CUA Health Member Guide

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HEALTH INSURANCE

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Introducing CUA Health

Thank you for trusting CUA Health to protect you and the ones you love. We've been helping Australians care for their health since 1976.

Navigating the Australian health care system and your private health cover can be complicated. That's why we've prepared this CUA Health Member Guide to help you understand the important things about your CUA Health insurance. It summarises our Fund Rules which sets out how your cover works, as well as your rights and obligations under your cover.

Remember, if you have to go to hospital or have any other treatment, call us beforehand to confirm what benefits you're entitled to - we may also be able to help you reduce your out-of-pocket expense. And don't forget to tell us if any of your details change.

CUA HEALTH TEAM

Phone: 1300 499 260
Email: cuahealth@cuahealth.com.au
Web: cuahealth.com.au
Post: Locked bag 2234, Brisbane QLD 4001

Understanding your cover

For specific information regarding your level of cover, this Member Guide should be read in conjunction with your CUA Health Product Summary. It's important that you fully understand your policy, so please read these documents carefully.

The Member Guide and Product Summaries are available to view on our **website**.

For a copy of the Private Health Insurance Statement (PHIS), please visit **privatehealth.gov.au**. You can also request a copy by contacting us on **1300 499 260**.

YOUR MEMBER CARD

You can use your member card to claim directly for some Extras services.

It's important to keep your card safe and advise us immediately if your card has been lost or stolen. CUA Health won't accept liability for the misuse of a lost or stolen card.

MEMBER DISCOUNT

Get a 4% discount on your CUA Health premium when you register to pay your premium by direct debit from a Great Southern Bank transaction account. Full terms and conditions available at **www.cuahealth.com.au/health-discount**

COOLING OFF PERIOD

If you change your mind, you have 30 days from the date of the policy change to make sure you are happy with your policy.

If you ask us to cancel your policy during this period, we'll refund any premiums paid as long as no claims have been made.

CHANGES TO TERMS AND CONDITIONS OF YOUR POLICY

All CUA Health members are subject to the CUA Health Fund Rules, which sets out the terms and conditions of your cover, including the benefits we will pay.

We may change the Fund Rules from time to time, including the benefits under your policy. If a change is detrimental to you, we'll let you know a reasonable time before the change is effective.

For a copy of the current CUA Health Fund Rules, visit **cuahealth.com.au**, call us on **1300 499 260** or email us at **cuahealth@cuahealth.com.au**

MEDICARE ELIGIBILITY

Your Medicare card indicates your eligibility for Medicare benefits. If you hold a Yellow (Reciprocal) Medicare card or no card at all, the benefits we can pay under your Hospital cover will be restricted. In some instances, we may be unable to pay the benefits under your cover, resulting in large out-of-pocket expenses for you.

If you hold a Yellow Medicare card, or are not eligible for Medicare, call us and let us know that you have limited Medicare eligibility. We'll be able to give you more details and see if the cover you've chosen is the most appropriate for your circumstances.

Please refer to the Commonwealth Department of Human Services for more information on Medicare eligibility and benefits.

OVERSEAS VISITORS

CUA Health does not provide cover specifically for overseas residents. If you have previously purchased Hospital cover or have added a family member to your policy as an overseas resident, it may not be the best cover option for you (even though it may be cheaper than an Overseas Visitor Cover), as we may be unable to pay any of the benefits under the cover if you are ineligible for Medicare.

In addition, you may not:

- Be eligible for the Australian Government Rebate on private health insurance
- Be covered for any outpatient consultations with Doctors/Specialists
- Be able to claim inpatient medical services, if admitted to hospital
- Comply with the conditions of your visa regarding health insurance. For example, we do not meet the requirements of a sub class 457 or similar visa

If you proceed with adding a family member or have previously purchased CUA Health Hospital cover as an overseas visitor (that is, you do not hold a green or a blue Medicare card), we will consider that you have read the potential consequences outlined in this section and have made an informed decision to purchase the cover. We strongly recommend that you call us if you do not have full Medicare eligibility to discuss your situation.

Government Initiatives

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

The Australian Government Rebate on private health insurance is a rebate funded by the Federal Government to help you cover the cost of private health insurance. The level of rebate applicable to you is dependent on your age and taxable income.

You can receive this rebate either as a reduction in your premium, or as an offset in your annual tax return. To receive the Rebate as a reduction in your premium, you'll need to complete and return to us the 'Application to receive Australian Government Rebate on Private Health Insurance' form. You can change how you receive the Rebate or change your nominated tier at any time during your membership.

This Rebate does not apply to any Lifetime Health Cover loadings.

For more information regarding this Rebate including current applicable rebate percentages, thresholds and calculating your relevant income, please refer to the Australian Taxation Office, **ato.gov.au/privatehealthinsurance**

If you have not yet applied for the Australian Government Rebate, you can find the form on our **website**.

MEDICARE LEVY SURCHARGE

The Medicare Levy Surcharge (MLS) is a levy paid by Australian tax payers who don't have Hospital cover and who earn above a certain income.

Having any of CUA Health's hospital policies will exempt you from the Medicare Levy Surcharge.

For further information regarding the MLS and the income thresholds that apply, visit the Australian Taxation Office at **ato.gov.au**

LIFETIME HEALTH COVER

The Australian Government's Lifetime Health Cover (LHC) initiative is designed to encourage people to take out Hospital cover earlier in life and to maintain their cover.

Generally, if you don't take out hospital insurance with an Australian registered private health insurer by 1 July following your 31st birthday, you'll pay a 2% loading on top of your normal premium for every year you are aged over 30 up to a maximum of 70%.

The LHC loading is removed once you've held Hospital cover and paid the loading for 10 continuous years.

There are some circumstances when you can have gaps in your Hospital cover without incurring or affecting a LHC loading:

- Short gaps in cover – you can have small gaps in your Hospital cover, such as when switching from one insurer to another, for periods totalling 1094 days during your lifetime without affecting your LHC
- Suspension of policy – if you suspend your policy for overseas travel or financial hardship
- Going Overseas – generally, if you cancel your Hospital cover to go overseas for at least one continuous year, the days you spend outside Australia are not counted towards the 1094 permitted days of absence. However, if during that time, you return to Australia for periods of 90 days or more they will be deducted from the 1094 permitted days of absence.

There are a range of circumstances where you may be exempt from the LHC loading. We recommend that you contact your Accountant, Financial Advisor or the ATO on **13 28 61** for advice on your eligibility for any exemptions.

Please note that MLS may still apply for the periods that you choose to have a break in cover for.

For more information on Lifetime Health Cover loading, visit the Australian Government's private health **website**.

UNDER 30S DISCOUNT

To help improve the affordability of private health insurance for young Australians, the Australian Government allows health insurers to provide premium discounts of between 2% and 10% on Hospital cover for persons aged 18-29 years.

