Policy Booklet

Important information about
AAMI Health Insurance

- General terms and conditions
- Hospital Cover
- Extras Cover
- Government initiatives

Read with your Product Information.
Effective 15 November 2018.

AAMI HEALTH INSURANCE

About the insurer

This health insurance is issued by nib health funds limited ABN 83 000 124 381 (nib) a registered private health insurer.

About the agent

nib has appointed Suncorp Insurance Ventures Pty Ltd ABN 53 158 182 042 (SIV) as its authorised agent to promote and distribute this health insurance on behalf of nib. SIV is paid a commission by nib for promoting and arranging this insurance.

About this document

This document is issued by nib as the underwriter of this health insurance. This document summarises your and our rights and obligations under the fund rules and is designed to help you understand what you will be covered for and important limitations and exclusions that apply. It should be read in conjunction with your product information which contains more information about your health cover. It is of a general nature only and you should always make enquiries with us before going to hospital or undergoing a new course of treatment. The information in this document is accurate and up to date as at the date of issue of this document, and may be amended from time to time. Please read this document and keep a copy for your records.

Contents

Section 1 – General terms of Cover 4

Applying for a health insurance Policy 4
Who is Covered 4
Adding a dependant or Partner 5
Adding a newborn dependant 5
Commencement of Cover 5
Waiting Periods for newly insured Customers 5
Waiting Periods when switching Funds or changing Products 7
Waiting Periods when splitting a Policy 7
Pre-Existing Conditions and Benefits 8
Waivers 8
30 day cooling off period 8
Who can view and change the Policy 9
Health Cover reviews 9
Policy suspensions 9
Resuming your Policy 10
Maintaining continuous Cover 10
Your Premiums 11
Your Customer Card 13
Claims 14
Obligations if entitled to Compensation 16
Standard Information Statements 16
Cancelling the Policy 17

Section 2 – General terms of Hospital Cover 19

Agreement Private Hospitals 19
What is Covered 19
What is not Covered 27

Section 3 – General terms of Extras Cover 29

Our Recognised Providers 29
What is Covered 29
What is not Covered 34

Section 4 – General terms of Benefits for ambulance 35

Our Recognised Providers 35
What is Covered 35
What is not Covered 35

Section 5 – Our obligations 36

Section 6 – Your obligations 37

Section 7 – Health insurance initiatives from the Australian Government 38

Medicare Levy Surcharge 38
Lifetime Health Cover 38
The Australian Government Rebate 39

Section 8 – Glossary of important terms 41

Section 9 – Privacy Statement 49

Section 10 – How to resolve a complaint or dispute 51

General terms of Cover

01 SECTION

Applying for a health insurance Policy

All applications for a health insurance Policy must be accompanied by proof of identity and any other relevant information We may require.

We may at Our discretion refuse to accept an application until such time as the relevant information is provided or until the Premiums for the minimum period relevant to the applicant have been paid.

- Subject to the Fund Rules, terms of this document and the Private Health Insurance Act, We may at Our discretion refuse an application to join a Customer, including in the circumstances below:
  - We have the right to refuse an application to join a Product that has been closed for sale.
  - We have the right to refuse an application to combine a Product currently for sale with a Product that has been closed for sale.
  - We have the right to refuse an application for a family on a Product available only to singles and couples or vice versa.
- If We refuse an application, We will provide a reason for the refusal to the applicant.
- You cannot have the same type of health Cover with more than one health Fund (e.g. you cannot have a Hospital package with 2 health Funds, nor can you have an Extras package with 2 health Funds).

Who is Covered

A health insurance Policy provides Benefits for the Policyholder, any additional listed Partner, Dependant Children, Adult Dependant or Student Dependant. In regards to a Policy:

- Children who are aged between 21 and up to 25 years can also be Covered if they are in full-time study and registered with Us as a 'Student Dependant'.
- We will allow a child who is between 21 and up to 25 years and no longer studying to remain on their parents' Cover as an 'Adult Dependant' for an additional fee determined by Us *(not available on all Covers and under all circumstances – check your Product Information and call Us to learn more).*
- Dependant Children, Adult Dependants and Student Dependants must be unmarried and not in a defacto relationship.
- To Claim for Hospital or medical Treatment, all those listed on the Policy must be Australian Citizens, Permanent Residents of Australia or entitled to full reciprocal rights under Medicare, registered for Medicare and listed on an active Medicare card.
- Unless otherwise approved by Us, a person under 16 years of age is not eligible to be a Policyholder.

Adding a dependant or Partner

Any Partner or Dependant Child (except newborns or newly adopted children) being added to a Policy will be required to serve Waiting Periods in line with the Product – unless transferring from a Previous Cover of equivalent level.

Adding a newborn dependant

We need to be notified by the Policyholder (or Partner with authority) to add a child to the health Cover.

Immediate Cover is provided under a Policy for newborns if an Adult under the Policy notifies Us of the birth and requests the newborn become an Insured Person under the Policy:

(i) within 2 months after the newborn's birth, where the parent/ guardian upgrades from an existing Single or Couples Policy; or

(ii) within 24 months after the newborn's birth, if the newborn is to be added to a Family Policy or a Single Parent Family Policy that was active at the newborn's date of birth.

Commencement of Cover

Subject to Our acceptance of an application for a Policy, a Policy commences on the date on which an application for the relevant Policy is lodged, or where We agree on another date nominated in the application.

Customers will be able to Claim for the services provided by the Policy once Waiting Periods have been served and provided that the Policy is financially up-to-date.

Additionally, Customers transferring from another health Fund can Claim once We have received and processed a Transfer Certificate from the previous health Fund, provided the Customer has served all relevant Waiting Periods and not claimed the full year's Annual Benefit Limits for Extras from their previous health Fund (in which case they would need to wait until the next Calendar Year before being able to Claim for that service).

Waiting Periods for newly insured Customers

Newly insured Customers need to be with a health Fund for a set period of time before being entitled to Claim for Treatment.

- Waiting Periods vary according to the service being provided.
- No Benefits are payable for Treatment provided during a Waiting Period.
- Customers should check their Product Information for the services they are Covered for and the Waiting Periods that apply to their Policy.

Standard Ambulance Waiting Periods	
Approved ambulance transport	1 day
Standard Hospital Waiting Periods	
Pregnancy & birth related services	12 months
Pre-Existing Conditions	12 months
Psychiatric treatment	2 months Customers may be entitled to waive this waiting period. For more information refer to 'Mental Health Waiver' on page 27.
Rehabilitation or palliative care (whether or not a Pre-Existing Condition)	2 months
Other Conditions requiring hospitalisation (except those listed above) that aren't Pre-Existing Conditions	2 months
Accidental Injury	1 day
Standard Extras Waiting Periods	
Hearing aids & Cochlear speech processors	36 months
Artificial aids	12 months
Non-specialty orthodontia	12 months
Dental specialty services, dental prosthetic services, inlays, onlays, facings, orthodontia, periodontia, endodontia & oral surgery	12 months
Dentures, denture maintenance/ repairs & other prosthodontic services	12 months
Periodontic surgical, root therapy & endodontic services by a dentist not registered as a specialist	12 months
Healthier Lifestyle	6 months
Optical appliances and repairs	6 months
All services and items except those listed above	2 months

Please refer to your Product Information for further detail relating to service limits and annual Benefits.

Waiting Periods when switching Funds or changing Products

We recognise the Waiting Periods you have already served on your Previous Cover as at the date of transfer. The following Waiting Period rules apply.

On the new Product:

- Waiting Periods will apply only to services with higher Benefits, to services not previously Covered or where a Customer has not fully served Waiting Periods on the Previous Cover (the balance of the Waiting Period will apply with Us).
- For services already Covered at an equivalent level, no Waiting Period will apply.
- Lower Benefits or reduced coverage on the new Product applies immediately.
- If the Hospital Excess on the new Cover is lower than the previous Cover, the previous Hospital Excess will apply for the duration of the Standard Hospital Waiting Period that applies to a Benefit (regardless whether a Customer is required to serve a Waiting Period in order to make a Claim for that Benefit).
- If the Hospital Excess on the new Product is higher it will apply straight away irrespective of a Pre-Existing Condition.
- A 30 day Cooling Off Period applies to all Product changes, providing no Claim is made on the new Product *(see 30 day cooling off period)*.
- When switching Funds, there must be a gap of no more than 59 days between terminating your Previous Cover and joining Us to maintain continuity of Cover and avoid having to re-serve Waiting Periods.
- When changing Products with Us, there must be no gap between terminating your Previous Cover and joining another to maintain continuity of Cover and avoid having to re-serve Waiting Periods.
- If you have used part or all of your annual Benefits under your Previous Cover, We will adjust your available new Benefits accordingly.

Waiting Periods when splitting a Policy

If Partners on a Policy separate, or a Dependant Child/Student Dependant/ Adult Dependant takes their own Cover they may join Us without serving any Waiting Periods where:

- The Benefits provided under the new Product are the same as Benefits provided under the Previous Cover; and
- The person applies for the Policy within 59 days of ceasing to be a Partner, Dependant Child/Student Dependant/Adult Dependant under a Policy with another private health Insurer.
- For persons who are an existing Customer with Us, they have 30 days to star their new Policy and it must be backdated to the date of leaving the previous Policy to maintain continuity of Cover.
- If Waiting Periods had not been served on the Previous Cover with Us, the remaining portion of the Waiting Periods will need to be served on the new Cover.
- Waiting Periods will apply to Benefits and services not previously Covered when changing to a different level of Cover. As will the other rules of changing Covers outlined above *(see Waiting Periods when switching Funds or changing Products).*

Pre-Existing Conditions and Hospital Benefits

Pre-Existing Conditions have a 12 month Waiting Period for Customers who are new to Hospital Cover.

- No Benefits are payable for Hospital Treatment during the first 2 months of membership irrespective of whether the Condition is pre-existing (except for Accidents – *see 'Waiting Periods'*).
- The Pre-Existing Condition Waiting Period also applies when changing Products, but only to the services not previously Covered (for the first 12 months on the new Product).
- If a Customer needs Hospital Treatment after the first 2 months but before the first 12 months of membership, We will require the medical practitioner who provided the referral and the treating specialist to complete Our documentation for Our medical practitioner to determine if the Condition is pre-existing.
- Our medical practitioner will have the final say as to whether the Condition is pre-existing or not.
- If the Condition is deemed not to be pre-existing then Benefits will be payable in line with the Product.
- If the Condition is deemed to be pre-existing no Benefits are payable (or in the case of changing Products Benefits may be payable in line with the Previous Cover).

