Australian Unity
Real Wellbeing

Health Insurance

Member guide

Effective from 28 February 2025

Do well, be well

Enjoy all of the moments that life has to offer and live happily ever after, now.

For more than 180 years, we've had the wellbeing of Australians at the heart of everything we do. You could go as far as calling it our bread and butter – and it's experience we're prepared to share.

We'll always make sure you know how to get the most from your cover – from encouraging regular use of your extras, to giving you choice when it comes to elective surgery and, of course, general wellbeing hints and tips that we hope will make a difference.

And please remember that if you have any questions, our team is here to help.

Welcome to Australian Unity.

Contents

Health insurance with us and what that means to you – our Member

This guide is a summary of Australian Unity Health Limited's (Australian Unity) Fund Rules.

It outlines your membership entitlements and responsibilities, including the terms and conditions of your cover.

Read this guide carefully in conjunction with the Fund Rules and your product Fact Sheet and be sure to keep a copy for your records.

The information provided in this document is current at the date of publication and is subject to change. To access the latest version and a copy of our Fund Rules visit **australianunity.com.au/importantdocuments**

Changes to your cover

We may at any time make changes to your cover. This may include adding or reducing the benefits or services available to you. We will ensure that we provide you with appropriate notice of these changes in accordance with the Private Health Insurance Act 2007, the Australian Consumer Law and the Private Health Insurance Code of Conduct prior to these changes taking effect. 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.

Requirement to provide accurate and complete information

When you complete a membership application, it is important that you provide us with all the information requested to allow us to maintain an accurate record of your membership. It is also important that the information you provide is true and correct.

Your responsibilities as a Member

The person first named under the health cover (the Member) is the owner of the health membership. As the Member, it's your responsibility to let us know of any changes to your circumstances that may affect your membership. These circumstances include, but aren't limited to, the following:

Adding or removing members from your policy

If you wish to add or remove a spouse/partner or a child to/from your membership, it's important to contact us in a timely manner as you may not be able to backdate this request. Please refer to the Terms and Conditions for details.

When you add a spouse/partner onto your membership, they will have the same delegated authorisation as you, the Member (including access to personal information about all members on the policy). However, they won't be able to cancel the policy, change the Member, remove the Member from the policy or nominate further or remove current delegated authorities. If you have a partner or spouse on your policy and don't want them to have delegated authority just let us know by contacting us on **13 29 39**.

Keep in mind that the cost of your cover may be affected if your membership changes from single to couple, single parent, family or vice versa. Details on different scales are available in our Fund Rules located at **australianunity.com.au/importantdocuments**. If your partner has Lifetime Health Cover (LHC) loading, adding, or removing them from your membership may affect the overall LHC loading applicable to your premium. You should consider any changes to household income, as this may affect the level of Australian Government Rebate (where eligible) that you're entitled to.

Children

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 Dependants 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

Termination of cover for children

A child turning 23 will be removed from your membership unless:

- You register them as Student Dependant before they turn 23 or,
- They are registered as a Non-Student Dependant

Any Student Dependant or Non-Student Dependant will be removed from your membership when we are advised by you that they have married, entered a de facto relationship or turned 31 whichever happens first.

To register a Student Dependant

If you have a child on your membership aged 23 and over studying fulltime, you need to contact us and register them as a Student Dependant. You may need to occasionally renew their student registration details, we will communicate with you beforehand if this needs to be done. For more information about registering a child as a Student Dependant, you can download the Student Dependant form from **australianunity.com.au/forms** or you can call us on **13 29 39**.

To register a Non-Student Dependant

If you have a child on your membership aged 23 and over not studying fulltime, you need to register them as a Non-Student Dependant, that means your membership will need to be on a 'plus scale'. If you are already on a plus scale when your child turns 23 or reaches their course end date this registration will happen automatically. For more information about this we're here to help on **13 29 39**.

Changing your address and contact details

It is your responsibility to ensure we have your current address and contact details so you continue to receive important notices or communication from us. If you move to a different state, the cost of your cover may also change so it's best you contact us as soon as possible to update your address details.

Understanding your cover

Getting the most from your hospital cover

Our range of hospital covers can take care of many of the expensive costs that come with a hospital admission, like accommodation, theatre fees and surgeons' fees – giving you greater comfort when you need it most.

To get the most out of your membership, it's important to familiarise yourself with the conditions of your cover which can also help you understand your benefit entitlements. Wherever possible, plan your hospital admission in advance so that you have a thorough understanding of what to expect from your cover when going to hospital, including any out-of-pocket costs.

Our hospital cover generally does not pay benefits related to attendance at a hospital emergency department, such as non-admitted (outpatient) hospital visits, any attendance at doctors' rooms, consultations with nurses or administration fees. For more details on what hospital costs we don't cover refer to the Important Things to Know section of this Member Guide. Please note for Podiatric Surgery (provided by a Registered Podiatric Surgeon) we pay reduced benefits. Refer to the 'Podiatric Surgery' section of this Member Guide for details.

Agreement Private Hospital

Depending on your level of cover, when you need elective surgery, you can avoid public hospitals and their waiting lists, by choosing to be treated at any one of more than 500 private hospitals we have an agreement with (our agreement hospitals). Find your nearest agreement hospital at **australianunity.com.au/agreementhospitals**

These private hospital agreements mean you'll be covered depending on your level of cover, for most in-hospital charges less any incidentals and excess or co-payment you may be required to pay.

Your hospital cover generally includes:

- accommodation in a hospital room/ward for an overnight or same-day admission
- operating theatre, intensive care and labour delivery room fees
- medication dispensed in hospital approved under the Pharmaceutical Benefits Scheme (PBS) (excluding medication you take home)
- allied health services that are directly related to your admission and provided by the hospital (e.g. physiotherapy) while you are admitted
- dressings and other consumables while admitted. Excludes 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.
- surgically implanted prosthesis up to the value listed on the Australian Government's Prostheses List (also known as the Prescribed List of Medical Devices and Human Tissue Products)
- private room (where available)

- attending doctor/surgeon fees incurred while admitted, up to the Medicare Benefit Schedule (MBS) fee
- most diagnostic tests during your admission e.g. pathology, and radiology (up to the MBS fee).

However, if your doctor or diagnostic service provider charges above the MBS fee, out-of-pocket costs will apply. Your out-of-pocket costs for your doctors' fees will be minimised if you're covered for Gap Cover and your doctor agrees to participate in our Gap Cover Scheme. In this case we'll pay above the MBS fee, up to the amount specified in our Gap Cover benefits schedule.

Please refer to your Fact Sheet, and to the Gap Cover section of this Member Guide for further details. We also recommend that you consult with your doctor about any out-of-pocket costs that may apply and whether they will participate in our Gap Cover scheme.

Non-Agreement private hospitals

In the event you are admitted to a private hospital that is not one of our agreement hospitals, the amount we pay is a set amount and may not cover the full cost of your stay so you may incur large out-of-pocket costs. You may also be required to pay an excess (or co-payment) prior to, or after, your hospital stay. It's the responsibility of the hospital to advise you of potential out-of-pocket costs before you're admitted into hospital. Please refer to the Informed Financial Consent section of the Member Guide for further details.

