Australian Unity
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Overseas Visitors Cover

Important things to know – terms and conditions

1 July 2024

Health cover with us

The Member

You become a health insurance fund Member once your application form is accepted by the fund. You must complete a true and proper disclosure on your application form about yourself and other people covered under your membership, which is held in your name.

We may ask you to supply evidence to support any information provided on your application form, such as identity or age. Except in circumstances of separation or divorce involving a dependant, you cannot purchase a membership with Australian Unity if you are insured under a hospital cover with another private health insurer.

Unless otherwise agreed by Australian Unity, you must be 16 years or older to hold a membership in your own right. Membership for a person under the age of 16 requires a legal guardian to agree to the terms and conditions of the membership on behalf of the dependant.

Member eligibility

You may purchase our Overseas Visitors Cover if you are;

- a resident of an overseas country and visiting Australia on a temporary basis,
- a citizen of an overseas country intending to reside permanently in Australia,
- a citizen of Australia who permanently resides overseas for greater than 5 years,

provided that in all cases you are ineligible for full Medicare benefits.

Evidence to support any information contained in your application, such as identity, nationality or age may be required at our discretion.

If you are already eligible for or become eligible for full Medicare benefits, you are no longer entitled to hold an Overseas Visitors Cover. Please contact us immediately on **1300 683 782** to arrange a more suitable cover.

Membership types

- A single membership covers one person (the member) only.
- A couple's membership covers the member and their spouse, de facto spouse or partner
- A single parent family membership covers the member and one or more eligible children.
- A family membership covers the member and their spouse, de facto spouse or partner and eligible children.

Dependants/Students

A child in respect of a membership means a natural child, legally adopted child, stepchild, a foster child of the Member or their partner/spouse. A child can be added into a membership if they are not married or living in a de facto relationship as:

- Child Dependant up to the age of 22 years (inclusive), or
- Student Dependant between the age of 23 (inclusive) and 30 (inclusive), if they are studying fulltime, or
- Non-Student Dependant between the age of 23 (inclusive) and 30 (inclusive), if they are not studying fulltime

Note, Australian Unity doesn't have any covers suitable for visitors on Student Visas.

Visa requirements

As an overseas visitor, it's your responsibility to understand the type of visa requirements you need to meet, as set out by the Department of Home Affairs (DHA) and to ensure that the health cover purchased meets these requirements.

Transferring from another Australian health fund

If your previous cover was provided by an insurer outside of Australia, you will be considered as a new member and any applicable waiting periods will apply.

If you are transferring from another registered Australian private health insurance fund and purchase health cover with us within 30 days of cancelling your old hospital or extras cover, we will recognise some waiting periods when you purchase one of these products with Australian Unity:

- **Non-working Visitors Cover:** the initial two-month waiting period will be waived. All other waiting periods will apply from the day of the commencement of the cover with Australian Unity
- **Working Visitors Cover:** If you held an eligible workers visitors cover with the previous Australian insurer, any applicable waiting periods already served will be recognised. If you held a non-working visitors cover, all waiting periods on the working visitors cover will apply from the day of the commencement of the cover with Australian Unity.
- **Extras Cover:** years of membership and extras benefits paid with another Australian registered private health insurance fund will be taken into account when calculating waiting periods and extras benefits payable by us.

You will need to provide a Transfer Certificate from your previous Australian insurer to show the details and claims history.

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Transferring from another Australian Unity Membership

If you are transferring from another Australian Unity Membership you need to start your new health cover with us within 30 days of cancelling your old membership to ensure continuity of cover. A gap in cover greater than 30 days means that you will have to re-serve all waiting periods.

To do that you must contact us within:

- 30 days (if you were a partner/spouse or Policy holder on the previous membership) or
- 3 months (if you were a Dependant on the previous membership)

from the day you ceased to be covered. Your new membership must commence within 30 days from the day after you ceased to be covered under your previous membership and you will be required to backpay any premiums owed. You won't have coverage for services received on the days when you had no coverage between the two memberships.