The permitted discount on Hospital insurance premiums is based on a person's age when they became insured under a policy that offered a discount.

The discount rates are shown in the table below.

Person's age at discount assessment date	Percentage
18-25	10%
26	8%
27	6%
28	4%
29	2%
30	0

Once a Policy Holder has a discount, they will retain that discount rate until the age of 41 after which the discount reduces by 2% every year until it is completely removed.

Once applied this discount can only be removed by attaining the age of 41, you moving to a product that does not have a discount or if CUA Health decides to not offer a discount on the product chosen by you.

Managing your Policy

CUA HEALTH MOBILE APP

Download our CUA Health Mobile App via Google Play or the App Store to manage your policy online. You'll be able to:

- Submit Extras claims
- Check your annual benefit limits on Extras services
- Change your contact details
- View policy details
- Find a Doctor
- Order replacement cards

ONLINE MEMBER SERVICES

CUA Health's Online Member Services is a convenient way of managing your policy online. You can sign up at **onlineservices.cuahealth.com.au**

You'll be able to;

- Submit some Extras claims
- Check your annual benefit limits on Extras services
- View policy details
- Change your personal details
- Manage premium payments

WHO CAN MANAGE MY POLICY?

	Type of request	Policy Holder	Partner	Dependants (Over 15 years old)
Change Personal details	Policy Holder details	✓	✗^	✗^
	Partner details	✓	✓	✗^
	Dependant details	✓	✗^	✓
Change Bank A/C	Premium payment	✓	✓	✗^
	Claims payment	✓	Own claims only^	Own claims only^
Update to policy	Change cover	✓	✗^	✗^
	Cancel policy	✓	✗^	✗^
Access to policy details	Policy Holder	✓	✗^	✗^
	Partner	✓	✓	✗^
	Dependant	✓	✗^	✓
Benefits Limit or Quote	Policy Holder benefits	✓	✗^	✗^
	Partner benefits	✓	✓	✗^
	Dependant benefits	✓	✗^	✓
Remove members	Policy Holder	✓	✗	✗
	Partner	✓	✓	✗^
	Dependant	✓	✗^	✓

^Unless otherwise authorised by the Policy Holder. If a member has told us that they wish to be kept private from other people on the policy, only that member will be able to make changes or request information on their policy details.

THIRD PARTY AUTHORITY

A Policy Holder can nominate a third party to deal with us on their behalf. A nominated third party will have similar authority over the policy as the Policy Holder however the nominated third party will not be able to:

- Add or remove other nominated third parties to the policy
- Close the policy
- Remove the Policy Holder from the policy

Nominated third parties must be at least 18 years old and will remain registered on the policy until they are removed by the Policy Holder.

We also recognise other legal arrangements (e.g. Power of Attorney). In such cases, we may also need some further information for identification purposes.

Please speak to us if you wish to give another person (including a partner or dependant) authority to administer your policy.

Managing your Premiums

Your premiums must be paid in advance. You can pay up to 12 months in advance.

The Policy Holder is responsible for the payment of premiums including ensuring that there are sufficient funds to cover a direct debit (if applicable).

PREMIUM PAYMENT OPTIONS

The following payment options are available to pay your premiums:

- Direct Debit – choose your preferred date and frequency and we'll debit the premiums from your nominated account
- Online – make one-off payments with a Visa or MasterCard through our Online Member Services
- Phone – make one-off payments over the phone with Visa or MasterCard

CHANGES TO YOUR PREMIUMS

If we change your premiums, we'll always write to you in advance.

Generally, the new premium won't apply until your first payment after the change is effective. However, the new premium will apply earlier if you:

- Add or remove a family member
- Change your State of residence
- Remove a component of your cover (e.g. Hospital or Extras)
- Reactivate your policy after a duration of suspension

In any of these instances, the new premium will apply from the day the changes take effect on your policy or you reactivate your policy. The amount of premiums you have paid in advance will still be applied to your account, but the date you have paid up to will adjust accordingly.

PREMIUM ARREARS

Your premiums must be paid in advance. If you miss a premium payment, your policy will be in arrears and we won't pay any benefits.

If your premiums are in arrears for more than two months, your policy may be terminated. We will try our best to contact you if your policy is in arrears, and we will also advise you in writing if your policy is terminated.

PREMIUM REFUNDS

If you cancel your policy, we'll refund any premiums paid in advance. Your refund will be calculated from the date of cancellation, provided you have not made a claim after the cancellation date.

Changing your Policy

WHO CAN BE COVERED ON YOUR POLICY

Depending on your type of cover, the following people can be covered on your policy:

	Family Scale			
Who can be covered	**Single**	**Couple**	**Family**	**Single Parent**
Policy Holder – responsible for the membership and payment of premiums	✓	✓	✓	✓
Partner – a person who lives with the Policy Holder in a marital or de facto relationship	✗	✓	✓	✗
Dependants – a child of the Policy Holder or their Partner. The child must not be married or living in a de facto relationship, and be: • Under 23 years old; or • Under 25 years old and enrolled as a full time student*	✗	✗	✓	✓

*Must be at a recognised Australian Educational Institution and with a full-time workload as determined by us. An apprenticeship does not qualify as full-time study.

ADDING OR REMOVING FAMILY MEMBERS

At different life stages, you may need to make changes to who is covered on your policy.

Members will usually be added from the date you advise us. Waiting periods may apply unless they have previously held cover for the same benefits and have not had a break in cover between their old and new cover. Where a member joins a CUA Health policy with a gap in cover of more than 2 months, or no previous cover, all relevant waiting periods will apply.

If joining a CUA Health policy within 2 months of leaving another Australian health insurer, generally we'll recognise any waiting periods already served on a comparable or lower level of cover. Waiting periods will only need to be served if:

- A treatment wasn't covered under the previous cover
- The waiting period for a treatment was not fully served under the previous cover
- The level of cover is upgraded

If your family member transfers to CUA Health on a higher level of cover, we'll pay benefits on the equivalent level of cover with us to their previous policy until any applicable waiting periods have been served. Please note that transferring from another insurer will not re-set annual limits on Extras benefits. Any benefits paid by a previous insurer during the current calendar year will be counted towards the first calendar year of membership with CUA Health.

We will need a Transfer Certificate from your family member's previous insurer to confirm their previous level of cover, waiting periods served and any benefits paid. We also use the information on the Transfer Certificate to verify whether a Lifetime Health Cover loading applies, as this could affect your premiums.

To keep it simple, we'll contact their previous health insurer to obtain the Transfer Certificate on their behalf. Please note that if a direct debit arrangement exists with the previous health insurer and a payment is due soon, it's best to cancel this yourself. If you don't, you should be issued a refund from them.