Public Hospital

If you choose to go to a public hospital and be treated as a public patient, you'll receive treatment by a hospital-appointed doctor and Medicare will cover the cost of your treatment and accommodation. If you choose to go to a public hospital, admission staff should explain that you have the option to be admitted as either a public or private patient. Remember that it is your choice whether you want to be treated as a public or a private patient. Choosing to be treated as a private patient in a public hospital requires you to sign an election form; this should note all the costs relating to hospital and medical fees you will incur, including excess. If you do elect to be admitted as a private patient in a public hospital there may be very little difference in the care you will be provided (compared to being a public patient), but you may be able to elect a doctor of your choice. All of our covers pay benefits towards shared room accommodation in a public hospital for services included in your cover. If you are admitted to a private room of a public hospital, you may experience large out-of-pocket costs as our covers only provide benefits up to the shared room amount in a public hospital, regardless of the room type. The hospital should advise you before your admission for any out-of-pocket costs prior to your admission. Please check your product Fact Sheet for more detail about benefits you can expect to receive.

Rehabilitation

As an admitted hospital patient, rehabilitation is treatment provided to you to assist in improving or restoring your independence and function following an illness or injury. Generally, you may undertake a program such as:

- Cardiac – following a heart attack, coronary artery bypass
- Neurological – following a stroke, spinal cord injury
- Orthopaedic – following a hip/knee replacement

These programs may be conducted in a rehabilitation ward of a general hospital or in a registered rehabilitation hospital/clinic. All Australian Unity hospital covers pay benefits (either Restricted or Covered) for Rehabilitation. Check your product Fact Sheet for more details, you can view your Fact Sheet online.

Alternatively, Australian Unity offers eligible members the opportunity to recover and receive rehabilitation in the comfort of their own home instead. Check your product Fact Sheet to find out whether our Rehabilitation at Home program is part of your cover.

Psychiatric

Psychiatric illness comprises a wide range of disorders and can vary in severity. Psychiatric conditions that might require hospitalisation include, but are not limited to:

- Clinical depression
- Anxiety disorder
- Post-natal depression
- Eating disorders
- Bipolar disorder
- Drug and/or alcohol addiction
- Post-Traumatic Stress Disorder

When you're an admitted patient, these programs can be provided in a psychiatric ward of a general hospital or in a registered psychiatric hospital/clinic. All Australian Unity hospital covers pay benefits (either Restricted or Covered) for Hospital Psychiatric Services. Check your product Fact Sheet for more details, you can view your Fact Sheet online.

All our hospital covers provide Mindstep, a health support program for members who experience depression or anxiety. For more details, including eligibility check **australianunity.com.au/mindstep**.

Surgically implanted prostheses

We generally cover you for Australian Government approved prostheses such as pacemakers, defibrillators, cardiac stents, joint replacements, intraocular lenses or other devices on the Australian Government's Prostheses List (also known as the Prescribed List of Medical Devices and Human Tissue Products), which must be surgically implanted during a stay in hospital. You're covered for all prostheses on the List, up to the value stated on the list.

You'll have an out-of-pocket expense where (in consultation with your doctor) you choose a prosthesis that isn't included in the Government's list at all. In that case, we won't pay any benefits and you'll be responsible for the full cost of the item.

Your doctor should discuss your prosthesis options with you and seek your Informed Financial Consent regarding additional costs you may have to pay.

Benefits are not payable for any prosthesis associated with an Excluded service under your cover. The Prostheses List is available at **health.gov.au**

Pharmaceuticals in Agreement Private Hospitals

For categories included on your cover, you are covered for the cost of pharmaceuticals administered during your hospital admission that are listed on the Pharmaceuticals Benefits Scheme (PBS).

We won't pay for:

- contraceptive drugs
- drugs issued for the sole purpose of use at home or not essential to the reason for your admission
- experimental and high cost drugs not listed on the PBS (see 'High cost drugs')
- pharmacy items charged in a public hospital

High cost drugs

High cost or experimental drugs are sometimes used for treatment of cancer or other conditions, yet they have not been approved by the Australian Government to be listed under the Pharmaceutical Benefits Scheme (PBS). These types of pharmaceuticals aren't covered under private health insurance or included under our agreement hospital contracts. This means you may have significant out-of-pocket cost if they are used in your treatment.

Podiatric Surgery (provided by a Registered Podiatric Surgeon)

Services provided in hospital by podiatric surgeons are not recognised under the Medicare Benefit Schedule (MBS). This means we won't be able to cover you for any medical costs associated with podiatric surgery. If you're being admitted for podiatric surgery, please consider the following:

- the surgery must be performed by a registered podiatric surgeon
- no benefits are payable towards theatre fees, the podiatric surgeon's fees or other participating doctors, such as anaesthetists

What we will pay benefits towards if Podiatric surgery is Covered or Restricted on your hospital cover:

- Accommodation in an agreement Private Hospital room/ward for overnight or same day admission
- Accommodation in a Public Hospital, shared room/ward for overnight or same day admission up to the minimum (default) rate as set by the Australian Government
- The cost of a prosthesis as listed in the prostheses list (also known as the Prescribed List of Medical Devices and Human Tissue Products) set out in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, as in force from time to time.

Most podiatric surgeons are aware health funds pay limited benefits for their services. We recommend you request a quote from your podiatric surgeon and associated anaesthetist before undergoing treatment so you are fully informed as to any out-of-pocket costs.

Dental surgery in hospital

Dental surgery in hospital can be covered by both hospital and extras cover. If you are covered for Dental Surgery under your hospital cover we will pay benefits towards the hospital accommodation and theatre fees, as well as MBS item numbers raised. However, in most cases, a dentist/dental surgeon doesn't utilise MBS item numbers, and will use dental item numbers for billing. This means we can only pay towards these dentist's charges under the applicable dental benefits on your extras cover (subject to your yearly limit/s).

Assisted Reproductive Services

Assisted reproductive procedures such as In Vitro Fertilisation (IVF) and Gamete Intra Fallopian Transfer (GIFT) are used to treat infertility. If your hospital cover includes benefits for Assisted Reproductive Services, please be aware you can only claim for those treatments where you are an admitted private patient in hospital. Most fertility treatments are classified as outpatient and therefore are not claimable under your hospital cover, although some services may be claimable through Medicare.

It's important to understand the full extent of services associated with your treatment and the level of benefits payable by us and Medicare (where applicable). We strongly recommend you understand your entitlements and obtain Informed Financial Consent from your doctor, anaesthetist or hospital to understand the potential out-of-pocket costs.

Informed Financial Consent

You have the right to know what your episode of medical treatment might cost. This is known as Informed Financial Consent. It's the responsibility of your treating doctor and hospital to advise you of potential out-of-pocket costs before you're admitted into hospital. If they don't provide an estimate of those costs, it is your right to ask for one. It's your responsibility to ensure you understand all potential costs before your admission to hospital and to discuss your treatment. We recommend you contact us before going to hospital and/or before you undertake any treatment to understand your health cover benefits and how you may be able to minimise or avoid out-of-pocket costs.

Avoid or reduce out-of-pocket costs with Gap Cover

Gap Cover helps to reduce or remove out-of-pocket medical costs and is available on selected hospital covers.

Please check your product Fact Sheet to find out if you're on an eligible level of cover. Gap Cover only applies to the medical treatment of illnesses or conditions available under your health cover.

What are 'gap' payments?

The Australian Government sets a schedule of fees for all medical treatments called the Medicare Benefits Schedule (MBS). When you're treated as a private patient in a public or private hospital, Medicare pays 75% of the MBS fee and Australian Unity pays the remaining 25%.