Waivers

We may waive the 2 or 6 month Waiting Periods for Extras for Customers who have recently joined or increased their level of Cover and hold a combined Hospital and Extras Product. A waiver is applied at Our discretion for Customers of an eligible Contribution Group.

- If a waiver applies, Customers will be able to Claim immediately for the Extras services to which the waiver applies.
- Waivers do not apply to Hospital Treatment.
- Waivers do not apply to any services which have a 12 month (or higher) Waiting Period.
- Customers can confirm if a waiver applies to them by calling Us.

30 day cooling off period

A 30 day cooling off period applies to all Our Products.

- New Customers can receive a full refund of Premiums if they decide to cancel the Policy within the first 30 days of membership – providing no Claims have been made during that time.
- Customers who have changed their level of Policy can also revert to the Previous Cover within 30 days with no impact on Waiting Periods – providing no Claims have been made during that time.
- If a Claim is made within 30 days the Policy can only be cancelled or changed from the day after the date of service of the Claim.

Who can view and change the Policy

The 'Policyholder' is the primary account holder and has full and total authority to make changes to the Policy and make Claims enquiries about anyone on the Policy.

- A Partner will only have authority to make changes to the Policy if nominated by the Policyholder (called 'Partner Authority').
- Partner Authority can be removed from the Partner by the Policyholder at any time.
- Dependant Children, Adult Dependants and Student Dependants can only make enquiries about their own Claim entitlements and Claims history.
- Policyholders can register others on the Policy to have their own Online Services login and password. Using these additional logins the Customer will only be able to view their own Claims history and entitlements.
- The Policyholder can nominate a person (e.g. relative) with Third Party Authority by writing or by calling Us. The person with Third Party Authority can make enquiries and operate the Policy but cannot change existing direct debit arrangements, or cancel the Policy unless permitted by the Policyholder.
- The Policyholder can nominate a person (e.g. relative) with Power of Attorney by writing or by calling Us. The person with Power of Attorney can make enquiries and operate the Policy along with changing existing direct debit arrangements and cancelling the Policy.

Health Cover reviews

It is the Policyholder's responsibility to understand what is, and what is not Covered, by their health insurance Policy. We recommend Policyholders review their health insurance at least once per year. We are happy to discuss your health Cover at any time, call or visit Us.

Each Product can be amended from time to time in accordance with its terms.

Policy suspensions

Customers can apply to suspend their health insurance for reasons of financial hardship, or overseas travel. Customers must be with Us for 12 continuous months before being able to apply for a suspension.

Financial hardship suspensions must be for a minimum 2 months and a maximum of 3 months. Overseas travel suspensions must be for a minimum of 2 months and a maximum of 24 months.

- A Policyholder who wishes to apply to suspend their Policy can do so by calling Us. The Policyholder will also be required to supply Us with the following proof to complete the suspension application:
  - Proof of travel dates (e.g. a copy of boarding pass, travel itinerary or stamped passport).
  - We will accept Policy suspensions from the date of notification providing the application to suspend is accepted.
- A Policy must be financially up-to-date before it can be suspended.
- No Premiums are payable for the Policy during a period of suspension.
- No Benefits will be paid by Us during a period of suspension.

- Where Waiting Periods had not been fully served, the remainder of the Waiting Period must be served once the Policy is resumed.
- Once a Policy is resumed after a period of suspension, 12 months of continuous Cover must be maintained before the Customer can apply to suspend again.
- Customers listed on the Policy may be liable for the Medicare Levy Surcharge for any period of suspension *(see Medicare Levy Surcharge).*
- If a Lifetime Health Cover loading applies to your Policy, your suspension period will not count towards your required 10 years of continuous Cover. Your Lifetime Health Cover anniversary date will be adjusted to factor in the period your Policy was suspended.

Remember to resume your Policy at the end of your suspension period. Failure to resume your Policy in time will impact on your ability to Claim.

Resuming your Policy

If a Policy has been suspended it must be resumed within 1 month of the suspension end date or the Policy will be cancelled. If the Policy is cancelled all Customers on the Policy will need to re-serve Waiting Periods if they re-join later.

- To resume the Policyholder will need to call Us within one month of the date of return to Australia.
- In the case of an overseas travel suspension, resumption of your Policy will be backdated to the date of return to Australia, with the applicable arrears requiring payment.
- For financial hardship suspensions, the suspension ends on the date nominated by the Policyholder or the end of the 3 month maximum suspension period, whichever comes first.
- Customers who have suspended their Policy for reasons of financial hardship and pay by direct debit will have their Policy automatically resumed after 3 months. The first payment taken by direct debit may be higher than normal to account for any difference between when the suspension ends and when the next payment falls due.

Maintaining continuous Cover

It is important to maintain continuous Cover with Us to ensure you are able to continue to Claim Benefits and to avoid having to re-serve Waiting Periods.

- If the Policy falls into arrears, all Customers on the Policy will be unable to Claim.
- After 2 months of non-payment the Policy will be cancelled.
- After more than 2 months without health insurance all Customers listed on the Policy will have to re-serve Waiting Periods if they decide to re-join later.
- It will be at Our discretion to determine whether the Customers listed on the Policy will be Covered for any Hospital, Extras or Ambulance Claims required during a period of non-payment.
- If the Policy lapses, Customer listed on the Policy may be liable for the Federal Government's Medicare Levy Surcharge and/or Lifetime Health Cover Loading *(see Medicare Levy Surcharge and Lifetime Health Cover Loading).*

Your Premiums

Premiums must be up to date to keep the Policy financially active and so that Customers listed on the Policy can continue to Claim.

- If Premiums are paid in advance and a Premium Rate change takes effect during the period of advance payment, the change will not come into effect until the next Premium falls due.
- However, if a change is made to a Policy during the period of advance payment (for example changing the level of Hospital Excess or the Policy Category), the rate protection will cease to apply and the current Premium applicable to the altered Policy will apply from the date of change.
- Premiums can be paid in advance by a maximum of 13 months from the date the advanced payment is requested.

Available payment method

- Direct debit from a bank, building society or credit union cheque or savings account. We may offer Customers choosing this payment method a discount on the cost of their health insurance Premiums (direct debits from a credit card are excluded.
- Credit card direct debit – automatic direct debit from a MasterCard, Visa, American Express.
- Phone Pay – make a credit card payment by calling **13 22 44**.
- Payment by BPay and Post BillPay payments are also accepted.

Available payment periods

Are set out below and must be paid in advance:

- For all Products unless otherwise permitted by Us:
  - Where Premiums are paid by automatic direct debit from a financial institution account or automatic charge to a credit card – fortnightly, monthly, quarterly, half yearly and yearly.
  - Where Premiums are paid by Phone Pay or at an Australia Post Office – monthly, quarterly, half yearly and yearly.

Direct debit Service Agreement

We will give the Policyholder at least 14 days notice in writing if there are changes to the details of their debit.

- Any information about the account will remain confidential, except where required to complete direct debits with the financial institution.
- When the due date is not a working day, We will debit the account on the first working day after the due date.

If there are insufficient funds in your account to make a payment on the due date, we will notify you and attempt a second deduction from your account within 7 days. If this second deduction attempt also fails, your direct debit arrangement will be cancelled. You will need to contact Us to pay the overdue amount and reinstate your direct debit arrangement.

It is the Policyholder's responsibility to:

- Ensure the nominated account can accept direct debits.
- Ensure there are enough funds available in the account to make the payment on the due date.
- Tell Us if the account details change, or if the account is transferred or closed.
- Arrange a different payment method if We cancel the debit arrangements.
- Ensure all account holders of the nominated account have authorised the direct debit request.
- Tell Us the new credit card expiry date.

Policyholders can change the debit arrangements in line with these terms and Conditions. The Policyholder must tell Us at least 7 working days before the next due date for any of the following:

- Stopping a payment.
- Deferring a payment.
- Suspending any future payments.
- Altering the direct debit nominated account details.
- Cancelling the debit arrangement.

We reserve the right to determine how to give instructions to stop or alter the direct debit details (e.g. written, verbal or electronic).

We reserve the right to cancel direct debit arrangements if the nominated financial institution dishonours debits, and to arrange a different payment method with the Policyholder.

The details of direct debit arrangement are contained in the direct debit Request submitted by the Policyholder. We will rely on those details to process payments until told otherwise.

Not all accounts held with a financial institution are available to be drawn on under the Bulk Electronic Clearing System. Customers should check with their financial institution if they are unsure whether their account can facilitate direct debits.

Policyholders may cancel, stop or dispute a drawing with their financial institution.

Policyholders with direct debit inquiries, or those who believe a debit has been made incorrectly, should contact Us immediately on **13 22 44** or write to:

Reply Paid 62208,
Locked Bag 2010,
Newcastle NSW 2300

Premium discounts

We can discount the cost of health insurance at Our discretion up to the maximum allowable under the Private Health Insurance Act.

We may offer:

- Discounts to Policyholders who agree to pay by automatic direct debit from a cheque or savings account. Automatic payments by credit card are also excluded.
- A discount to Corporate Groups, Broker Groups, Association Groups or any other pre-defined Contribution Group at Our discretion. Discounts afforded to Consultation Groups will be inclusive of the automatic direct debit discount.
- Closed Products may also be excluded from receiving the discount at Our discretion.

Premium changes

Premiums may change as a result of:

- A change in Premiums approved under the Private Health Insurance Act.
- A change in Product.
- A change in Hospital Excess level.
- A change in state or territory of residence.
- A change in Policy Category (single, couple, family, single-parent family, extended family).
- Adding Customers onto the Policy who have a Lifetime Health Cover loading *(see Lifetime Health Cover Loading).*
- Inclusion or removal of discounts.
- A change in Rebate tier (see *Health insurance initiatives from the Australian Government*).
- Removal of Lifetime Health Cover loading in accordance with Lifetime Health Cover rules.
- Failure to complete the necessary application for Australian Government Rebate.

Your Customer Card

By using the Customer Card, you agree:

- To tell Us if any information on the card is incorrect.
- To show additional ID if requested by a Provider.
- To use the card to Claim for services used to treat a Customer listed on the card.
- To tell Us if any Customer listed on the Policy is claiming for Treatment where they have or could receive Compensation from another party (e.g. workers' Compensation, third party insurance).
- That the Customer Card does not confirm that the Policy is financially up-to-date.
- That the Customers details must be confirmed by Us before We can pay any Claims.
- To let Us share information with other people listed on the Policy. This means We may make other Customers aware, for example, of some Benefits and services claimed on the Policy.

More important information about the Customer Card:

- The card is not transferable.
- The card must not be left with any Provider or other party.
- The card is Our property – Customers must return it if asked.

