Your Membership Guidelines

Welcome to GU Health

- About your Membership
- Important information for Overseas visitors
- Your responsibilities as a Member
- Government incentives and surcharges

This publication is effective July 2023.

GUHealth

This guide is a summary of GU Health's fund rules and policies. It outlines your Membership entitlements and responsibilities, including the terms and conditions of your cover.

Read this guide carefully in conjunction with *Your Cover at a Glance, Your Plan Information and Your GU Health Welcome Book,* and keep a copy for your records. The information contained within this document is current from the publication date and is subject to change. To access the latest version visit **guhealth.com.au**

If you're planning a treatment for which you anticipate a benefit from GU Health, contact us in advance to confirm your benefit entitlement.

To access a copy of our current Fund Rules visit **guhealth.com.au**, at the bottom of the page click on Fund Rules. For further information about your GU Health cover or queries in relation to this document, please contact your GU Health Member Relations Team **1800 249 966** or you can email us at **corporate@guhealth.com.au**.

This publication is effective November 2022.

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Going to hospital

01 SECTION

Our hospital plans can take care of many costs associated with a hospital admission, such as accommodation, theatre fees and surgeons' fees. To get the most out of your GU Health Membership and understand your benefit entitlements, it's important to familiarise yourself with the conditions of your Hospital Cover as well as your benefit entitlements. Wherever possible, plan your hospital admission in advance so that you have a thorough understanding of what to expect from your health plan when going to hospital. If your hospital plan has an excess you may also be required to pay the excess prior to, or after, your hospital stay.

Eligible hospitals

Depending on your level of cover, your hospital accommodation and theatre fees are typically covered in either a public hospital or a partner private hospital (including day and overnight stays for services where you're admitted as an inpatient). **Some levels of Hospital Cover provide benefits for all public and private hospitals Australia wide, so it's important to refer to *Your Plan Information* for details specific to your plan.**

Partner private hospitals

If your level of cover provides benefits for partner private hospitals, you can choose to be treated as a private patient in a private hospital contracted with GU Health. Partner private hospitals are facilities that have entered into an agreement with us. These agreements mean that you'll be covered for inpatient accommodation and theatre fees for contracted hospital services, less any excess that you may be required to pay based on your level of cover.

A small number of hospitals may charge a fixed daily fee. If this is the case, the hospital should inform you of this fee when you arrange your booking. This fee is paid in addition to any hospital excess you may have to pay.

Non-partner private hospitals

In the event you're admitted to a private hospital where no agreement exists you'll only receive restricted benefits. This means the amount we pay is a set amount and may not cover the full cost of your stay and you may incur large out-of-pocket costs. If you choose to proceed with your admission, please ask the hospital to explain the out-of-pocket costs that will apply for your specific procedure. **Please refer to the section on Restricted benefits in this guide for more information.**

On selected plans there will also be a benefit limit of $300 per person per Membership year for in-hospital pharmaceutical drugs so check ***Your Plan Information* for more details**.

We recommend that you check to ensure your chosen hospital is listed as a partner private facility before commencing your hospital treatment. We have agreements with a range of private hospitals throughout Australia, and you can visit our website **guhealth.com.au** and **use the 'Find a provider' search function, or contact your Member Relations Team for details**.

Inpatient versus outpatient treatment

Inpatient services are hospital treatments that result in an admission to hospital. Hospital visits that don't result in an admission are referred to as outpatient services. This includes treatment received in a hospital emergency room and any medical services received outside of hospital.

Public hospitals

If you choose to go to a public hospital, ask admission staff to explain your options as either a public or a private patient. As a public patient, you'll receive treatment by a hospital-appointed doctor and Medicare will cover the cost of your treatment and accommodation and the doctor's fees.

Choosing to be treated as a private patient in a public hospital requires you to sign an election form; this should note all the costs relating to hospital and medical fees you will incur. If you do elect to be admitted as a private patient, there is little difference in the care you will be provided (compared to being a public patient), but where possible you should be able to elect a doctor of your choice.

If you're admitted to a public hospital as a private patient for treatment that is covered in your hospital plan, we'll pay for the cost of same day or overnight accommodation in a shared room. On selected covers, we may also pay benefits for a private room where available, **so check *Your Plan Information* for more details**.

Medical benefits from GU Health for inpatient services

For Residents

The benefit we pay toward a medical service while you're a private patient in hospital is based on the Medicare Benefits Schedule (MBS). This is a list of fees issued by the Australian Government that sets out the minimum amounts that Medicare will pay towards each medical service listed. It's used by health insurers to determine the benefit they'll pay to members.

If your specialist, doctor or pathology or radiology laboratories connected to the hospital send you a bill for in-hospital treatment, you'll need to claim from Medicare first. The easiest way to do this is via Medicare Two Way. Just complete the Two Way form and the standard Medicare claim form, attach your doctors bills and send them to Medicare. Medicare will pay 75 per cent of the MBS fee and forward it to us. We'll pay our 25 per cent of the MBS fee to the person or businesses who billed you.

In some cases a doctor may choose to charge more than the MBS fee, which may leave you with an out-of-pocket expense, this is referred to as the medical gap. We can help you cover this gap if your doctor chooses to participate in the GU Health Medical Gap Network.

See GU Health Medical Gap Network for more details.

In line with Australian private health insurance legislation, GU Health can't pay benefits for outpatient medical services for Resident Members. Benefits for these services are provided by Medicare only.

For Overseas visitors

If you're an Overseas visitor with reciprocal health entitlements Medicare will cover medically necessary hospital and medical treatment as a public patient.

However, if you choose to be a private patient in a public or private hospital, Medicare won't pay any benefits. As a private patient with or without reciprocal health entitlements we'll pay benefits for your treatment in line with your level of cover. **Please refer to *Your Plan Information***.

Medical gap

If you're a Resident who has GU Health Hospital Cover you'll be covered for the difference between the benefit paid by Medicare and the Medicare Benefits Schedule (MBS) fee for eligible services performed while you're in hospital.

However, some doctors and specialists may charge more than the MBS fee, which may result in out-of-pocket expenses. This difference is known as the medical gap. Your doctor should provide you with Informed Financial Consent before your treatment begins. This document outlines all the charges and out-of-pocket expenses you may incur.

If you're an Overseas visitor, **please refer to *Your Plan Information* for details** of the level of cover provided. If your cover pays less than 100 per cent of the total cost, you may also experience out-of-pocket expenses associated with the medical gap. Therefore it is important to discuss possible out-of-pocket costs with your doctor.

GU Health Medical Gap Network

You should always ask your doctor if they'll be participating in the GU Health Medical Gap Network before your admission to hospital.

If your doctor or specialist has agreed to use the GU Health Medical Gap Network, we can help pay some or all of the medical gap. They will need to tell you in advance what the cost of service will be and if they will charge a higher amount called a 'known gap'. This will be a payment you will need to make to cover the difference between the Medical Gap benefit and their fee. Providing you with an estimate of their charges is known as Informed Financial Consent. **See the section on Informed Financial Consent**.

Please note that doctors who agree to use the GU Health Medical Gap Network do not automatically provide a no gap or known gap service. They may choose to make this decision on a case-by-case basis so you must ask the doctor if they will participate in the scheme for each admission you arrange.

If a doctor agrees to participate, they should send their bill directly to us. If the doctor gives the bill directly to you, and they have charged under the GU Health Medical Gap Network cover, it's important that you send your claim directly to us for processing – **don't send it to Medicare first**.

If a GU Health Medical Gap Network claim is processed by Medicare first, we will not be able to pay above the Medicare Benefits Schedule (MBS) fee and cover the agreed gap.

Please keep in mind that GU Health Medical Gap Network cover doesn't cover costs such as hospital excess, or services such as blood tests and x-rays provided by pathologists and radiologists. In addition GU Health Medical Gap Network cover will only cover medical services provided during your inpatient hospital stay. Any Consultations before and after your hospital stay won't be covered under the scheme, including any administration and booking fees that may be charged.

Informed Financial Consent

It's the responsibility of your treating doctor or specialist and the hospital to advise you of potential out-of-pocket expenses before you're admitted into hospital.

It's your responsibility to ensure you understand all the potential costs before your admission to hospital and to discuss your treatment with the hospital and doctor/s. We recommend you contact your Member Relations Team before going to hospital and/or before you undertake any treatment so that you understand your benefits and learn how you may be able to minimise or avoid out-of-pocket expenses.

What's covered in Partner Private Hospitals?

Our partner (or agreement) private hospitals have an arrangement with GU Health that means you'll be covered (depending on your level of cover) for most in-hospital charges such as those listed below, less any incidentals and excess you may be required to pay. **These charges may include**:

- accommodation for overnight or same-day stays
- operating theatre, intensive care and labour ward fees
- medication dispensed in hospital that is approved under the Pharmaceutical Benefits Scheme (PBS) – excluding medication you take home
- allied health services that are directly related to your admission and provided by the hospital (e.g. physiotherapy)
- dressings and approved consumables
- most diagnostic tests (e.g. pathology, radiology)
- surgically implanted prosthesis up to the applicable benefit on the government's Prostheses List
- private room (one bed and private en-suite) where available.

For any Exclusions specific to your level of cover, please refer to *Your Plan Information*.

We recommend that you contact your Member Relations Team before your treatment to understand your benefits and entitlements, including any excess that applies.

What we don't cover

There are hospital costs for which we don't pay benefits, in addition to any specific Exclusions listed under your Hospital Cover. These include:

- for luxury room surcharge
- for admission or booking fees charged by the hospital or specialist
- for in-hospital services not covered by the MBS, including but not limited to practitioner fees for surgical podiatry, most elective plastic and cosmetic surgery, experimental treatments and robotic surgery consumables unless stated on *Your Plan Information*
- medical fees for treatment not listed under the Medicare Benefits Schedule (MBS), except for psychiatric, Rehabilitation and Palliative care
- treatment in hospital as a non-admitted patient (or outpatient), for example emergency room, outpatient Consultations in a doctor's room or Consultations with a nurse
- Special nursing, for example your own private nurse not employed by the hospital
- respite care or where you are deemed a nursing home patient (except where a small benefit is payable as listed under the *Private Health Insurance Act*)
- if you choose your own allied health provider (e.g. chiropractor, dietician or psychologist) rather than the hospital's practitioner for services that form part of your in-hospital treatment
- pharmaceuticals and other supplies not directly associated or essential to the reason for your admission
- pharmacy items dispensed upon leaving the hospital
- instances where a treatment is excluded under your cover extends to any associated hospital services, for example medical gap, prosthesis and pharmacy
- the gap on Australian Government approved prostheses, including gap-permitted items and the gap for prostheses in non-agreement private hospitals
- personal in-hospital expenses such as pay TV, Internet (wifi), non-local phone calls, newspapers, boarder fees, meals ordered for your visitors, and any other personal expenses charged to you
- treatments not included under your level of cover, or where a treatment is subject to a waiting period
- for storage and transportation of eggs and similar IVF expenses (please see section on **IVF and other Assisted reproductive services in hospital** for details).
- any claims submitted more than two years after the date of service
- any claims containing false or misleading information
- any claims where you have the right to claim compensation, damages or benefits from another source (e.g. TAC or WorkCover), now or at a later date.

This information is to be read in conjunction with *Your Plan Information*.

Restricted benefits

To offer a lower cost health plan, selected hospital treatments on your chosen cover may be listed as a 'restricted' benefit. This means we will only pay the minimum default benefit, which is determined by the Australian Government and covers you in a shared room of a public hospital.

Going to a private hospital or a private room of a public hospital for a treatment that is restricted will result in large out-of-pocket costs as we'll only cover a limited proportion of your accommodation costs. We'll not cover fees for private hospital theatre, labour ward or costs associated with an admission to an intensive or coronary care unit.

If you wish to be covered in a private hospital, we recommend that you consider selecting a more comprehensive level of cover. Members with restricted benefits for Hospital psychiatric services have a once in a lifetime opportunity to upgrade their cover immediately to private hospital benefits and access the Mental Health Waiver. **Please refer to the section on Hospital psychiatric services for more details**.