Sometimes a doctor or a specialist will charge more than the MBS. The difference, known as the 'medical gap', is normally an out-of-pocket cost you have to pay. To help reduce or avoid these 'gap' payments, we've set our own Gap Cover schedule of fees, which are generally higher than the MBS.

Gap Cover doctors

If your doctor or specialist agrees to participate in Australian Unity's Gap Cover scheme, we can pay for some, if not all, of the gap.

If Gap Cover won't fully cover your participating doctor's fees, your doctor must tell you how much you'll have to pay in writing before treatment can begin. This is known as Informed Financial Consent; refer to the 'Informed Financial Consent' section of this member guide for further details.

Australian Unity Gap Cover is available to all doctors who treat private patients in hospitals or day surgeries, but not all doctors participate.

Before you go to hospital

To find doctors who may choose to participate in Gap Cover for your procedure visit **australianunity.com.au/gap-cover** or call us on **13 29 39**.

Before going to hospital

When you can, we recommend doing these things before going to hospital:

- Call us to discuss your cover and check for any waiting periods, exclusions, restrictions, excess or co-payment that may apply
- Talk to your doctor about a referral to an appropriate specialist
- Check whether your specialist practises from one of our agreement hospitals (including day hospitals). To find an agreement hospital visit **australianunity.com.au/agreementhospitals**
- Talk to your specialist about your treatment options, how much their fee is, if you will have any out-of-pocket costs to pay, and obtain an estimate of these fees and costs in writing. Refer to the 'Informed Financial Consent' section of this Member Guide for further details.
- Check with your specialist about any other charges from other health professionals associated with your in-hospital treatment e.g. anaesthetists
- Ask if your doctor/s (including anaesthetist) will participate in our Gap Cover scheme (refer to the 'Gap Cover doctors' section of this Member Guide for more details), which could reduce or eliminate your out-of-pocket medical costs
- Consider checking your Fact Sheet to see whether your policy includes Hospital Care at Home and discussing it with your specialist as an option to reduce your time in hospital.
- Contact the hospital to see if you'll have to pay your excess before you're admitted and if there will be any additional expenses you may incur and when they have to be paid
- Prepare for your stay by deciding what to take and follow any preparation instructions from your hospital or doctor

And remember, if you feel even slightly unsure; call us on **13 29 39**.

After you've left hospital

- **Hospital bills –** for hospital items such as accommodation, surgical prostheses and theatre fees, the hospital will normally send the bill directly to us. If you have an excess /co-payment to pay and didn't pay it on admission, or if you have incidentals that would not be covered by your health insurance, the hospital will usually send you a separate invoice
- **Doctors' bills –** if your doctor has participated in our Gap Cover scheme they will bill us directly. If they give you an account, please make sure you claim from us first. This will enable us to process your account and provide you with your full benefit entitlements, either through Gap Cover or by directing the account straight to Medicare on your behalf

Please note: If you or your doctor send the bill to Medicare first, you are not eligible to claim any Gap Cover benefits from us. You should always send your doctor's bills to us first.

A little bit extra to make you smile

Extras cover can help you get some of your money back on common health treatments that aren't covered by Medicare, like dental, physiotherapy and optical.

With our extras cover, you can choose your preferred health care provider from any of those who are recognised by Australian Unity. To check, ask your provider before you visit or call us on **13 29 39**. For further details on recognised providers refer to the 'Recognised providers' section of this Member Guide for more details.

And to help make New Year's Day an even happier one, we'll automatically refresh your extras claim yearly limits each time 1 January rolls around. Your product Fact Sheet provides details of your claims limits.

Dental

Australian Unity pays your claims for dental services based on the Australian Schedule of Dental Services and Glossary produced by the Australian Dental Association (ADA).

Depending on your level of extras cover, you can claim for dental services, up to your yearly limit. We use the Australian Dental Association (ADA) guidelines, Dental Reasonability Rules and our Fund Rules to determine whether we pay benefits for certain services. For example, the ADA guidelines help us to categorise each dental service (e.g. 'diagnostic', 'orthodontics') and may indicate that a certain dental item number can't be charged by a provider with another service during the same visit.

We recommend you obtain a quote from your dentist before undergoing any treatment, along with a full list of associated dental item numbers. You can then contact us or log in to Online Member Services (OMS) or the App to get an estimate of benefits before proceeding with treatment.

Orthodontic services

Two types of orthodontic claims limits apply:

- **Yearly limit** – the maximum claimable per person, per calendar year (may be combined with other dental services)
- **A lifetime limit** – the maximum claimable per person per lifetime carried across any product and/or health fund

Orthodontic benefits aren't included under all extras covers, please refer to your product Fact Sheet for more details.

Claiming orthodontic instalment payments

If you're paying your orthodontic treatment in instalments, you can submit a claim for each payment charged by your dentist. The date each instalment is paid will be processed as your 'Date of Service', and your claim will be assessed according to the Terms and Conditions. We'll pay your claim as per your level of cover (subject to any applicable waiting periods) and take into consideration your yearly and lifetime limit. This will continue until the orthodontic work is complete or the yearly/lifetime limit is reached.

Claiming up-front payments for orthodontic services

If you pay for an entire course of orthodontic treatment up-front or make the final payment in advance, you'll need to provide a treatment plan from your dentist or orthodontist when submitting your claim. The plan will need to show, the treatment start and end date, and you will need to provide a receipt showing the total cost paid, date of payment, item code and patient name.

You can then claim for subsequent calendar year/s. To do this you must submit an itemised account from the dentist outlining the patient name, item codes and showing that at least one treatment date is scheduled for the new calendar year.

Make visiting the dentist painless

Many of us will put off visiting the dentist until a problem arises, like a severe toothache. But the truth is that preventative care can make all the difference.

Regular dental check ups can assist in detecting conditions early before they become costly visits. If your cover includes No Gap Dental, you can get up to 100% back on the cost of selected dental services (up to your yearly limit, depending on your level of cover), if you visit one of our recognised No Gap Dental network providers.

Some of these dental services include:

- scale and clean
- x-rays
- topical fluoride treatment
- custom mouth guards for protecting your teeth during contact sports

Claims paid for No Gap Dental may be deducted from your yearly dental limits under your extras cover (depending on your level of cover), and subject to our Fund Rules. No Gap Dental is not offered under all extras covers, so please refer to your product Fact Sheet for more details. Find your nearest No Gap dentist at **australianunity.com.au/nogapdentists** or by calling us on **13 29 39**.

Pharmaceutical benefits

Depending on your level of Extras cover, eligible non-PBS pharmaceuticals and certain travel vaccines are covered, as long as you provide an official pharmacy receipt/script or itemised vaccine account from your provider. Please call us for more information about the travel vaccines that we will cover.

To claim, the pharmacy item and script must:

- be on the Australian Register of Therapeutic Goods (ARTG) for the indication for which they have been prescribed to the patient, and listed as a Schedule S4 or S8 pharmaceutical.
- not be on the Pharmaceutical Benefits Scheme (PBS) list i.e. non-PBS
- include drug name, strength and quantity
- include supply/dispensed date
- cost more than the current maximum patient contribution amount that applies to medications listed on the PBS
- include patient's and prescribing doctor's name and
- include pharmacist's name, address and prescription number

There are some items that are not covered, such as over-the-counter and non-prescription pharmaceuticals, contraceptives, items not related to a medical condition and hormones for fertility treatment. Weight loss medication and body enhancing medications aren't covered unless they're prescribed by your treating specialist. After you've paid a sum equal to the Australian Government's current Pharmaceutical Benefits Scheme (PBS) maximum patient contribution amount, we'll pay the remaining cost above that amount, up to your per item limit.