For adding a newborn to your policy, please see the section ADDING A BABY TO YOUR COVER on page 15.

MOVING? CHANGED DETAILS?

Premiums are determined by the State or Territory that you live in, even if you are only living there for a short time or have a house or PO Box in another state. Also, there could be difference in coverage for some services based on the state you live in. For example, ambulance is covered through a state government levy in NSW, through a state scheme in QLD and paid by health insurers in VIC.

If you move interstate, your premiums will be adjusted to reflect the change from the date you move. It's therefore important that you tell us of any change of address.

It's also important that you keep your phone number or email address updated with us so that we can contact you.

SUSPENDING YOUR POLICY

You can suspend your policy if:

- You've been a CUA Health member for over 12 months,
- Your policy is paid up to your departure date, and
- You're travelling outside of Australia for more than two months.

We won't pay any benefits while your policy is suspended.

Your suspension won't affect any loyalty limits you may have under your cover as the period of suspension will still count towards the years of continuous cover. However;

- The period of suspension does not count towards any applicable waiting periods, and
- You may be subject to the Medicare Levy Surcharge during the duration of your suspension. This is because the Australian Taxation Office (ATO) sees you as not holding an appropriate level of Hospital cover for the period your policy was suspended. Please contact your Accountant, Financial Advisor, or call the ATO on **13 28 61** for more detailed advice

Your policy will automatically be reactivated on the day of your advised return to Australia and premiums will be payable from this date.

If your return date changes, you will need to contact us within 30 days of your arrival into Australia to reactivate your policy. You will also need to provide proof of your revised return date. Please contact us to suspend your policy.

CANCELLING YOUR POLICY

If you cancel your policy, the cancellation will take effect from the date you contact us unless you nominate a future date.

We'll refund any premiums paid in advance as at the cancellation date.

We'll only assess any claims for services provided before your requested cancellation date.

TERMINATING YOUR MEMBERSHIP

We will never terminate your membership on grounds of your health or claim status. However, we may do so if you or someone on your policy:

- Has attempted to obtain an improper advantage or, has committed or attempted to commit fraud or any other criminal act in relation to the operation of CUA Health
- Holds another membership of the same type with another private health insurer (E.g. a Hospital cover with us as well as with another private health insurer. This does not include members having Hospital cover with CUA Health and Extras cover with another private health insurer, or vice versa)
- Has, in our opinion, behaved inappropriately towards CUA Health staff, providers or other members
- Has premiums that are more than 2 months overdue

We will give written notice to the Policy Holder advising of the termination of the membership and the effective date. We'll refund any premiums paid in advance as at the termination date.

Having a baby?

If you're planning to start a family within the next 12 months, it's important to make sure your cover includes Pregnancy and Birth. In order to be covered, you'll need to serve a 12-month waiting period before the baby is born.

If you've switched from another insurer, we will of course recognise any waiting period you've served under any previous cover.

ADDING A BABY TO YOUR COVER

Once your baby is born, make sure they're added to your cover from birth. This is particularly important if they require hospital treatment immediately.

WAITING PERIODS FOR YOUR BABY

No waiting periods will apply to the baby, provided that:

- The policy commenced no later than the child's date of birth;
- The application is received by CUA Health within 2 months of the date of birth; and
- Relevant premiums are paid for the membership.

A Dependent Child that is added to a Single Parent, Couple or Family policy more than 12 months after the date of birth will be added from the date of application and waiting periods apply.

HOSPITAL COSTS

Generally, a newborn isn't separately admitted to hospital as an inpatient because the baby comes under the mother's admission. This means that you won't be charged for hospital accommodation for your baby unless the baby is admitted to hospital (e.g. a special care nursery or intensive care). Unfortunately, this does mean that any paediatric consultations while in hospital won't be covered under your policy.

However, if you're having a multiple birth, some hospitals may have additional charges for hospital accommodation if you have more than one baby. In that case, you'll need to ensure your babies are added to your policy from birth so that we can cover this additional cost under your policy.

Remember, your hospital Excess will apply for the mother's admission, but no Excess will apply for Dependants.

Hospital Cover

Hospital policies can help reduce the cost of inpatient hospital treatment by a Doctor or Specialist as well as hospital costs such as accommodation and theatre fees.

It's important to call us before you receive any treatment so that we can help you understand whether your treatment will be covered, and your potential out-of-pocket expenses.

WHAT'S COVERED?

This depends on your chosen cover. Please refer to your Product Summary, Private Health Information Statement or the website for a list of services and treatments included under your cover.

Where a service or treatment is covered under your policy, benefits will be paid towards the following:

- Hospital accommodation charges in a private or shared room
- Same day admissions
- Intensive care fees
- Theatre fees
- Labour ward fees
- Doctors' fees for in-hospital medical services
- Fees for any supporting doctor e.g. Assistant Surgeon, Anaesthetist.
- Surgically implanted Government approved prostheses
- PBS medications prescribed while you are an inpatient
- Medical Gap for Doctors and Surgeons in hospital

WHAT ISN'T COVERED?

Check your Product Summary or contact us for a list of services or treatments that are excluded from your cover. In addition, we will not pay benefits under your Hospital policy for:

- Outpatient services
- Services or treatments that are subject to a waiting period
- Any Hospital, Medical or Ambulance services received or purchased outside of Australia
- Any period where your policy is suspended or in arrears
- Services which can be claimed as compensation or damages from a third party
- Treatment which is part of a chronic disease management program that is intended to delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease
- Treatment or services if false or misleading information is provided
- Extras services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment
- Any treatment or services provided by a family member
- The cost of residential aged care e.g. nursing homes, aged care facilities or for associated respite care

RESTRICTED SERVICES

Where a service is restricted on your cover, it means that we'll only pay the minimum amount that a private health insurer must contribute towards hospital accommodation charges, as determined by the Federal Government. This is called a 'default benefit'

Default benefits may not cover the full cost of your hospital accommodation and you may be left with large out-of-pocket expenses.

Restricted services include benefits towards:

- Shared room accommodation at a public hospital or a reduced level of accommodation benefits at a private hospital
- Surgically implanted prostheses
- Doctors' fees for in-hospital medical services when you're treated as a private patient
- Medical Gap for Doctor's and Surgeons' in-hospital medical fees

Please note, any excess and/or co-payment applicable to your cover will be charged even where only default benefits are paid.

MEDICAL COSTS

The benefit we pay towards in-hospital medical services is based on the fees set by the Australian Government under the Medicare Benefits Schedule (MBS). If a service is listed in the MBS and is covered under your Hospital cover, Medicare will pay 75% and we will pay 25% up to the MBS fee. Where a Doctor or Specialist charges more than the Medicare Schedule fee, you'll incur an out-of-pocket expense unless they participate in the Access Gap Cover Scheme.