On selected covers restricted benefits apply in instances where you're undergoing a treatment which isn't listed under the Medical Benefits Schedule (MBS) such as elective plastic and cosmetic surgery.

Multiple treatments

Subject to the sections below regarding 'Associated treatments for complications and unplanned treatments' and 'Common and support treatments', where a patient undergoes more than one type of hospital treatment during a hospital admission, we will only cover accommodation and theatre fees for the covered treatment performed as part of that admission.

If one or some hospital treatments are covered as a restricted service, we will pay restricted benefits towards any part of the costs associated with that treatment.

If one or some hospital treatments are excluded, no benefits will be paid toward any part of the costs associated with the excluded treatment.

In the event of multiple treatments, the Medicare Multiple Operation Rule may apply to the doctors' and specialists' fees. This affects the total Medicare scheduled fee and, therefore, your out-of-pocket costs.

Additional treatments under your Hospital Plan

Common and Support treatments: When you have a hospital admission, you may receive additional treatments commonly used in conjunction with the in-hospital services listed on your plan, such as a laparoscopy or lumber puncture, we refer to these as common treatments. Also you may have services that are often associated with your hospital treatment such as pathology, anaesthesia and scans, we refer to these as support treatments. Services under these treatment types are listed within the Medical Benefits Schedule (MBS). This means you'll receive benefits for these common and support treatments according to the level of cover you'll receive for your principle hospitalisation.

Associated treatment for complications and unplanned treatments: Sometimes a medical complication can occur during your hospital admission so it's reassuring to know that you have cover for any further unexpected treatment. In the event you require further treatment as a result of a medical complication we refer to this as associated treatment for complications. Associated unplanned treatment is unplanned treatments you may need to have during your planned hospitalisation because your medical practitioner considers the treatment medically necessary and urgent. Both these types of associated treatments will be eligible for benefits at the same level of cover you will receive for your principle hospitalisation.

For example, if your cover provides restricted benefits for your principle hospital treatment, you'll only receive restricted benefits for these additional treatments provided to you during your hospital stay.

Contact your Member Relations Team before your admission to understand the full extent of your benefit entitlements.

Continuous hospitalisation

If you're discharged from hospital and then re-admitted again within seven days – to the same or a different hospital for the same or related condition – the two admissions are regarded as one continuous hospitalisation. If your cover has a hospital excess, you may not have to pay the excess for the second admission.

Emergency room treatment

Treatment received in a hospital emergency department, whether public or private, that doesn't result in an admission, is classified as an outpatient service. Under our Resident covers, benefits are not paid for this type of treatment or for any facility fees which may be charged in private hospital emergency rooms.

If you're an Overseas visitor, benefits are paid in line with the outpatient benefit entitlements which may be available under your particular level of cover.

Accidental injury

In the event that treatment is required as a result of an accident we may require you to:

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

This enables us to determine if the reason for the treatment is directly the result of an accident and not an aggravation of an underlying condition or injury, or related to a compensable claim. **See the section on Third party compensation for more information.**

Benefits we pay for accident-related treatment is in line with the benefits detailed in *Your Plan Information*. We define an accident as an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object requiring treatment from a medical practitioner within seven days of the event. Cover for an accident excludes injuries arising out of surgical procedures, unforeseen illness, drug use and aggravation of an underlying condition or injury.

The accident must have occurred after the date of joining the fund and cannot be a compensable injury.

Hospital admissions within 12 months

Unfortunately, accidents or illness often hit when we least expect. Therefore, it's important to contact us to discuss if the pre-existing condition waiting period applies to you. Psychiatric, Rehabilitation and Palliative care admissions have a maximum two-month waiting period whether or not the condition is pre-existing. For other conditions, if you make a hospital claim in the first 12 months of your Membership or where you have upgraded your cover, we will ask you to get your consulting doctors (e.g. your dentist, GP or specialist) to complete a medical report. Please consider this when you agree to a hospital admission date, allowing sufficient time for us to carry out the medical report assessment and your eligibility for benefits.

In the case of an emergency, we may not have time to confirm your eligibility for hospital benefits so this could mean that you may incur large expenses if you are assessed as having a pre-existing condition and haven't held your current cover for more than 12 months.

For example, you may need to pay some, or all of, your hospital and medical charges if:

- You choose to be treated as a private patient at either a public or private hospital.
- We later determine that your condition was pre-existing.

To avoid unexpected out-of-pocket expenses in emergency situations you may prefer to be admitted as a public patient.

In addition, private hospital emergency room fees are not covered under any Resident cover plans. If you're an Overseas visitor and are covered for outpatient services, **please refer to the outpatient services section of *Your Plan Information*.**

IVF and other Assisted reproductive services in hospital

Services included in this category are used to treat infertility and include assisted reproductive procedures such as In Vitro Fertilisation (IVF) and Gamete Intra Fallopian Transfer (GIFT).

If you're covered under a Resident plan which includes benefits for Assisted reproductive services, you can only claim for inpatient services (treatment that requires a hospital admission). If the service is classified as outpatient, no benefits are payable from GU Health. For example, egg collection/ harvesting is typically carried out in an operating theatre, where you'd be admitted as a hospital inpatient. On the other hand, Consultations with your doctor at a clinic, scans, ultrasounds, some diagnostic procedures and pathology services are outpatient treatments and may only be claimable through Medicare.

Overseas visitor cover options may provide benefits on eligible treatment for both inpatient and outpatient services.

If you're an Overseas visitor please refer to *Your Plan Information* for details.

It's important to understand the full extent of services associated with your treatment and the level of benefits payable by GU Health and Medicare (where applicable). For example, there may be additional fees you may incur for services such as egg transportation, testing and freezing, storage, as well as costs for certain pharmaceuticals.

We strongly recommend that you contact your Member Relations Team before undergoing treatment to understand your entitlements. This includes obtaining Informed Financial Consent from your doctor and anaesthetist to understand the medical fees being charged and any potential out-of-pocket expenses.

Plastic, reconstructive and cosmetic surgery

Plastic and reconstructive surgery is the treatment of any physical deformity that can be corrected by surgery, whether acquired or congenital. It may include elective cosmetic procedures not recognised by Medicare, or Medicare-recognised clinically-necessary treatments.

Elective cosmetic surgery, along with other non-surgical cosmetic procedures, isn't typically recognised by Medicare (not listed under the Medicare Benefits Schedule). This means you won't be covered by GU Health for any medical costs associated with the surgery. Restricted benefits may be paid for the cost of hospital accommodation only, depending on your level of Hospital Cover.

Plastic and reconstructive surgery on the other hand may be considered clinically necessary and be listed under the MBS. Services may include surgery following burns or traumatic injuries, breast reconstruction and other surgery following removal of cancer/tumour, and similar services.

In cases where the service is recognised by Medicare, and depending on your level of cover, you may be able to receive a benefit from us.

It's important you refer to *Your Plan Information* to understand whether elective plastic and cosmetic surgery or plastic and reconstructive surgery is covered, restricted or excluded under your level of cover.

If these services are excluded, you won't receive any benefits from GU Health.

If the services are restricted, you'll receive minimum benefits. It's likely you'll have out-of-pocket expenses. **Please refer to the Restricted benefits section for details.**

If you're planning a plastic and reconstructive surgery procedure, obtain as many details from your doctor as possible (including MBS item numbers, if applicable), and contact your Member Relations Team before booking your treatment so you can fully understand the extent of the benefits you'll receive from us.

Podiatric surgery in hospital

Only a podiatric surgeon who holds specialist registration in the specialty of Podiatric surgery under the National Law is recognised by GU Health. Not all hospital plans cover Podiatric surgery (provided by a registered podiatric surgeon) as an inpatient in hospital.

If you're being admitted as a private patient for Podiatric surgery, please consider the following:

- Coverage for treatment for investigations and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, is limited to cover for:
  - accommodation; and
  - the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules.
- **No benefits are payable for:**
  - theatre fees
  - podiatric surgeon's fees
  - other participating doctors, such as anesthetists and radiologists
  - outpatient Podiatric surgery performed in the podiatrist's rooms.

Most podiatric surgeons are aware that health funds pay limited in-hospital costs for their services. We recommend that you request a quote from your podiatrist and associated anesthetists before undergoing treatment so you fully understand any out-of-pocket expenses.

If you have Extras Cover that includes benefits for podiatry, you can claim podiatrist's Consultations fees under your annual podiatry limit, but not any surgical fees.

If the surgery is performed by a registered medical practitioner and/or specialist, such as an orthopaedic surgeon, and the service is listed under the MBS associated with your procedure, you'll receive full benefits in line with your level of Hospital Cover. This includes theatre fees and eligibility for GU Health Medical Gap Network cover (if the doctor participates in the scheme).

Surgically implanted prostheses

Government-approved prostheses have a recommended fee, similar to a recommended retail price. They're classified by the government as 'no gap' or 'known gap' prostheses. We'll pay up to the minimum benefit as set out in the government's Prostheses List. This list includes pacemakers, defibrillators, cardiac stents, Joint replacements, intraocular lenses and other devices that are surgically implanted during a stay in hospital.

If your doctor chooses a 'no gap' prosthesis and it's implanted as part of your hospital treatment, you won't have any out-of-pocket expenses.

If the prosthesis used is listed as a 'known gap' prosthesis, you'll have to pay any gap charged by the hospital. The hospital or doctor proposing to charge you the gap for your prosthesis needs to provide you with Informed Financial Consent. **Please see the section on Informed Financial Consent**. You can ask your specialist to choose a 'no gap' prosthesis where available and medically appropriate for your treatment.

In line with legislative requirements, GU Health's cover options don't provide benefits for non-approved prostheses, including custom-made prostheses.

For a benefit to be paid, the prosthesis must be an approved device and listed on the government's Prostheses List.

Dental surgery in hospital

Benefits for dental surgery in hospital are paid from both your hospital and Extras Cover (if any).

Your hospital costs are covered in line with your hospital level of cover and includes your hospital and anaesthetist fees.

The dentist cannot use the Medicare Benefits Scheme items, so the fees can only be paid where you have dental benefits as part of your Extras Cover and subject to your available annual limit. If you only have Hospital Cover with no extras, you won't receive any benefits for dentists' fees in hospital. The dentist's fees aren't eligible for GU Health Medical Gap Network cover.

Pharmaceuticals in hospital

If you're eligible for Medicare we'll pay benefits toward the cost of in-hospital pharmaceuticals listed under the Pharmaceutical Benefits Scheme (PBS) for your condition.

Benefits are only paid for pharmaceutical items that are essential to your episode of care and approved under the PBS for use in Australia as part of the standard treatment.

We won't pay benefits:

- for contraceptive drugs
- for drugs issued for the sole purpose of use at home (applicable to Resident members only)
- experimental, high-cost drugs and exceptional drugs (unless we've agreed to pay for these items under a hospital contract with one of our partner private hospitals)
- for pharmacy items charged in a public hospital.

If you're an Overseas visitor, you may be charged for PBS pharmaceuticals at a rate determined by the hospital. In these instances, we'll cover you for in-hospital pharmaceuticals in line with your level of cover (including drugs administered upon discharge, if they form part of the admitted episode of care).

High-cost and exceptional drugs

High-cost drugs and exceptional drugs are sometimes used for treatment of cancer and other conditions, and may not be part of the standard treatment. These types of pharmaceuticals are often new and typically not listed under the Pharmaceutical Benefits 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) and aren't covered under private health insurance or included under private hospital contracts. It is the responsibility of the treating doctor, and hospital, to inform you about the potential for large out-of-pocket expenses as a result of high-cost drugs used in your treatment.

Hospital psychiatric services

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

- clinical depression
- anxiety disorder
- post-natal depression
- eating disorders
- bipolar disorder
- drug and/or alcohol addiction
- post-traumatic stress disorder.

It's strongly recommended that you contact us prior to starting psychiatric services to ensure you have an appropriate level of cover. Selected Hospital Covers list these services as restricted so limited benefits will apply.