Health aids and devices

Depending on your level of extras cover, you may be able to claim for aids or devices such as asthma pumps or blood glucose monitors. In determining whether a device is eligible for payment we consider that it is intended for repeated use, can alleviate or assist a medical condition and is not useful where no illness or injury exists.

An appliance must be supplied by a reputable supplier, who has a registered Australian Business Number (ABN), and may need to be authorised by the attending doctor or allied health professional. For a benefit to be paid on some aids and devices, a letter is required (no more than 6 months old) from your treating doctor or health practitioner indicating the medical condition for which the item is required. Please check your Fact Sheet for more details.

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".

Extras purchased online

Depending on your level of cover we will pay claims on eligible goods (excluding consultations) that have been purchased via the internet from Australian companies or providers e.g. prescription eyewear or blood monitoring devices. Australian Unity does not pay claims for services or goods directly supplied from overseas or from suppliers that are not registered in Australia to conduct their business, for example businesses that are not registered with Australian Securities & Investments Commission or the Australian Taxation Office.

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.

Why it's worth the waiting period

Without waiting periods, it's likely that most people would only buy and keep health insurance for when they need to make a claim – and you can imagine what that might do to your health cover premiums.

A waiting period is the amount of time you and anyone on your membership is required to wait before you can first make a claim or claim a higher amount for a particular service or treatment on your new health cover. Waiting periods apply to both hospital and extras cover.

A waiting period applies when you:

- first join or upgrade your health cover
- re-join after a break in cover
- reduce your hospital excess or co-payment

Please note: The service or treatment received must have occurred after the waiting period has been served to be eligible for a benefit payment.

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.

How long are waiting periods if you've come from another fund?

If you've transferred to us from another health fund within 30 days of leaving them and chosen a level of cover that's at a similar or lower level than your previous one, you won't need to re-serve any completed waiting periods. Even if you haven't completed a waiting period, we'll apply any time already served towards your new cover.

To check, call us on **13 29 39**.

Waiting periods

The waiting periods that typically apply are set out in the table below. However, for the specific waiting periods that apply to your cover, please refer to your product Fact Sheet in your welcome pack or visit **australianunity.com.au/factsheets**

Hospital Cover	
12 months	• Pregnancy and Birth • Pre-existing Conditions except for Psychiatric, Rehabilitation and Palliative Care services.
2 months	• All Psychiatric, Rehabilitation and Palliative Care services regardless of it being due to a Pre-existing Condition. • All other treatments not listed above.
0 months	• Hospital Treatment or Hospital-Substitute Treatment that is required as a result of an Accident that took place after a Member's Commencement Date.
Extras Cover	
12 months	• Major dental – including Dentures, Prosthodontics (crowns, bridges and implants) and Orthodontics; • Surgical tooth extraction(s); • Endodontic; • Periodontics; • Orthotics; • Hearing Aids • Non-Surgical Prostheses; • Braces and Splints • Asthma Pumps/Nebulisers, Blood Glucose Monitors, Blood Pressure Monitors, Peak Flow Meters, Oral Device for Sleep Apnoea, T.E.N.S. pain management machines, and C.P.A.P. airway pumps; • BumptoBaby and Health Support Programs; • All other Preventative Health Services not listed in this table.
6 months	• Optical; • Health Management Programs; • Gym Membership; • Nicotine Replacement Therapy; • Skin Checks.
2 months	• All other services and treatments not listed in this table.
0 months	• Preventative Dental (including scale and clean); • Dental Diagnostic Services; • Travel Vaccinations; • Doctor Health Checks; • Cervical Cancer Vaccinations; • Quit Smoking; • Weight Loss Programs; and • Home Nursing • Emergency Ambulance Transportation and Ambulance Attendance • Personal Health Coaching • On-Site Accommodation • School Accident Top-Up Benefit

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. If you make a hospital claim in the first 12 months of your joining or upgrading your cover, we will ask you to get your consulting doctors or other practitioner (e.g. your dentist, GP or specialist) to complete a medical report. You should ask us to carry out this assessment before going into hospital.

Please consider this when you agree to a hospital admission date so we have sufficient time to review your individual situation. If you're admitted into hospital before seeking confirmation from us about your eligibility for cover, and we later determine your condition is pre-existing, you'll need to pay any hospital and medical charges not covered by Medicare – no benefits will be paid by us.

Clever ways to save

Save 4% with direct debit

It's simple to apply. Log in to Online Member Services at **australianunity.com.au/memberservices** and add your details in the 'Payments' section.

Australian Government Rebate on Private Health Insurance

If you are eligible for Medicare you may be entitled to a rebate on your private health insurance depending on your income.

There are two ways to apply:

1. By calling us on 13 29 39 and providing your details to one of our friendly staff members. When you call please ensure you have your Medicare card details available.
2. Complete and return the Australian Government Rebate Application Form that's in your welcome pack.

For assistance in determining your appropriate rebate tier please contact your registered tax agent or the Australian Tax Office at **ato.gov.au**

Avoid paying a Lifetime Health Cover (LHC) loading

By taking out private hospital cover on or before 1 July following your 31st birthday, you'll avoid having to pay 2% extra for your hospital cover. The extra 2% applies for each additional year that you don't have private hospital cover, up to a maximum loading of 70%.

The good news is that you stop paying a LHC loading after you've held hospital cover for ten continuous years. These ten years are counted as paid days of hospital cover so if you suspend your membership, that suspension period won't be counted towards the ten years (subject to some exceptions, see 'Gaps in hospital cover' below).

To avoid paying LHC, new Australian Citizens and Permanent Residents must take out a PHI hospital cover within 12 months of becoming eligible for full Medicare entitlements.

Gaps in hospital cover

To cover small gaps in hospital cover, such as switching from one fund to another, you are able to be without hospital cover for up to 1094 days (one day less than three years) during your lifetime, without affecting your LHC loading.

Going overseas for one year or more

If you cancel your hospital insurance after your Lifetime Health Cover base day

to go overseas for at least one continuous year, the days you spend outside of Australia are not counted towards the 1094 Days of Absence. You can return to Australia for periods of up to 90 consecutive days, per visit, and be considered to be overseas. Any periods of 90 days or more which you spend in Australia during this time will be deducted from the 1094 Days of Absence.

Visit the Private Health website at **privatehealth.gov.au/health_insurance/surcharges_incentives/lifetime_health_cover.htm** to find out more about Lifetime health cover loading.

We also offer the ability to suspend your cover if you travel overseas. Refer to the 'Suspension of membership' section of this Member Guide for details.

Medicare Levy Surcharge (MLS)

The MLS is levied on Australian taxpayers who don't have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to take out private hospital cover and use the private system to reduce the demand on the public Medicare system. The surcharge is calculated at the rate of 1% to 1.5% of your income for MLS purposes. The MLS is in addition to the Medicare Levy of 2% which is paid by most Australian taxpayers.

Visit **ato.gov.au/Individuals/Medicare-levy/Medicare-levy-surcharge** to find out more about MLS.

Services and support

Making a claim is easy

Getting back what you're owed shouldn't be tricky. That's why we've created these simple ways for you to submit extras claims.