When you join a new membership, regardless of the gap between your old and new membership, we will calculate what yearly limits you have used on your hospital cover as well as extras claims you have already made in the relevant calendar year as these will be deducted against the yearly benefit limits for equivalent services, until they reset on 1 January. Where relevant, lifetime limits will also be deducted.

Waiting periods

Generally, you may claim on services received from the commencement of your cover, except where waiting periods apply as outlined in your Overseas Visitors Cover Fact Sheet.

Waiting periods apply when you join, upgrade your cover, reduce your excess or re-join after a break in cover.

When you upgrade your cover, you won't be able to claim the higher benefit amount for services received until your waiting period has been served. While you serve your waiting period, we will only pay equivalent to your previous level of cover.

Pre-existing conditions

The waiting period on pre-existing conditions is applied to protect our existing membership against claims made by new members, or those who have upgraded their cover, for ailments, illnesses or conditions that they had before joining or upgrading their cover which may require immediate treatment. Applying the waiting period assists insurers manage the risk of members joining the fund only to make such a claim and then leave after claiming.

Refer to your Overseas Visitors Cover Fact Sheet for more information as selected covers do not pay any benefits for treatment of pre-existing conditions.

A pre-existing condition is an ailment, illness or condition that in the opinion of a medical practitioner appointed by Australian Unity (not your own doctor), the signs or symptoms of that ailment, illness or condition existed at any time in the period of six months ending on the day on which you joined Australian Unity or upgraded your cover, irrespective of whether you were aware of it.

Contact us to discuss if the pre-existing condition waiting period applies to you prior to booking any hospital procedures or outpatient services. We need up to five working days to carry out the initial pre-existing condition assessment, after receiving information about any signs and symptoms related to your condition from your first consulting medical practitioner.

Managing your membership

Changing your cover

You can change your level of cover at any time over the phone by calling us on 1300 683 782.

Upgrading your cover means increasing your level of hospital or extras benefits or reducing your excess. You may have to serve new waiting periods for services you weren't previously covered for.

If you become eligible for full Medicare benefits, meaning you hold a blue or green Medicare card, contact us immediately to arrange alternative cover as you will no longer be entitled to hold Overseas Visitors Cover.

Planning a family

Contact us if you are planning for a baby. We can check your level of hospital cover to see if it includes benefits for pregnancy and related services. Checking your cover is also important because a 12 month waiting period applies for pregnancy and related services. Please refer to your Overseas Visitors Cover Fact Sheet.

Adding a child to your cover

Family, Single Parent Family or Couple membership as at the birth or adoption/fostering date: It is important that you notify us within 12 months of your baby's birth or adoption/fostering date and add them to your policy effective from their date of birth or adoption date, for waiting periods to be waived. Please note that Couple memberships will also need to change to a Family membership and back pay any difference in premium (if applicable).

Single membership as at the birth or adoption/fostering date: To avoid your baby serving waiting periods, it is important that within 30 days of the birth or adoption you:

- Upgrade to a Family or Single Parent Family cover; and
- Add your child to the policy.

These changes will be made effective from the child's date of birth or adoption/fostering and you will be required to back pay any difference in premium.

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Delegated Authority

If you have a partner or spouse covered by your policy they have automatic delegated authority.

This means they have the same authorisation as the Member (including access to personal information about all members on the policy, and the authority to change, suspend or cancel the membership), except they won't be able to nominate further delegated authorities or remove delegated authorities.

If you have a partner or spouse on your policy and don't want them to have delegated authority you can opt out by contacting us on **1300 683 782**.

You also have the option to authorise any other person to have delegated authority on your policy by completing a Delegated Authority form or calling us.

Adding members to your cover

If you wish to add or remove a spouse or a dependant from your membership, it's important to advise us as soon as possible as we may not be able to backdate the request.

If your spouse or dependant was removed from your membership and you later wish to add them back on, to ensure they will not have to re-serve waiting periods, you must contact us within 30 days (for your Partner/Spouse) or 3 months (for your Dependant) from the day they ceased to be covered. They will need to be added from the day following the day they ceased to be covered and if this changes the scale of your membership, you will be required to backpay any premiums owed. Alternatively, they can be added from the day you contact us to request reinstatement or a future date, and waiting periods may need to be served.