ACCESS GAP COVER SCHEME

Access Gap Cover is a scheme aiming to help eliminate or reduce your out-of-pocket costs for medical or Doctors' fees.

If your Doctor or Specialist chooses to participate in our Access Gap Cover scheme you will have lower or no out-of-pocket expenses.

A Doctor or Specialist can choose to participate in the scheme on a per claim, per treatment and per patient basis. It is important to confirm with your Doctor or Specialist directly prior to treatment to confirm if they will participate in the scheme for your procedure.

Access Gap Cover does not apply to diagnostic services, out of hospital medical services or services not included on your cover. Excess and Co-Payments will still apply.

Access to a list of Doctors and Specialists participating in the Access Gap Cover Scheme is available on our **website**.

When you are admitted to hospital, there are 2 types of costs: fees charged by your Doctor or Specialist, and fees charged by the hospital. The table on the next page explains how to check:

		Agreement Hospital	Non Agreement Hospital	Public Hospital (if admitted as a private patient)
Accomm and Intensive Care Unit (ICU) Charges	Included Service	**CUA Health pays:** the cost of shared room or private room accommodation in hospital or same day facility **Your out-of-pocket expenses:** Any hospital excess/ co-payments applicable to your cover	**CUA Health pays:** A fixed benefit for accommodation and ICU services **Your out-of-pocket expenses:** Any charges above that fixed benefit any hospital excess/ co-payments applicable to your cover	**CUA Health pays:** The default bed fees set by the Federal Government **Your out-of-pocket expenses:** Any charges above the default bed fees and any hospital excess/ co-payment applicable to your cover
	Restricted Service	**CUA Health Pays:** The default benefit set by the Australian Government **Your out-of-pocket expense:** Any charges above the default benefits and any hospital excess/co-payments applicable to your cover		
Theatre Fees	Included Service	**CUA Health pays:** As per our agreement with Hospital **Your out-of-pocket expenses:** Limited to any hospital excess/ co-payments applicable to your cover	**CUA Health pays:** A fixed benefit for Theatre fees **Your out-of-pocket expenses:** Any charges above that fixed benefit	**No charge for theatre applies** **Your out-of-pocket expenses:** Any charges above the default bed fees and any hospital excess/ co-payment applicable to your cover
	Restricted Service	**CUA Health pays no benefit** **Your out-of-pocket expenses:** Any charges by the Hospital for theatre related fees.		
Surgically Implanted Prostheses	Included and Restricted Service	CUA Health will pay the minimum benefit set out in the Federal Government's Prostheses List **Your out-of-pocket expenses:** • Any charge above the minimum benefit on the list • The full cost of prosthesis if it is not on the list		
In-hospital doctors' medical services	Included and Restricted Service	**CUA Health pays:** 25% of the Medicare Benefit Schedule (MBS) fee. Medicare pay 75% of the MBS fee. Or, Access Gap agreed fees if your Doctor participates in the Access Gap Cover scheme. **Your out-of-pocket expenses:** • Doctors participating in Access Gap Cover Scheme: Any charge above the Access Gap Cover agreed fee per service • Not participating in Access Gap cover Scheme: Any charge above the MBS fee per service or full charge if the service not listed on MBS		
In-hospital Diagnostics	Included and Restricted Service	**CUA Health pays:** 25% of Medicare Benefit Schedule (MBS) fee. Medicare pays 75% of the MBS fee. **Your out-of-pockets expenses:** Any charge above the MBS fee per service or full charge if the service is not listed on the MBS.		

Going into Hospital

AGREEMENT HOSPITALS

We have agreements with many private hospitals throughout Australia.

Generally, for services which are included under your Hospital cover, these private hospital agreements mean that you don't have to worry about out-of-pocket expenses for the hospital component of your fees. Please be aware that Doctor or Specialist fees are separate, and you will still need to pay for any Excess or Co-Payments applicable on your policy.

This does not apply to restricted or excluded services. If you receive treatment in an agreement hospital for a restricted service, we will only pay default benefits and you may be significantly out-of-pocket.

No benefits will be paid for any treatment on an excluded service.

NON-AGREEMENT HOSPITALS

If you are admitted to a hospital that we do not have an agreement with and receive treatment which is either included or has restricted cover on your policy, we'll only pay the default benefit and you may have significant out-of-pocket expenses. You'll also still need to pay any Excess or Co-Payment, if applicable.

No benefits will be paid for any excluded treatment or service.

PUBLIC HOSPITAL

Under the Medicare system, any Australian resident admitted as a public patient in a public hospital is entitled to treatment by a Doctor appointed by the hospital, at a time determined by the hospital. Medicare will pay for your accommodation, meals, medical and nursing care, theatre and other fees related to your treatment.

This means that even if you have private health insurance, you can choose to seek treatment at a public hospital instead of a private hospital and be treated as a public patient without having to use your private health insurance.

If you are asked to use your private health insurance when being admitted to a public hospital, there are a few things you should consider:

- Will I have any out-of-pocket costs?
- Do you get to choose who treats you? Or, are you being treated by a hospital appointed Doctor
- Is it your choice of hospital?

- Will you receive a private room?
- Will you have to wait on a public wait list for your procedure if you don't elect to be treated privately?

It is ultimately your choice whether to be treated as a private or public patient irrespective of the type of hospital you choose to attend, and it is important to be informed at every step of the way.

You can call us to discuss your situation and we can provide you with information to help you make an informed decision.

Other things to consider

OUT-OF-POCKET EXPENSES

The benefit we pay towards in-hospital medical services is based on your level of cover for the services under your policy, and whether you are admitted to an Agreement hospital or non-agreement one.

You may incur out-of-pocket expenses for:

- Services which are not medically necessary or treatments that are not eligible for Medicare benefits
- Charges above the Medicare Benefits Schedule
- Admission into a non-agreement hospital
- Treatment for a restricted service
- Personal items (e.g. Newspapers, toiletries, TV etc.)
- Prostheses that are not on the Government list or that are not surgically implanted
- Some pharmaceuticals E.g. high cost drugs, trial medications etc.
- Treatment received from a service provider e.g. Physiotherapist who aren't directly employed by the hospital you're treated in. (Benefits may be payable towards these services if you have an Extras cover)

PROSTHESIS CHARGES

A prosthesis is a surgically implanted artificial item or device such as a pacemaker, defibrillator, cardiac stent (for coronary arteries) and grommets. Provided the surgery is covered on your policy, we'll pay the minimum benefit listed on the Government's Prostheses List (called the Prostheses List in this document).

The Prostheses List includes over 10,000 items together with a minimum benefit and, in some cases a maximum benefit. There may be more than one clinically appropriate prosthesis available for your procedure.