All you need to do is make an extras claim using one of the options below and, if required, we'll get in touch later to ask you to send us any other additional documents we require. Or go to our website to find out more information about other claiming options.

Claim on-the-spot

If your healthcare provider has HICAPS or other electronic claiming, simply swipe your Australian Unity member card. Once your claim is authorised, you can pay any difference there and then.

Online Member Services

Go to **australianunity.com.au/memberservices** to submit extras claims online and upload scanned or photographed receipts. Refer to the 'Online Member Services' section of this Member Guide for more details.

Apps and devices

Download the Australian Unity Health app from the App Store or the Google Play Store (Android) and you can submit extras claims by photographing and uploading your receipts.

If you've given us your mobile number, we'll send you an SMS once we've successfully processed your claim.

Online Member Services

Our Online Member Services (OMS) boasts a range of tools to help you manage your membership with us. You can use it to:

Go paperless

Choose to receive important updates about your health cover by email.

Update your membership and personal details

It's great for changing your contact details and adding or removing a child.

Calculate how much you'll get back before you go

Want to avoid any out-of-pocket surprises? Search for a specific extras treatment and, if you know which provider you're going to visit, you can calculate how much you'll get back for it.

Submit claims easily

To make a claim online:

1. Head to 'make a claim' on your Online Member Services (online account).
2. Select 'extras services' and answer each question in the online form, making sure to upload your itemised invoice from the provider and/or any other documents required to support your claim.
3. Once we've processed your claim, we'll make a payment into your nominated bank or credit union account. If you haven't paid your provider, it will be your responsibility to pass it on.
4. If there's any amount outstanding after our payment, you'll need to pay this.

Check how much you've claimed

You'll find this function particularly useful when you want to schedule extras treatments at the end of the year before most of your extras claim limits are refreshed on 1 January.

Check specific details about your cover

Find out about any waiting periods or exclusions that might apply, view your payment history and set up or update your direct debit or direct credit details.

View important communications

Documents like your tax statement will be stored online for you to download at any time.

Making the most of your health insurance

Preventative Health Services

Claim back on selected personalised support programs designed to bring about positive change in your life. Depending on your level of cover, you may be able to get money back on the following services:

- Weight Loss programs
- Quit Smoking programs
- Doctor Health Checks
- Personal Health Coaching
- Diabetes Australia Membership
- Bone Density Scans
- Lift for Life
- Mammogram Screenings
- Cervical Cancer Vaccinations

Health Support Programs

We give you added support to improve and sustain your health and wellbeing. Depending on your level of cover, the following programs may be available to you:

- Mental health support through the MindStep® program
- Health coaching through the HealthierMe program

Further benefits

Depending on your level of cover, the following benefits may be available to you:

- Healthcare in the Home
- Accident Cover

Support for new and expectant parents

On selected levels of cover, we offer BumptoBaby, an innovative program for eligible Australian Unity health insurance members. BumptoBaby provides practical support to expectant parents via regular access to a qualified midwife, via telephone and email, throughout your pregnancy and right up until your baby's first birthday, plus an informative website relating to pregnancy and parenting.

No Gap Dental Network

On selected covers get up to 100% back on preventative dental treatment such as scale and clean, fluoride treatment and mouthguards when you visit any provider in our No Gap Dental Network. Please note, No Gap Dental providers are not available in all states and territories.

At some No Gap Dental clinics, not all dentists participate in the No Gap Dental network. Please confirm with Australian Unity or the clinic whether your dentist participates prior to treatment. At Australian Unity Dental Centres, all dentists participate.

Get rewards and discounts

We offer our members a wide range of ongoing discounts and rewards, so you will get more than just great health insurance.

Save money on everyday items like groceries, petrol and entertainment on our Wellplan Reward Portal that you can access through the Online Members Services (OMS).

Right Cover Check

If you haven't reviewed your private health cover in the past couple of years, it may be worth your while to do so. Needs change depending on things like lifestyle, life stage, health issues and financial situations. In addition, there may be new features or products available that suit your circumstances better.

Check your Fact Sheet to see what you're covered for and decide if it's still right for you or call us on **13 29 39** for a Right Cover Check

Find out more

To check your eligibility for any of these programs or services listed, please review your Fact Sheet, or call us on **13 29 39** to have a chat with us today to see how we can help you.

australianunity.com.au/wellnessbenefits

Interested in finding more about how you can support your Real Wellbeing? Find tips, tools and stories on our online Real Wellbeing Content Hub.

australianunity.com.au/wellbeing

Important things to know

Terms and conditions

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.

Membership types

- A single membership covers one person (the Member) only
- A couple's membership covers the Member and one other adult being their spouse or de facto partner
- A single parent family membership covers the Member and one or more eligible children
- A family membership covers the Member and their spouse or de facto partner and eligible children

Children

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 Dependants 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

Health cover for non-residents

Australian Unity hospital cover is suitable for people with full Medicare entitlements. If you are an overseas visitor with no Medicare entitlements or limited reciprocal benefits, please refer to our Overseas Visitor Health Covers for more options.

Waiting periods

A waiting period is a set period of time where you can't claim benefits for certain treatments. It starts on the date you join or when you upgrade your level of cover (including reducing your hospital excess). Refer to your product Fact Sheet for details on waiting periods that apply to your chosen level of cover.

If you upgrade your cover and increase your level of benefits for a particular service, you can claim the higher benefits, except where a waiting period applies. In that case, the benefit we will pay is equivalent to your previous cover until the waiting period on your new level of cover has been served. Refer to the 'Waiting periods' section of this Member Guide for the list of waiting periods that may apply.

Where benefits are payable for a hospital treatment service (even if you have upgraded and are still serving a waiting period to access higher benefits), and your cover includes Gap Cover at the time you receive the service, no waiting periods apply before you may access Gap Cover. See the 'Gap cover' section of this Member Guide for further information and conditions that may apply.

Transferring Memberships

If you are transferring from another Australian private health insurance fund or transferring between Australian Unity memberships, you need to start your new health cover with us within 30 days of cancelling your old membership to ensure continuity of cover.

- For members who transfer from another Australian private health insurance fund, your Australian Unity membership will commence from the day you contact us and purchase your policy or a later day.
- For members who are transferring from another Australian Unity Membership, you must contact us within:
  - 30 days from the day you ceased to be covered (if you were a Partner/ Spouse or Policy holder on the previous membership) or
  - 3 months from the day you ceased to be covered (if you were a Dependant on the previous membership)

    Your new membership must commence within 30 days from the day after your 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. A gap in cover greater than 30 days means that you will have to re-serve all waiting periods.

When you join a new membership, regardless of the gap between your old and new membership, we will calculate the 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. Days without hospital cover may be considered absent days for Lifetime Health Cover purposes, and you may also be liable for the Medicare Levy Surcharge.

If you are transferring from another fund, we'll request a Transfer Certificate from your previous fund. This lets us know what waiting periods you have already served on your previous cover. If your benefits with us are greater than the benefits payable by your previous fund, you may have to serve waiting periods for the additional benefits. Please note: Accrued entitlements and loyalty bonuses are not transferable between funds.

Pre-existing Conditions for hospital covers only

A pre-existing condition is an ailment, illness or condition where, 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. If you make a hospital claim in the first 12 months of your joining or upgrading your cover, we will ask you to get your consulting doctors or other practitioner (e.g. your dentist, GP or specialist) to complete a medical report. You should ask us to carry out this assessment before going into hospital.