Separation/divorce

It's possible to remain on the same membership following a separation or divorce. Please keep in mind that any claim payments will be paid into the account listed under the membership, regardless of who paid for the treatment. If any disputes arise we will keep the agreement with the named Member (the 'policyholder') who holds authority over the membership.

Unless advised otherwise, the spouse named on the membership will have automatic delegated authority. You can opt out by contacting us on **1300 683 782** (see Delegated Authority above).

Premiums

Unless otherwise offered or agreed by Australian Unity, your premiums are payable monthly, or in monthly multiples, in advance. If you pay for a period in excess of 12 months, we may only accept payment for a period of 12 months and refund you the remainder. Advance payments do not fix the terms and benefits of your product, which we can change at any time in accordance with the Fund Rules and the Changes to your cover section of these terms and conditions.

For some of our Overseas Visitors Covers, the premiums for the membership are set based on your age at the time of joining. It is the oldest person under that membership that will be used to determine the premium tier payable.

Notice of premium and benefit changes

Australian Unity's rate guarantee policy ensures that your premiums paid in advance are protected against a premium change, which usually occurs on 1 April, until the next payment due date, unless you make changes to your cover in the interim.

Australian Unity can change your benefits (i.e. adding or reducing benefits) at any time in accordance with the Changes to your cover section of these terms and conditions. Please refer to the 'Changes to your cover' section of the Member Guide for more information. If you receive rebate on your extras cover, the level of rebate applied to your premium changes annually in line with the Australian Government's adjustments to the rebate tier percentages, which occur on 1 April each year.

Notice will be provided in writing to you of any premium or benefit change by either the post, or email address as notified to Australian Unity. Please ensure that your address and other contact details are kept up to date.

Making claims

The benefits, yearly limits and excesses on your cover are calculated from 1 January each calendar year, except when a Benefit Replacement Period or Lifetime Limit applies. The conditions and benefits payable for your claims are based on the date the service was received. When faxing, emailing or submitting a claim online, you should retain your original receipts for at least two years.

We will only pay on claims you have made for products and services purchased within Australia and are limited to the insured rate or the actual amount charged, whichever is less. If your membership falls into arrears or is suspended, we will not pay your claims for services received during that period.

Remember to send your claims to us promptly as we will not pay on any claims submitted more than two years after the date of service.

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Compensation

Australian Unity benefits are not payable for claims where you have received compensation, damages or benefits from another source or we reasonably believe you have an entitlement under a statutory compensation scheme, now or at a later date, so it is in your interest to pursue that entitlement. Where it becomes known that you have, or may have a right to compensation, you are obliged to:

- inform us as soon as you know or suspect that such a right exists; and
- inform us of your decision to claim (or not to claim) compensation; and
- keep us updated as to the progress of your claim; and
- let us know as soon as practicable the determination of settlement of the claim or the establishment of a right to receive compensation.

Where we have paid on related claims and you have received compensation from another source, you will be required to reimburse us to the extent that the compensation received includes amounts reasonably attributable to the related claim. If you notify us that you will not be making a claim for compensation, then we may assume your legal rights in respect of all or any parts of the claim. Please contact our Customer Service team for advice concerning compensation claims.

Claim quality reviews

Australian Unity is committed to keeping fund premiums to a minimum, and one way of doing this is to ensure that claims for treatment or services raised by healthcare providers are charged, and the benefits paid, are accurate and correct. Australian Unity may undertake audits of hospital or extras claims and may contact either you or your provider to assist. By submitting a claim, you provide consent for Australian Unity to obtain your personal information (including sensitive information), as it relates to the claim, directly from your provider.

Suspension of membership

If you're travelling overseas for an extended period or returning back to your home country temporarily, you may be able to apply to suspend your membership, depending on your level of cover. Your application must be received in advance of your departure from Australia, and your membership must be paid up to or in advance of the proposed suspension date. Members with a separate hospital and extras memberships will need to suspend both simultaneously.

