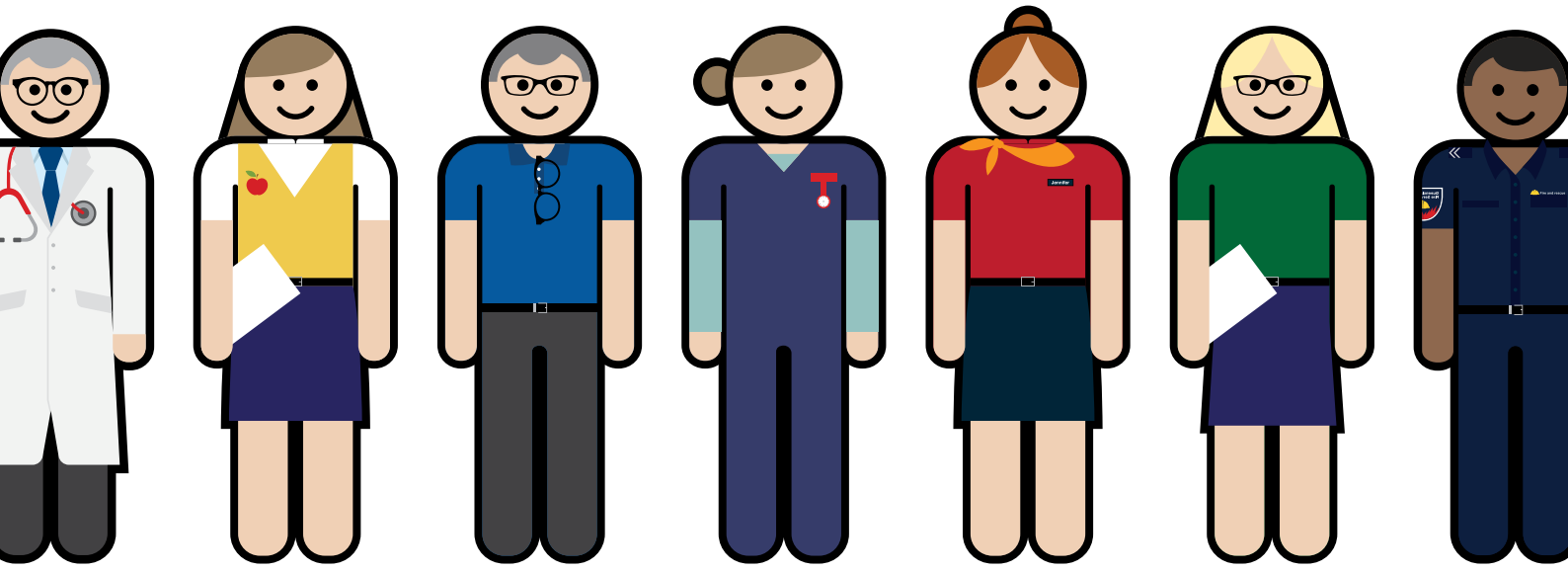
TUH Health Fund

Important Information Guide



Effective 1 August 2018

This publication contains general information to help you understand your health insurance and make informed choices about your cover. Please read in conjunction with information on our website and the relevant product guide.

Contents

Terms that are highlighted are explained further in the Terms, conditions and definitions section.

Information in this brochure is correct at time of printing and may be subject to changes, which may include premiums, closing a policy type and removing or restricting services or benefits. If any changes have a detrimental impact on your cover, we will provide you with notice in writing before the changes come into effect. Changes will apply regardless of whether premiums have been paid in advance.

You can change your cover at any time. For details and conditions, see Changing your level of cover.

Contact us if you'd like a copy of our fund rules.

A few things you should know about your private health insurance policy.

Membership

Your membership starts when you first purchase your TUH health insurance policy. You'll be issued with a membership card, which you'll need when you make claims. So keep it handy, and contact us for a replacement if you lose it.

Categories

Single membership covers one adult only.

Single parent membership covers one adult and their dependants.

Couple membership covers two adults on a single policy.

Family membership covers two adults and their dependants.

The policyholder

If you are the policyholder, the membership is held in your name and you are legally responsible for the membership. Only the policyholder can terminate the membership or remove dependants under 18 years of age. See Spouse/partner authority.

Payments

Your health insurance premiums are payable in advance and must be up to date when you make claims. There are several ways to pay:

- **Direct debit:** We can automatically debit payments from your financial institution or bank account on a fortnightly, monthly, quarterly, or half-yearly basis.
- **Automatic credit card charge:** We can charge your preferred credit card monthly, quarterly, or half-yearly.
- **Account:** If you haven't set up an automatic payment, we'll send your account to your nominated email or postal address on a monthly, quarterly, or half-yearly basis. Pay by BPAY, credit card (over the phone, online, through our mobile app, or at our Health Hub).