A general two month waiting period applies to all our hospital covers (unless treatment is required as the result of an Accident sustained after joining or upgrading cover; see the 'Waiting periods' section of this Member Guide for details.).

In addition, if you have a Pre-existing Condition, a 12 month waiting period will apply. The 12 month waiting period for Pre-existing conditions runs concurrently with the two month general waiting period, and does not apply to hospital treatments for psychiatric, rehabilitation and palliative care which only have a waiting period of two months.

Where you have only held your current cover for less than 12 months, contact us to discuss if the Pre-existing Condition waiting period applies to you prior to booking your hospital procedure.

We need up to five working days to carry out the pre-existing assessment, after receiving information about any signs or symptoms related to your condition detailed on a completed Medical Report from your first consulting medical practitioner.

Managing your membership

Changing your cover

You can change your level of cover at any time either over the phone or by filling out a 'Change of Membership Details' form which can be downloaded from **australianunity.com.au/downloads**

In most cases, changes or updates to your cover or the membership, or where there is a change in circumstance can alter the premium you pay. For example, your premiums may be affected if you:

- change your level of cover
- change your excess or co-payment level
- change your State of residence
- add or remove dependants, which results in a change from single to family cover or vice versa
- experience a change to your Lifetime Heath Cover loading status (for example, if we receive a Transfer Certificate from your previous health fund, or you reach 10 years of continuous hospital cover)
- update your level of rebate and/or rebate tier

If you upgrade your cover by increasing your level of hospital or extras benefits or reducing/removing your excess or co-payments, you may have to serve new waiting periods for services you weren't previously covered for or where your new cover offers a higher level of benefits.

We recommend you familiarise yourself with your new chosen cover for any changes and entitlements. If you change your mind a cooling-off period of up to 30 days applies to changes in your level of cover. Refer to the 'Additional Information' section of this Member Guide for further details on the cooling-off period.

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. This is important because there is a 12 month waiting period applied to these services.

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 child's birth or adoption/fostering date and add them to your policy effective from their date of birth or adoption/fostering, 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/fostering you:

- Upgrade to a Family or Single Parent Family cover; and
- Add your child to the policy. You may also be able to add your Partner to your membership effective your child's date of birth, or adoption/fostering date

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.

Adding or removing members from you membership

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 were 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. Unless otherwise prescribed by the Private Health Insurance Legislation, they will need to be added from the day following 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 **13 29 39** (see Delegated Authority below).

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), except they won't be able to cancel the policy, change the Member, remove the Member from the policy or nominate 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 **13 29 39**.

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.

Premiums

Unless otherwise offered or agreed by Australian Unity, your premiums are payable monthly, or in monthly multiples, in advance. You can lock-in your premiums for up to 12 months in advance from the date the payment is made; however, if you make a payment that exceeds this period, we may not accept the payment. Advance payments do not fix the terms and benefits of your product, which we can change at any time in accordance with the Changes to your cover or Fund Rules and the Terms and Conditions section of these terms and conditions.

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 in this Member Guide for more information. 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 hospital and extras 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 apply 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 benefits 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 during that period, unless your claim has a date of service prior to suspension or falling into arrears. 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.

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 your decision to claim (or not claim) compensation
- inform us of your decision 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. 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

Overseas travel – If you're travelling overseas, you can suspend your membership for a minimum of two months and up to two years. You need to have at least a hospital cover and your membership must have been active for at least one continuous month prior to your application request and you must be paid up to or in advance of the requested suspension date. Your application must be submitted to us before your departure. A minimum of 12 months must have elapsed since your last suspension.

Financial hardship – If you have been a Member with hospital cover for at least 12 continuous months and face financial hardship, you may apply to suspend your membership. Your membership must be paid up to the requested suspension date and the maximum period you can suspend is three months. A minimum of 12 months must have elapsed since your last suspension and only three periods of financial hardship suspension will be allowed in a lifetime.

Conditions of suspension – While your membership is suspended, we will not pay on any claims for services or treatments that occur during that period. Any remaining waiting periods must be served on reactivation of your membership and if you have a Lifetime Health Cover (LHC) loading, the 10 year anniversary end date will be delayed by the period your membership was suspended.

For overseas travel suspension 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 another Membership) is not eligible for suspension.

For overseas travel – 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.

For financial hardship – suspension will apply from the day you nominated on the form or from the date after the policy is paid to, whichever is earlier

If you earn over the Medicare Levy Surcharge income threshold, you may have to pay this surcharge for the period the membership was suspended.

You can download the 'Health Cover Suspension' guide for more details from **australianunity.com.au/downloads** or call us to apply.

Your hospital cover

Hospital

For those treatments that are included under your hospital cover, we pay benefits towards fees charged for accommodation and theatre when you're an admitted patient at either a private or public hospital. For long hospital stays, your medical provider must certify after 35 days that you still need ongoing acute care. We pay benefits towards in-hospital pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS), doctors' fees raised during your admission (up to the MBS fee) and surgically implanted prosthesis up to the benefit set out in the Australian Government Prostheses List (also known as the Prescribed List of Medical Devices and Human Tissue Products). Please note for Podiatric Surgery (provided by a Registered Podiatric Surgeon) we pay reduced benefits. Refer to the Member Guide for details. It's important that you discuss the potential fees with your surgeon and hospital prior to any treatment.

While services and treatments are covered under your hospital cover, you may still incur out-of-pocket costs such as excess or medical gap payments.

Agreement private hospitals

Agreement private hospital means a private hospital or day hospital facility that has a negotiated contract agreement with Australian Unity to minimise your out-of-pocket costs when you are admitted to hospital. For private hospitals, where no agreement exists, you'll receive reduced benefits for the cost of your hospital treatment. Therefore, you can face large out-of-pocket costs. Refer to **australianunity.com.au/agreementhospitals** for a list of our agreement private hospitals. Please refer to your Fact Sheet for more detail about benefits you can expect to receive.

Public Hospitals

If you are admitted to a public hospital as a private patient for treatments that are included under your hospital cover, we will pay up to the minimum (default) benefit. This is the minimum dollar amount set by the Australian Government for accommodation as a private patient in a shared room of a public hospital. It's important to confirm with your surgeon and your hospital any out-of-pocket costs or advantages to being a private patient. Please refer to your Fact Sheet for more details about the benefits you can expect to receive.

Medical costs

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, or sent to us directly where you have an eligible cover. Your practitioner may wish to participate in our Gap Cover scheme to eliminate or reduce your out-of-pocket medical costs. If your practitioner does not participate in the Gap Cover scheme and you do not hold an eligible cover, you are likely to incur out-of-pocket costs for your practitioner's fees.

Exclusions

If you select a hospital cover that has treatments listed as 'Not Covered', this means that we will not pay any benefits for the treatment you have received and this can result in you incurring large out-of-pocket costs. Always refer to your product Fact Sheet for more details about your hospital cover entitlements.

Restricted benefits

To lower your hospital premium, some hospital treatments on your cover may be listed as 'Restricted'. This means we will pay the minimum (default) benefit, which is determined by the Australian Government and covers you for the cost of a shared room of a public hospital. Going to a private hospital for a treatment that is restricted will result in large out-of-pocket costs as we will only cover a limited proportion of your accommodation costs.

We will not cover fees for private hospital theatre, labour ward or costs associated with an admission to an intensive or coronary care unit for hospital treatments with restricted benefits. Contact us to discuss your cover prior to undergoing any hospital treatment.

