Private Health Insurance

Important things to know – terms and conditions

1 July 2020

Health cover with us

The Member

You become a health insurance fund Member once you 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 are not eligible for 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, de facto or partner
- A single parent family membership covers the Member and one or more eligible dependent children
- A family membership covers the Member and their spouse, de facto or partner and eligible dependent children

Dependants/Students

A dependant is a child aged up to 23 years old that is unmarried or not in a de facto relationship. Dependants can continue to be covered under the family membership as a Student Dependant up until the age of 25 years, while they remain unmarried or not in a de facto relationship and continue to attend a full-time course of study at a school, college or university.

You can download the 'Student Dependant' guide for more details from **australianunity.com.au/downloads**

Health cover for non-residents

Australian Unity hospital and extras 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.

Transferring from another fund

If you are transferring from another registered Australian private health insurance fund, you need to take out health cover with us within 30 days of cancelling your old policy to ensure continuity of cover. Any gap in cover greater than 30 days means that you will have to re-serve all waiting periods.

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. We also calculate what 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.

Please note: Accrued entitlements and loyalty bonuses are not transferable between funds.

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 page 19 of the Member Guide for the list of waiting periods that may apply.

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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 Gap Cover (page 13) for further information and conditions that may apply.

Pre-existing conditions

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 page 6). 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. The 12 month waiting period for Pre-existing conditions does not.

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 or upgrade your level of cover
- change your excess 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 your excess, you will 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 on page 7 for further details on the cooling-off period.

Save money on premiums by taking a higher hospital excess or by claiming the Australian Government Rebate on Private Health Insurance, if you are eligible.

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.

Family, Single Parent Family or Couple memberships

It is important that you notify us within 12 months of your baby's birth and add them to your policy effective from their date of birth, 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 memberships

To avoid your baby serving waiting periods, it is important that within 30 days of the birth you:

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

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

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Adding members to your cover

If you wish to add or remove a spouse or a dependant from your membership, it's important to advise us as soon as possible. Spouses or dependent children may need to serve waiting periods.

It's important to notify us if any student dependants on your cover are no longer studying full-time or are no longer dependent on you. We will remove dependents over the age of 23 from your membership unless we're notified of their student status.

Separation/divorce

It's possible to remain on the same membership following a separation or divorce. Please keep in mind that any electronic 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 further 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.

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; however, if you make a payment that exceeds this period, we may not accept the payment.

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 with appropriate notice to you. Please refer to the 'Changes to your cover' section on page 7 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. 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 the right to claim compensation, damages or benefits from another source, 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 compensation
- include in any claims for compensation the full amount of all expenses for which benefits are, or would otherwise be, payable by us
- 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

Australian Unity at its absolute discretion may require you or a person under your membership in respect of whom a claim maybe otherwise payable, to sign an irrevocable undertaking.

This means where we have paid on related claims and you have received compensation from another source, you will be required to reimburse us. Please contact our Customer Service team for advice concerning compensation claims.

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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 you to assist or seek written consent.

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 month prior to your application request and you must be paid at least one continuous month 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, we may request ~~and~~ documentation evidencing the reason ~~must~~ be supplied with the application. 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.

If you hold hospital and extras products under the same Membership will need to suspend both simultaneously. This means you will not be able to suspend the hospitals product without also suspending the extras product at the same time. For example, you will not be able to suspend the extras product without also suspending the hospital product at the same time. Please note, a standalone extras product (where hospital cover is not also held under the same Membership) is not eligible for suspension.

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**

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 365 days of the year. 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 minimum amount as listed in the Private Health Insurance Act and Rules. 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 an 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 hospital for treatments that are included under your hospital cover we will pay up to the minimum (default) benefit. It's important to confirm any out-of-pocket costs or advantages to being a private patient. Please refer to your Fact Sheet for more detail about benefits you can expect to receive.