If you choose one (in consultation with your Doctor) that costs more than the minimum benefit, any amounts more than the minimum benefit will need to be paid by you.

If the item isn't included on the Prostheses List, we won't pay benefits and you will be responsible for the full cost of the item. The Prostheses List is available at **health.gov.au**

PHARMACEUTICALS PROVIDED IN HOSPITAL

If you're admitted into hospital, you may be given medication as part of your treatment.

Where your Hospital policy includes coverage for an inpatient service or treatment, and the pharmaceutical provided is directly related to the treatment of the condition for which you are admitted, benefits will apply for Pharmaceutical Benefit Scheme (PBS) medications.

NURSING HOME TYPE PATIENTS

A nursing home type patient is a patient who is in hospital, but not in need of acute hospital care. Benefits for these types of patients are set by the Federal Government.

If you're admitted to hospital for more than 35 successive days, you'll be regarded as a 'nursing home type patient', unless your Doctor certifies your need for ongoing acute care.

This means lower benefits will be paid towards the daily hospital accommodation charge which could result in significant out-of-pocket expenses.

OUTPATIENT SERVICES

Medicare covers 85% of the Medicare Benefit Schedule (MBS) fee when you receive medical services outside hospital, such as visits to your GP or specialists. Treatment in an emergency ward is classified as an outpatient service.

Under Federal Government legislation, health insurers are generally not allowed to pay benefits for outpatient services. Therefore, we won't pay any benefits where you're not admitted to hospital. A rebate may be claimable from Medicare for outpatient services.

EXCESS

An Excess is an amount you contribute towards the cost of your hospital stay or day surgery. Having an Excess is a way of reducing your premium which would otherwise apply to the policy. If your policy has an Excess, the Excess will apply:

- Per adult member, per calendar year (Excess does not apply to Dependants), and
- Per hospital admission, including same day admissions or overnight admissions

If the charge for your first admission is less than the total Excess amount on your policy, any remaining amount must be paid if you're admitted to hospital again in the same calendar year. Any Excess on your Hospital cover will apply even where only the default benefit is paid.

Please refer to your Product Summary, PHIS or contact us to check whether an Excess applies to your cover.

CO-PAYMENT

A Co-Payment may apply to some of our Hospital policies. A Co-Payment is a daily amount that a member pays towards their hospital accommodation costs when admitted to hospital. This may be separate or in addition to any Excess applicable on your cover.

If your cover has a Co-Payment, it will apply:

- Per adult member and
- Per night to a maximum amount per admission

A Co-Payment does not apply to Dependants or to same day hospital admissions.

Please refer to your Product Summary, PHIS or contact us to check whether a Co-Payment applies to your cover.

Hospital Waiting Periods

When you first take out a Hospital cover or if you have upgraded your cover, there's a period you'll need to wait before you're able to claim certain services.

Please refer to your Product Summary for applicable waiting periods.

MENTAL HEALTH WAIVER

If your Hospital cover restricts Hospital Psychiatric services, you can upgrade your cover to one which includes Hospital Psychiatric Services without having to serve the 2-month waiting period. You can only do this once in your lifetime, regardless of whether you've transferred between insurers. You must have already completed an initial 2 months of membership on any level of Hospital cover.

The waiver will only apply to the 2-month waiting period for Psychiatric Services and all other applicable waiting periods will apply.

PRE-EXISTING CONDITIONS

Pre-existing Conditions (PEC) are subject to a 12-month waiting period from when you're first covered for treatment for the relevant condition. A pre-existing condition is defined by law as any condition, illness, or ailment that in the opinion of the medical practitioner appointed by us (not you, or your doctor), you had signs or symptoms of during the six months before you joined a hospital policy, or upgraded to a higher hospital policy. It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed.

A condition can still be classed as pre-existing even if you had not seen your doctor about it before joining the hospital policy or upgrading to a higher hospital policy.

Our appointed Medical Practitioner will decide if a condition is pre-existing based on medical notes and standard medical practice. If the ailment, illness or condition is deemed pre-existing and you have not served the 12-month waiting period, no benefits will be payable. If you already have a hospital policy but have transferred to a higher level of cover, you may only receive the (lower) benefits that you had on your previous level of cover for a pre-existing condition in the first 12 months on your new policy.

Please allow up to five working days for an assessment of a Pre-existing Condition to be made, and you should consider this when you agree to a hospital admission date.

If you're admitted into hospital without confirming your benefit entitlements and your condition is deemed pre-existing, you'll be required to pay any hospital and medical charges not covered by Medicare.

Ambulance Cover

Where it is included in your cover, we will pay benefits towards ambulance services if you do not hold a subscription with an ambulance provider, are not eligible for concession, or a free ambulance transport or state ambulance scheme does not provide cover.

Because most state schemes cover their respective residents within their state of residence only, some states have entered into reciprocal agreements that allow you to be covered for ambulance services when you travel outside your state of residence.

The table below summarises how Ambulance cover works depending on your State of residence:

State you reside in	Cover at home	Cover while interstate
ACT NSW	Private Cover	
VIC NT Country WA	Private Cover or Subscription	
Metro WA	Private Cover	
SA	Private Cover or an SA Ambulance Subscription	
TAS	State Service Scheme Covers you	The State Service Scheme covers you, except in QLD and SA
QLD	State Service Scheme covers you everywhere in Australia	

NSW & ACT
If you have a Hospital cover, you pay as part of your premium an ambulance levy that entitles you to free emergency ambulance transport.

When you receive an invoice for ambulance transport, simply send it to us and we will pay it for you.

QLD & TAS
You are covered under the State service scheme.

VIC, SA, WA AND NT
You are covered for emergency ambulance transport and on the spot treatment under your policy, providing you don't have an ambulance subscription with your state ambulance service.

If you fall outside of your state-based arrangement, including any reciprocal agreements and are not covered for emergency ambulance, you will be covered by CUA Health, providing:

- You hold either a Hospital or Extras policy with CUA Health; and
- The services are provided by a recognised provider.

EMERGENCY AMBULANCE

If you have a Hospital or Extras cover, you're only covered for Emergency Ambulance services provided by a CUA Health approved ambulance provider. We don't pay benefits for ambulance subscriptions and we don't cover you for other ambulance services such as:

- Transfer between a public and private hospital
- Changing hospitals to be closer to home
- Travelling from home to hospital for tests or consultations
- Any transport on discharge from hospital (e.g. hospital to home)
- Any other service classified as non-emergency by the ambulance service

If you want cover for the above circumstances, we recommend you take out an Ambulance Subscription with your recognised state ambulance provider if it's available in your state. This will provide you certainty of ambulance coverage in all scenarios, emergency or non-emergency.