Excess and Co-payments

In exchange for a lower premium, excess and co-payment are set amounts of money you agree to pay towards the hospital accommodation costs if you or a family member is admitted to hospital. The excess and co-payment 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 or co-payment. Please check your product Fact Sheet to confirm how much excess or co-payment you'll have to pay.

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)
- treatment at hospital as a non-admitted patient or outpatient, e.g. emergency room, outpatient consultations in a doctors room or consultations with a nurse
- special nursing (e.g. your own private nurse not employed by the hospital)
- respite care or where you are deemed a nursing home patient (except where a small benefit is payable as listed under the Private Health Insurance Act)
- 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 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

- 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.

Accidents

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.

For services that are Covered or Restricted, and where a waiting period would normally apply before you are eligible for benefits for those services, you will not need to serve the waiting period to access benefits for those services when they are required as the result of an Accident that occurs after joining Australian Unity hospital cover.

Benefits are not payable, and may have to be repaid by you, for treatment where you have the right to claim compensation, damages or benefits from another source (e.g. TAC or Workcover) now or at a later date. Refer to the Compensation section on this document for further details.

We will require you to:

- complete an accident declaration;
- provide medical evidence to verify the occurrence of an accident after joining the cover; and
- provide documentary evidence of an admission to hospital.

This is for us to determine your entitlement to benefits.

Please note we do not pay benefits related to attendance at a hospital emergency department.

Accident cover

Some of our hospital covers have an "Accident Cover" feature. For these covers, if you need hospital treatment for an injury sustained during an Accident (as defined above) that occurred after joining this cover, and the hospital treatment is within a Clinical Category that is listed as Restricted or Not Covered, that hospital treatment will be treated as Covered.

For hospital covers that don't have an "Accident Cover" feature, we will pay benefits towards hospital treatment required as a result of an accident (as defined above) in the same way we would if that treatment was required for reasons other than an accident. This means that if your cover has any hospital treatments that are Not Covered or Restricted, then they would also be Not Covered or Restricted if they are required as a result of an accident.

Ambulance

Emergency ambulance transportation is usually defined as when you are at risk of serious morbidity or mortality and require urgent assessment, resuscitation and/or treatment. Medicare does not cover the cost of ambulance services and therefore without some form of cover you can incur a costly service charge.

Claims for emergency ambulance transportation are payable Australia wide and only in accordance with your level of cover and when the account is coded and invoiced as an emergency transportation by a recognised State ambulance authority. All covers also offer Ambulance Attendance which means we will pay for the cost of the arrival of an ambulance and attendance and treatment by a paramedic of a patient, where the condition is stable enough that transportation to hospital is not required. These accounts do not need to be coded as 'emergency'.

We will not cover Ambulance service charges that are provided by a non-recognised service provider, including private providers. We will also not cover Ambulance transport that's not billed or coded as an emergency transport such as, inter-hospital transport (unless classified as emergency and not covered by the hospital) or any ambulance transport required after discharge from hospital.

If you are a resident of NSW/ACT (and hold hospital cover), QLD or TAS, benefits for ambulance costs may be covered by your state ambulance scheme. Where available, you may wish to purchase an ambulance subscription if you reside in VIC, SA, NT and rural WA to provide you with a broader cover beyond emergency ambulance only cover under eligible Australian Unity covers.

Some residents in each State or Territory may be eligible for free ambulance services when holding a healthcare, pension or seniors' concession card.

Where an Extras cover with Ambulance cover is taken with Hospital cover, benefits are payable under the Hospital cover only, except where the Extras cover offers additional benefits not included on the Hospital cover.

Australian Unity will not pay for ambulance services that are covered by a State scheme or subscription.

Please refer to

australianunity.com.au/health-insurance/using-your-cover/emergency-ambulance.

Your extras cover

What's covered

Your extras cover provides benefits towards services that aren't claimable from Medicare, 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.

Some treatments are also eligible for benefits where the consultation can be appropriately delivered as a telehealth appointment. Benefits are only payable for one consultation with a provider on the same day, for the same member. The benefits you can claim are outlined in your product Fact Sheet and the criteria are set out in our Fund Rules which are available online at **australianunity.com.au/importantdocuments**

When making a claim and submitting documents please keep copies if required, as Australian Unity will not return originals. Invoices must detail 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 an approved health management program, Health Support Programs, BumptoBaby or recognised telehealth consultations as listed on your cover
- 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 "Your hospital cover" section above.

Benefit replacement periods

Benefit Replacement Period means:

- **For full denture replacements** – a continuous period of time that must occur between any two purchases of the same type of artificial aid/ appliance item before benefits are payable; or
- **For artificial aids or devices** – a continuous period of time that must occur before the benefit limit for a type of artificial aid/appliance item resets following the initial purchase of that same type of artificial aid/ appliance item.

Please refer to 'Benefit replacement periods for aids and devices' section in this Member Guide for further details.

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 **13 29 39**.

Additional information

Changes to your cover or Fund Rules and 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.

Membership arrears

Keeping your health cover 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 canceled. All entitlements to claim benefits during the period of arrears and after the cancellation date will cease. Should you wish to reinstate your cover at a later date you will have to re-serve all waiting periods as a new Member.

30 day cooling-off period

We will allow any new member who has not yet made a claim to cancel their membership and receive a full refund of any premiums paid within 30 days from the commencement of their membership. When you change your level of cover, we will also allow you 30 days to change your mind and switch back to your previous level of cover unless it has become discontinued, and you have not yet made any claims.

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 as we may able to offer you other options.

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 nor 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 cooling off period, we will refund any premiums you have paid beyond the cancellation date.

Becoming a Member of Australian Unity

Australian Unity health fund members may be eligible to become a member of Australian Unity Limited (AUL) once they meet eligibility criteria determined by the board of AUL. By applying to become a Member of the health fund, you consent on your behalf and on behalf of the other members on your policy, to become a member of AUL if you meet that criteria, and agree to be bound by the constitution of AUL. In particular, you agree on your behalf and on behalf of the other members on your policy, 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 in the constitution of AUL. The member rules and the constitution of AUL are available at **australianunity.com.au/investor-centre/who-we-are/corporate-governance**.

Summary of Fund Rules

This important information contains only a summary of the Fund Rules. The complete rules of the health fund detailing the terms and conditions of membership including the rights and obligations of you our Member and us in relation to the Australian Unity health fund are available for inspection at Australian Unity, 271 Spring Street, Melbourne or online at **australianunity.com.au/importantdocuments**

For a copy of the product schedules, please contact Australian Unity on **13 29 39**.

Direct Debit Request Service Agreement

Our commitment to you

This document sets out your rights, our commitment to you and your responsibilities to us, together with who you should contact for assistance in respect of your direct debit arrangement with Australian Unity.

Initial terms of the arrangement

In terms of the Direct Debit Request (DDR) arrangement made between us and authorised by you, all payments are taken in advance so we undertake to periodically debit the nominated account in accordance with your authority to direct debit. You also authorise us to alter the amount to be debited in the event of any changes to your Membership, subject to us providing notice to you as described below.

Drawing arrangements

If any drawing falls due on a non-business day, it will be debited to the account on the next business day following the scheduled drawing date.

We will give you at least 14 days' notice when we intend to make changes to the initial terms of the arrangement unless the debit was dishonoured. In that case, then the following month we will attempt to draw both the previous debit and the current amount due.