From 1 April 2018, a Mental Health Waiver was introduced for members on hospital plans with restricted benefits for in-hospital psychiatric services. Members who have served their initial two-month waiting period can upgrade their Hospital Cover to immediately access private hospital psychiatric services and elect to have the two-month waiting period for those higher benefits waived.

To access the Mental Health Waiver, contact your Member Relations Team to discuss upgrading hospital plan options and that you wish to use the waiver to be covered in a partner private hospital for in-hospital psychiatric services. While it's best to upgrade you cover prior to any admission, in situations where an admission is unplanned you have up to five business days from the date of admission to contact us to upgrade your cover.

To be eligible for the waiver, you must have served the initial two-month waiting period for psychiatric services, you have been admitted to a hospital under the care of an Addiction Medicine Specialist or Consultant Psychiatrist and have not previously used this waiver with GU Health or any other fund.

Note: All other applicable waiting periods will continue to apply.
Please contact us for eligibility details.

Rehabilitation

As an admitted hospital patient, Rehabilitation is treatment provided to you to assist in improving or restoring your independence and function following an illness or injury.

Generally, you may undertake a program such as a:

- **cardiac program** – following a heart attack or coronary artery bypass
- **neurological program** – following a stroke or spinal cord injury
- **orthopedic program** – following a hip and/or knee replacement.

These programs may be conducted in a Rehabilitation ward of a general hospital or in a registered Rehabilitation hospital/clinic.

As this service may be listed as restricted on your Hospital Cover we strongly recommend you contact us prior to commencing Rehabilitation treatment to understand your entitlements under your cover. We also recommend you obtain Informed Financial Consent from your doctor(s) to understand the potential out-of-pocket costs you may incur.

Acute care and hospitalisations longer than 35 days

Hospitals must ensure that a certificate is provided to GU Health for any patient who remains in hospital for more than 35 days due to the need for ongoing acute care. The certificate must be completed by your treating doctor and validate that there's a clinical reason you're still in need of medical treatment. A new certificate is required every 30 days thereafter. If you remain in hospital for maintenance care only, after 35 days you'll be deemed as a nursing home type patient.

Nursing home type patients

If you're in hospital awaiting nursing home placement, but not in need of acute hospital care, you'll be classified as a nursing home type patient. In such instances, you may be required to contribute a daily co-payment towards the cost of your hospital stay (co-payments are an amount determined by state government/s).

Travel and accommodation benefits

Depending on your level of Hospital cover, you may be entitled to long-distance travel and accommodation benefits within Australia for yourself and a carer, if you need to travel over 200kms (round trip) to access medical treatment. **Refer to *Your Plan Information* for details specific to your level of cover.**

If you're eligible for this benefit, it will be available to you when you need to travel for a hospital admission. The service you're being treated for needs to be included, or restricted under your level of cover and you need to have served all necessary waiting periods.

The benefit is for travel and accommodation expenses incurred by you and/or your carer. A carer is someone who accompanies you to hospital – it's not someone who visits you. Carer benefits are only paid for one carer per claim, and the benefit is deducted from your annual limits.

To claim travel and accommodation benefits under your Hospital Cover:

- you must submit a completed Travel and Accommodation Claim Form
- the accompanying hospital claim must be paid by GU Health.

In-hospital Carer Benefit

Depending on your level of cover, you may be entitled to an In-hospital Carer Benefit.

If you're admitted as a private patient, this benefit can be claimed to help cover the cost of accommodation and meals for your carer (Partner, family member or caretaker). The carer needs to stay with you in the hospital overnight in order for accommodation and the meal/s benefit to be paid. This benefit does not cover the cost for accommodation anywhere else. Only hospital cafeteria or patient menu meals are covered.

Ambulance cover

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Depending on the state you live in and your level of Hospital Cover, you'll either receive full ambulance cover, or you may be entitled to emergency transport only. **Your benefit level will be outlined in *Your Plan Information*.**

Full ambulance cover

If your level of cover includes full ambulance (and you're not fully covered by a state-based ambulance scheme or subscription) you're covered for Medically-necessary ambulance transport and on-the-spot treatment by a recognised ambulance provider Australia-wide.

Emergency transport only

Emergency ambulance transport specifically refers to urgent life or death-type situations, whether it's riding in an ambulance as a patient or requiring urgent assessment and having paramedics perform life-saving treatment.

Claims for emergency ambulance transportation under our Hospital Covers are only payable in accordance with your level of cover and when the account is coded and invoiced as an emergency transportation by a recognised state ambulance authority. Where available in some states, you may wish to purchase an ambulance subscription to provide you with a broader cover beyond emergency ambulance only.

Eligibility

If you live in Queensland or Tasmania you are covered by your state ambulance scheme and, therefore, no benefits will be payable by us.

As a Resident of NSW or ACT, a levy is included in your Hospital Cover to provide free ambulance services. To qualify for benefits, the ambulance service must be provided by a GU Health-Recognised provider. All state and territory government ambulance services are approved as Recognised providers. This includes ambulance providers contracted to the state government ambulance service for road, sea or air transport.

We'll only pay ambulance benefits in line with your level of cover if you're not eligible to claim the service under your state's ambulance transport scheme and you're not subscribed with an ambulance provider.

If you're eligible for certain concession cards, for example some types of Centrelink cards or the Department of Veterans' Affairs (DVA) card, you may be entitled to free ambulance services. **The above information may be subject to change. Please refer to your local ambulance website to obtain the most up-to-date information.**

What's not covered?

- Transport by a non-recognised service provider, including private providers.
- Ambulance transport that is not medically-necessary, including general patient transport (such as transport from hospital to home or to a nursing home).
- Inter-hospital transport (unless classified as emergency and not covered by the hospital).
- Any ambulance transport required after discharge from hospital.
- Transport from your home, a nursing home or hospital for ongoing medical treatment, e.g. chemotherapy, dialysis (unless certified as medically-necessary and you have full ambulance cover).
- Any ambulance costs that are fully covered by a third party arrangement, including, but not limited to, ambulance subscription or federal/state/territory ambulance service, WorkCover or the Transport Accident Commission.
- Ambulance subscriptions.

Chronic disease management programs

03 SECTION

GU Health's chronic disease management programs may make a real difference to the lives of members suffering from or at risk of chronic disease. Each program employs specific behavioural change techniques that are designed to encourage, negotiate and support positive and sustainable health behaviours. They provide you with ongoing support and motivation to enable you to effectively set and achieve your health goals.

We may determine that you're eligible to participate in one of our chronic disease management programs based on your claims data. If so, we'll send you a letter with more details and invite you to participate in an appropriate program. Participation is completely voluntary and you're free to opt-out at any time.

Understanding your Extras Cover

04 SECTION

Extras Cover includes out-of-hospital services that are not covered by Medicare, such as dental, physiotherapy and optical.

This section provides further details on eligibility and claiming conditions for services which may be included under your Extras Cover. Unless specified otherwise, benefits are only payable for one-on-one Consultations. You can claim on telehealth Consultations for the following services with a Recognised provider: Psychology, Physiotherapy, Dietetics, Speech Pathology, Occupational Therapy, Exercise Physiology, and Podiatry. This is subject to your chosen level of cover, availability at your chosen clinic, policy Exclusions, waiting periods and limits. Telehealth Consultations may not be appropriate for all Consultations.

This isn't a comprehensive list of extras benefits, so please read this in conjunction with *Your Plan Information*. For general Exclusions, please see the section What's not covered, in this document.

Dental benefits

Depending on your selected level of cover, we provide benefits for Dental services based on the itemised treatments listed in the Australian Schedule of Dental Services and Glossary produced by the Australian Dental Association (ADA).

This means an ADA recognised dental item number, indicating the treatment you received, needs to be detailed as part of your dental claim.

We define Dental services within the following categories:

- Preventative dental (scale and clean)
- General dental (simple tooth extractions, basic fillings)
- Major dental (perio and endodontic, crowns, implants and dentures)
- Orthodontics (braces and plates).

Not all of the above Dental services may be covered under your Extras Cover. Please refer to *Your Plan Information* for details.

In determining what benefits are payable towards your dental treatment, we refer to the ADA Dental Services and Glossary and our fund rules. For example, ADA guidelines may indicate a certain dental item number can't be charged with another service during the same visit. We recommend that you obtain a quote from your dentist before undergoing any major treatment, along with a full list of associated dental item numbers.

Orthodontic services

Benefit limits and course of treatment

There are three types of orthodontic limits that may apply:

- An annual limit – annual limit per person, per Membership year (may be combined with other services).
- A lifetime limit – limit per person per lifetime.
- A course of treatment limit – one course of treatment is available every five years (subject to annual and lifetime limits). Treatment commenced within five years of a previous course is considered a continuation of the previous course of treatment.

Claiming orthodontic installment payments

If you're paying your orthodontic treatment in installments, you need to submit a treatment plan along with your first claim. You will need to submit a claim for each payment charged by your provider. Benefits will be paid as outlined under your level of cover and take into consideration your annual and/or lifetime limits. Benefits will continue to be paid while you're undertaking active treatment until the work is completed or the annual/lifetime limit reached.

Claiming up-front payments

If you pay for an entire course of orthodontic treatment up front or make the final payment in advance, then you'll need to provide a treatment plan from your dentist or orthodontist when submitting your claim.

If you're claiming a benefit in the subsequent Membership year/s, you must submit a letter/receipt/account from the provider outlining the patient name, item codes and at least one treatment date in the new Membership year.

What is a treatment plan?

Your treatment plan should include the following:

- patient's name
- item number(s)
- duration of treatment
- treatment commencement date
- **contract type:**
  - estimated/total cost of treatment
  - or instalment financial agreement
  - an itemised invoice or account showing the total cost paid, Date of Service, item code and patient name.

You are only eligible for benefits during the period of active treatment, as indicated by the orthodontist/dentist on the treatment plan, and when treatment provided after the waiting period has been served. If your treatment continues longer than the period indicated, please provide us with an updated treatment plan.

If you're claiming a benefit in the subsequent Membership year/s, you must submit a letter/account from the provider outlining the patient name, item codes and at least one treatment date indicating treatment is still active (e.g. braces are attached) in the new Membership year.

Orthodontic benefits aren't included under all Extras Covers, **please refer to *Your Plan Information* for details specific to your plan.**

Physiotherapy

Physiotherapy benefits are paid for one-on-one Consultations only. If your claim relates to group classes provided by a physiotherapist, benefits cannot be paid under the physiotherapy limit.

Please note physiotherapists may provide exercises in your Consultation that may be considered Pilates in style. If provided within the scope of practice of the physiotherapist, benefits will be payable.

Pharmaceutical benefits

Depending on your level of cover, eligible pharmaceuticals are covered in line with your extras benefit limits after you've paid a sum equal to the Australian Government's highest, current Pharmaceutical Benefits Scheme (PBS) co-payment charge. You must provide an official pharmacy itemised invoice or account/script with the claim.

In order to receive a benefit, the script must:

- include the drug name, strength and quantity
- include the supply/dispensed date
- be for a prescription item that's approved under the government's PBS
- cost above the current PBS amount
- include the patient's and prescribing doctor's name
- include the pharmacist's name, address and prescription number.

Weight loss medication and body enhancing medications (e.g. anabolic steroids and erectile dysfunction drugs) aren't covered unless they're prescribed for the indication by your specialist for treatment of a medical condition or ailment and/or specifically included under your level of cover.

Please contact your Member Relations Team for the latest PBS threshold or refer to the Department of Health website at health.gov.au

Aids and appliances

In order to claim benefits for artificial aids you must have an appropriate level of Extras Cover and have served your relevant waiting period in order to claim for health aids or appliances such as asthma pumps or blood glucose monitors. To be eligible for benefits the aid/appliance must be approved by us, it must be intended for repeated use, used primarily to alleviate or address a medical condition, and not be useful to a person where no illness or injury exists.