- Customers must return or destroy the card if the Policy is cancelled.
- Customers must notify Us immediately if the card is lost or stolen.
- If the card is forgotten the Customer will need to pay for the Treatment in full, obtain an Official Provider Receipt, and Claim Benefits from Us later.
- Replacement cards can be requested by calling Us.
- If any changes are made to the persons Covered on a Policy, a new card will be issued to reflect the Customers Covered on the Policy.

Claims

- Benefits will only be paid for Claims which meet Our Fund Rules and criteria. If you're unsure what might be Covered We'd encourage you to contact Us before claiming by calling **13 22 44**.
- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to Our Fund Rules and criteria.
- The Customer number on the front of the Customer Card must be quoted for all Claims.
- Some methods of claiming for Extras are subject to a per Claim session limit of $300. No additional Claims can be made using these facilities until We receive the Claim form and Official Provider Receipts for the first session of Claims. Not all types of Extras can be claimed using these facilities.
- Customers will not be paid any Benefits if their Policy is not financially up-to-date. If Premiums are in arrears We may cancel a Policy that is more than 2 months in arrears.
- Medical Benefits (e.g. for services provided by a specialist, or Pathology and radiology services) will only be paid if the services were administered whilst you were an admitted Private Patient in a Hospital.
- Claims for medical Benefits (e.g. for services provided by a specialist, or Pathology and radiology services) provided while you were an admitted Private Patient in a Hospital must be submitted to Medicare before you forward the Claim to Us.

Supporting documentation for Claims

Claims for Benefits must:

- Be made in a manner approved by Us; and
- Be supported by an Official Provider Receipt meaning accounts and/or receipts on the Provider's letterhead or showing the Provider's official stamp, and showing the following information:
  - The Provider's name, Provider number and address;
  - The Patient's full name and address;
  - The date of service;
  - The description of the service;
  - The amount(s) charged; and
  - Any other information that We may reasonably request.
- Be accompanied by a Health Management Program supporting document form, which has been signed by your health professional (required only for Claims made for the Healthier Lifestyle Benefit).
- Unless otherwise agreed by Us, all documents submitted in connection with a Claim become Our property.

Time limit on Claims

Benefits are not payable where a Claim is lodged more than 2 years after the date on which the service is provided. We may authorise a Customer to delegate to another Customer on the Policy the right to Claim or assign Benefits to which the Customer may be entitled.

Method of payment of Benefits

We may pay Benefits by electronic funds transfer in accordance with arrangements that We determine.

Benefits not payable

Benefits are not payable for:

- Services not Covered by the Product in accordance with the Fund Rules.
- Services provided during a Waiting Period.
- Services provided after the Annual Benefit Limit, Service Limit or Lifetime Limit has been reached.
- Policy applications or Claims where false or inaccurate information is supplied.
- Services by Providers not recognised by Us.
- Services that are for Treatment, where a Customer received or established a right to receive Compensation from a third party. Where rights to receive payments by way of liable third party/ Compensation have not been determined, We may make provisional payments of Benefits pending the determination or settlement of the Claim. We have the right to recover any such payments once a determination or settlement has been granted.
- Services given to Customers by a Provider who is a spouse, de facto partner, dependent, family member or business partner of the Customer, or services given to a Customer by the spouse, de facto partner, dependents, or family members of the Provider's business partner.
- Services like examinations for life insurance, health certificates, mass immunisation, health screens and other expenses incurred for services required by employers.
- Services that have already been claimed from your annual limits under Previous Cover. If you have used all or part of your annual Benefits with your previous health Fund or your Cover with Us, We will adjust your new annual Benefits accordingly.
- Incomplete Claims.
- Consultations Covered by a Medicare Primary Health Care Plan e.g. psychology or dental plans.
- Services performed by a medical practitioner, specialist, radiologist, radiographer, sonographer or pathologist when you were not an admitted Private Patient in a Hospital.

- Services provided outside of Australia.
- Treatment received in international waters.
- Goods purchased outside of Australia.

See also *General terms of Extras Cover* for more information relating to when Benefits are payable.

Obligations if entitled to Compensation

Subject to the following, a Customer who has, or may have, a right to receive Compensation in relation to an injury, must:

- Inform Us as soon as the Customer knows or suspects that such a right exists;
- Inform Us of any decision of the Customer to Claim for Compensation;
- Include in any Claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;
- Take all reasonable steps to pursue the Claim for Compensation to Our reasonable satisfaction;
- Keep Us informed of and updated as to the progress of the Claim for Compensation;
- Inform Us immediately upon the determination or settlement of the Claim for Compensation; and
- Repay Us any Benefits paid in respect of the injury.

Benefits are not payable for expenses incurred (including after the Customer has received any Compensation) in relation to an injury where the Customer has received, or may be entitled to receive, Compensation in respect of that injury.

Where We reasonably form the view that a Customer has or may have a right to make a Claim for Compensation in respect of an injury, but that right has not been established, We may withhold payment of Benefits for expenses incurred in relation to that injury.

Provisional payment of Benefits

Where a Claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalised, We may at Our absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury. In exercising its discretion, We may consider factors such as unemployment or financial hardship or any other factors that it considers relevant. We have the right to recover any part of a provisional payment once a determination or settlement has been granted.

Standard Information Statements

The Australian Government requires all health Funds to provide information about their health Covers in a format that is consistent across all health Funds. This format is called a Standard Information Statement.

- We will provide a Standard Information Statement to the Policyholder on commencement of a Policy with Us and at least once every 12 months.
- We will maintain and make available Standard Information Statements in accordance with the requirements of the Private Health Insurance Act.
- To receive a Standard Information Statement visit Our website or call Us.

Cancelling the Policy

Unless otherwise permitted by Us, any cancellation of a Policy:

- Must be authorised by the Policyholder in writing or by calling Us;
- Can only be implemented from the date notice is provided and may not have retrospective effect; and
- Must be in accordance with other arrangements specified by Us.

Refund of Premiums

We may in Our discretion refund any Hospital Excess Premiums when a Policy is cancelled if requested to do so by the Policyholder in writing, or by the Policyholder calling Us.

Termination of a Policy

We may terminate a Policy:

- If a Policyholder is in arrears by more than 2 months.
- If a Policyholder fails to reactivate the Policy following a suspension.
- If We transfer all the Customers Covered under a Closed Product or Closed Policy Category within an Open Product to an Open Product. Closed Product or Closed Policy Category means a Product or Policy Category which is no longer open for new Policyholders to join; and Open Product means a Product which any new Policyholders may join.
- We will provide any Policyholders subject to a transfer and termination reasonable prior notice of the transfer and termination.

Improper advantage or unacceptable behaviour

We may, by notice in writing to the Policyholder, terminate a Policy where, in Our opinion:

- A Customer Covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, whether for the Customer or for any other person, to which the Customer is not entitled; or
- A Customer has engaged in inappropriate behaviour including abuse of Our employees.

This page has been intentionally left blank.

General terms of Hospital Cover

02 SECTION

This section should be read in conjunction with your Product Information brochure. Not every health Cover includes Benefits for Hospital Treatment.

Always call Us before going to Hospital.

We will help you check if the procedure will be Covered on your Policy and help you to understand the best ways to avoid potential Out-Of-Pocket Expenses.

Agreement Private Hospitals

To reduce the amount of Hospital charges you pay including Accommodation charges, operating theatre fees and to minimise Out-Of-Pocket Expenses Customers should attend an Agreement Private Hospital for Hospital Treatment. For example, if a Customer chooses to attend an Agreement Private Hospital, they are fully Covered for Accommodation and operating theatre fees for services included in the Hospital agreement.

If a Customer chooses to attend a Hospital, private or public, that is not an Agreement Private Hospital, they are responsible for paying any difference between the Hospital's total charges (including Out-Of-Pocket Expenses) and the Benefit We pay. For example, if the Customer receives a private room at their request. If you choose to be treated at a Private Hospital that does not have an agreement with Us, you are likely to incur higher Out-Of-Pocket Expenses for most Hospital related services than you would at an Agreement Private Hospital.

It is the Hospital's responsibility to inform Customers in writing of applicable Hospital charges and any potential Out-Of-Pocket Expenses prior to their Admission. The Customer should also provide their written consent to these charges. This is called Informed Financial Consent.

To check if the Hospital is an Agreement Private Hospital call Us or visit Our website.

What is Covered

We will pay Benefits for Hospital Treatment only where the:

- Service is included under the Customer's Product, in accordance with the Fund Rules;
- Service has been recognised by Medicare;
- Customer has served all relevant Waiting Periods;
- Policy is financially up to date;
- Service is provided to an admitted Patient;
- Other Conditions for the Claim have been met *(see 'Claims' under General Terms of Cover).*

Hospital Excess

Many Hospital Products require the payment of a Hospital Excess *(check your Product Information)* as a means of lowering the Premium that would otherwise apply to a Product.

- The Hospital Excess is payable to the Hospital prior to receiving Treatment from the Hospital. To avoid doubt, a Hospital Excess is payable where We pay a Benefit for Claimable Hospital Expenses under a Hospital Product which meets the requirements for Admission to hospital.
- The number of times a Hospital Excess is payable per Calendar Year varies *(check your Product Information)*.
- Some Hospital Products waive the Hospital Excess for Dependant Children under 21 *(check your Product Information).* However if it is the Policyholder who is under 21 years, the Hospital Excess will apply irrespective of the Product held.
- When changing to a new Hospital Product:
  - If the new Policy has a higher Hospital Excess the higher Hospital Excess will be payable immediately.
  - If the Hospital Excess on the new Cover is lower than the previous Cover, the previous Hospital Excess will apply for the duration of the Standard Hospital Waiting Period that applies to a Benefit (regardless whether a Customer is required to serve a Waiting Period in order to make a Claim for that Benefit).
- The Hospital Excess cannot be claimed through Us or Medicare.

Informed Financial Consent

It is the responsibility of the treating specialist and the Hospital to advise of potential Out-Of-Pocket Expenses prior to the Customer's Admission to Hospital. This is called Informed Financial Consent.

Customers should always call Us when they learn they need to go Hospital. We can help check what will be Covered and advise on the best ways to avoid potential Out-Of-Pocket Expenses.

Included Services

If the Treatment is an 'Included Service', We will pay Benefits towards the following when provided to an admitted Patient in an Agreement Private Hospital:

- Hospital Accommodation (i.e. the Patient's bed and a private room if available).
- Operating theatre fees.
- Intensive care, coronary care, neonatal care and labour ward fees.
- Patient meals.
- Ward drugs and sundry medical supplies (e.g. bandages, non-prescription pain killers).