GOVERNMENT CONCESSION HOLDERS

Certain types of concession cards are issued by Centrelink or the Department of Veterans Affairs (DVA) and entitle the cardholders to free ambulance services. These arrangements also vary per state and should be checked directly with Centrelink, DVA or the State Department of Health.

RECOGNISED AMBULANCE PROVIDERS

We'll pay benefits towards Ambulance Services when they are provided by the following providers.

We also pay benefits for Ambulance services that are provided by another provider on behalf of and invoiced by one of the below State Ambulance schemes or for services provided by Royal Flying Doctor Service.

ACT Ambulance Service
Ambulance Service of NSW/NEPT-PTS
Ambulance Victoria
Queensland Ambulance Service
South Australia Ambulance Service
St John Ambulance
Tasmanian Ambulance Service

Extras Cover

WHAT'S COVERED?

Depending on your chosen cover we'll pay benefits towards a wide range of services provided outside of hospital that are not covered by Medicare, like dental, optical, podiatry or physiotherapy.

Please check your Product Summary for specific details of your cover.

With a CUA Health Extras policy, you are not restricted by a network of preferred providers, so you can choose when and where you're treated, and which healthcare provider you see.

CONSULTATIONS

We'll pay benefits for consultations for services covered under your policy, if it's provided by a private healthcare practitioner who is a member of a professional association recognised by CUA Health.

Some services include separate benefits for initial and subsequent consultation. Benefits for an initial consultation are payable up to three times per person per year, up to your annual limits.

If you're unsure if the provider you have selected, or service you require is covered under your policy, please contact us for more information.

WHAT ISN'T COVERED?

Benefits are not payable for any items or services that are:

- Able to be claimed by a way of compensation or damages
- Not included under your level of cover
- Subject to any waiting periods or benefit replacement period
- Where the member has reached their annual limit, sub-limit, or lifetime limit for the item or service, or a group of items or services
- Provided by a family member
- A treatment considered an outpatient service e.g. radium
- For products, goods, services or treatments purchased from or provided by practitioners overseas, whether you buy them in person, by mail order or online

- In relation to sport, recreation or entertainment unless they are a part of a CUA Health approved chronic disease management or a health management program, or wellness plan. For example, you can't claim for any sports club membership, gym membership, or sporting equipment (including footwear or clothing).
- Claimed together with at least one other service which is not covered under the policy and the services are within a 2-hour period by the same provider to the same member
- Products, goods, services or treatments if false or misleading information is provided
- Where a Medicare benefit is payable
- Telephone or Video consultations (exceptions apply)
- Where the treatment or service took place two years or more before the date you lodge the claim

Types of limits

ANNUAL LIMITS

An annual limit is the maximum amount of benefits payable towards services, items or groups of services/and or items within a calendar year. Annual limits are calculated for a calendar year i.e. 1 January to 31 December each year.

If you have changed your cover (or insurer), limits that have been used under your previous level of cover will be carried over and considered when determining the first year limit on your CUA Health policy.

COMBINED LIMIT

A combined annual limit is the maximum amount of benefits you can claim, distributed across a group of services.

SUB-LIMIT

A sub-limit is the maximum amount within an Annual or Combined Limit you can claim towards specific services.

PER PERSON LIMIT

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

PER FAMILY LIMIT

This is the total amount that can be claimed by all members on your policy. This applies to any Single Parent, Couple or Family policy.

LIFETIME LIMIT

A lifetime limit is the total benefit you can claim for this service in a lifetime.

If you have changed your cover (or insurer), lifetime limits that have been used under your previous level of cover will be carried over and considered when determining the lifetime limit on your CUA Health policy.

LOYALTY LIMIT

As a way of rewarding our members for staying with CUA Health, some of our products include loyalty limits. The annual limit will increase over the first three years by a set amount. The loyalty limits are calculated using the anniversary of you joining the policy.

Other things to consider

EXTRAS WAITING PERIODS

When you first take out a Extras cover or if you have upgraded your cover, there's a period you'll need to wait before you're able to claim certain services.

BENEFIT REPLACEMENT PERIOD

A Benefit Replacement Period may apply to Extras items payable under some of our covers. It is a set period you need to wait from the date of purchase for an item before you can receive another benefit to replace the item. This is separate to any waiting periods you may have to serve.

Please refer to your Product Summary to check what Benefit Replacement periods apply to your policy.

HEALTH AIDS AND APPLIANCES

Some of our Extras covers pay benefits towards the purchase and the repair of Health Aids and appliances. Individual sub-limits and benefits apply for each type of Health Aid or Appliance.

If your cover includes Health Aids and Appliances, benefits will be paid subject to the following conditions:

- Benefits for repairs will only be paid if the appliance is not under warranty. The benefits paid for repairs count towards the limit of that Health Aid/Appliance.
- Benefits are payable for custom made braces or orthotics only. No benefit is payable on pre-made or customised items.
- Some benefits may be payable on mastectomy bras and wigs for chemotherapy and alopecia. Please contact us for further information
- Benefits for compression stockings or circulation boosters are payable if they are purchased from approved providers for chemotherapy or lymphedema only.
- No benefits are paid for the rental of a health aids, appliances or devices.

We may ask for additional supporting documentation to pay a benefit for some other health aids and appliances e.g. sleep study report for a CPAP device, proof of custom made orthotics, etc. Benefits are only paid on purchases from companies with a registered Australian Business Number (ABN).

ADDITIONAL EXTRAS BENEFITS

MEMBER DISCOUNTS FROM OPTICAL RETAILERS
From time to time, members with Extras cover are eligible for additional discounts and free services from services providers such as optical retailers.

Refer to **cuahealth.com.au** for details of discounts available at each provider.

BONUS DENTAL CHECK-UPS
Some of our Extras covers include additional general dental benefits to help reduce or eliminate the cost of dental care. These benefits are paid out of the general dental benefit.

Please refer to your Product Summary to see whether your policy includes these services.

HEALTHY START BONUS
Each person covered under the Healthy Start Package receives a $100 credit every year, which can be used to offset any gaps on the Extras services until it has been used up. A new $100 bonus is available each year that you hold the package and any unused portion does not roll over into next year. This benefit is only available under the Extras component of the Healthy Start Package and is not available on other Extras covers.

WELLNESS BENEFITS

Some of our Extras covers include benefits for services that assist with early diagnosis or prevention of an illness or condition.

Please refer to your Product Summary to see whether your policy includes these services, and if any sub-limits apply.

Services covered include the following:

QUIT SMOKING
You can claim benefits towards nicotine replacement therapy (patches, gum, lozenges and inhalers) to assist in quitting or reducing smoking when such services aren't claimable under the PBS.