If you are finding it difficult to make regular payments, please contact us to discuss your options. Your membership will automatically cease if your payments are outstanding for more than two months.

How to claim

You'll be able to claim benefits from TUH once you've paid your first premium and met any relevant waiting periods, as detailed in the product guide.

We offer four easy ways to claim:

- Swipe your membership card at your HICAPS/iSoft participating health care provider to apply your benefit immediately.
- Claim through the TUH mobile app, available on Google Play and the iTunes Store.
- Claim for eligible services on our website.*
- Send your claim form and original accounts or receipts to PO Box 265, Fortitude Valley 4006.

If a benefit is payable to you, we will pay it directly into your nominated bank account. Adults on the membership may nominate account details other than the policyholder's for payment of claims made in their own name.

*Please retain your original accounts/receipts for 12 months after your claim has been paid, as they may be subject to audits. For more information, see Claiming.

Want to change your membership?

As your situation changes throughout life, your health cover needs to change with it. We recommend you review your cover periodically and around any significant events. Getting hitched? Switch from single to couple membership. Welcoming your first child? Increase your level of cover and later switch to family membership. Kids over 21 years of age and still need cover? Get extended dependant cover. Kids all grown up and moving out? Remove them from your policy.

You can update most of these details on our website, or by downloading a Change to Membership Details form and posting it to us. Some details can also be updated in our mobile app or by calling us.

Changing your level of cover

Waiting periods apply for

- existing TUH members who increase or upgrade cover, including changing to a different excess; and
- new TUH members transferring from a lower level of cover at another fund.

The previous level of cover continues to apply until all appropriate waiting periods for the new cover have been served. Years of membership with your previous fund are not recognised. Please contact us if you wish to discuss your individual circumstances.

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

To authorise your partner/spouse or other adult on the policy to operate the policy, please see Partner/spouse authority.

Changing who is covered

Adding a new adult or dependant to your policy or removing someone from your policy (including a deceased person) may lead to a change of membership category, so please let us know as soon as you can.

Changing your contact details

You can change your contact details on our website, on our mobile app, or by calling us.

Changing your payment preferences

You can change your payment method or frequency on our website, on our mobile app, or by calling us. See Payments.

About hospital cover

What is covered?

With hospital cover, you are covered for medically necessary inpatient 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 doctors' charges. TUH will cover the remaining 25%. Any amount above this will be paid by you directly to the doctor, see Access Gap Cover.

Your cover includes accommodation, theatre fees, intensive care, coronary care, industry approved prostheses (see Surgically implanted prostheses), and hospital medication that health insurers can pay under the law.

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

Some covers may have restrictions or exclusions, please refer to the product guide for details.

What is not covered?

We pay benefits in accordance with the law and with 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
- hospital treatment that is not eligible for Medicare benefits
- cosmetic surgery
- outpatient treatment, GP visits, specialist consultations
- charges above the Medicare Benefit Schedule (MBS) fee
- some pharmacy items
- personal incidentals
- experimental procedures or therapies
- high-cost medications*
- robotic surgery consumables*
- medical devices not included in hospital theatre fee charges as determined by law
- treatment in an emergency department
- procedures or services that are excluded from your policy
- treatment while you are serving a waiting period.

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

Hospital types

Contracted private hospitals

TUH has contracts in place with an extensive network of private hospitals. Each contract sets out agreed rates and benefit schedules, enabling us to pay for the services included on your cover (less any applicable excess) in line with the Private Health Insurance Act. Please visit our website to search for contracted hospitals, or call us prior to hospital admission.

Non-contracted private hospitals

At non-contracted private hospitals, we only pay the default benefits as determined by the Government. If you choose to be admitted to one of these hospitals, you may incur significant out-of-pocket costs.

Public hospitals

You can be treated as a public patient in a public hospital at no charge, even if you have private health insurance.

TUH has no contracts with public hospitals, and no agreed rates. Should you choose to be treated as a private patient in a public hospital, this may result in higher costs to TUH, leading to higher premiums for all members over the long term. You should confirm the costs with the hospital prior to admission. See Informed financial consent.

Hospital excess

See Excess.

Inpatient/outpatient

You become an 'inpatient' when you are admitted to a hospital for treatment. You're an 'outpatient' if you receive medical services without being admitted into hospital, including specialist appointments, post-surgical follow-up consultations, prenatal visits, diagnostic imaging, pathology, or emergency triage.