GU Health will take into account the following criteria when considering a benefit for an aid or appliance:

- accompanied with a fully itemised invoice
- purchased from an Australian registered business with a valid ABN
- supplied by a specialist medical supplier or pharmacy (unless a specific brand is recommended by the medical practitioner)
- provided and invoiced directly from the treating Allied health professional
- purchased online from a recognised medical supplier
- purchased as new (not second hand)
- shipped from an Australian address.

Unless the aid/appliance is purchased from a recognised association or directly from a GU Health-Recognised provider, you may need to provide a supporting letter (no more than 12 months old) when submitting your claim. This is so we can assess your eligibility for benefit payment. The letter must be supplied by your doctor or a GU Health-Recognised provider.

Please refer to the Aids and Appliances Fact Sheet available on our website. It's best you contact your Member Relations Team for more details before making the purchase and submitting your claim.

Benefits can't be claimed for:

- rental or hire of any aids/appliances
- purchases via online third-party websites e.g. eBay or Amazon
- items which are second hand devices
- any GST, credit card, processing fees or postage charges.

Benefit replacement periods

After your first claim for hearing aids or dentures, we apply a set period of time you have to wait before you can claim further benefits on the purchase of a replacement. These set periods of time are called benefit replacement periods, and vary depending on the particular health aid or device. For example, hearing aids have three years. We believe aids and dentures should last for a reasonable period of time with the right amount of care, and any faults should be covered under warranty. Where required, when a hearing aid is outside the warranty period, claims will be payable for repairs, including replacement parts or re-programming on existing hearing aids, subject to your yearly limit.

Orthotics

Benefits will only be paid for orthotics that are custom made, medical grade or made to measure by a recognised podiatrist; or by a pedorthist or orthotist on behalf of a podiatrist following a biomechanical examination, gait analysis, negative cast or 3D digitised impression taken of the feet. No benefits are payable for orthotics or orthopedic shoes purchased off-the-shelf from a retail store or provider.

Therapies

GU Health will pay benefits towards therapies that are permitted by legislation and are included under your cover. The therapies you are covered for will be outlined in *Your Plan Information*. Payment of benefits applies only for the Consultation and with a Recognised provider in private practice.

Benefits aren't payable for ointment or medications required as part of the treatment. This also extends to remedies dispensed by providers such as naturopaths or herbalists.

From 1 April 2019, in accordance with the *Private Health Insurance Act*, benefits won't be paid on the following list of natural therapy treatments.

Excluded therapy treatments are any of the following services:

Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi and yoga/yogalates.

Therapies such as acupuncture, Chinese herbal medicine and remedial massage will continue to be eligible for benefits under selected Extras plans. **To see if you're covered, please refer to *Your Plan Information*.**

Health Management Services

Only certain GU Health cover options include benefits for health management. To see if you're covered, please refer to *Your Plan Information*.

Health management services include, but are not limited to, classes and programs targeting conditions such as alcohol or drug addiction, weight management, asthma and diabetes, mental health, cancer and coronary health. They may include injury prevention and risk assessments as well. Health appliances must be purchased from a chemist, medical supplier, Recognised provider or a medical association.

In order to claim benefits on health management services that are available under your level of cover, you'll need to show that they are being used to help prevent or improve a specific health condition. It's a legislative requirement that classes/courses can't be covered if undertaken to learn a new skill or for recreational purposes. In addition, benefits are payable only if the service you're claiming for isn't covered by Medicare.

When submitting your claim, you must supply a letter from your doctor or practitioner specifying that the service is required to manage a particular medical condition, and what the recommended length of the treatment is (where applicable). **Alternatively, your doctor can complete a Health Management Form, which can be downloaded from our website at guhealth.com.au under 'Forms and publications'.** The letter and/or Health Management Form is valid for a maximum of 12 months from the date the approval is signed.

Travel and accomodation benefits

Depending on your level of Extras Cover, you may be entitled to long-distance essential travel and accommodation benefits within Australia for yourself and an attendant. **Refer to *Your Plan Information* for details specific to your level of cover.**

If you're eligible for this benefit, it will be available to you when extended travel over 200km (round trip) is necessary for you to access the nearest treatment centre for a disease, injury, illness or condition.

The service you're being treated for needs to be included under your level of cover and you need to have served all necessary waiting periods.

The benefit is for travel and accommodation expenses incurred by you and/or your attendant. An attendant is someone who accompanies you to the treatment and/or to hospital – it's not someone who visits you. Attendant benefits are only paid for one attendant per claim, and the benefit is deducted from your annual limits.

If you're traveling to visit a doctor or a medical specialist but no hospitalisation is required, please supply:

- a copy of the invoice as proof of attendance
- a letter from the referring doctor showing you've attended the nearest treatment centre or practitioner for the required specialist treatment.

Benefits are not payable if your travel and accommodation claim is for a routine check up; for dental and other extras services or if not medically necessary for the management or prevention of a disease, injury, illness or condition. In addition, there's no benefit for services associated with Elective cosmetic surgery, Assisted reproductive services, reversal of sterility or infertility procedures.

School Health Care

Certain cover options may include benefits for School Health Care. This service provides cover for Child dependants included under your Membership if they're injured or require medical treatment while at school, on a school activity or travelling directly to and/or from school.

The benefit is only payable if the medical care is for essential healthcare services and you can't claim benefits from any other source or third party, including Medicare.

In order to qualify for benefits, you need to provide a letter from the school confirming the accident happened at school or on the way to or from school. A completed accident report must also be provided.

What's not covered

05 SECTION

Extras benefits will not be payable:

- where treatment is provided by a practitioner not in private practice
- where a provider is not recognised by us
- for any claims, where the treatment is rendered by a provider to themselves, their Partner, dependant, business partner or business partner's partner or dependant. Where the service includes a cost for materials, we may consider payment towards the purchase and supply of those materials
- when provided in a public hospital
- where Medicare, an Australian Government body or third party provide a benefit
- where services are delivered online or over the telephone, unless part of our approved chronic disease or health support programs
- where services are delivered as a group class or Consultation, unless specifically included in your cover
- services not eligible for health fund benefits as listed under the *Private Health Insurance Act 2007*
- where more than one treatment or Consultation has been charged per patient, per practitioner, per day
- where you have reached your yearly maximum limit and/or lifetime limit
- where a benefit replacement period applies and you have already claimed a benefit in that period
- for treatments or healthcare services required under your employment, life insurance or part of a visa/residency application, (e.g. health checks)
- where treatment is not included under your cover
- where treatment is subject to a waiting period
- for services or items rendered or purchased outside of Australia
- for any claims submitted more than two years after the date of service
- for any claims containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised.

All conditions and benefits apply to claims based on the Date of Service, not the date the claim is submitted. **This information is to be read in conjunction with *Your Plan Information*.**

About your Membership

06 SECTION

Pre-existing conditions

Pre-existing conditions are subject to a 12-month waiting period from the time you join or transfer to GU Health, or upgrade or change to a higher level of Hospital Cover. There is an exception if the service required falls under psychiatric, Rehabilitation and Palliative care, which only attracts a two-month waiting period, regardless of whether the condition is pre-existing or not.

A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which were known or which a medical practitioner appointed by us (i.e. not your own doctor) considers existed at any time up to six months before and on the day you joined us, upgraded or changed your level of cover. This is irrespective of whether you were diagnosed or aware of the pre-existing condition.

We may request further medical evidence when trying to determine your eligibility for benefits. Where required, the determination of whether a condition is pre-existing will be made by a medical practitioner appointed by GU Health. To enable us to make an assessment, you'll need to provide us with all the information we request from you and/or your treating medical practitioner(s). Please consider this when you agree to a hospital admission date so we have sufficient time to review your individual situation.

If you're admitted into hospital without confirming your benefit entitlements and we later determine your condition is pre-existing, you'll need to pay any hospital and medical charges not covered by Medicare – no benefits will be paid by GU Health. If you're an Overseas visitor and not eligible for Medicare, you'll be liable for the full cost of your treatment/admission.

In some cases where you're admitted to hospital for an emergency, we may not have time to assess if the preexisting condition applies. As a result you may have to pay for all or some of the hospital and medical charges.

This is especially the case if:

- you've held your current level of Hospital Cover for less than 12 months
- you're admitted to hospital and choose to be treated as a private patient
- your condition is later determined to be pre-existing.

Waiting periods

A waiting period is a limited period of time during which you and anyone covered under your Membership can't claim benefits for certain treatments. It starts on the date you join GU Health or when you upgrade your level of cover.

If you're new to health insurance, you'll be covered immediately for all treatments except those that attract waiting periods. **Please refer to *Your Plan Information* for details.**

Other than accessing the once off Mental Health Waiver to upgrade your cover for Hospital psychiatric services, if you select or upgrade to a higher level of cover that offers services that you weren't previously covered for a waiting period may apply. This means you won't be eligible to make a claim or a claim for higher benefits until those waiting periods have been served.

Please refer to the section on Hospital psychiatric services for more details.

If the excess on your new cover is lower than the excess on your previous cover, the previous level of excess will apply to pre-existing conditions for the first 12 months under the new cover.

Transferring from another fund or between covers

You don't have to serve waiting periods if you've already done so with your previous registered Australian health insurer and you transfer to a level of cover with comparable benefits with GU Health within 60 days of your old cover ceasing. This is called continuity of cover, and also applies if you move between GU Health plans. If your benefits with us are greater than the benefits payable by your previous fund, you may have to serve waiting periods for the additional benefit. Likewise, if you upgrade between GU Health covers, waiting periods may apply to any services which weren't previously included.

We reserve the right to take into consideration the benefits you've claimed under your previous cover when we calculate your benefit limit for equivalent services under your new cover. Also, if the excess on your new cover is lower than the excess on your previous cover, the previous level of hospital excess will apply to pre-existing conditions for the first 12 months under the new cover.

Please note accrued entitlements and loyalty bonuses are not transferable between funds or covers. If you're coming across from another registered Australian health fund, we'll be notified of your claims history through the Transfer Certificate you supply to us upon joining.

If you're transferring from a recognised international health insurer, you may apply to GU Health and request that consideration be given for waiting periods already served. When submitting your request, please enclose your previous Membership details along with your certificate of cover (documents must be in English or provided with a certified English translation). We reserve the right to assess transfers from international insurers on a case-by-case basis and continuity of cover is not guaranteed.

Changes to your cover

We may, at any time, make changes to your cover. This may include adding or reducing the benefits or services available to you. We'll ensure that we provide you with appropriate notice of these changes in accordance with the *Private Health Insurance Act 2007*, the Australian Consumer Law and the Private Health Insurance Code of Conduct prior to these changes taking effect. If you do not wish to continue under the changed cover, you have the option of transferring to a different cover or cancelling your Membership. If you do cancel, you're entitled to a refund of any contributions you have paid to us in advance.

Excess structures

An excess is an agreed amount that you must pay before benefits can be claimed for certain healthcare treatments. It needs to be paid each excess year. Depending on your selected cover, the excess can be applied on either a per person, or per Membership basis. We also offer nil excess options, unless your cover is pre-determined under a corporate arrangement.

Hospital excess

Depending on your level of cover, the hospital excess may be applied in full or in part upon admission to hospital.

Under most GU Health Hospital Covers, the excess is paid in full by the first person on the Membership to be admitted into hospital within that excess year. It applies to all types of hospital admissions including day/overnight stays. Once the excess is paid in full, no further excess applies within that excess year for any person under the Membership.

Certain covers include an excess that's payable either per admission or per person, up to a yearly maximum. In this case, the excess is payable on admission by any Member on the Membership, unless stated otherwise. For example, on a family Membership you may only be required to pay the excess at the single rate upon being admitted to hospital, up to a maximum of twice per excess year. Some covers don't include an excess, for same-day admissions or for Child Dependants/Non-Classified Dependants/Student Dependants.

Due to various excess types being available, **please refer to *Your Cover at a Glance*** document to ensure you understand the excess arrangement that applies to your particular level of cover.

Overall excess

This type of excess is deducted from any benefit that you receive from us until your excess is paid in full. It's applied to hospital and/or extras services – depending on which benefit you're claiming first – until the excess is paid. In the case of extras claims, annual limits are reduced by the amount that goes towards the excess.