Please note, a standalone extras product (where hospital cover is not also held under the same or other Membership) is not eligible for suspension.

If eligible, the criteria for temporary suspension are:

- Minimum period of membership – 3 months
- Minimum suspension time – 1 month
- Maximum suspension time – 12 months

You will not be able to suspend it again for a further 12 months from the date of resumption from the previous suspension. We will not pay for any hospital, medical or extras services that occur during the suspension period. Waiting periods cannot be served while a membership is suspended.

Suspension will apply from the day after the departure date you nominated on the form or from the date of the receipt of the application form, whichever is later.

Minimum Duration of Cover

The minimum duration of your cover is one month. Where a request to cancel your membership is received within one month of commencing cover, there shall be no refund of the first month's premium. Any monies you have paid beyond the first month will be refunded in accordance with Australian Unity's Refund Policy.

Cancellation of a membership

You have the right to cancel your membership at any time. If you are considering cancelling your membership, please contact our Customer Service team on **1300 683 782** as we may able to offer you other options.

If your reason for cancellation is due to a visa not being granted, we will refund your policy payment. A copy of the letter of visa denial must also be forwarded with the cancellation request.

Where in the opinion of the fund a member may have engaged in fraudulent activity, misleads or deceives the fund, materially or repeatedly breaches any of these Terms and Conditions or any other term or condition of membership with the fund, the fund may terminate or suspend a membership at any time by giving reasonable notice, describing the reason for the cancellation to the member concerned and providing a refund of any premiums paid in advance. Neither the fund or you shall be liable to the other party for any loss or damage arising from the termination or suspension of membership (except for the refund of any premiums paid in advance).

Refund policy

If you cancel your membership after the Minimum Duration of Cover period has passed (one month), we will refund monies you have paid beyond the cancellation date.

In the case of visa denials, a refund of monies paid will be provided where you have been unsuccessful in obtaining an entry visa to Australia. A copy of the letter of visa denial must also be forwarded with the cancellation request.

Membership arrears

Keeping your health membership active is important, therefore your premium payments should always be paid in advance. If you don't make a payment and your membership falls into arrears for a period of more than 60 days, your cover will be cancelled. All entitlement to claim benefits during the period of arrears and after the cancellation date will cease.

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Hospital cover

Hospital accommodation

Cover for hospital accommodation under your policy includes costs for the hospital bed, theatre fee, patient meals and, if applicable, 100% of the minimum cost for Government approved surgical prosthesis while you're an admitted patient at either a private or public hospital. We will cover you at the insured rate, where your medical provider certifies that you still need ongoing acute care, or until your overall yearly maximum policy limit has been reached. Additional services such as telephone calls and internet usage charges are not covered under these policies.

Exclusions

If you select a hospital cover that has treatment listed as 'Excluded' or 'Not Covered', this means that we will not pay anything towards the costs you incur for that treatment. This can result in you incurring large out-of-pocket expenses. Always refer to your Overseas Visitors Cover Fact Sheet for more details about your hospital cover entitlements.

Restricted Cover

To lower your hospital premium, some hospital services on your cover may be listed as 'Restricted'. This means that we will pay reduced benefits for your hospital accommodation and theatre fees. Large out-of-pocket expenses may apply.

Refer to your Overseas Visitors Cover Fact Sheet to confirm which services may be restricted. Contact Australian Unity before undergoing any treatment.

Excess

In exchange for a lower premium, an excess is a set amount of money you agree to pay towards the hospital accommodation costs if you or a family member is admitted to hospital. The excess is applied in accordance with your level of cover. If a child is on your policy and needs to go to hospital, you won't have to pay the excess. Please check your Overseas Visitors Cover Fact Sheet to confirm how much excess you'll have to pay.

Accident

Accident means an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object requiring treatment from a Medical Practitioner (defined here as a medical doctor who is not the member or a relative of the Member) within 7 days of the event, but excludes injuries arising out of: surgical procedures; unforeseen illness; pregnancy; drug use; and aggravation of an underlying condition or injury.