We will also Cover the following things in-line with Our agreement with the Hospital. Patients may have an Out-Of-Pocket Expense if they exceed the contracted allowance for these services:

- Other allied health services provided during the Admission such as physiotherapy, hydrotherapy or occupational therapy.
- Dressings, sutures, needles and other disposable items.
- Pharmaceuticals to the extent set out below.

Pharmaceuticals provided in Hospitals

Where a Hospital Product includes Benefits for PBS medications, We will meet the full cost of the PBS pharmaceutical to the Patient if it is directly related to the Treatment for which the Patient was admitted.

- The full cost referred to above includes the Patient co-payment, and any special or Patient contribution, brand Premium or therapeutic Premium otherwise payable by the Patient under the Pharmaceutical Benefits Scheme; and
- Benefits for non-PBS medications supplied to Patients are payable in accordance with the agreement with the Hospital if:
  - Benefits are specifically included in the agreement with the Hospital; and
  - The pharmaceutical is directly related to the Treatment for which the Patient is admitted.

The Benefits described above are only payable for pharmaceutical items that are:

- Approved by the Therapeutic Goods Administration for use in Australia as part of the standard Treatment;
- Published within the MIMS Schedule; and
- Where the item is intrinsic to the Patient's episode of care.

No Benefits are payable for:

- Contraceptive drugs;
- Drugs issued for the sole purpose of use at home; or
- Pharmacy items charged in a Public Hospital, unless We have agreed to pay for them under a Hospital purchaser Provider agreement with a Hospital.

High cost drugs

High cost drugs are sometimes used in oncology and other Treatments. You may be left with large Out-Of-Pocket Expenses as some of these drugs are not Covered by the Pharmaceutical Benefits Scheme and may not be part of the standard Treatment. Therefore health insurance does not normally Cover them. You may be able to Claim part of the cost of these drugs where:

- *Received as an admitted Patient* if the drug is included in Our agreement with the Hospital for your particular type of Treatment.
- *Received as an Outpatient* if your Extras Product includes the pharmaceutical prescriptions Benefit and it covers these drugs.

Doctors and specialists fees

Fees apply to GPs, specialists, radiology, Pathology and ultrasound services provided to admitted Patients. For every item recognised by Medicare they also provide a recommended fee called a Medicare Benefits Schedule Fee. Medicare will pay:

- 75% of the Medicare Benefits Schedule Fee for GPs and specialists.
- 75% of the Medicare Benefits Schedule Fee for scans and tests.
- We will pay the remaining 25% of the Medicare Benefits Schedule Fee.

In the case of GPs and specialists who charge more than the Medicare Benefits Schedule Fee, We may be able to help Cover these costs too, providing the GP or specialist agree to participate in Our MediGap Scheme.

Our MediGap Scheme means that We will agree to pay an extra amount in addition to the standard 25% for services Covered under nib's MediGap Scheme. We've built up a network of doctors and specialists who may charge Us directly, at no additional cost to the Patient. However:

- Doctors can choose on a case-by-case basis if they are going to treat Our Customer as a MediGap Patient (or not).
- Customers are advised to ask the doctor if they can be treated as a MediGap Patient, and if other Providers who will be treating them (e.g. an anaesthetist) will also treat them as a MediGap Patient.
- MediGap will only Cover services provided during the Hospital stay.
- Any Consultations before and after the Hospital stay will not be Covered.
- Administration and booking fees are not Covered by Our MediGap Scheme.
- We will only pay a Benefit for services provided by a doctor or specialist if those services were administered whilst you were an admitted Private Patient in a Hospital.

If the GP or specialist does not agree to participate in the MediGap Scheme, you must pay the difference between what the GP or specialist's charge and the Medicare Benefits Schedule Fee.

Government Approved Prosthetic Devices

Depending on the type of procedure a Government Approved Prosthetic Device may be required. The Federal Government lists prostheses that may be fully Covered by health insurance.

- For every prosthesis recognised by the Government they also provide a recommended fee – similar to a recommended retail price.
- We will pay Benefits equivalent to the fee recommended by the Government.
- If the specialist chooses a prosthesis and the price charged by the Hospital is equal to the Government's recommended fee, the Patient won't have any out-of-pockets to pay.
- Where the price is greater, the Patient will only be partly Covered and will have an out-of-pocket to pay.
- In cases where a specialist has recommended the use of a prosthesis that may result in an Out-Of-Pocket Expense, you should also be provided with a second no out-of-pocket option from the Prostheses List.
- Some devices aren't recognised on the Government's list and won't be Covered at all by Us.
- Be sure to ask your doctor or specialist if the device they have chosen will require you to pay an Out-Of-Pocket Expense. If they aren't certain they may ask you to speak with the Hospital.

Same day Hospital patients

Benefits for same day Hospital Accommodation are payable only where the Customer is an admitted Patient. Same day Benefits are determined by the Patient classifications and guidelines issued by the Minister.

Continuous Hospitalisation

Where a Patient is discharged, and within 7 days is admitted to the same or a different Hospital for the same or a related Condition, the two Admissions are regarded as forming one period of Continuous Hospitalisation. Patients will not normally be required to pay a Hospital Excess for the second Admission.

Multiple procedures

Where a Patient undergoes more than one operative procedure during the one theatre Admission, or on the one day, if the Primary Item Number as indicated by the highest MBS fee, is excluded under the Product, We will pay nothing towards the Admission for any of the procedures. If the primary item is a Restricted Service, We will pay the Restricted Benefits for that item and any other Covered items performed as part of that Admission. If the primary item number is Covered under the Product, We will Cover Accommodation and theatre fees for that item and any other Covered items performed as part of that Admission.

Where a Patient undergoes an operative procedure that is covered under their Product, and additional procedures are performed during the one theatre Admission that are deemed as Cosmetic (no MBS), We will only cover Accommodation and theatre fees for the covered items performed as part of that Admission. No benefits will be paid toward any part of the costs associated with the Excluded Cosmetic Procedure.

In the event of multiple procedures, the Medicare Multiple Operation Rule may apply. This affects the total Medicare scheduled fee and therefore your out-of-pocket costs.

Restricted Services

If a Customer goes to Hospital for a Restricted Service on their Hospital Product they will only be paid Benefits equivalent to those paid for Private Patients receiving Treatment in a shared ward of a Public Hospital.

- Not every health Cover has Restricted Services *(check your Product Information).*
- Patients will have significant out-of-pockets to pay if they attend a Private Hospital for a Restricted Service.
- Restricted Services do not provide any benefits for labour wards or theatre fees and some other services in a Private Hospital.
- Patients will also have out-of-pockets to pay if they stay in a private room of a Public Hospital for a Restricted Service. Restricted Services may not apply in the event a Customer requires Treatment as the result of an Accident – depending on the Customer's level of Cover *(see Accidental Injury Benefit).*
- Public Hospitals (at their discretion) have the right to refuse private doctors. If you are planning Treatment as a Private Patient in a Public Hospital, contact the Hospital beforehand to see if your preferred doctor is permitted to treat you in your chosen Public Hospital.

Restricted Services may not apply in the event a Customer requires Treatment as the result of an Accident – depending on the Customer's level of Cover (see Accidental Injury Benefit).

Call us to find out more about the Benefits that apply to your Treatment.

Benefit Limitation Period

Benefit Limitation Period is a period of time during which a new Customer is entitled to Restricted Benefits or Minimum Benefits Payable for a particular Condition or Treatment, as set out in their Product Information.

From 1 July 2018, all Benefit Limitation Periods have been removed from our Products. If a Benefit Limitation Period applied to your Product, and you received Treatment prior to 1 July 2018, the Benefit Limitation Period will continue to be applied for that Treatment and Customers may experience significant out-of-pocket costs in relation to that Treatment.

Nursing Home Type Benefit

A Nursing Home Type Benefit is a Benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care.

Where a Customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

Emergency Admissions

In most cases during an emergency Customers will be taken to a Public Hospital and if required would normally be admitted as a public (Medicare) Patient.

On other occasions, the Hospital may ask the Customer, or their family, if they wish to be admitted as a Private Patient. It is important to remember:

- In this situation if there is no time to go through the proper Informed Financial Consent process, Customers may experience unexpected Out-Of-Pocket Expenses as result of being treated as a Private Patient (e.g. they may have to pay a Hospital Excess as a Private Patient).
- Health insurance provides little advantage to Treatment during an emergency (i.e. no choice of doctor, no choice of Hospital). It may help the Customer receive a private room after Treatment, but this is not guaranteed and may mean the Customer pays any private room Accommodation charges depending on their Product in accordance with the Fund Rules.
- During an emergency where there's no time to obtain proper Informed Financial Consent, We advise Customers to ask to be admitted as a public (Medicare) Patient. After Treatment Customers can ask to be re-admitted as a Private Patient once they have had time to ask the Hospital if there may be additional cost to them to do so.

Private Hospital emergency room fees are not Covered by Us.

Accidental Injury Benefit

Some of Our health Covers will Cover Accidents only in line with the Benefits provided by the Product (e.g. a Restricted Service remains Restricted irrespective of an Accident).

Other health Covers provide extra coverage where services that would ordinarily be Excluded Services or Restricted Services. These services will be included if required directly as the result of an Accident – this Benefit is referred to as the 'Accidental Injury Benefit'.

- Not every health Cover has the Accidental Injury Benefit *(check your Product Information).*
- To ensure a Customer is Covered for the immediate necessary Treatment or procedures required as the result of an Accident, it may be necessary to provide evidence to Us that they sought Treatment at a Hospital Emergency Department within 24 hours of the Accident. The Emergency Department attendance as an Outpatient service is not classed as an Admission and is not payable by the Fund.
- If the criteria for applying the Accidental Injury Benefit has been met, this Benefit may apply after the Customer has been admitted as an inpatient. This can include being admitted initially and/or being sent home after the Emergency Department consult to be admitted at a later date (but within 90 days of the Accident).
- If further Treatment is needed in Hospital as an admitted Patient, the Customer must be re-admitted to a Hospital within 90 days of date of Accident. Further Treatment or procedures relating to the Accident will only be Covered if the initial Treatment or procedure was Covered by the Accidental Injury Benefit.
- Any additional Hospital Treatment (after the initial 90 days) will be paid as per the level of Benefits on the Customer's level of Cover if applicable.
- If a Customer suffers an Accident, they and the attending doctor in Hospital may be asked to complete an Accident Form (available from Us) or to contact Us.
- Benefits are not payable for expenses incurred in relation to an injury where Compensation may be claimed for that injury.

Dental surgery in Hospital

Not every health Cover includes dental surgery in Hospital *(check your Product Information).* It is important to be aware that the dentist's fees for dental Treatment performed in Hospital are paid out of the Customer's Extras Benefits and therefore subject to Annual Benefits Limits and not eligible for the MediGap Scheme.