Extras excess

The extras excess is deducted from any benefit you receive from us for extras services, until the excess is paid in full. Your extras annual limits will be reduced by the amount that goes towards the excess.

Excess year

In most cases, your excess year will start on the date you first joined the cover with an excess. A new excess year may begin when a change is made to your excess level or excess structure, depending on the cover option selected. It's important to remember that your excess year may start at a different time to your Membership year.

If you're changing your level of cover and are unsure if this will affect your excess year, contact your Member Relations Team. You can view your excess year online at any time by logging in to Online Member Services at **guhealth.com.au**.

Membership year

Your Membership year determines the time when your annual limits reset each year.

The Membership year on your Hospital Cover is based on calendar year. On some products, excess year and Membership year are the same.

The Membership year on your Extras Cover may vary depending on your level of cover or corporate plan arrangement, and may be affected by changes you or your employer make to your Membership, including if you change your single/family status. Certain cover options or corporate arrangements have a set Membership year that isn't affected by Membership changes.

To view the membership year applicable to your Extras Cover, please log in to Online Member Services at guhealth.com.au.

Benefit limits

Benefit limits may apply on a per person or per Membership basis. Claims are paid and remaining limits calculated based on the Date of Service, which is the date the treatment or service was received, not the date when the claim was submitted to us.

Most corporate cover options pay extras benefits based on a percentage of cost, up to annual limits. A small number of covers pay benefits based on a set dollar amount per service type, up to annual limits. These are called set benefits. Some covers may also include service limits, which means you may only claim a set number of services each Membership year. *Your Plan Information* includes details specific to your Membership.

Annual limits

Extras Covers have set annual limits on the amount of benefits that can be claimed for treatments and services. This is the maximum amount we'll pay in a 12-month period and is based on your Membership year. If the annual limit for a particular service is reached, no further benefits are payable for the remainder of the Membership year.

Annual limits generally apply per person; however, on some covers they're combined under a family limit.

If you're on an Overseas visitor cover designed for members from a country that doesn't have a Reciprocal Health Care Agreement with Australia (non-RHCA), you may also have an overall annual limit on your hospital and medical cover. **Refer to *Your Plan Information* for more details.**

You can check your extras benefit limits online by logging in to Online Member Services at guhealth.com.au.

Per person limits

Each person on your Membership can claim up to the 'per person' limit, except where a combined 'family limit' applies and has already been reached by other members included on the cover.

Per family limits

This is the total combined amount that can be claimed by all members on your cover.

Lifetime limits

A lifetime limit is the total cumulative benefit you can claim for a service in a lifetime. Once this limit is reached no further benefits are payable, regardless of when the Membership year renews.

Benefits under previous cover/s

If you're transferring from another health fund or between GU Health covers, the benefits you've claimed with your previous health fund or cover can be taken into consideration when we calculate your benefit limit for equivalent services under your new GU Health cover. Please keep in mind, accrued entitlements and loyalty bonuses are not transferable between funds or covers. In addition, GU Health does not apply age-based discounts to its current products.

Recognised providers

As a GU Health member, you can choose to see any provider, as long as they're recognised by us. So you can enjoy competitive treatment fees, we've locked in lower rates with our network of dentists, optometrists and physiotherapists who offer their services at a reduced cost for members. They're known as First Choice providers. Visit our website to find out more at **guhealth.com.au/my-membership/find-a-provider**.

A Recognised provider has appropriate qualifications in the field they practice in, and is registered with an appropriate Australian industry body or association relevant to their field of practice. The provider recognition by GU Health is for benefit payment purposes only. It should not be taken or construed in any way as sponsorship; approval of; or a recommendation of the practitioner or therapist's qualifications, skills or services.

Ask your provider if they are recognised with GU Health before you book your Consultation. If they are not registered with HICAPS or recognised with GU Health ask them to contact us via our GU Health website. **The Provider Registration Application can be found under the 'Forms and publications' tab.**

Discretionary benefits

Health insurers in Australia operate within health insurance legislation and internal fund rules and guidelines; therefore, limitations apply in regards to benefits that can be paid. In order to ensure benefit equality for all our members, discretionary benefit payments are generally not considered.

If you believe your request is valid, the service being claimed hasn't been listed as an exclusion and meets the eligibility criteria outlined in this document and in *Your Plan Information,* you can submit it for consideration. **Please send us a written request along with supporting documentation, in a timely manner. GU Health provides no guarantee that such requests will be granted if they don't meet our fund rules.**

Important information for Overseas visitors

07 SECTION

Medicare benefits

The Reciprocal Health Care Agreement (RHCA) provides visitors from countries that have an agreement with Australia, to access Medicare and the Pharmaceutical Benefits Scheme (PBS) for treatment that is 'medically necessary'. This is defined as any ill-health or injury that occurs during the Overseas visitor's stay in Australia and requires treatment before they return home.

The following countries have an RHCA agreement with Australia: Belgium, Finland, Italy, Malta, New Zealand, The Netherlands, Norway, Republic of Ireland, Slovenia, Sweden and the United Kingdom (including Northern Ireland).

RHCA members may have different entitlements depending on the agreement with each country **so please refer to the Department of Health website for further details via health.gov.au.**

If you're an Overseas visitor from a country that doesn't have RHCA with Australia (non-RHCA), you're not entitled to any Medicare benefits.

Eligibility for Overseas visitor cover with GU Health

You're only eligible to be covered on an Overseas visitor cover option if you don't have access to full Medicare entitlements and you're not a Resident of Australia. If you're a permanent Australian Resident or already have access to full Medicare entitlements – through a spousal visa, interim Medicare card or any other means – please contact your Member Relations Team for information about the cover options available to you.

Outpatient benefits

Depending on your level of cover, if you're an Overseas visitor member you may be eligible to claim outpatient services with GU Health. Should your doctor, surgeon, anaesthetist or other medical specialist charge us an unreasonable fee for your medical costs, compared to the standard practice, we reserve the right to investigate the fee.

Repatriation benefit

If you're covered under an Overseas visitor level of cover, you may be entitled to a repatriation benefit, including the repatriation of mortal remains **(please refer to *Your Plan Information* for details specific to your cover).**

If included under your level of cover, this benefit covers you (or another person listed on your Membership), if you suffer an injury or illness during the term of your Membership that is considered to be sufficiently critical in nature and prevents your continued employment in Australia. In such instances, we may pay the cost of your repatriation to your country of origin, including medical supervision if deemed necessary. The benefit is restricted to economy airfare charges only, for a one-way trip on a scheduled flight with a scheduled airline.

In the unfortunate event of death, the cost of repatriating your mortal remains to your home country may be covered by GU Health, if legally permissible.

The benefit limit is for one one-way repatriation per Membership or per person, per Membership year, up to a maximum benefit as outlined in *Your Plan Information*. We reserve the right to assess applications for the repatriation benefit on a case-by-case basis and payment of the benefit is at GU Health's absolute discretion.

Becoming a permanent Resident or qualifying for full Medicare

As soon as you become eligible for full Medicare entitlements, register with Medicare – Services Australia. Once you register, ask for a Lifetime Health Cover (LHC) letter and then immediately contact us to arrange your transfer to GU Health's Resident cover.

It's against GU Health's fund rules for you to remain on an Overseas visitor Membership if you're eligible for full Medicare entitlements.

Ensuring you have an appropriate level of Hospital Cover as a Medicare-eligible Australian Resident is also strongly recommended due to government surcharges, such as the Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC) loading.

Lifetime Health Cover (LHC) loading

Lifetime Health Cover (LHC) loading doesn't apply to Overseas visitors. However, if you become a Resident of Australia you will have until either 1 July in the year following your 31st birthday or 12 months from the day you registered for full Medicare benefits (whichever occurs last) to take out appropriate hospital cover and avoid LHC loading.

Purchasing hospital cover after this date may mean that you'll need to pay an LHC loading of two percent for each year you don't hold cover.

Detailed information about LHC, including exemption categories, is available from the Private Health Insurance Ombudsman (PHIO) website.

Overseas visitors on Resident plans

We strongly recommend that all Overseas visitors purchase an appropriate Overseas visitor cover option. If you don't have full Medicare eligibility, you'll experience significant out-of-pocket expenses if you're covered under a Resident plan. This is because Medicare benefits won't apply to you.

Even if you're from a country that has a Reciprocal Health Care Agreement (RHCA) with Australia and qualify for limited Medicare benefits for medically-necessary treatment, these benefits won't apply if you're admitted to hospital as a private patient.

Australian Government Rebate on Private Health Insurance for Overseas visitors

You may apply for the Australian Government Rebate on Private Health Insurance if you have a Reciprocal Health Care Agreement (RHCA) Medicare card and you're covered under one of our tailored RHCA plans. These plans are specifically designed for Overseas visitors from RHCA countries.

If you don't hold a RHCA Medicare card, you won't be able to apply for the rebate through GU Health. For example, if you're from New Zealand or The Republic of Ireland, you generally won't be issued with a RHCA Medicare card. Therefore any rebate entitlement may be claimed via completing your tax return instead. If you're enrolled under a non-RHCA cover option, it's not possible to apply for the rebate through GU Health.

Private Health Insurance Statement (PHIS)

If you're an Overseas visitor from a country that has a Reciprocal Health Care Agreement with Australia (RHCA), and you're covered under a Complying Health Insurance Product (CHIP), GU Health provides you with a Private Health Insurance Statement (PHIS) every year and every time you make a change to your cover.

It will only provide generic information and won't reflect specific details about your individual cover, such as any discounts.

We encourage you to review your current level of cover to ensure it will meet your future needs.

Temporary Skill Shortage visa (Subclass 482)

The Department of Home Affairs (DHA) provides a set of minimum private health insurance standards for Temporary Skill Shortage (TSS) visa (Subclass 482) visa holders. The standards require Overseas visitors from non-Reciprocal Health Care Agreement (non-RHCA) countries to obtain at least a minimum level of health insurance for themselves and their dependants before they arrive in Australia, and to maintain their cover for the duration of their visa.

If you purchase an appropriate level of Overseas visitor cover with GU Health, we can issue you with a confirmation letter in a Department of Home Affairs approved template confirming your cover meets the minimum standards. You're permitted to purchase a more comprehensive Overseas visitor cover than what is outlined in the minimum standards.

All TSS visa holders terminating their private health insurance with GU Health will be provided with an approved Transfer Certificate and must maintain continuity of appropriate cover with another insurer for the length of their visa. We may notify Department of Home Affairs if you terminate your cover.

Goods and Services Tax (GST)

All health insurance covers that don't meet the Complying Health Insurance Product [CHIP] classification, as set by the *Private Health Insurance Act 2007*, are subject to GST. An individual on such products or product components isn't eligible to receive the Australian Government Rebate on Private Health Insurance.

GU Health members from non-Reciprocal Health Care Agreement (non-RHCA) countries will have GST applied to their hospital and medical products. Members from RHCA countries will have GST applied to their medical product only.

Managing your Membership

08 SECTION

Your GU Health Member Card

Once you join GU Health you'll receive your GU Health Member Card. It's recommended you check your card to ensure all your dependants are listed.

If you have a smartphone, you can access your digital GU Health Member Card through the GU Health App.

Present your card to the hospital upon your admission, or use it to instantly claim on any extras included under your level of cover if your provider has a HICAPS machine.

Terms of use:

- Keep your Membership payments up to date to ensure your card is active.
- Don't leave your card with any service provider or other party.
- Only use the card to claim for services that have been provided to you or another person named on the card.
- The card is not transferrable.
- If your card is lost, stolen or requires changes, please let your Member Relations Team know immediately or request a new card via Online Member Services by logging in to **guhealth.com.au**.
- Return or destroy the old card once a new card is issued.
- Your Member Card remains the property of GU Health.