Your rights. Changes to the arrangement

If you want to make changes to the drawing arrangement, please notify us in writing at least four business days prior to your next scheduled drawing date. These changes may include:

- deferring the drawing
- altering the schedule
- stopping an individual debit
- suspending the DDR
- cancelling the DDR completely

Enquiries

If you have any enquiries, they should be directed to Australian Unity or your financial institution. All information relating to the DDR held by us will remain confidential except for information that may be provided to our financial institution to initiate the drawing to your nominated financial institution account or information disclosed to a third party as allowed by law. Information may also be provided to Australian Unity Limited or any of its wholly-owned subsidiaries to enable this DDR to be effected.

Disputes

If you believe that there has been an error in debiting your account, you should notify us directly and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up directly with your financial institution.

- If *we* conclude as a result of our investigations that *your* account has been incorrectly debited *we* will respond to your query by arranging for *your financial institution* to adjust *your account* (including interest and charges) accordingly. *We* will also notify you in writing of the amount by which *your account* has been adjusted.
- If *we* conclude as a result of our investigations that *your account* has not been incorrectly debited *we* will respond to *your* query by providing *you* with reasons and any evidence for this finding in writing.

Your commitment to us

It is your responsibility to ensure that:

- the nominated account can accept direct debits (the financial institution can confirm this) and
- You have the necessary permission to authorise a debit from the nominated bank account, and
- on the drawing date there are sufficient cleared funds in the nominated account and
- you advise us if the nominated account is transferred or closed and
- you give us the updated expiry date when you are issued a new credit card if applicable

If your drawing is returned or dishonoured by the financial institution, we will notify you in writing. Any transaction fees payable by us in respect of the above may be passed on to you.

Consecutive returns or dishonours will result in the direct debit facility being withdrawn and we will send you account notices.

We welcome your feedback

We are committed to resolving complaints in a fair and efficient manner and view feedback as a vital opportunity to improve our services, products and policies. If you are dissatisfied with any aspect of Australian Unity's service, your health cover or feel that our service has failed to meet your expectations, we would appreciate hearing from you.

To commend us on our service or to lodge a complaint, contact our customer service team via one of the options below.

Phone:	**13 29 39**, Monday – Friday 8.30am–8.00pm AEST
Online:	**australianunity.com.au/email**
Mail:	Australian Unity 271 Spring Street Melbourne, VIC 3000
Webchat:	available on **australianunity.com.au/health-insurance**
Email:	available through the App

We also have escalation procedures in place to address your complaint. If you have a complaint, Australian Unity will endeavour to acknowledge your complaint within two business days of receipt of your complaint.

If I have a complaint, how will it be handled?

Australian Unity is committed to resolving your complaint the first time you contact us. We understand that it is important to listen to you and address each of your concerns.

We encourage you to discuss your complaint with the first Customer Service Representative you speak with, however, if you are not satisfied with their response, your complaint will be escalated to their manager to review and resolve. We are confident that in most cases, our Customer Service staff will address your concerns to your satisfaction.

If you are not satisfied that your complaint has been fully resolved, you have the option of escalating service and product related matters to a case manager within Australian Unity's Customer Experience department.

The case manager will investigate your complaint and attempt to resolve your complaint within five business days upon receipt of your complaint.

What if I am not entirely satisfied with the handling or resolution of my complaint?

Where possible we like to resolve the issue directly with you. If you believe that Australian Unity has not made reasonable attempts to address your complaint or you are not satisfied with our resolution and your complaint relates to a private health insurance policy, you can contact the Private Health Insurance Ombudsman, a division of the Commonwealth Ombudsman.

This organisation is an independent office, appointed by the Australian Government, whose services are free to all health fund members. The Ombudsman handles enquiries, suggestions and complaints and will assist you in resolving a dispute.

For more information on this service visit **ombudsman.gov.au**

If you wish to contact this service you may do so via any of the following channels:

Phone:	**1300 362 072**
Online:	**ombudsman.gov.au**
Mail:	Private Health Insurance Ombudsman, Office of the Commonwealth Ombudsman GPO Box 442 Canberra ACT 2601

To ensure you have the best possible customer experience, please make sure that you:

Gather all supporting documents and information relating to your complaint and think about any questions you need answered that will help resolve the issue more efficiently.

Your Privacy

As a Member, your personal information and those of other members under your membership, are managed in line with our Privacy Policy. The security of your personal information is important to us and we take strict measures to ensure it is handled responsibly.

Your personal information (including sensitive information such as health information) is collected for the purpose of processing your application and fulfilling our obligation to manage your health cover and inform you of new products, services and special discount offers. Your health information (e.g. medical/patient records, treatment plans, etc.) may be collected from third parties such as medical practitioners and healthcare providers to assess and review your claim and for purposes such as the investigation of suspected fraudulent activity. We also use your personal information to assess your eligibility for membership of Australian Unity Limited and, if eligible, place your name, address and other required personal information on Australian Unity Limited's member register. We may also collect personal information from you or third parties to manage your accounts and services and to better understand you, your preferences and interests. If for any reason we need to send your information overseas, we will require that the recipient of the information complies with our Privacy Policy and applicable laws to maintain the security of the data.

As a Member it is your responsibility to ensure that any other individual on your membership is aware of how we handle their personal information. Each person on a membership aged 16 or over may request that we keep that individual's personal information confidential and to specify which person under your membership can receive information about that individual's health claims.

You or any person under your membership has the ability to restrict the personal information we obtain from that person which may prevent us from providing health cover to you or that person.

You also have a right to stop receiving any direct marketing material at any time. To opt out, contact us on **13 29 39** or by changing your communications preferences at **australianunity.com.au/memberservices**

Private health insurance members' personal information may be disclosed to:

- intermediaries through which you deal with Australian Unity (e.g. agent, financial adviser, employer or industry association)
- the Member (including sensitive and health information about benefits claimed under the membership by any person on the membership, unless they have requested that we not disclose this information)
- a partner or spouse included on your policy (unless you have opted them out of automatic delegated authority)
- any other person acting on your behalf to whom you've granted a delegated authority

- claims assessment participants (for instance a medical referee used to assess a claim)
- debt collectors, fraud bureaus or other organisations to identify, investigate or prevent fraud or other misconduct, government departments, regulators or for legal reasons, disclosure may need to be made to law enforcement such as police or the courts
- third parties we deal with (e.g. hospitals, doctors) to assess claims and enable us to supply health programs based on your health needs
- other reputable service providers including HICAPS electronic claiming system, Australian Health Service Alliance (AHSA) and Australian Unity selected mailing houses.
- other health funds when you transfer your health membership to or from Australian Unity
- external dispute resolution schemes
- other organisations, who we partner with to offer or provide products or services to you, or who provide analytical or marketing services to assist us improve the delivery of products and services, and to enhance our customer relationships.
- other entities in the Australian Unity Group, to provide you with information about other products and services within the group, and to offer a streamlined customer-experience between businesses within the group.

Our Privacy Policy contains more information about our privacy practices, including how we use your information. The Policy also details how you may request access to, or correction of, personal information we hold about you, how you can lodge a privacy complaint and how we manage such complaints. You can obtain the latest version of our Privacy Policy by contacting us or at **australianunity.com.au/privacy**

For Real Wellbeing Since 1840

13 29 39
australianunity.com.au

271 Spring St
Melbourne VIC 3000

A Members Health Fund

Australian Unity Health Limited ABN 13 078 722 568

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