Customers who have only a Hospital Product (i.e. do not also have Extras Cover) will not receive Benefits for dentists' fees in Hospital. But the other Hospital costs (anaesthetist fees, Hospital fees) will be Covered in line with the Benefits provided by the Policy.

IVF and other assisted reproductive Treatments in Hospital

Not every health Cover includes Treatment for IVF or GIFT in Hospital *(check your Product Information).* It is important to be aware that health insurance will only Cover the portion of these costs that relate to an Admission to Hospital. Outpatient specialist fees or other Outpatient fees in relation to assisted reproductive services (for example, laboratory and storage fees) are not Covered.

Podiatry surgery in Hospital

Only Commonwealth Accredited Podiatric Surgeons are recognised by Us. We will only provide minimal Benefits (equivalent to a Restricted Service, less any theatre fees) for any podiatric surgery performed in a Hospital under any of Our Hospital Products.

Cancer Treatment in Hospital

Not every health Cover includes cancer Treatment in Hospital *(check your Product Information).*

It is important to be aware that health insurance will only Cover the portion of these costs that relate to an Admission to Hospital. Specialist fees outside of Hospital, or other Outpatient fees in relation to chemotherapy or radiotherapy aren't Covered.

High cost drugs are sometimes requested for the Treatment of some cancers. Typically high-cost drugs are for newer Treatments that are not recognised by the Pharmaceutical Benefit Scheme (PBS) because the PBS considers them to be still under clinical trial and therefore experimental Treatments. Health insurance will not Cover high cost drugs for the same reasons (or may only Cover a small portion of the cost). It is the responsibility of the treating doctor, and Hospital, to inform Patients about the potential for large out-of-pockets as a result of high cost drugs *(see 'General terms of Hospital Cover' and 'High cost drugs').*

What is Covered for Cancer Treatment

- Surgical procedures for the diagnosis and Treatment of cancer as an admitted patient, where the Treatment is unrelated to a Restricted Service or Excluded Service e.g. if eye surgery is excluded on your Cover then cancer of the eye would also not be Covered *(check your Product Information)*.
- In-hospital cancer Treatments such as an initial chemotherapy cycle and some radiotherapy Treatments.
- Medications approved under the Pharmaceutical Benefits Scheme and delivered as part of in-hospital Treatment.

What is not Covered for Cancer Treatment

- Outpatient treatments and associated expenses including, but not limited to, outpatient and home based chemotherapy, radiotherapy, radiology, pathology, psychological support and physical therapy.
- High cost drugs not approved under the Pharmaceutical Benefits Scheme *(see 'High cost drugs').*
- Cancer Treatment and surgery where the item is excluded on your cover e.g. if eye surgery is excluded on your Cover then cancer of the eye would also not be Covered *(check your Product Information)*.
- Outpatient services performed by a doctor or specialist.
- Other excluded services listed in this Policy Booklet under General terms of Hospital Cover subheading 'What is not Covered'.

Minimum Benefits Payable (MBP) when applied to Psychiatric Treatment, Palliative Care and Rehabilitation

Minimum Benefits are payable for Psychiatric Treatment, palliative care and Rehabilitation, if no Medicare Benefit is payable for that part of the Treatment and higher level benefits for these services are not included on your policy.

Where Minimum Benefits Payable is applied to these services, We will not pay a Benefit for services performed by a medical practitioner, specialist, radiologist, radiographer, sonographer, or pathologist that may be provided during or associated with Psychiatric Treatment, palliative care or Rehabilitation.

If you're attending a Private Hospital for Psychiatric Treatment, palliative care or Rehabilitation services where MBP applies, there will be significant Out-of-Pocket Expenses. If the Treatment is limited to MBP and is important to you, We recommend you take out a higher level of Cover.

Mental Health Waiver

The Mental Health Waiver allows Customers to upgrade their Hospital Cover and waive the Standard 2 Month Waiting Period to access full benefits for Psychiatric Treatment. This waiver is only available to Customers who have held Hospital Cover for at least the previous 2 months, have not previously used their waiver with Us or any other fund, have been Admitted to a Hospital and are under the care of an Addiction Medicine Specialist or Consultant Psychiatrist.

Customers who are eligible to receive the Mental Health Waiver may backdate their cover change to access full benefits beginning on their date of Admission, provided they contact Us on or before the fifth business day after their date of Admission.

To find out more, call us on **13 22 44**.

Excluded Services

If a Customer goes to Hospital for an Excluded Service on their Hospital Product they will not be Covered by Us.

- Not every health Cover has Excluded Services *(check your Product Information).*
- Patients will have to pay the full cost (less any Benefits payable by Medicare) if they are admitted as a Private Patient.

Excluded Services may be Covered in the event of an Accident – depending on the Customer's level of Cover *(see Accidental Injury Benefit).*

What is not Covered

- Any service listed as an Excluded Service for a Product under the Fund Rules on a Customer's Policy.
- Any Hospital Excess.
- Procedures within Waiting Periods.
- In-Hospital Treatment, drugs or disposable items not recognised for payment of Benefits by Medicare (for example, some items associated with robotic surgery or other new or experimental drugs/technologies)
- Cosmetic procedures to enhance appearance (including dental implants).
- Beauty services, phone calls, TV hire, car parking, luxury rooms and other Hospital Treatment that aren't directly related to a Patient's Treatment and care.
- Admission or booking fees charged by a specialist or the Hospital.
- Pharmaceuticals available under the PBS.
- Oral contraceptives.
- Services rendered in a nursing home.

- Private room Accommodation for a same day procedure.
- Respite care.
- Take-home items.
- Experimental and/or Treatment not Covered by Medicare.
- Autologous blood collection and storage.
- Procedures performed in a doctor's surgery.
- Private Hospital emergency or Outpatient fees.
- Special nursing.
- Nursing care at home for patients who have been discharged from Hospital early.
- Outpatient services performed by a doctor or specialist.
- For Claims that do not meet Our General Terms *(see 'General terms of Cover' and 'Claims').*

While We have done Our best to summarise the Benefits We will pay for Hospital Treatment, We recognise that circumstances may change.

Always call Us before going to Hospital. We can check what circumstances will be Covered and help you understand the best ways to reduce the amount you have to pay in Hospital charges and avoid potential Out-Of-Pocket Expenses. We can also provide a Going to Hospital Pack to help you through the process.

General terms of Extras Cover

03 SECTION

This section should be read in conjunction with your Product Information brochure. Not every health Cover includes Benefits for Extras Treatment.

Always call Us before starting a new course of Treatment for Extras.

Call Us before undergoing a major course of Treatment for Extras to check if you will be Covered and to understand the best ways to avoid potential Out-Of-Pocket Expenses.

Our Recognised Providers

We will pay Benefits for Extras if the Customer attends a Provider recognised by Us. Our Recognised Providers must meet all the minimum criteria outlined by Us relating to:

- Their education, qualifications and active membership of any governing body specified by Us; and
- In most cases, the Provider must be in Private Practice.

We will not pay Benefits for any Providers who are no longer one of Our Recognised Providers.

Customers should check if their Provider is already recognised by Us before starting Treatment. If not, ask the Provider to contact Us by phone or by email at **providers@nib.com.au**.

What is Covered

Extras are the out-of-Hospital Treatments which are not normally Covered by Medicare – like visits to the dentist, a pair of glasses or physiotherapy.

- We will Cover the Extras included in a Customer's Product in accordance with the Fund Rules.
- Normally only the cost of the Consultation will be Covered, unless otherwise stated.
- Services must be provided by one of Our Recognised Providers.
- If a Customer sees the same Recognised Provider twice on the same day, only one Benefit will be payable.
- If a Provider performs multiple services within one Consultation (like remedial massage and acupuncture), the Treatment that attracts the higher Benefit will be paid.
- Only face-to-face Consultations are Covered.
- *See also 'General terms of Cover' and 'Claims'.*

Refer to your Product Information to see if the following specific Extras are included on your Policy.

"Acupuncture" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is recognised by Us as an acupuncturist.

"Antenatal Classes" means General Treatment that is:

(a) approved by Us; and

(b) provided by a midwife or physiotherapist in Private Practice

"Artificial Aids" means General Treatment that is:

(a) included on Our Schedule of approved artificial aids

Waiting Periods vary according to the device. Restrictions, appliance limits and replacements vary according to the device. Benefits are not payable for second-hand aids. Benefits are not payable for hire of aids. Call Us to see if your chosen artificial aid will be Covered and whether any appliance limits apply.

"Chiropractic" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is recognised by Us as a chiropractor.

Chiropractic x-rays are also Covered in line with the Benefits provided by the Product *(check your Product Information).*

"Dental Treatment" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is recognised by Us as a Dental Practitioner (a person registered or licensed to practice as a dental practitioner under a law of a State or Territory that provides for the registration or licensing of dental practitioners or dentists).

Only items recognised by the Australian Dental Association are Covered. Teeth whitening and other purely cosmetic Treatments are not Covered. We recommend you obtain a quote before undergoing major Treatment. We require the dental item numbers before providing an estimate of the Benefits to be paid.

"Dietary" or **"Dietary Advice"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is recognised by Us as a dietician or a nutritionist.

"Exercise Physiology" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us as an exercise physiologist.

"Healthier Lifestyle" includes:

(a) Weight management programs recognised by Us. No Benefit is payable for food, books, videos.

(b) Quit smoking programs and nicotine replacement therapy (including nicotine patches, inhalers, lozenges and gum) that have been recognised by Us.

(c) First aid programs recognised by Us – payable for courses provided by a first aid Provider approved by the National Training Information Service. No Benefits are payable for first aid kits.

(d) Fitness Centre/gym or personal training services recognised by Us where:

i. The membership of a fitness centre, visits to a fitness centre or sessions with a personal trainer is required to enable the Customer to undertake a health management program for the Treatment of a health related Condition; and

ii. The health management program has been recommended to the Customer by a medical practitioner or Provider who has the Customer under their care for the Treatment of the health related Condition; and

iii. All supporting documentation required by Us in relation to the health management program has been completed in the manner requested by Us.

iv. The membership is not provided as part of a corporate membership program.

(e) Preventative testing procedures recognised by Us.

(f) Pilates classes performed by a Pilates instructor recognised by Us where:

i. Sessions with a Pilates instructor is required to enable the Customer to undertake a health management program for the Treatment of a health related Condition; and

ii. The health management program has been recommended to the Customer by a medical practitioner or Provider who has the Customer under their care for the Treatment of the health related Condition; and

iii. All supporting documentation required by Us in relation to the health management program has been completed in the manner required by Us.