Membership holder authority

As the Membership holder, you're the only person listed on your Membership who can cancel or suspend your cover. Cancellation may also be requested by GU Health, other funds and/or your employer. **Please refer to the Cancellation of Membership section for further details.**

You can nominate a third party to have the same level of access to your Membership as you do, and to make changes on your behalf (with the exception of cancelling the Policy). **If your Partner is not named on the Membership and you want to give them, or someone else, access to your Membership, you must complete a Third Party Access Form.**

The form can be downloaded from our website at guhealth.com.au.

As the Membership holder, you'll receive most correspondence and benefits associated with the Membership on behalf of every person covered under the Policy, unless prescribed differently by legislation or agreed with GU Health.

If you are the Membership holder, please ensure all those covered under the Policy are aware and agree to you receiving correspondence on their behalf. Also, when you receive updates from us it's important, where applicable, you inform other members listed on your cover of these updates.

Your responsibilities as a Member

09 SECTION

It's your responsibility to let us know of any changes to your circumstances that may affect your Membership.

Some of these circumstances may include but are not limited to the following:

Adding or removing members from your Policy

If you wish to add or remove a spouse or a dependant from your Membership, it's important that you contact us in a timely manner. This includes notifying us if any student dependants on your cover are no longer studying full-time or are dependent on you. We will remove dependants over the age of 21 from your Membership unless we're notified of their student status. You need to contact GU Health at the start of each calendar year to confirm that any dependent student over the age of 21 is still studying.

Keep in mind that your Membership contributions will be affected if the scale of your Membership changes from single to family or vice versa. In addition, if your Partner has Lifetime Health Cover (LHC) loading, adding or removing them from your Membership may affect the overall LHC loading on your contributions.

If the number of dependants on your Membership is changing, this may be a good time to ensure the tier you elected for your Australian Government Rebate on Private Health Insurance (if you're eligible) accurately reflects your household income.

Registering a student dependant

You need to register your student dependant/s under your Membership by providing us with their student number and the details of the educational institution they are attending. It's also important to notify us if/when their student status changes.

A student dependant is anyone covered under your family Membership who is between the ages of 21 and 24 inclusive, without a Partner, dependent on the Membership holder, and studying full-time at an approved Australian school, college or university. This also includes trade apprenticeships and industry, employer or government training schemes.

Changing your address

It's essential that we have your most current address and contact details so that you continue to receive important notices or communication from us. If you move to a different state, your Membership contributions may also change so it's best that you contact us as soon as possible to update your address details.

Separation/divorce

It's possible to remain on the same Membership following a separation or divorce. If this is what you and your Partner decide to do, please keep in mind that any electronic payments (via FastBack) will be sent to the account listed under the Membership. This may mean that claims payments will be made to the Membership holder, regardless of who paid for the treatment. If any disputes arise from separation or divorce, GU Health is obliged to keep the agreement made with the original Membership holder upon joining.

Please note that you can only have one Partner listed on your Membership at any given time.

Planning to have a baby

It's important that if you are planning for a baby and wish to use a private hospital you ensure your health plan includes benefits for pregnancy. Pregnancy and Birth-related services carry a 12-month waiting period for private hospital benefits, so it is important to take out cover or upgrade your cover well in advance before becoming pregnant.

If you have a single Membership, to ensure that your newborn is covered you must notify Us to add a newborn to your health Cover. Immediate Cover is provided under a Policy for newborns if the Policy Holder notifies Us of the birth and requests the newborn become an Insured person under the policy within 2 months after the baby's birth, where the parent/guardian upgrades from an existing single policy.

If you have a family Membership to ensure that your newborn is covered you must notify Us to add a newborn to your health cover. Immediate Cover is provided under a Policy for newborns if the Policy Holder notifies Us of the birth and requests the newborn become an Insured person under the policy within 12 months after the baby's birth.

If you're on Resident cover or if you're an Overseas visitor who is eligible for RHCA benefits, adding your newborn in a timely manner is also encouraged for tax-related purposes (such as the Medicare Levy Surcharge). For more information about the Medicare Levy Surcharge and income thresholds applicable to family Memberships, **please contact the Australian Taxation Office on 13 28 61**. For Overseas visitors, please contact us if your baby has a different residency or Medicare eligibility status than you do.

Having a pre-existing condition

It's your responsibility to advise us if you have any known pre-existing conditions, and to familiarise yourself with any applicable waiting periods.

Remember, a pre-existing condition is a condition where your signs or symptoms were evident up to six months before you joined GU Health or upgraded your level of Hospital Cover. It is not based on the date of your actual diagnosis. Pre-existing conditions carry a 12-month waiting period. **Please refer to the Pre-existing conditions section for further details.** For Overseas visitors, please contact us if your baby has a different residency or Medicare eligibility status than you do.

Leaving your employer

Leaving your employer means you may no longer be eligible for cover under the company's corporate plan. The good news is that you can remain with GU Health by transferring to an individual Membership.

To maintain continuity of cover, you must transfer to a new personally funded Membership within 60 days of leaving your existing company health plan. You'll only need to reserve waiting periods if you're upgrading to a higher cover option, not if you transfer to a level of cover with comparable benefits. Contact your Member Relations Team when you know you're leaving your employer and we'll help to make the transfer easy.

It's important to bear in mind that being without appropriate private health cover may impact your Lifetime Health Cover (LHC) status and could attract the Medicare Levy Surcharge (MLS). **See the Government incentives and surcharges section for details**.

Changing your level of cover

Depending on the type of change you make to your Membership, you may experience a change in:

- contributions
- benefit limits
- benefit entitlements
- excess amount
- excess and/or Membership year
- waiting periods.

If the excess on your new plan is lower than the excess on your previous cover, the previous level of hospital excess will apply until the applicable waiting period has been served. If you are seeking treatment in a hospital, please check the waiting period that applies to your particular pre-existing condition. For most pre-existing conditions the waiting period is 12 months, while for psychiatric, Rehabilitation and Palliative care services, the waiting period is two months, regardless of whether the condition is pre-existing or not.

If you choose to downgrade your plan, you may no longer be able to claim certain benefits. If you upgrade, you may have waiting periods for services not covered on your previous level of cover.

The benefits you've claimed under your previous cover can be taken into consideration when determining your benefit limit under your new cover. **See Transferring from another fund or between covers for details.**

We strongly recommend that you contact your Member Relations Team before you make any adjustments to your cover so that you can fully understand what might change.

Keeping your Membership financial

It's your (the Membership holder's) responsibility to ensure that your Membership remains financial at all times – members can only pay contributions up to 24 months in advance – unless the Membership is fully funded by your employer. If your Membership becomes inactive due to arrears and is not resumed within 60 days of its last 'paid to' date, waiting periods may apply. Your Membership may also be suspended or cancelled if left in arrears for 60 days or more.

We reserve the right to withhold benefit payments for any period where the Membership is deemed 'in arrears'. Your GU Health Member Card may not be active during this time and may not work at HICAPS terminals. Your online claiming through the GU Health App or Flex-eClaim may be compromised. You may also be unable to use GU Health Rewards.

Direct Debit Service Agreement

The Direct Debit Service Agreement sets out your rights and responsibilities and our commitment to you in terms of your direct debit arrangement. It applies to members who pay contributions directly to GU Health via credit card or bank account deduction.

We reserve the right to terminate a Membership if contribution payments are in arrears for more than 60 days.

For more details about your direct debit responsibilities, refer to GU Health's Direct Debit Service Agreement at **guhealth.com.au** or contact us to request a copy.

SplitPay

If your Membership is funded by both you and your employer using our SplitPay solution, you (the Membership holder) are responsible for maintaining member contributions for your component of the cover via direct debit.

Memberships with a SplitPay arrangement may be downgraded, suspended or terminated if in arrears for more than 60 days, depending on the corporate plan arrangement. Please contact your Member Relations Team for more information on conditions specific to your corporate Membership.

Suspension of Membership

Suspension is permitted in the event of Overseas travel or employment for periods greater than one month and less than three continuous years, or if you are unable to pay your premiums due to financial hardship. If you are going Overseas, to suspend your cover you need to let us know your departure and expected return dates, and provide supporting documentation such as copies of travel itineraries or e-tickets before you leave the country.

Suspension and resumption dates will be based on the documentation supplied. Before you depart, we request that you provide us with an active email address you'll be using when you're Overseas so that we can send you any important information regarding your Membership.

If you need to extend your suspension – provided it's within the maximum period allowed – or wish to resume the Membership earlier than when you initially advised, you must let us know in advance.

Once you return from Overseas, you must contact us within 30 days and provide us with appropriate documentation showing your return date so that we can resume your Membership. If you don't reactivate your Membership within 30 days from when you arrived back in Australia and/or on your nominated resumption date, you may incur waiting periods.

GU Health reserves the right to terminate a Membership if suspension guidelines aren't followed.

In addition to guidelines outlined, the following conditions also apply:

- The Membership must have been active for at least one continuous month prior to the suspension request being made.
- If you have paid your contribution in advance and apply to suspend your membership during the period of advance payment, the suspension will end the rate protection that applies to your contribution. In these circumstances, and where a contribution increase occurs during or after the resumption of your Policy, GU Health will calculate an earlier date for the recommencement of contribution payments. This calculation will take into account the proportion of the prepayment remaining and the higher rate.
- The membership must be paid at least one month in advance of the proposed date of suspension.
- If you are suspending due to Overseas travel, you must be departing Australia for a temporary period of time.
- The suspension period must be a minimum of one month up to a maximum period of three continuous years.

- The total period of suspension may be no longer than three years either continuous or accumulative over the lifetime of your Membership.
- The suspension applies to all those covered under the Policy. Partial Membership suspension is not possible.
- Benefits are not payable for claims incurred while Membership is suspended.
- If you haven't served all your waiting periods before your Policy was suspended, you'll need to continue serving them once the Policy is resumed.
- All suspension requests are subject to approval by GU Health.

If you wish to request a suspension due to financial hardship, please contact your Member Relations Team. GU Health reserves the right to assess such requests on a case by case basis.

Important notes:

- Suspended days are classified as days without cover for the purposes of Medicare Levy Surcharge (MLS). Your annual private health insurance tax statement will therefore not include your suspended days when showing the total period during which you held an appropriate level of Private Hospital Cover.
- By contrast, if Lifetime Health Cover (LHC) loading applies to your Membership, days of suspension won't affect your LHC loading as you'll be considered to be maintaining your cover.

For further details see Lifetime Health Cover (LHC) loading under the Government incentives and surcharges section.

Cancellation of Membership

If you're the Membership holder, you have the right to cancel your Membership.

Other parties authorised to cancel your Membership are:

- your employer, if you're covered under your employer's corporate health plan, regardless of whether contributions are funded by you or your employer
- GU Health
- another health fund, as part of a Transfer Certificate request.

Cancellation by GU Health member

As a Membership holder, you have the right to cancel your Membership at any time. This includes Memberships on corporate funded plans. If you wish to cancel your Membership, please provide us with a written request.

Your Partner or dependants are not authorised to cancel your Membership, unless a Financial or Enduring Power of Attorney exists. They can however remove themselves from the Membership.

Cancellation by employer

If your Membership is part of your employer's corporate health plan, your employer has the right to cancel your Membership. In such instances, brokers may also request the cancellation, on behalf of their client (the employer).

If your corporate plan is cancelled by your employer, you can remain with GU Health by transferring to an individual level of cover and paying the applicable contribution.

Please see the Leaving your employer section for more details.

Cancellation by GU Health

Your Membership with us can be cancelled if:

- contribution payments are in arrears for more than 60 days, and/or the allowed period of suspension is exceeded
- you obtain your residency/full Medicare eligibility, and continue to be covered under an Overseas visitor plan option
- you engage in inappropriate behaviour including abuse of GU Health staff
- we believe you have engaged in fraudulent activity, misled or deceived the fund materially or repeatedly. In such cases, we reserve the right to seek compensation from any involved parties.

Breaches of our fund rules, or any other terms of condition of Membership against the fund, can mean your Membership may be terminated or suspended. This can be done at any time by giving you reasonable notice in writing, describing the reason for the cancellation and refunding any contributions you have paid in advance.

Cancellation by another health fund

As part of the Transfer Certificate request, you may provide authority to another Australian health insurer to cancel your GU Health Membership.