Hospital benefits only apply for medically necessary inpatient treatment as determined by law. For medical services not related to inpatient treatments (outpatient treatment), Medicare will cover 85% of the MBS fee. The law does not allow for any benefit to be paid by health insurance.

About extras cover

What is covered?

Your extras cover pays benefits toward a wide range of dental, optical, and allied health services, such as physiotherapy and remedial massage. Your product guide contains a complete list of benefits and annual limits that apply. The limits reset on 1 January, and you can check your usage on our website and the mobile app.

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, and to confirm the benefits you can claim.

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 extras 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 that took place two years or more before the date you lodge 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) treatment by yourself or your partner, parent, sibling, child, or other insured person on the policy
- midwife services at a home birth
- 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 in-hospital medical expenses for our members by including Access Gap Cover with all levels of hospital cover.

Medicare covers 75% of the Medicare Benefit Schedule (MBS) fee set by the Government for eligible inpatient services. TUH covers the remaining 25% of the MBS fee. But if your medical practitioner charges above the MBS fee, you'll need to pay an additional out-of-pocket amount, known as the 'gap'. See also Medical Gap.

If your practitioner chooses to participate in our Access Gap Cover scheme, you will have lower or no out-of-pocket costs. In most cases, TUH will receive the account, make Medicare claims on your behalf, and pay the practitioner directly.

Participation in this scheme is the personal choice of individual medical practitioners, so prior to treatment, please

- request an estimate of costs from your doctor (see Informed financial consent)
- ask your doctor if they have chosen to participate in our Access Gap Cover scheme
- ask your doctor to confirm if any assisting specialists use Access Gap Cover.

Our website has an Access Gap checklist to help you before you go to hospital.

Accidents

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

An accident is an unexpected incident that results in injury and requires immediate treatment. Accidents are not related to any other ailment, illness or condition.

If you have been involved in an accident and received compensation or damages from a third party

- you cannot claim additional benefits in relation to this accident
- you must repay TUH any benefits and associated costs already paid by TUH.

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 the Health-e-Profile, our online health assessment, in each consecutive twelve month period. You may use the bonus to pay the out-of-pocket costs for extras treatments (up to the annual limit).

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
- 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

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 privatehealth.gov.au for more information.

Ambulance

Subject to the state-based terms below, emergency ambulance is covered when it results from an event that is unplanned, non-routine, and requires 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.

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 or attendance by NSW ambulance is included in your hospital cover. If you receive a NSW Ambulance account, send it to us. If you require ambulance assistance 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 cover 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

You are entitled to cover for emergency ambulance transportation or attendance if you have both hospital and extras cover. Benefits for air ambulance services are limited to a maximum of $6,000 per person per annum and are only payable for state-owned air ambulance services. A waiting period of 1 day will apply to emergency air ambulance benefits. 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 guide for a list of benefits payable under your cover or please call us.

Benefits cannot exceed the fee for service incurred.

Calendar year

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

Chronic Disease Management Programs

We offer a range of Chronic Disease Management Programs that are designed to decrease the risk of developing a chronic disease or to assist in the management of diagnosed chronic diseases. Note that product and clinical eligibility apply to these programs.

Current programs:

- **Disease Management Programs** - you must have held hospital cover for at least six months and clinical eligibility applies.
- **Healthy Weight for Life** - you must have held eligible hospital cover for at least twelve months and extras cover for at least six months and clinical eligibility applies.
- **Care Coordination** - you must have held eligible hospital cover for at least twelve months and extras cover for at least six months and clinical eligibility applies.

Claiming

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

We offer four easy ways to claim for your extras:

- Swipe your membership card at your HICAPS/iSoft participating health care provider to apply your benefit immediately.
- Claim through the TUH mobile app, available on Google Play and the iTunes Store.
- Claim for eligible services on our website.*
- Send your claim form and original accounts or receipts to PO Box 265, Fortitude Valley 4006.

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 laws, Fund Rules and policies and procedures.

*Please retain your original accounts/receipts for 12 months after your claim has been paid, as they may be subject to audits.

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, provided there are no claims made during the period. The 30-day period commences from

- the joining date;
- the date the level of cover increases; or
- the date the level of cover decreases.

For the latter two, the cover will revert back to the previous level of cover.

Cosmetic surgery

Cosmetic surgery refers to procedures performed that are non-medically necessary. 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, or if applicable choose a contracted hospital.

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.