(g) Yoga classes performed by a Yoga instructor recognised by Us where:

i. sessions with a yoga instructor is required to enable the Insured Person to undertake a health management program for the Treatment of a health related Condition; and

ii. The health management program has been recommended to the Insured Person by a medical practitioner or Provider who has the Insured Person under their care for the Treatment of the health related Condition; and

iii. All supporting documentation required by Us in relation to the health management program has been completed in the manner required by Us.

Services Covered may vary by health Cover *(check your Product Information).*

"Hearing Aids" means:

(a) an appliance to correct a hearing defect; or

(b) a component of such an appliance, that has been prescribed during a Consultation with a Provider who is recognised by Us as an audiologist.

Includes the cost of one repair for each Customer in each Calendar Year.

"Home Nursing" means:

(a) services provided by a registered general nurse in Private Practice;

(b) Treatment of illness, disease, incapacity or disability when the Patient is totally dependent on nursing care.

Benefits are not payable for services such as Mothercraft, Tresillian or Karitane nursing or a nurse-housekeeper during recovery after illness.

"Natural Therapies" means General Treatment that is:

(a) approved by Us;

(b) provided during a Consultation with a Provider who is recognised by Us as to provide natural therapy Treatment.

No Benefits are payable for ointment or medications required as part of the Treatment.

"Naturopathy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us as a naturopath.

"Non PBS Pharmaceuticals" means General Treatment that is payable when the drug is:

(a) Dispensed by either a registered pharmacy in Private Practice or a doctor;

(b) Only available on prescription;

(c) Listed on the Australian Register of Therapeutic Goods (ARTG);

(d) Published within the MIMS Schedule as S4 or S8; and

(e) Not listed on the PBS.

For compound drugs, at least one component needs to be listed on MIMS and the rest on either MIMS OR the Poisons Schedule and the drug must not be listed on the PBS.

Benefits are not payable for:

(a) Prescriptions dispensed to Hospital Inpatients;

(b) Items used for contraceptive purposes; and

(c) Drugs that are available over-the-counter, even when prescribed.

Depending on your level of Cover you may be required to pay an amount equal to the maximum PBS Patient contribution charge before Benefits are payable by Us *(check your Product Information).*

"Occupational Therapy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us to provide occupational therapy Treatment.

"Optical Appliance" means:

(a) an appliance to correct a sight defect; or

(b) a component of such an appliance, that has been prescribed during a Consultation with a Provider who is recognised by Us as an optometrist, an ophthalmologist or optical dispenser.

Optical Benefits are not payable for:

(a) replacing a lens as part of the process for repairing spectacles

(b) sunglasses

(c) tinting, coating or hardening of lenses

"Optometrist" means a person registered or licensed as an optometrist or optician under relevant State or Territory laws.

"Orthotics" means an appliance to correct a deformity of the foot or lower limbs that has been prescribed during a Consultation with a Provider who is recognised by Us as a podiatrist, physiotherapist, chiropractor or osteopath.

Orthopaedic shoes/boots must be custom made or medical grade.

"Orthoptics" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us to provide orthoptics Treatment.

"Osteopathy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is recognised by Us as an osteopath.

"Pharmaceutical Prescriptions" *(see Non PBS Pharmaceuticals)*

"Physiotherapy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us as a physiotherapist.

Benefits are payable for group physiotherapy depending on your Cover *(check your Product Information).*

"Podiatry" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised by Us as a podiatrist.

"Psychology and Counselling" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Psychologist who is recognised by Us as to provide psychology and counselling Treatment.

No Benefits are payable for tests or assessments. Depending on your Cover Benefits may be payable for couple or group sessions *(check your Product Information).*

"Speech Therapy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is recognised Us as a speech therapist.

Benefits are not payable for group speech therapy.

What is not Covered

- Extras not included in the Customer's Product in accordance with the Fund Rules.
- Extras already Covered, in whole or part, by Medicare (except for certain types of Hospital-substitute Treatment).
- Providers who do not meet Our criteria.
- Providers who are not one of Our Recognised Providers.
- Extras or prescriptions provided to an admitted Patient (these may be Covered under a Hospital Product).
- Extras Benefit entitlements accrued under another Fund's loyalty bonus scheme.
- Consultations that are not provided face-to-face. Skype and telephone Consultations are not considered face-to-face.
- Claims that do not meet with Our General Terms *(see 'General terms of Cover' and 'Claims').*

General terms of Benefits for ambulance

04 SECTION

This section should be read in conjunction with your Product Information brochure. Not every health Cover includes Benefits for ambulance transportation.

Our Recognised Providers

Ambulance transport provided by a State or Territory ambulance service.

What is Covered

Emergency ambulance transport to Hospital provided by a State or Territory ambulance service.

- Emergency ambulance call out fees (where the Customer is treated at the scene by paramedics and it is determined that transport to Hospital is not required).
- Transport between Hospitals when the transfer is required as a result of the existing Hospital not specialising in the Treatment required.

What is not Covered

- Private ambulance services.
- Residents of Queensland and Tasmania who have ambulance services provided by their State ambulance schemes.
- Pension and health care card holders who have ambulance services provided by State ambulance schemes (check entitlements with Centrelink if unsure).
- Claims that do not meet Our General Terms *(see 'General terms of Cover' and 'Claims').*
- Transport from Hospital to your home, for example if you are unable to make your own way home from Hospital after Treatment.

Also, you may not be Covered for:

- Transport between Hospitals unless the transfer is required due to medical necessity determined by the treating doctor (with sufficient evidence provided to Us), and the transfer is provided by a State or Territory Ambulance Service.

Our obligations

05 SECTION

We will:

- Treat Customers as valued Customers;
- Answer questions promptly and accurately at the first point of contact (wherever possible);
- Provide detailed health Policy information and help Customers understand what they are Covered for;
- Deal with feedback and complaints in a timely and responsible manner;
- Help Customers understand any potential Out-Of-Pocket Expenses that they may face when going to Hospital;
- Provide timely and accurate Hospital eligibility checks;
- Comply with all aspects of the Private Health Insurance Act and the Private Health Insurance Code of Conduct;
- Provide 30 to 60 days written notification of detrimental Product changes and 14 days notification of a Premium increase;
- Meet the terms outlined in Our direct debit Agreement;
- Provide a 30 day cooling off period on all health Cover sales and Product changes (providing no Claims are made during that time); and
- Treat personal information with respect and in total accordance with Our Privacy Policy and the Australian Privacy Principles.

Your obligations

06 SECTION

By taking out a Policy with Us you agree to:

- Be accurate and truthful in your health insurance application and Claims;
- Undertake to understand Waiting Periods and what you are Covered for, and if unsure – ask Us;
- Call Us as soon as you learn you need to go to Hospital;
- Review your health Cover at least once per year, or as your needs change (e.g. get married);
- Keep your health insurance Premiums up to date to ensure you remain Covered;
- Meet the terms outlined in Our direct debit Request Service Agreement;
- Seek information about your Out-Of-Pocket Expenses from your doctors and the Hospital before any Hospital Admission;
- Provide all information reasonably required by Us in relation to all Policies;
- Notify Us as soon as reasonably possible after a change in Policy details; and
- Give full and complete disclosure on all matters required by Us.

Health insurance initiatives from the Australian Government

07 SECTION

Medicare Levy Surcharge

If your taxable income is above the Medicare Levy Surcharge Thresholds, and you do not have an appropriate level of Private Hospital Cover you may have to pay the Medicare Levy Surcharge.

This can be up to an additional 1.5% in tax (on top of the normal Medicare Levy).

See below:

	Base Tier	Tier 1	Tier 2	Tier 3
Income level Singles	$90,000 or less	$90,001 to $105,000	$105,001 to $140,000	$140,001 or more
Income level Families	$180,000 or less	$180,001 to $210,000	$210,001 to $280,000	$280,001 or more
Medicare Levy Surcharge				
	0%	1%	1.25%	1.5%

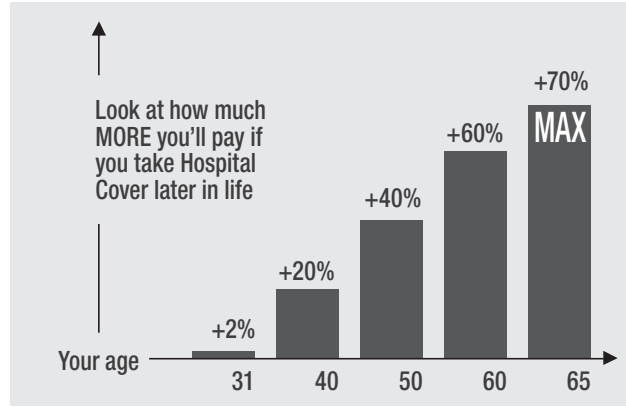
Source: Australian Tax Office. These thresholds apply for the 2018/2019 financial year. For families the thresholds increase by $1,500 for each Dependant Child after the first. There are specific rules for calculating income for Medicare Levy Surcharge purposes. For more information go to **www.ato.gov.au**

Lifetime Health Cover

Lifetime Health Cover (LHC) is a Federal Government initiative that encourages people to join private health Cover earlier in life.

Under LHC, if you join Hospital Cover after 1 July following your 31st birthday, you will have to pay a 2% loading on top of the normal Premiums for each year you waited before taking out private health Cover. Not just with Us, but with any health Fund. The loading applies for 10 years of continuous Hospital Cover.

For example, if someone waits until they are 40 they will pay 20% more than someone on the same Cover who joined before they were 31.



- The LHC loading does not apply to the health Cover of those born before 1 July 1934.
- LHC allows for changes in circumstances, and lets Customers drop their Hospital Cover for a cumulative total of 1094 days in their lifetime.
- After 1094 days absence from Hospital Cover, a 2% loading will be added to the Premiums for every 365 days they do not have it. If a Customer suspends their Cover, this period will not be deducted from the 1094 days.
- After 10 years of continuous Hospital Cover, loading will be removed on the 10 year anniversary date.
- If transferring from another health Fund your Lifetime Health Cover information will be provided to Us from your previous health Fund.

For more information about Lifetime Health Cover, visit **www.privatehealth.gov.au** or The Department of Health at **www.health.gov.au**

The Australian Government Rebate on Private Health Insurance

The Australian Government Rebate offers a saving on the cost of private health Cover funded by the Federal Government. The level of Rebate you could be entitled to receive is based on the age of the oldest person on the Policy and your taxable income (or combined family income for couples and families). The table below will help you determine which rebate level you could be entitled to. The Rebate percentages are set annually by the Australian Government.

If you have a Lifetime Health Cover (LHC) loading, the Rebate is not claimable on the LHC loading component of your Premium.