HEALTH ASSOCIATION FEES & SUBSCRIPTIONS
You can claim benefits towards the membership fees for the Arthritis Foundation, Asthma Foundation, Coeliac Society, Diabetes Australia, Heart Foundation, Crohn's and Colitis Association, Parkinson Australia, Australian Breastfeeding Association and Ostomy Associations to help manage and receive support for these diagnosed chronic conditions or life stages.

HEALTH CHECKS, SCANS & SCREENINGS
Benefits can be claimed for health checks and Healthy Heart checks conducted by a Doctor to assist with early diagnosis and/or prevention of an illness or condition. You can also claim benefits towards some services that assist with early diagnosis and/or to prevent an illness or condition e.g. Health screenings at a pharmacy. However, you can't claim a benefit when the health check is related to employment or immigration requirements (such as pre-employment or pre-visa health checks) or when it can be claimed through Medicare or a third-party insurer.

KIDS' SWIMMING LESSONS
You can claim benefits towards swimming lessons for Dependent Children covered on your policy. The lessons must be provided by an Austswim® or Swim Australia accredited swim school or instructor and recommended by a medical practitioner for the management of a specific health condition. You'll need to provide us with evidence of the medical practitioner's recommendation.

TRAVEL EXPENSES
You can claim travel expenses within Australia when a hospital admission is required for anyone covered on the policy a return distance of 400km away from their usual place of residence. Benefits are not paid for any accommodation required for family members during hospital admission or when no hospital admission is needed e.g. visits to Specialists.

TRAVEL VACCINATIONS
Benefits can be claimed for travel vaccinations when no Medicare rebate is payable.

MAMMOGRAMS
Benefits can be claimed for mammograms when no Medicare rebate is payable.

WEIGHT CONTROL
You can claim benefits towards approved weight management programs that are intended to prevent or manage a diagnosed health condition. Benefits are payable for services when they're part of a health management program and a letter from a medical practitioner must be provided. The letter must include a referral to the program, and clearly outline how the referred program will manage the diagnosed condition and also the expected outcomes. Please note that the food component of any health management programs are not covered.

HEALTH MANAGEMENT PROGRAMS

You can claim benefits towards approved health management programs intended to prevent or manage a diagnosed health condition. Benefits are payable for services where they're part of a health management program or are provided on the advice of a health professional approved by us, and where the treatment is intended to improve a specific health condition/s. A health management program approval form renewal is required every year.

Please note that we can only pay for a Health Management Program when it is:

1. intended to either reduce complications in a person with a diagnosed chronic disease, or prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease;

2. documented in a written plan that:

- specifies the allied health service or services, and any other goods and services to be provided; and
- specifies the frequency and duration of the provision of those goods and services; and
- specifies the date for review of the plan; and
- has been provided to the patient for consent, and consent is given to the program, before any services under the program are provided; and
- co-ordinated by a person approved by us; and who has accepted responsibility for:
  - ensuring the services are provided according to the plan; and
  - monitoring the patient's compliance with the agreed goals and activities specified in the plan

Private Health Insurance (Health Insurance Business) Rules 2018 defines Chronic Disease as a disease that has been, or is likely to be, present for at least 6 months, including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis and a musculoskeletal condition.

Risk factors for chronic disease include, but are not limited to:

- lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and
- biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and
- family history of a chronic disease

You're in good hands
with CUA Health

How to Claim

Before you claim, please remember:

- Invoices for Extras claims under $500 need to be paid in full prior to claiming benefits from CUA Health. For unpaid invoices over $500, the benefit can be paid directly to the provider, with their approval
- Relevant waiting periods will need to be served
- Premium payments must be up to date
- The service must have already been provided and paid for (you can't claim for a service before it's been provided)
- Claims need to be lodged within two years from the date the service was provided
- The healthcare provider must be recognised by us
- You should retain receipts for auditing purposes

HOSPITAL CLAIMS

Claims for treatment you receive in hospital after being admitted will be sent to us for assessment. Please read the claim form carefully, sign and return. If your policy requires you to pay an Excess, then you'll need to pay this directly to the hospital.

MEDICAL CLAIMS

If your Doctor participates in Access Gap Cover Scheme, your account will be automatically forwarded to us for processing. Any medical account you receive should be submitted to Medicare on a 'Two Way' form.

EXTRAS CLAIMS

Most Extras providers offer electronic claiming using your CUA Health member card. Simply swipe your card and all you need to pay for is the remaining balance to your provider. If electronic claiming isn't accessible, one of the following options is available to submit your claim:

CUA HEALTH MOBILE APP

With our mobile app, you can use your smartphone to claim on Extras. To claim, all you need to do is take a photo of your invoice and then submit with just the click of a button.

Our app is free to download and works on iPhone, Android and most tablets. To download the app, just head to the App Store or Google Play and search for 'CUA Health'.

ONLINE
Submit your claim online at **onlineservices.cuahealth.com.au** for the following services:

- General Dental
- Optical
- Physiotherapy
- Chiropractic & Osteopathic
- Occupational Therapy
- Dietitian
- Podiatry
- Speech Therapy
- Exercise Physiology

EMAIL
Complete a claim form available from our website **cuahealth.com.au**, and email your completed form and invoice to **cuahealth@cuahealth.com.au**.

POST
Fill out your claim form, attach your invoice and receipt and post to:

CUA Health Pty Ltd
Locked bag 2234
Brisbane QLD 4001

Benefits will be credited to your nominated bank account, or a cheque will be posted to you if we have no account details registered.

REJECTED CLAIMS

If your claim is rejected, we'll write to you to explain the reason for this. We may also ask you for additional details to assess your claim.

Important Information

COMMUNICATING WITH YOU

We'll use the communication method that you nominate to send all information about your CUA Health cover. You can update your communication preferences at any time on our Online Services Portal or by calling us.

This means that we'll email or post all important notifications like any changes to your cover as well as important documents like your Private Health Information Statements to you in the way that you ask us to.

PRIVATE PATIENTS' HOSPITAL CHARTER

The Australian Government has produced a Private Patients' Hospital Charter to inform health insurance members of their rights.

You can view the charter online or download a copy from **health.gov.au**

PRIVATE HEALTH INSURANCE CODE OF CONDUCT

CUA Health is a signatory to the Private Health Insurance Code of Conduct. The code was developed by the health insurance industry and aims to maintain and enhance regulatory compliance as well as promote the standards of service to be applied throughout the industry. The code is designed to help you by ensuring that:

- You receive the correct information on private health insurance from appropriately trained staff
- You are aware of the internal and external dispute resolution procedures available in the event that you have a dispute with a private health insurer
- Policy documentation contains all the information you require to make a fully informed decision about your purchase and that all communications between you and your insurer are conducted in a way that the appropriate information flows between the parties. This includes staff, agents and brokers who from time to time may interact with you
- That all information between you and your insurer is protected in accordance with national and state privacy principles

A copy of the code is available online at **privatehealth.com.au/codeofconduct**

CHANGES TO YOUR POLICY

All members of CUA Health are subject to our Fund Rules, which set out the terms and conditions of their cover, as well as the services we pay benefits for.