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 for whom the policyholder is the legal guardian or who is in the policyholder's legal custody.
- The policyholder's adult child, who is not married or in a de facto relationship and who is 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 (i.e. not married or in a defacto relationship) and not covered as a student dependant to be covered on their parents'/guardians' policy until the age of 25.

Extended dependant cover is available on all hospital and combined covers except Young Choice and Total Care Hospital. Please contact us for details regarding closed products.

Student dependants

A policyholder's student dependant child is

- a full-time student at a recognised education facility for the whole of the academic year;
- under age 25; and
- unmarried and not in a de facto relationship.

A policyholder must complete and return to TUH an ***Adult 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. An excess is only payable once per adult per calendar year.

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 two 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

- pregnancy and birth-related treatment
- labour ward
- infertility investigations and assisted reproductive services
- sterility reversals
- joint replacements and revisions
- cataracts, eye lens, glaucoma and macular degeneration
- dialysis for chronic kidney disease.

Please refer to your product guide for exclusions and restrictions that might apply to your level of cover.

Gap

See Medical gap and Access Gap 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 treatment 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 hospital cover early in life and to maintain membership. If you take out hospital cover after 1 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 standalone extras cover will not exempt you from paying the Lifetime Health Cover loading.

Lifetime mental health waiting period waiver

From 1 April 2018, policyholders will be able to upgrade from a policy which offers restricted benefits for hospital psychiatric services to a policy which fully covers psychiatric services without having to serve the normal two-month waiting period.

This option is part of a Government reform designed to make it easier for policyholders to access psychiatric services when they need it.

This exemption from the two-month waiting period can only be used once in a person's lifetime, regardless of whether you have transferred between insurers.

If you have not fully served the waiting period on your previous policy, the unexpired waiting period will still apply. If your previous policy had an excess, the excess provisions of the previous policy will apply for the first two-months of any upgrade.

The hospital admission must have been as a result of a referral by a consultant psychiatrist and the option to upgrade your policy must be taken within five working days of your admission to hospital. On upgrading, your premium will change to the rate of the upgraded policy.

Limit

Annual limit

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

Sublimit

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 $2,000. Crowns and bridges have a sub-limit of $670 for your first year, so this is the maximum you can claim for these items. Your overall annual limit will then be reduced to $1,330 which you can use for other treatments within the major dental category.

Maternity

See Pregnancy and birth-related treatment.

Medical Gap

Medicare covers 75% of the Medicare Benefit Schedule (MBS) fee set by the Government for eligible inpatient services. TUH covers the remaining 25% of the MBS fee. If your doctor charges above the MBS fee, you'll need to pay an additional out-of-pocket cost, known as the 'gap', unless it is covered by our Access Gap Cover.

Medical practitioner

A person registered or licensed as a medical practitioner under a law of a State or Territory that provides for the registration or licensing of medical practitioners, in accordance with the Health Insurance Act 1973.

Membership eligibility

To qualify for membership with TUH, you must be aged over 18 and meet either of the eligibility criteria below:

- A current or former member of any Australian union.
- 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 at mbsonline.gov.au, or by asking your medical practitioner.

Nursing Home Type Patients

Non-acute certified admissions exceeding 35 days may be defined as a Nursing Home Type Patient. A co-payment may apply, please contact us 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
- 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*
- 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 Gap/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 ombudsman.gov.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. See our website for a list of TUH's preferred dental and optical providers.

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.

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.

Pharmaceutical Benefits Scheme (PBS)

The 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 pbs.gov.au.

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

Benefit excludes medicines or medications which are

- prescriptions less than PBS co-payment
- available without a medical practitioner's prescription
- not approved by the Therapeutic Goods Administration
- prescribed for contraceptive purposes.

Plastic and reconstructive surgery

Plastic and reconstructive surgery refers to the evaluation and treatment to correct functional impairments caused by trauma or 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 receive any benefit 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.

Pregnancy and birth-related treatment

While most of our covers include cover for obstetrics, some do not. Please refer to the relevant product guide 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 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.

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
- TUH website (credit card only)
- telephone.

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 for the period covered by your premium payment 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

See Australian Government Rebate on Private Health Insurance.

Remote travel and accommodation

A benefit is payable towards accommodation for the person requiring medical treatment or, in the case of hospitalisation, the accompanying person who must also be covered under the membership. Benefit is only payable where a tariff is charged by a registered accommodation facility and valid receipts will be required. Under this benefit members travelling 300 kilometres or more return are also able to claim for travel expenses incurred to a maximum of one (1) claim only per family per trip (this includes appointments at the TUH Health Hub).