	Base Tier	Tier 1	Tier 2	Tier 3
Income level Singles	$90,000 or less	$90,001 to $105,000	$105,001 to $140,000	$140,001 or more
Income level Families	$180,000 or less	$180,001 to $210,000	$210,001 to $280,000	$280,001 or more

Source: Australian Tax Office. These thresholds apply for the 2018/2019 financial year. For families the thresholds increase by $1,500 for each Dependant Child after the first. There are specific rules for calculating income for Australian Government Rebate purposes. For more information go to **www.ato.gov.au**

Australian Government Rebate
From 1 April 2018 to 31 March 2019

	Base Tier	Tier 1	Tier 2	Tier 3
Aged under 65	25.415%	16.943%	8.471%	0.00%
Aged 65-69	29.651%	21.180%	12.707%	0.00%
Aged 70 or over	33.887%	25.415%	16.943%	0.00%

Most Policyholders Claim the Rebate upfront as it reduces the Premium paid to Us. However you can choose to Claim the Rebate at tax time.

All Our Products are eligible to receive the Rebate.

To be eligible for the Rebate:

- All Customers listed on the Policy must be eligible for Medicare.
- The Policyholder needs to let Us know that they wish to Claim the Rebate when they join (or otherwise complete an Application to receive the Australian Government Rebate or provide this information via Our website).
- If the Policyholder does not inform Us that they wish to Claim the Rebate, We will not apply the Rebate. This may result in higher Premiums.

If the Policyholder applies a Rebate in excess of their entitlement the difference will be worked out at tax time by the Australian Tax Office, meaning you may have a tax bill (or tax credit) for the difference.

For more information about the Australian Government Rebate visit **www.privatehealth.gov.au** or The Department of Health at **www.health.gov.au** or the Australian Taxation Office at **www.ato.gov.au**

Glossary of important terms

08 SECTION

"Accident" means an event leading to bodily injury caused solely and directly by violent, accidental, external and visible means and resulting solely, directly and independently of any other cause.

"Accidental Injury Benefit" means additional Cover provided on certain levels of Cover as the result of an Accident.

"Accommodation" means the Hospital bed, Patient meals and nursing care in a Hospital. It does not include Treatment by health professionals such as doctors.

"Admission" means Treatment for an illness or Condition as a Private Patient in a registered public, private or day Hospital where a Customer has been admitted by a medical practitioner. Treatment in the emergency room of a Private Hospital is not an Admission.

"Adult" has the same meaning as in the Private Health Insurance Act.

"Adult Dependant" is a person who:

(a) is not a Policyholder;

(b) is aged between 21 and up to 25 years;

(c) is not in full-time study;

(d) is not married or in a defacto relationship; and

(e) who the Policyholder has nominated to stay on the Policy for a fee.

"Agent" means Our Agent whose details appear on the front Cover of this Policy Booklet.

"Agreement Private Hospital" means a Hospital with which We have negotiated a Hospital purchaser Provider agreement to minimise Out-Of-Pocket Expenses for most Hospital related costs.

"Annual Benefits Limits" means the maximum amount of Benefits payable for a specific good or service in a Calendar Year.

Depending on your level of health Cover, a Family Cap may apply to your Policy. This means that the total Benefits claimable for each Extras service are limited to 4 times the per person limit for all Family Policies. For more information, refer to your Product Information.

"Benefit" means an amount of money payable from the Fund to or on behalf of a Customer, in respect of approved expenses incurred by a Customer for Treatment.

"Calendar Year" means the period from 1 January to 31 December.

"Claim" means a Claim for the payment of Benefits which complies with the requirements of this document.

"Claimable Hospital Expenses" means expenses incurred for Hospital Treatment in respect of which a Benefit is payable.

"Combined Product" means a Product that includes Benefits for fees and charges for Hospital Treatment and General Treatment.

"Compensation" means an entitlement or a potential entitlement to receive Compensation or damages (including a payment in settlement of the Claim for Compensation or damages) in respect of any Condition.

"Complying Health Insurance Product" has the meaning given in the Private Health Insurance Act and includes any Product which is deemed to be a Complying Health Insurance Product in accordance with the Private Health Insurance Act.

"Condition" includes any illness, injury, ailment, disease or disorder for which Treatment is sought.

"Consultation" means the attendance by a Customer with a Provider in a manner approved by Us.

"Continuous Hospitalisation" where a Patient is discharged, and within 7 days is admitted to the same or a different Hospital for the same or a related Condition, the two Admissions are regarded as forming one period of Continuous Hospitalisation.

"Contribution Group" means a group of Policyholders approved by Us.

"Couples Policy" means a Policy that covers the Policyholder and their Partner.

"Cover"/"Covered" indicates the level of Benefit for a procedure or service, e.g. Full Cover/Restricted Cover or Excluded.

"Customer" means any Policyholder (including Adults and Dependant Children) insured by Us under a Policy.

"Default Benefits" means the minimum Benefit payable under a Hospital Product for a particular Hospital Treatment in a Hospital that is not an Agreement Private Hospital under the Private Health Insurance Act 2007.

"Dependant Child" means a person who is not a Policyholder or Partner and who:

(a) is aged under 21 years of age; and
(b) is not married and does not have a defacto Partner.

"Excess Premiums" means any Premiums paid beyond the date of cancellation or termination of the Policy.

"Exclusions" or **"Excluded Services"** means procedures excluded from some Hospital Products – which means Customers will not be Covered in a public or private and will not receive a Benefit from Us for that procedure. Always check with Us before you go to Hospital to find out if you've got the Cover you need.

"Extended Family Policy" is a Policy with one or more Adult Dependants (not available on all Covers and under all circumstances – *check your Product Information and call Us for more information*).

"Extras"– *see General Treatment.*

"**Family Policy"** means a Policy comprising the Policyholder, their Partner and one or more Dependant Children.

"Fund" means the health Benefits Fund established by Us.

"Fund Rules" mean the Fund Rules established by Us under the Private Health Insurance Act that relate to the day-to-day operation of the Fund.

"General Product" means a Product for General Treatment.

"General Treatment" (or **"Extras"**) means Treatment (including the provision of goods or services) that:

(a) is intended to manage or prevent a Condition;

(b) and is not Hospital Treatment;

which is permissible under the Private Health Insurance Act and in respect of which Benefits are payable.

"Government Approved Prosthetic Device" means a surgically implanted item like an artificial knee or hip joint.

"Hospital" has the meaning given under the Private Health Insurance Act.

"Hospital Excess" means the amount a Policyholder must pay for Claimable Hospital Expenses before a Benefit is paid under their Policy.

"Hospital Product" means a Product which includes Benefits for fees and charges for:

(a) some or all Hospital Treatment; and

(b) some or all associated professional services rendered to a Patient receiving Hospital Treatment, and includes Combined Products.

"Hospital Treatment" means the provision of goods and services) that:

(a) is intended to manage a disease, injury or Condition; and

(b) is provided to a person:

i. by a person who is authorised by a Hospital to provide the Treatment; or

ii. under the management or control of such a person; and

(c) either:

i. is provided at a Hospital; or

ii. is provided, or arranged with the direct involvement of a Hospital.

"Included Services" means Hospital Treatment or General Treatment Covered under a Customer's Policy to the extent described in this document.

"Informed Financial Consent" is where a Patient is told in writing about, and consents to, the cost of Hospital Treatment before being provided with that Treatment. The Patient should be informed of the cost of Treatment before they are admitted to Hospital to enable Informed Financial Consent to be given.

"Inpatient" has the same meaning as 'Patient'.

"Lifetime Limits" means the maximum amount of Benefits payable for a specific good or service provided to a Customer over the lifetime of the Customer.

"Medicare Benefits Schedule" means the Schedule set by the Commonwealth Government for the purpose of paying Medicare Benefits.

"Medicare Benefits Schedule Fee" means the amount set under the Medicare Benefits Schedule. A scheduled fee is like a recommended retail price set by Medicare. GPs and Specialists can choose to charge more than the scheduled fee if they wish.

"Medicare/Public Patient" means a Patient who has elected to be admitted as a 'Public' Patient in a Public Hospital which means that all Benefits are claimable through Medicare only and are not claimed under your Policy.

"MediGap Patient" means a Patient, in respect of whom a doctor or specialist determines is eligible for the MediGap Scheme.

"MediGap Scheme" is Our scheme to reduce Out-Of-Pocket Expenses for Patients where GPs or specialists charge above the Medicare Benefits Schedule Fee for Hospital Treatment.

"Minimum Benefits Payable (MBP)" means the minimum amount of Benefits that We are required to pay under the Private Health Insurance Act, to or on behalf of a Customer for Hospital Treatment under a Hospital Cover.

"Minister" means the Federal Minister for Health or his or her delegate with the powers vested in the Minister by the Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and includes any regulations and rules made pursuant to that Act.

"Nursing Home Type Benefit" means a Benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care.

"Official Provider Receipt" meaning accounts and/or receipts on the Provider's letterhead or showing the Provider's official stamp, and showing the following information:

(a) the Provider's name, Provider number and address;

(b) the Patient's full name and address;

(c) the date of service;

(d) the description of the service;

(e) the amount(s) charged; and

(f) any other information that We may reasonably request.

"Out-Of-Pocket Expenses" are charges and fees not Covered by Us.

For example, We will not pay for medical fees above the MBS fee (where doctors don't participate in MediGap), any Hospital Excess, or some personal and take home items like toiletries, newspapers and long-distance and mobile phone calls provided in Hospital. These are billed to Patients by treating doctors and the Hospital. Customers are advised to ask the Hospital and their doctors what their potential Out-Of-Pocket Expenses might be (*see also Informed Financial Consent*).

"Outpatient" means medical Treatment provided to a Customer which does not require an Admission to Hospital.

"Partner" means a person who lives with a Policyholder in a marital or de-facto relationship.

"Partner Authority" is where the Policyholder gives their Partner, authority to operate the Policy. This lets the Partner make Claims on behalf of all people on the Policy, and make some changes to or make enquiries about the Policy. Without Partner Authority a Partner can only make Claims for themselves.

"Pathology" is the study of the nature of disease and its causes, processes, development and consequences.

"Patient" means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. This definition:

(a) includes a new born child who:

i. occupies a bed in a Special Care Unit; or

ii. is the second or subsequent child of a multiple birth; and

(b) excludes:

i. any other new born child whose mother also occupies a bed in the Hospital; and

ii. a member of the staff of the Hospital who is receiving Treatment in his or her own quarters.

"PBS" means the Pharmaceutical Benefits Scheme.