Government incentives and surcharges

SECTION 10

The Australian Government Rebate on Private Health Insurance

If you're eligible for Australian Medicare and hold a current Medicare card, you may be entitled to the Australian Government Rebate on Private Health Insurance.

Your rebate entitlements will depend on your household income and age.

The government has set four income thresholds and four corresponding rebate tiers. If you fall within the lowest income threshold, you're eligible for the full entitlement under Base Tier. Individuals that fall into the thresholds that correspond with Tier 1 and Tier 2 will be provided with a lower level of rebate, while those who fall under Tier 3 won't be eligible for any rebate.

In addition to the income test, there's also an age-based test, with a higher rebate applied to anyone between the ages of 65 and 69. This increases again for anyone over the age of 70.

Since 2014, the government adjusts the rebate amount on 1 April every year. The income thresholds may also be subject to change on 1 July each year.

If you're eligible for the rebate, you can choose to receive it as a reduction in your contributions, or as a rebate on your annual income tax return. To receive your rebate as a reduction in contributions, you should advise us of the rebate tier that applies to you. If you're on a company-funded health plan, your employer may nominate a rebate tier on your behalf.

If you don't nominate a rebate tier, the Base Tier will be applied to your Membership as the default. In this instance, as well as in instances where the rebate tier selected doesn't accurately reflect your entitlement as determined by the Australian Taxation Office (ATO), any tax liability or credit will be reconciled when you lodge your tax return.

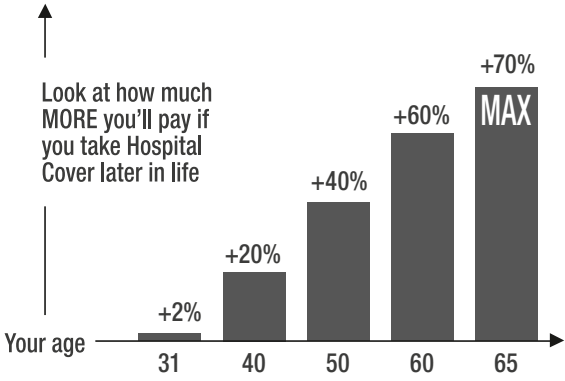
Go to our website at **guhealth.com.au** to view current income thresholds and the tiers associated with the Australian Government Rebate on Private Health Insurance. For further details, visit the ATO website at **ato.gov.au**.

Lifetime Health Cover (LHC)

LHC is a government initiative that was introduced on 1 July 2000 to encourage people to take out Private Hospital Cover at a younger age and lock in lower hospital contribution rates throughout their lifetime. It applies to all Australian Residents born after 1 July 1934.

If you take out an appropriate level of Private Hospital Cover before the end of the financial year in which you turn 31, you'll pay the standard contribution rate that applies to your cover.

However, if you take out Private Hospital Cover after 1 July following your 31st birthday, you'll pay a two per cent loading for each year you're over 30. The loading is applied to your standard hospital contribution rate, not your Extras Cover, and the maximum loading a person can be required to pay is 70 per cent.



Once you've held your paid Hospital Cover for 10 continuous years, any LHC loading will be removed. Please keep in mind that only paid days of cover count towards your 10 year accumulative period, so if there is a period where your Membership is under suspension that period won't be included.

Overseas visitor cover options (including Overseas student health cover, travel insurance and other international forms of insurance) are not considered to be 'appropriate' Hospital Cover for LHC purposes.

There are certain circumstances where you may be exempt from LHC loading, or you're allowed a period of grace beyond your 31st birthday before LHC loading applies.

Some examples of exemption categories include, but are not limited to:

Gaps in cover – to cover small gaps, such as switching from one health fund to another. Once you've taken Hospital Cover, you can use permitted Days of Absence. This means you can be without Hospital Cover for a period totalling 1,094 days during your lifetime, without affecting your LHC loading.

Suspension of Membership – if you suspend your Hospital Cover, the period of suspension won't affect your LHC loading. However, please note that since your Membership is not 'paid' whilst on suspension, your eligibility to have LHC removed after holding 10 years of continuous cover may be affected.

Going Overseas – if you cancel your cover in order to go Overseas, the days you spend outside of Australia don't count towards your allowed 1,094 Days of Absence, as long as you're Overseas for a continuous period of at least one year. You're able to return to Australia for periods of up to 90 consecutive days, per visit, and are still considered to be Overseas. However, if you choose to cancel your cover, keep in mind that waiting periods may apply if you decide to re-join. If you're an Australian tax payer you may be liable for the Medicare Levy Surcharge. **Please see the Medicare Levy Surcharge section for details.**

New migrants to Australia – you have 12 months, from registering with Medicare and being eligible for full Medicare entitlements, to become covered under a Resident Hospital Cover – Compliant Health Insurance Product [CHIP] and avoid LHC loading.

Lifetime Health Cover (LHC) letter

If you're a new Resident, you need to provide us with a LHC letter from Medicare so we can determine whether LHC should apply to you.

Medicare provides the letter to the Medicare cardholder only – health funds cannot request it on your behalf. **To obtain a copy, contact Medicare on 132 011**, send them a request in writing, or visit any Medicare Service Centre in person.

To find out more about LHC and other exemption categories, visit the Department of Health website at **health.gov.au**.

To view if LHC applies to your Membership, go to Online Member Services at **guhealth.com.au** or contact your Member Relations Team.

Medicare Levy Surcharge (MLS)

The MLS is a government scheme that imposes an additional tax on top of the standard Medicare levy. This tax applies to Australian tax payers who don't have Hospital Cover under a Complying Health Insurance Product [CHIP] and whose income exceeds a certain threshold that is nominated by the ATO.

An income test is applied to determine the level of MLS, if any, that applies to you. If your household income is above the 'base' income threshold, there are three different MLS tiers you can fall into. Your MLS tier will depend on your household income.

Income thresholds and the associated Medicare Levy Surcharge rates are available on our website **guhealth.com.au**.

For further information or queries relating to the MLS, please contact the ATO on 13 28 61 or visit their website at ato.gov.au.

Other fund rules and guidelines

SECTION 11

Changes affecting your contribution

In most cases, changes to your contributions will be due to updates you make to your Membership, and/or changes to your circumstances.

For example, your contributions may be affected if you:

- change or upgrade your level of cover
- change your excess level
- change your state of residence
- add or remove dependants, which results in a change of scale
- add or remove dependants who have Lifetime Health Cover (LHC) loading
- experience a change to your LHC status (for example, if we receive a Transfer Certificate from your previous health fund, or you reach 10 years of continuous Hospital Cover)
- update your level of Australian Government Rebate on Private Health Insurance and/or rebate tier
- are on a corporate plan and your employer changes the subsidy arrangement.

Legislative changes may affect the cost of your Membership, particularly if you're claiming the Australian Government Rebate on Private Health Insurance. Your Membership contribution may also change due to adjustments implemented by GU Health. We adjust contributions where necessary to ensure your cover is sustainable into the future.

All contribution increases for Compliant Health Insurance Products [CHIPs] are approved by the government. If your contributions are paid in advance and a rate adjustment takes effect, the new contribution will apply from your next payment.

Changes to your contributions may also occur in the unlikely event that detrimental changes are made to your product or suite of products. If this is the case we're required, by legislation, to provide you with sufficient advance notice.

Third party compensation

If you're injured as a result of an accident and you may be able to claim compensation or damages from a third party, including a workers' compensation claim, you're not eligible to claim benefits from GU Health. This is regardless of whether or not you choose to pursue the claim and includes future costs of treatment.

If we've paid you benefits for services for which you then receive a compensation or damages settlement, you're required to refund us any benefits paid in relation to this incident.

Provisional payment

In certain situations, where a claim for compensation in respect of an injury or a medical condition is in the process of being made or has been made but remains unfinalised, GU Health may use its discretion to review a request for the provisional payment of benefits. Such cases will be strictly reviewed on a case-by-case basis. We reserve the right to recover any provisional payment (or part thereof). For more details contact your Member Relations Team.

Fraud

We regularly conduct claim audits and employ various techniques to monitor unusual treatment and/or claiming patterns. It's against GU Health fund rules to claim for:

- treatment or services which haven't been provided
- falsify documents or alter accounts to increase benefits
- withhold relevant information or provide false information
- engage in any other activity which may damage or defraud GU Health. This extends not only to GU Health members, but also providers and/or any other party.

GU Health will not be liable should an application or claim form contain false or inaccurate information.

If you're a GU Health member who is being investigated for fraud, your claiming ability may be suspended. This includes online claiming via Flex-eClaim and the GU Health App. We reserve the right to prosecute any person who is suspected of being involved in any fraudulent activity relating to our products and/or services.

How you can help:

- Never leave your Membership card with a provider.
- Immediately report to us if your Membership card is lost or stolen.
- Always check the details on your account – especially your electronic claiming account.
- Regularly check your claims history by logging in to Online Member Services via **guhealth.com.au**. Or check your claims history via the GU Health App.
- Report any suspicious activities relating to your Membership or providers, so we can investigate it. **Any information you provide about third parties will be kept confidential unless you advise us otherwise.**

Recovery of monies

We reserve the right to recover any money paid in error, or obtained fraudulently or by any other means contrary to GU Health's fund rules and guidelines.

Broken appointments

Benefits won't be paid for broken appointments, so if you've been charged for not attending or cancelling an appointment, you won't be able to claim for it.

How we protect your privacy

The security of your personal information is important to us and we take strict measures to ensure it's handled responsibly. In addition to complying with Australian privacy laws and regulations, we've obtained an ISO27001 certification, which ensures your data is protected in line with internationally recognised best practice standards.

You have a right to opt-out of receiving any direct marketing material at any time, by simply contacting your Member Relations Team or emailing **corporate@guhealth.com.au**

GU Health's privacy policy is available at **guhealth.com.au**. This Policy outlines the types of personal information we collect, how we use your information, who we disclose your information to, how you may request access to or correction of your personal information, and how to make privacy related enquiries or complaints.

Annual Statement of Claims

When requested by the Membership holder, a private health fund must provide an Annual Statement of Claims. This statement gives a breakdown of how much each person under your Membership has claimed under the categories of medical, hospital, extras and dental treatment in a given financial year. The exact details of each treatment aren't specified. If a Partner or dependant covered under your Membership request privacy over their personal claims, the statement we issue to you won't reflect their information. This statement may assist you if you're applying for the Net Medical Expenses Tax Offset. **Please contact the ATO on 13 28 61** for more details about eligibility and the applicable income thresholds, or visit **ato.gov.au**.

Annual Private Health Insurance tax statement

Your annual Private Health Insurance tax information is available to you when you select the pre-fill option if you complete your annual tax return online. If a tax agent assists you with completing your tax return, the tax agent can also access this information online.

In addition, all eligible GU Health members and Partners who are covered under one of our Complying Health Insurance Products [CHIP] can access a tax statement each financial year. By mid-July, you can download your tax statement from the previous financial year via Online Member Services (OMS). We will also email your statement to you upon request.

If you're an Overseas visitor from a country that has a Reciprocal Health Care Agreement (RHCA) with Australia and you're covered under an appropriate RHCA cover option, you'll also have access to a tax statement via OMS. Overseas visitors covered under non-RHCA options will not be provided with a statement as these products are not classified as CHIP.

You'll need your tax information in order to:

- Claim the Australian Government Rebate via your income tax if you haven't already claimed it as an up-front reduction in your health insurance contributions.
- Enable the Australian Taxation Office (ATO) to make any adjustments necessary if the amount of rebate you've claimed as an up-front reduction doesn't correspond with the amount of rebate you're entitled to (which could result in a credit or a liability).

- Apply for an exemption from the Medicare Levy Surcharge (MLS) if you and all your dependants held an appropriate level of Hospital Cover during the year.

Private Health Information Statements (PHIS)

The Federal Government requires all health funds to provide information about their Complying Health Insurance Products [CHIP] in a consistent industry-set format. This format is called a Private Health Information Statement (PHIS).