If you have a hospital admission that is a result of an Accident that occurred after joining your hospital cover, the follow waiting periods will apply for that procedure:

- Basic/Mid/Top Non Workers Cover - 24 hr,
- All other hospital covers - No Waiting Period

If the Accident happened prior to joining the cover, your Accident waiting period will not be applicable but all other waiting periods listed on your product fact sheet are.

Before we determine your claim for benefits for an Accident, we will ask you to complete an accident declaration and your doctor to complete a medical report and any other supporting documentation required by Australian Unity to assess the claim.

Pharmaceuticals

Pharmaceutical drugs are covered up to a dollar value limit as specified on your Overseas Visitors Cover Fact Sheet. We'll only pay for drugs provided in hospital that are included under the agreement with the hospital and listed under the Pharmaceutical Benefits Scheme (PBS) for your specific condition. Under selected covers we will also pay medications not-listed on the PBS. See your Fact Sheet for benefits payable.

We won't cover you for high cost or experimental drugs that are not listed under the PBS and are not Therapeutic Goods Administration (TGA) approved for use for the specific condition. We will not pay for oral contraceptives or for pharmaceuticals prescribed for cosmetic purposes.

Under selected covers we'll also pay some costs on pharmaceutical scripts provided out of hospital. You may be required to contribute an amount equivalent to the maximum general patient charge as noted on the PBS website prior to us paying your claim.

Emergency Department

Services provided in the Emergency Department at a hospital is deemed in Australia to be an out-of-hospital service. This is because you are not an admitted patient while receiving treatment..

Subject to your chosen level of cover, we may contribute to the cost of treatment at a hospital Emergency Department when it precedes a hospital admission.

Ambulance

Ambulance benefits are payable in accordance with your level of cover. Refer to your Overseas Visitors Cover Fact Sheet to confirm when benefits are payable. Some Overseas Visitors Covers only include benefits for emergency ambulance transportation. To be eligible for this benefit, the account must be coded and billed as an emergency by the state or territory's relevant ambulance authority.

Some covers also offer Ambulance Attendance which means we will pay for the cost of the arrival of an ambulance and attendance and treatment of a patient by a paramedic, where the condition is stable enough that transportation to hospital is not required. These accounts do not need to be coded as an 'emergency'.

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For some Overseas Visitors Covers, we will pay for ambulance transportation that is medically necessary for admission to hospital, emergency treatment onsite, or inter-hospital transfer for emergency treatment. This includes inter-hospital transfers that are necessary because the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

Where an Extras cover with benefits for Ambulance is taken with your Overseas Visitors Cover, benefits are payable under the Overseas Visitors Cover only, except where the Extras cover offers additional benefits not included on the Overseas Visitors Cover.

We won't pay ambulance transportation charges where you are covered under an ambulance subscription scheme or the transportation is claimable from another source. We will not cover Ambulance service charges that are provided by a non-recognised service provider, including private providers.

Where your cover provides you with Emergency Ambulance and/or Attendances coverage, you may still want to purchase a stand-alone Ambulance cover or an Ambulance Subscription with your applicable State Ambulance provider to provide you with broader cover, including non-emergency transport, where available (VIC, SA, NT and rural WA). Please be sure to check your eligibility with the provider prior to purchasing as there may be restrictions for non-residents.

Medical cover

As a private patient, you can have the choice of your own doctor at a private hospital or public hospital, if available. Fees charged by your specialist, surgeon and anaesthetist for treatment received while you're in hospital will be billed to you.

On selected covers, we may also pay benefits for medical claims incurred out of hospital, such as a general practitioner (GP) consultation. The amount of benefits we pay towards your practitioner's fees either in hospital or out of hospital is detailed in your Overseas Visitors Cover Fact Sheet. The reference document we use to determine the amount we pay for all eligible medical claims is the Medicare Benefits Schedule of Fees and Services.