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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 or private room of a public 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

In exchange for a lower premium, an excess is a set amount of money you agree to pay towards the hospital accommodation costs if you or a family member is admitted to hospital. The excess is applied in accordance with your level of cover. On selected hospital covers if a child is on your policy and needs to go to hospital, you won't have to pay the excess. Please check your product Fact Sheet to confirm how much excess 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 (including gap-permitted items and the gap for prostheses in non-partner private hospitals)
- 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 the right to claim compensation, damages or benefits from another source (e.g. TAC or WorkCover), now or at a later date
- some robotic surgery consumables.

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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.

Accident cover

Some of our hospital covers have an "Accident Cover" feature. For these covers, we will pay benefits towards hospital treatment required as a result of an accident (as defined above) including for treatments that are otherwise Not Covered or Restricted under your cover so long as Medicare benefits will be payable for, and limited to, accommodation and prosthesis (even though no Medicare benefit is payable). Theatre fees will not be 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 Not Covered or Restricted services, then they would also be Not Covered or Restricted if they are required as a result of an accident. However, for services that are Covered, 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.

We do not pay benefits for hospital treatment required as a result of an accident 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.

In order for benefits to be payable for an accident, the accident **must have occurred after you joined the cover.** 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 if the reason for the hospital admission is directly the result of an accident and not an aggravation of an underlying condition or injury .

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

Emergency 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 under our hospital covers are only payable 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. 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 the Australian Unity hospital covers.

If you live in QLD you are covered by your state ambulance scheme therefore no benefits will be payable by us.

If you live in TAS you are also covered under your state ambulance scheme unless you make a claim in QLD or SA. In those instances where you are not able to claim elsewhere (e.g. travel insurance) you may submit a claim to us.

As a resident of NSW or ACT a levy is included in your hospital cover to provide free ambulance transportation in all states excluding QLD and SA. If you receive an ambulance account, you may send it to us, and we will endorse it and forward to the required service provider (unless it is a claim from QLD or SA, in which case you may submit a claim to us).

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.

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

The above information may be subject to change. Please refer to your local ambulance website to obtain the most up to date information.

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

Claims for artificial aids/appliances such as a C-PAP and 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 Australian Unity chronic disease or health management program
- 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

Benefit replacement periods

For claims on certain types of artificial aids or devices (like 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. For example, you can only claim once during the period for the replacement of a set of dentures, regardless of whether you have reached your yearly limit. A "benefit replacement period" applies where your product Fact Sheet says, for example, "1 set every 3 years".

However, for claims on most types of artificial aids or devices, whether the claim is for a replacement doesn't matter. Instead, 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 policies, the maximum dollar limit only resets every two calendar years for devices like blood glucose monitors. During this time you can still claim benefits towards another blood glucose monitor up to the set limit, which resets every two calendar years. Where this applies, your product Fact Sheet will say, for example, "Benefit for each item is payable every 2 calendar years."

Recognised providers

Recognition of providers for payment of your claims is based on our criteria. This includes providers being a member of an appropriate board in their field of practice and operating in private practice. If a provider is not recognised or has been de-listed, benefits will not be payable for their services. Recognition by Australian Unity is for benefit payment purposes only and should not be taken or construed in any way as sponsorship, approval of, or any recommendation as to the qualifications and skills of, or services provided by, a practitioner or therapist. Before commencing treatment, find out if your provider is recognised by calling us on **13 29 39**.

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Additional information

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 in accordance with the Private Health Insurance Act 2007, the Australian Consumer Law and the Private Health Insurance Code of Conduct, prior to the 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.

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 your membership falls into arrears and you will not receive any benefit payments for services or items purchased during this time. If your cover is in arrears for a period of more than 60 days, your cover will be cancelled and all entitlement to benefits 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 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 if 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 be able to offer you other options.

Where, in our opinion a Member has engaged in fraudulent activity, misleads or deceives us, materially or repeatedly breaches any of our Fund Rules or terms and conditions of membership with us, we may terminate or suspend your membership at any time by giving you reasonable written notice, and may refund any premiums you have paid beyond the cancellation date.

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.

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**.

Contact us

13 29 39
australianunity.com.au