We'll provide you with a PHIS when you commence your Membership and/or if you change your level of cover, and at least once every 12 months. We'll maintain and make your PHIS available in accordance with the requirements of the *Private Health Insurance Act*.

The PHIS is a standard industry product summary indicating included services, the product tier and the indicative monthly cost (minus any discounts) in a comparable format. It does not reflect all features of your cover or any corporate discounts you may be entitled to.

For details specific to your Membership, we recommend that you refer to your Welcome Pack or view your cover details through Online Member Services at **guhealth.com.au**.

If you wish to receive a copy of your PHIS, you can contact your Member Relations Team or download a copy from the government website at **privatehealth.gov.au**.

Cooling off period

You're entitled to cancel your Membership and receive a full refund of contributions you have paid within 30 days of your Membership start date or upgrade in cover, provided you haven't made any claims. Contributions under a funded or part-funded arrangement will be returned to your employer.

Code of Conduct

GU Health is a signatory to the Private Health Insurance Code of Conduct. Managed by Private Healthcare Australia (PHA), this is a voluntary industry code. It promotes informed relationships between private health insurers, consumers, and intermediaries (such as agents and brokers). The objective of the Code of Conduct is to maintain and enhance regulatory compliance and service standards of policies across the private health insurance industry.

For a full copy of the code, please visit **privatehealth.com.au/codeofconduct**.

Making a complaint

To ensure your concerns are managed in a timely and efficient manner, your Member Relations Team is trained and authorised to resolve most issues immediately. We have an internal complaints resolution procedure, as well as an escalation procedure, to address your complaint if you're not satisfied with the initial response or resolution provided to you.

You can view our complaint resolution factsheet on our website at **guhealth.com.au**.

Complaints can be lodged by:

Email: corporate@guhealth.com.au

FreeCall: 1800 249 966, Monday to Friday 8.30am to 5pm (AEST)

FreePost to: GU Health, Reply Paid 2988, Melbourne Vic 8060
(no stamp required)

Where possible we like to resolve the issue directly with you. If you believe that we haven't made reasonable attempts to address your complaint or you're not satisfied with our resolution, you can contact the Private Health Insurance Ombudsman.

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman deals with enquiries and complaints about any aspect of private health insurance. **You can contact the Ombudsman for free advice or to lodge a complaint.**

To make a complaint, contact the Commonwealth Ombudsman at **ombudsman.gov.au**

For general information about private health insurance, see **privatehealth.gov.au**

Phone: **1300 362 072**

Related websites

SECTION 12

The following websites may be useful for further information relating to private health insurance:

guhealth.com.au

is GU Health's website. It provides details about private health insurance and allows you to view details of your Membership online via Online Member Services. You can view your cover details and remaining annual limits, claim online using our intuitive online claiming system Flex-eClaim, and much more.

ato.gov.au

is the official website of the Australian Taxation Office. It provides information regarding tax benefits in relation to private health cover, and includes calculators, income testing threshold tables and more.

health.gov.au

is the official website of the Department of Health. Among many other areas, it covers public and private healthcare, Medicare, and provides a link to MBS Online – a listing of item numbers under the Medicare Benefit Schedule (MBS).

homeaffairs.gov.au

Home Affairs brings together Australia's federal law enforcement, national and transport security, criminal justice, emergency management, multicultural affairs and immigration and border-related functions, working together to keep Australia safe.

ombudsman.gov.au

is the official website of the Private Health Insurance Ombudsman (PHIO). PHIO provides an independent service to help consumers with health insurance problems and enquiries.

privatehealth.gov.au

is run by the Private Health Insurance Ombudsman, providing information on private health insurance, government surcharges and incentives, and details on policies available in Australia. This is where you can access and download your Private Health Information Statements (PHIS).

privatehealthcareaustralia.org.au

provides information about private health insurance including various calculators, research papers and statistics. Private Healthcare Australia is the peak representative body for the Australian private health insurance industry.

Definitions

SECTION 13

Accredited practitioner
is a health practitioner who has obtained appropriate qualifications in a profession within the health industry in their field of expertise, and has been accredited by an Australian industry body or association recognised by GU Health.

Assisted reproductive services
are services provided in hospital to assist with fertility, relating to the retrieval and implantation of eggs. **See IVF and other Assisted reproductive services in hospital section for details.**

Birth-related services
are services associated with management of pregnancy, labour, delivery and/or the associated care provided as an inpatient in hospital.

Cataracts
is hospital treatment for surgery to remove a cataract and replace with an artificial lens.

Complying Health Insurance Product [CHIP]
is a hospital, extras or combination health insurance product that complies with the Private Health Insurance Act.

Consultation
is a one-on-one Consultation between a provider and a patient. This doesn't include group session Consultations, visits and/or classes, unless specifically listed as 'group' visits/Consultations under your level of cover.

Dental service
is a service, treatment, item or appliance provided by a registered dentist or dental prosthetist and included in the Australian Dental Association (ADA) Schedule.

Dependant
[Note: 'Child Dependant' replaces the current definition of 'Dependant Child']

- **Child Dependant**
  means a person who is not a Membership Holder or Partner and who:
  a. is aged under 18 years of age; and
  b. does not have a Partner; and
  c. includes a Foster Child, (as defined in the Fund Rules) legally adopted child or stepchild.

[Note: 'Non-Classified Dependant' is a new definition]

- **Non-Classified Dependant**
  is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Membership Holder or Partner who:

a. is aged 18 to 20 (inclusive); and
b. does not have a Partner; and
c. includes a Foster Child, (as defined in the Fund Rules) legally adopted child or stepchild.

[Note: 'Student Dependant' replaces the current definition of 'Student Dependant']

- **Student Dependant**
  is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Membership Holder or Partner who:
  a. is aged 21 to 24 (inclusive); and
  b. is receiving full-time education at a school, college or university; and
  c. does not have a Partner.

Elective cosmetic surgery
is any treatment, surgery or procedure that's not medically required and for which a Medicare item number isn't allocated under the Medicare Benefits Schedule (MBS). **Please refer to the Plastic, reconstructive and cosmetic surgery section for details.**

Eye (not cataracts)
is hospital treatment for the investigation and treatment of the Eye and the contents of the Eye socket.

For example: retinal detachment, tear duct conditions, Eye infections and medically managed trauma to the Eye. Laser surgery (e.g. Lasik) isn't covered as it's not listed under the MBS. **Cataract procedures are listed separately under their own clinical category.**

Exclusions
are any services listed as 'Exclusions' under Your Plan Information for which benefits aren't payable, including general Exclusions outlined under the section What GU Health does not cover.

Flex-eClaim
is GU Health's online claiming system.

GU Health App
is available on the App Store and Google Play. You can access photo claiming and check your cover and remaining benefits. The app also gives you access to GU Health Rewards.

Heart and vascular system
is a hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins, open heart and bypass surgery, insertion of stents or pacemakers or defibrillators, and other invasive cardiac procedures such as angiograms.

Hospital psychiatric services
is private inpatient treatment received in a partner private or public hospital that's licensed to provide psychiatric services, and where the reason for admission was for the treatment of a psychiatric condition through a program approved by GU Health.

In-hospital midwifery services
are covered only if a midwife is registered in private practice and is recognised by us for benefit purposes. Services provided by midwives not registered in private practice aren't covered. This means that if you're seeing a midwife at the hospital for birthing or pre/post natal care they must be in private practice and not an employee of the hospital.

Joint replacements
is a hospital treatment for surgery for Joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint, spinal disc replacing it with an artificial joint (prosthesis) to restore the functionality of the joint.

Joint fusions are listed under the service category Bone, joint and muscle. Spinal fusions are listed under the service category Back, neck and spine Joint reconstructions are listed under the service category Joint reconstructions.

Medicare – Services Australia
is the national health scheme operated by the Australian Government that provides protection against the costs of essential medical and hospital care. It's funded by a Medicare levy that applies to most Australian tax payers.

All permanent Australian Residents, regardless of age or personal circumstances, are eligible to participate in Medicare. Medicare may also provide 'medically necessary' treatment to Overseas visitors from countries that have a Reciprocal Health Care Agreement (RHCA) with Australia.

Medicare Benefits Schedule (MBS)
is a schedule of fees for medical services set by the Australian Government, listing a wide range of medical Consultations, procedures and tests that are eligible for Medicare benefit payments.

Medically-necessary ambulance
is when a medical practitioner would recommend an ambulance service to be used for the purpose of preventing, diagnosing, or treating a condition that is in accordance with accepted standards of medical practice, clinically appropriate and not primarily for the convenience of the patient.

Membership
means a health insurance Policy that covers eligible benefits for hospital treatment, or a combination of hospital and extras treatment.

Membership holder
is the person in whose name the Membership is registered.

Family Membership
can include the Member (Membership holder), their Partner, and all Child and Non-Classified Dependants up to the age of 20 (inclusive) or, if registered as a Student Dependant, up to and including 24 years of age.

Single Membership
a Single Membership covers you, the Membership holder.

Single Parent Family Membership
covers the Membership holder and all Child Dependants up to the age of 18, and Non-Classified Dependants up to the age of 20 (inclusive) or, if registered as a Student Dependant, up to and including 24 years of age.

Midwife-assisted home birth
is a home birth assisted by a registered midwife. This benefit is not included on most GU Health covers, **so please check *Your Plan Information* for**

details. If covered, benefits under this modality are provided for births at home only, not if there's a hospitalisation related to the birth.

Optical service
is an optical appliance (or repair of) such as frames, lenses and contact lenses, provided by a registered optician or optometrist and excludes non-prescription sunglasses. Optical Date of service is the day the glasses/contact lens are ordered.

Orthotics and orthopaedic shoes
are shoes and/or in-shoe appliances used to aid in the management of diagnosed conditions of the foot, ankle and lower limb. **Please refer to the Orthotics section for details.**

Overseas visitor
means a person not eligible for full Medicare entitlements who is an Overseas visitor. This includes members from countries that have a Reciprocal Health Care Agreement (RHCA) with Australia who may be eligible for an RHCA Medicare card.

Palliative care
is hospital care provided to a patient whose condition has progressed beyond the stage where curative treatment is effective and attainable, or where the patient chooses not to pursue curative treatment. It provides relief of suffering and enhances the quality of life. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the Palliative care if they are undertaken specifically to provide symptomatic relief.

Partner (spouse)
is a legally married spouse, domestic partner or de facto partner, living together in a bona fide domestic relationship with the Membership holder.

Pharmaceutical Benefits Scheme (PBS)
is the national pharmaceutical scheme funded by the Australian Government that subsidises the cost of pharmaceuticals. Visit the Department of Health website at **health.gov.au** for more information and to view the latest PBS amount.

Podiatric surgery
is the in-hospital surgical treatment of conditions affecting the foot, ankle and lower leg by qualified and registered podiatric surgeons. Refer to the Podiatric surgery section for details.

Recognised providers
are practitioners who meet GU Health's accreditation requirements (see Accredited practitioner definition). For details refer to Recognised providers section.

Rehabilitation
is hospital treatment received in an approved hospital that is licensed to provide Rehabilitation treatment in a program approved by GU Health.

Resident
means a person who is eligible for full Medicare entitlements, for purposes of ensuring you're covered under a Complying Health Insurance Product [CHIP]. This includes people eligible for interim Medicare cards.

Restrictions
are hospital services covered only at the 'restricted' benefit level. This is the amount set by the Federal Government as the minimum benefit a fund

is required to pay for accommodation in hospital. See Restricted benefits under the Going to hospital section for details.

Special nursing
is included on select covers only. To qualify for benefits on eligible covers, the service must be recommended by a registered medical practitioner and provided by a registered nurse in private practice.

Therapeutic Goods Association (TGA)
is a regulatory authority for therapeutic goods (under the Department of Health). The TGA carries out assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard and are safe and fit for their intended purpose. These include goods ranging from vitamin tablets and sunscreens, through to prescription medicines, vaccines, blood products and surgical implants/prosthesis.

You
means a Membership holder and/or a member of GU Health.

We/us/our
means GU Health.

Notes

Notes

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