Australian Unity's Medical Gap Cover Scheme is not available to Overseas Visitors Covers. You may have an out-of-pocket cost if your medical practitioner charges more than what is paid by Australian Unity.

What we don't cover

There are hospital costs that we don't pay, in addition to any specific exclusions listed under your hospital cover. These include:

- medical fees for treatment not listed under the Medicare Benefits Schedule (MBS)
- special nursing (e.g. your own private nurse not employed by the hospital)
- respite care or where you are deemed a nursing home patient
- pharmaceuticals and other supplies not directly associated or essential to the reason for your admission
- pharmacy items dispensed upon leaving hospital
- if a treatment is excluded under your cover, any associated services are also not covered (e.g. medical gap, prosthesis, pharmacy)
- the gap on Australian Government approved prostheses
- for personal in-hospital expenses such as pay TV, non-local phone calls, newspapers, boarder fees, meals ordered for your visitors, and any other personal expenses charged to you
- where treatment is not included under your hospital cover or is specifically excluded
- where treatment is subject to a waiting period
- for services or items rendered/or purchased outside of Australia
- for any claims submitted more than two years after the date of service
- for any claims containing false or misleading information
- for any claims where you have received compensation, damages or benefits from another source (e.g. TAS or WorkCover) or where we reasonably believe that you are likely to have an entitlement to compensation under a statutory compensation scheme
- robotic surgery consumables unless otherwise covered for your treatment by the agreement between Australian Unity and the hospital. Please contact your hospital about any out-of-pocket costs.

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Extras cover

What's covered

Extras cover allows you to claim on services such as dental, physiotherapy, optical, remedial massage and acupuncture. You can claim for these types of services where it is offered under the level of cover you have chosen and the treatment was given by a recognised provider in private practice. The benefits you can claim are outlined in your Extras product Fact Sheet and the terms of the Member Guide.

When making a claim you must submit an original account (not photocopies) or take a photo of an original account detailing the date of service, the item number, the description of service and the cost.

Claims for some artificial aids/appliances such as a TENS require a health practitioner's referral stating the condition being treated, to accompany the claim.

What's not covered

Extras benefits will not be payable:

- where treatment is provided by a practitioner not in private practice
- where a provider is not recognised by us
- for any claims, where the treatment is rendered by a provider to themselves, their partner, dependant, business partner or business partner's partner or dependant. Where the service includes a cost for materials, we may consider payment towards the purchase and supply of those materials.
- when provided in a public hospital
- where Medicare, an Australian Government body or third party provide a benefit
- where services are delivered online or over the telephone, unless part of a recognised Telehealth consultation as listed on your product Fact Sheet
- where more than one treatment or consultation has been charged per patient, per practitioner, per day
- where you have reached your yearly maximum limit, including lifetime limits and benefit replacement periods
- where treatment is not included under your cover
- where treatment is subject to a waiting period
- for services or items rendered/or purchased outside of Australia
- for any claims submitted more than two years after the date of service
- for any claims containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
- for any claims where you have received compensation, damages or benefits from another source (e.g. TAS or WorkCover) or where we reasonably believe that you are likely to have an entitlement to compensation under a statutory compensation scheme.

Ambulance

See "Ambulance" at the "Hospital cover" section above.

Benefit replacement periods for aids and devices

On certain types of artificial aids or devices (including sets of dentures), we apply a set period of time you have to wait until you can claim further benefits towards the purchase of a replacement of that particular aid or device. These are called "benefit replacement periods", and vary depending on your level of cover.

There are two types of Benefit Replacement Periods:

- **For Dentures:** A full denture replacement is limited to one purchase for a set period of time as listed on your product, regardless of the benefit you received on that first purchase. If for example the fact sheet says that "a full denture replacement is limited to once every three years", you will only be able to claim benefits again for the same type of denture 3 years after your initial purchase was made, and up to the available dental limits you have at the time of claim.
- **For artificial aids or devices:** such as Hearing Aids or Blood Pressure Monitor, your cover may specify a longer period of time over which the yearly dollar limit applies for that particular aid or device (noting the yearly limit still applies for groups of aids/ devices). For example on some covers, the maximum dollar limit only resets every two calendar years for devices like blood pressure monitors. During this time you can still claim benefits towards another blood pressure monitor up to the remaining set limit, which resets every two calendar years. Where there is a combined limit for a group of devices or aids, benefits are subject to the remaining limits of the combined group. Where this applies, your product Fact Sheet says, for example, "Benefit for each item is payable every 2 calendar years".