"Pharmaceutical Benefits Scheme" or **"PBS"** means the scheme under which the Federal Government heavily subsidises the cost of medicines. We do not pay for medicines on the PBS. It is available to Australian residents and eligible visitors from countries with reciprocal arrangements with Australia. For more information about the PBS visit **www.health.gov.au**

"Policy" means a Policy of private health insurance between a Policyholder and Us issued for a Product.

"Policy Booklet" means this document, as amended from time to time.

"Policy Category" means the following groups:

(a) only one person (being the Policyholder) – a Single Policy;

(b) two Customers who are Adults (and no-one else) – a Couples Policy;

(c) two or more Customers, none of whom is an Adult;

(d) two or more Customers, only one of whom is an Adult – a Single Parent Family Policy;

(e) three or more Customers, only two of whom are Adults – a Family Policy; and

(f) three or more Customers, at least three of whom are Adults – an Extended Family Policy.

"Policyholder" means a person in whose name an application for a Policy with Us has been accepted.

"Pre-Existing Condition" means a Condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by Us, were exhibited by the Customer:

(a) in the case of a new Customer (or any new person being added to or Covered under an existing Policy) at any time during the 6 months prior to joining.

(b) in the case of a Customer upgrading from one Hospital Product to another Hospital Product providing higher Benefits for Hospital Treatment, at any time during the 6 months prior to the Customer paying Premiums for the upgraded Hospital Product (note: changing to a lower level of Hospital Excess constitutes an upgrade. The Pre-Existing Condition Waiting Period will be applied in this circumstance).

The medical practitioner is appointed by Us and will examine relevant information (including information supplied by the Customer's medical practitioner) to determine if the Condition is classified as a Pre-Existing Condition.

"Premium" means an amount of money a Policyholder is required to pay to Us in respect of a specified period of Cover for a Product under a Policy.

"Premium Rate" means the rate of Premiums for a Product set out in the Schedules as amended from time to time.

"Previous Cover" means in respect of a Customer who transfers to a Complying Health Insurance Product with Us from:

(a) another Complying Health Insurance Product issued by Us or one of Our related entities, including such a product carrying a third party brand;

(b) a Complying Health Insurance Product of another Australian private health insurer;

(c) a health insurance product issued in New Zealand by one of Our related entities; or

(d) overseas student health cover, overseas visitor cover or expatriate health insurance issued by Us or one of Our related entities.

"Private Health Insurance Act" means the Private Health Insurance Act 2007 (Cth) and includes any regulations and rules made pursuant to that Act.

"Private Hospital" means a facility for which a declaration under section 121-5(6) of the Private Health Insurance Act is in force where the declaration includes a statement in accordance with section 121-5(8) of the Private Health Insurance Act that the hospital is a private hospital.

"Private Patient" means a Patient electing to Claim under their Policy for Treatment in a Public or Private Hospital.

"Private Practice" means a practice (whether sole, partnership or group) which receives its entire income from the fees charged to its patients without subsidy or funding from any public sector body.

"Product" means a defined group of Benefits which are payable to a Customer under their chosen level of health Cover, subject to relevant rules, for approved expenses incurred by a Customer and in respect of which Premiums are payable at the Premium Rates. These include all AAMI Health Insurance branded Products made available from time to time.

"Product Information" is the material that relates to your health insurance Policy, such as Standard Information Statements, Policy Statements and Product Information Sheets.

"Professional Attention" means:

(a) medical or surgical Treatment by or under the supervision of a medical practitioner; or

(b) obstetric Treatment by or under the supervision of a medical practitioner or a registered nurse with obstetric qualifications; or

(c) Dental Treatment by or under the supervision of a Dental Practitioner.

"Provider" – *see Recognised Provider.*

"Psychiatric Treatment" means Treatment of a mental illness or addictions at a psychiatric facility. This may include Treatment for mood disorders, eating disorders, drug and alcohol detoxification and addiction therapy.

"Public Hospital" means a Hospital owned and operated by the State or Territory or Federal Governments.

"Recognised Provider" or **"Provider"** means:

(a) Hospitals; and

(b) General Treatment Providers that:

i. are registered or hold a license under relevant State or Territory legislation to provide the General Treatment sought;

ii. are professionally qualified, or a current member of a professional body recognised by Us;

iii. are in Private Practice; and

iv. satisfy any other criteria reasonably required by Us to pay Benefits for General Treatment provided by the Provider.

"Rehabilitation" means intensive physical therapy and Treatment at a specialist Rehabilitation facility for a Patient to recover from an acute catastrophic illness or injury with a significant impairment for which the goal of Treatment is functional improvement e.g. following a joint replacement or stroke recovery.

"Restricted Benefits" means the lower level of Benefits payable for some services under a Product as set out in the Product Information. Benefits paid will be equivalent to Treatment in a shared-ward of a Public Hospital.

"Restricted Services" means services for which Restricted Benefits are payable.

"Schedules" means the Schedules of Complying Health Insurance Products outlined in Our Fund Rules.

"Self-Insured Patient" or **"Uninsured"** means a Patient has opted to take full financial responsibility for the Claim and all associated costs.

"Single Policy" means a Policy comprising the Policyholder only.

"Single Parent Family Policy" means a Policy comprising the Policyholder and one or more Dependant Children.

"Special Care Unit" means a unit of a Hospital approved by Us for the purpose of providing special care, and includes facilities such as intensive care units, critical care units, coronary care units and high dependency nursing care units.

"Standard Information Statement" means a statement about a Product under the Private Health Insurance Act.

"Student Dependant" means a person who is not a Policyholder or Partner and who:

(a) is aged 21 and up to 25;

(b) is engaged in full time study; and

(c) is not married and does not have a defacto Partner.

"Treatment" means:

(a) in respect of Hospital Products: Hospital Treatment, Professional Attention and any other item in respect of which Benefits are payable from a Hospital Product; and

(b) in respect of General Products: services and items for General Treatment for which Benefits are payable under the Fund Rules.

"Waiting Period" means a period of time during which a Policyholder must continuously hold a Policy for a particular Product before a Customer under that Policy has an entitlement to receive a Benefit under that Product.

"We", "Us" and **"Our"** in this document refers to nib health funds limited abn 83 000 124 381.

Privacy Statement

09 SECTION

We are the registered health insurer and administrator of this Policy and We have authorised the Agent to act on Our behalf in the collection use and disclosure of personal information, including sensitive information (such as health information) in connection with this Policy.

We and Our Agent collect personal information from the Policyholder and other Customers insured under the Policy. If necessary, We also collect personal information from third parties such as other health insurers and health service Providers.

We will use the information We collect to:

- process your application for a Policy with Us
- provide Benefits for health and related services, including Our online services
- determine eligibility to provide or receive a health or related service
- conduct research (including but not limited to Customer surveys) concerning nib's current and future health and related services
- manage Our relationship with you
- as otherwise authorised or required by law.

If you do not provide the personal information We request, We may not be able to provide you with the particular Product or service you are seeking, including health insurance.

We may need to disclose your personal information to other parts of Our wider company, or other people and organisations assisting Us with Our services, located both in and outside Australia (including The Philippines).

Those include:

- The named Policyholder who has your authority
- Any other authorised individual under your Policy
- Our related companies
- Health service Providers including private and Public Hospitals, doctors and medical specialists and their state registration boards and professional associations
- Private health insurers and government agencies
- Our contractors and service Providers who perform services such as marketing, market research, mail-house services and Product research and development

When We pass on personal information to others or outside Australia, We take steps to ensure that it is treated in the same way that We would treat it.

We will also use the information and disclose it to Our Agent to:

- Promote and market Our current and future health and related services
- Promote and market existing and future other co-branded products and services

From time to time you may receive direct marketing or research communications from Us by mail, telephone, email, sms. You may at any time request to stop receiving these communications from Us by a particular channel or at all by contacting Our Privacy Officer by calling **13 14 63** or emailing **PrivacyOfficer@nib.com.au.**

You may request to stop receiving direct marketing from Our Agent by contacting **13 22 44**. For information about Our Agent's Privacy Policy please refer to **aami.com.au**

For more information about the personal information We collect about you and how We handle it, how to access and correct your information, how to make a privacy complaint and how We will respond to complaints, please read Our full Privacy Policy.

The Privacy Policy is available on Our website at **nib.com.au**

You should read Our Privacy Policy before applying for a Policy with Us, and you must ensure that all members on the Policy are made aware of this privacy statement and Our Privacy Policy.

We reserve the right to change Our Privacy Policy from time to time.

Changes will take effect when Our updated Privacy Policy is posted on Our website at **nib.com.au**

How to resolve a complaint or dispute

10 SECTION

We understand the importance of providing excellent service, and how to help Customers get value from their health Cover. We also know that Customer feedback can help improve the quality of service. We have a process for dealing with complaints to ensure they are heard, this is free of charge.

Step 1: Talk to Us

The first thing you should do is talk to one of Our consultants about your concern. Phone Us on **13 22 44**.

The consultant may be able to resolve the complaint for you.

Step 2: Contact Customer Resolutions

If the consultant cannot resolve your complaint, you may request the matter be referred to Our Customer Resolutions Team.

The Customer Resolutions Team will aim to acknowledge receipt of your complaint within 2 working days and assign a Case Manager to conduct an independent review of the matter. Their commitment is to ensure that all complaints are dealt with respectfully, sensitively, fairly, promptly, knowledgeably and consistently.

You can choose to contact them by writing to:

Customer Resolutions Team
Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

Or

Email: aamihealthcomplaints@nib.com.au

Your Case Manager will aim to contact you with a decision usually within 5 working days of making contact with you over the phone and within 15 working days for all other correspondence.

Step 3: Seek an external review of the decision

We will make every possible effort to resolve your complaint to your satisfaction. In the event that you are not satisfied with the outcome of your complaint, you may wish to contact the Private Health Insurance Ombudsman.

Phone:	**1300 362 072** (option 4 for private health insurance)
Email:	**phio.info@ombudsman.gov.au**
Mail:	GPO Box 442 CANBERRA ACT 2601
Fax:	02 6276 0123

Or submit a form online at www.ombudsman.gov.au

For more information about the Private Health Insurance Ombudsman visit **www.ombudsman.gov.au**

Notes

nib proudly supports and complies with The Private Health Insurance Code of Conduct. A copy of the Code is available at privatehealth.com.au/codeofconduct

Going to hospital?

Contact us before you go to hospital or undergo a new course of treatment to make sure you are covered under your Policy.

Need help?

Call us on **13 22 44**

Mon to Fri: 8am – 8.30pm Sat: 8am – 1pm (AEST)

Go to **aami.com.au/health**

AAMI HEALTH INSURANCE

nib369607_09112018