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
- pregnancy and birth-related treatment
- surgery by a podiatrist
- gastric banding and obesity surgery
- plastic and reconstructive surgery.

Refer to individual product guides 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
- physiotherapy (in addition to other physiotherapy benefit entitlements).

Spouse/partner authority

A policyholder can request that their spouse/partner (on the same policy) be authorised to operate the policy on the same level as the policyholder (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 policyholder 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 twelve months. Suspension will be approved for an initial period of six months with an option to extend to a maximum period of twelve 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. Premiums must be paid up to the date after you depart Australia, i.e. your suspension date plus one day. 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.

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

Travel information to verify departure and return dates will be required at the time of application for suspension, unless you have a one-way ticket, in which case verification of return date will be required on resumption.

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 not completed prior to departure will continue when the 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 first year benefits and limits (for covers that have annual limits that increase with years of membership) for all services, 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 level of cover that provides services not covered by your previous fund, all relevant waiting periods for these services must be served with us.

Any benefits paid by your previous fund will be deducted from the TUH limits until the waiting period is served.

Continuity of membership will only be taken into account if you join TUH within two months of ceasing membership with your previous health fund.

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 waiting periods will apply:

- two months for all hospital and extras services, unless specified otherwise
- two months for palliative care, psychiatric services*, rehabilitation and home care programs
- six months for Active Health Bonus, outpatient midwife services and optical (Young Choice, Family Extras, Healthy Options Extras and Mid Range Extras only)
- twelve months for pre-existing ailments or conditions (excluding palliative care, psychiatric services and rehabilitation), pregnancy and birth-related treatment, and prostheses
- twelve months for major dental, orthodontia, orthotics, hearing aids and mechanical/health appliances
- two years for refractive laser eye surgery

If you have transferred from another health fund on a comparable level of cover and have served waiting periods you will be able to claim straight away.

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 guide for details on services available on your level of cover.

* Refer to Lifetime mental health waiting period waiver for details on circumstances where this may not apply.

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
- 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 two 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

Address: 438 St Pauls Terrace, Fortitude Valley QLD, 4006

Post: PO Box 265, Fortitude Valley QLD 4006

Phone: 1300 360 701

Email: enquiries@tuh.com.au

TUH Health Fund

Complaints Officer

Phone: 1300 360 701

Email: customerrelations@tuh.com.au

TUH Health Hub

Complaints Officer

Phone: 1300 709 076

Email: healthhub@tuh.com.au

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

Privacy policy

We are committed to protecting all personal information we obtain, in accordance with the Privacy Act 1988. This includes the Australian Privacy Principles, which specify how we must handle, hold, use, access, and correct personal information.

This section is a simple guide to our Privacy Policy. For the latest version of the complete policy, please visit our website or call us on 1300 360 701.

What is personal information?

Personal information is information or an opinion about an identified individual, or an individual who is reasonably identifiable.

Sensitive information is a subset of personal information, including union membership and health information, that is subject to stricter controls. When we refer to personal information below, we include sensitive information.

Why do we collect and use personal information?

Our primary reason for collecting and using personal information is to provide private health insurance benefits and healthcare services and programs. We may also use your personal information for direct marketing purposes, unless you opt out of marketing communications.

We will direct all correspondence to the policyholder, unless we are responding to a request from another person covered by the policy, or a suitable alternative authority is in place.

Policyholder and membership

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

What personal information do we collect?

We only collect the personal information we require to provide you with products, services, or information, or to manage our relationship with you. This information will vary depending on the nature of our relationship and the products or services you've used. We only collect information with your consent or as permitted by law.

How do I provide consent?

By enquiring about our products or services, becoming a member or client, claiming benefits, or otherwise using products or services offered by TUH (including our services offered through contracted organisations), you consent to TUH

- collecting personal information from you and third party providers
- using and disclosing personal information, in accordance with this policy
- Should you provide us with the personal information of other individuals covered on your policy, we consider you to have
- authority to provide this information for anyone under 18 years of age
- consent to provide this information for anyone aged 18 and over.

You can deal with us anonymously where it is lawful and practicable to do so, such as when making some general enquiries about memberships or benefits, or when requesting a quote for cover. If you choose to deal with us anonymously, this may restrict the products, services and benefits we can offer you.

How do we collect personal information?

Where it is reasonable and practicable to do so we will collect personal information directly from you.

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

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.

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.

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

Phone: 1300 360 701

Visit **tuh.com.au** or contact us on 1300 360 701 for more information about products and services, government initiatives, our privacy policy, the complaints process, and fund rules.