Recognised providers

Recognition of providers for payment of your claims is based on our criteria. This includes providers being a member of an appropriate board in their field of practice and operating in private practice. If a provider is not recognised or has been de-listed, benefits will not be payable for their services. Recognition by Australian Unity is for benefit payment purposes only and should not be taken or construed in any way as sponsorship, approval of, or any recommendation as to the qualifications and skills of, or services provided by, a practitioner or therapist. Before commencing treatment, find out if your provider is recognised by calling us on **1300 683 782**.

Consultations and Telehealth Appointments

Some treatments are also eligible for benefits where the consultation can be appropriately delivered as a telehealth appointment. Telehealth means delivery of healthcare that involves the treatment or management of clinical conditions via phone or video link (or similar), delivered in real-time and proven to be effective in the treatment or management of a diagnosed clinical condition.

Please check your product Fact Sheet for eligible Telehealth consultations.

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Additional information

Changes to your cover or these Terms and Conditions

We may make changes to our Fund Rules and these Terms and Conditions at any time by publishing the new or amended version on our website. We may make changes to your cover at any time by publishing a new or amended fact sheet on our website or Online Member Services.

If the new or amended Fund Rules, Terms and Conditions or Fact Sheet are or might be detrimental to the interests of Members, we will provide the Policy Holder (and other Members if required under the Fund Rules) on the affected Policies with reasonable prior written notice. For the avoidance of doubt, any such notice must comply with any relevant requirements of the Private Health Insurance Legislation, the Australian Consumer Law and the Private Health Insurance Code of Conduct. The Policyholder must inform each adult on the membership of the change to the Terms and Conditions within a reasonable period.

If you do not wish to continue under the changed cover, you have the option of transferring to a different cover or cancelling your membership. If you do cancel, you're entitled to a refund of any premiums paid in advance as long as you have met the Minimum Duration of Cover. Please see the 'Refund Policy' section of the Member Guide for more details.

GST

A Goods and Services Tax (GST) applies (currently 10%) to Overseas Visitors Cover in accordance with A New Tax System (Goods and Services Tax) Act 1999. GST does not apply to other types of private health insurance cover, including extras covers. GST is included in your Overseas Visitors Cover premium.

Becoming a health fund member

OVC membership alone will not entitle you to AUL membership but holding an Extras product may. Subject to you meeting the membership eligibility criteria determined by the Board of Australian Unity Limited ('AUL') the Board of AUL may determine that you will become a member of AUL. By becoming a private health insurance policyholder, you consent on behalf of yourself and the other members on your policy, to become a member of AUL and agree to be bound by the constitution of AUL, in particular, you agree to contribute an amount not exceeding $1 to the property of AUL in the event of AUL being wound up while you are a member of AUL or within 1 year afterwards as set out on the constitution of AUL.

Summary of terms and conditions

This important information contains only a summary of the Fund Rules. The complete rules of the health fund are set out in full within the terms and conditions of membership and liability under the fund. These rules are available for inspection online at **australianunity.com.au/forms** or at Australian Unity, 271 Spring Street, Melbourne.

This documentation should be read carefully and retained. To fully understand your cover please refer to the Member Guide particularly the Important Things to Know – Terms and Conditions section and your product(s) Fact Sheet.

Australian Unity respects your wishes. If you received this by unsolicited direct mail from Australian Unity, and don't wish to receive similar product offerings in the future (including special offers and discounts), please let us know by calling 13 29 39. View our privacy policy at australianunity.com.au/privacy Australian Unity Health Limited – ABN 13 078 722 568.

Contact us

1300 683 782
australianunity.com.au