The Fund Rules can be changed from time to time. If any changes will have a detrimental effect on your entitlement to benefits we will provide the Policy Holder with reasonable notice in writing before they are due to come into effect.

Occasionally, we may need to make changes to a health insurance cover. These changes will apply regardless of whether premiums have been paid in advance and may include:

- Closing a cover
- Removing a service or item from a cover
- Reducing or removing a benefit or benefits under a cover
- Adjust the premiums of a cover

If we close a cover you're on:

- We may allow you to stay on the cover, but not make any changes (e.g. adding or removing a member or component of cover). If you want to make a change to your membership, you'll need to select a new cover; or
- We may not permit you to stay on this cover and will move you to a cover as similar as possible. We will advise you in writing if this occurs

If we make a change to your cover and you choose to continue your membership (under the new or changed cover) you will be bound by its terms and conditions. If you do not wish to continue under the new or changed cover you have the option of transferring to a different cover or cancelling the membership.

OTHER IMPORTANT INFORMATION FOR THE POLICY HOLDER

The Policy Holder is the first person listed on the membership. They are responsible for the payment of premiums and have full authority to make any changes to the membership. Please note the Policy Holder must be over the age of 18.

Please note that the Policy Holder:

- receives all correspondence and benefits for the policy on behalf of every person covered under the policy
- agrees to our Privacy notice (page 39) and warrants that every person covered under their policy also agrees to our Privacy Policy
- agrees to the joining statement or change of cover declaration, and so agrees to abide by the Fund Rules and policies and to provide us with correct information required under the cover at all times
- agrees to let us know as soon as possible if any circumstances of anyone on the membership change, or if any of the details we hold change or are incorrect

Complaints

If you have any complaints or concerns, please call us on **1300 499 260** or email us at **cua.health.correspondence@cuahealth.com.au**

One of our team will also assist you, if required, to provide an official complaint in writing to verify our records.

If your concerns cannot be dealt with to your satisfaction immediately, the matter will be referred to a team leader.

If the issue has still not been resolved within five working days of your initial contact, we'll notify you in writing as to the reason why and how long it will take to resolve the matter.

If you're still not satisfied with our service, you may request that the matter be further considered and reviewed by senior management who, after consideration of your situation, will advise you in writing of our decision within 10 working days of your request.

If you're not satisfied with the outcome of any complaint, you may contact the Private Health Insurance Ombudsman. The Ombudsman is available to accept complaints from customers of private health insurer via the following contact details:

- To make a complaint, contact the Commonwealth Ombudsman at www.ombudsman.gov.au
- For general information about private health insurance, see www.privatehealth.gov.au

The Commonwealth Ombudsman can also be contacted via phone on 1300 362 072.

The Ombudsman is totally independent of CUA Health and the health insurance industry and provides free, expert and impartial advice to private health insurers' customers.

Privacy notice

HOW WE COLLECT YOUR PERSONAL INFORMATION

CUA Health Pty Ltd ('CUA Health', 'we', 'us', 'our') wherever possible, will collect information directly from you. This information will generally come from what you provide when you apply for a CUA Health policy or when you ask us to take certain action on your policy e.g. make a claim.

However, in some circumstances, we may also collect information about you from third parties. These third parties include:

- Joint Policy Holders (Partner or Dependants)
- Your agents, representatives and other people authorised by you such as your lawyers and accountants
- Insurance brokers and our third-party distributors
- Another health insurance provider, hospitals and other health service providers and organisations which manage the transfer of information between health service providers and us

We may also collect your personal information from related companies.

If you provide us with personal information about another person (for example a Third Party Authority or a joint Policy Holder), you must ensure that you are authorised to do so. You must also inform that person of who CUA Health is, that CUA Health will use and disclose their personal information in accordance with this notice, and that they can gain access to that information in accordance with our policy.

WHY WE COLLECT YOUR INFORMATION

We only collect information that is necessary for us to provide you with the products and services you request, and to maintain our relationship with you. If you do not provide us with the information that we request, there may be times when we are unable to provide you with membership or a product or service.

At the time we collect information from you, we will tell you why we are collecting that information.

MARKETING

CUA Health and our related entities (which from 1 October 2021 includes HBF Health Limited ABN 11 126 884 786) may use your information, including your contact details, to provide you with information about products and services, including those of third parties, which we consider may be of interest to you.

You may opt out at any time if you no longer wish to receive marketing information or do not wish to receive marketing information through a particular channel, like email. To do so, you will need to request that we no longer send marketing materials to you. You can make this request by calling us on **1300 499 260**, or by 'unsubscribing' from our email or SMS marketing messages, which always include an unsubscribe option.

DISCLOSURE

We may disclose your information to other organisations, for example:

- External organisations that are our assignees, agents or contractors
- Our service providers including those used for identity verification, software/IT support, account management (including payments), mailing material to you, member and product research and accounting, legal and audit services
- Your representative, for example, lawyer, broker, financial advisor or attorney, as authorised by you
- Your health service providers including your Doctor or hospital
- Other companies within the HBF Group
- Courts and external dispute resolution schemes
- Government agencies when required or authorised by law
- Organisations involved in the administration of our rewards programs
- Other organisations with your consent

We also share limited information, such as your email address, with data aggregators and analysts (including social media and virtual community providers).
This helps us provide you with more personalised and timely communications. If you're uncomfortable with this, please let us know and we won't use or share your information in this way.

We take all reasonable steps to ensure that our suppliers are reputable organisations and, where appropriate, are bound by written agreements to abide by the confidentiality and non-disclosure requirements of CUA Health.

When you are admitted to hospital or attend other health care facilities, personal information which assists in the processing of your claim is provided to us by the hospital or facility. Our agent, Australian Health Service Alliance Ltd ("AHSA") manages the transfer of this information. You should visit the AHSA website at **ahsa.com.au** for complete details about how they comply with the Privacy Act.

Unless you request us not to, we may also disclose to your joint Policy Holders or family members whether you are eligible to be covered for a particular procedure (without disclosing details of past claims) in circumstances where you do not have capacity and this information is needed to decide whether to consent to the procedure.

Some of our service providers to whom we disclose your personal information are located overseas. Please refer to HBF Group privacy policy for a list of the countries where they are located.

OUR PRIVACY POLICY

We respect the privacy of our members' personal information.

We joined HBF on 1 October 2021 and from this date the HBF Group Privacy Policy (available at **www.cuahealth.com.au/privacy-policy**) contains information on how we manage your personal information. This Policy includes information on how to access and correct your information, how to complain (and how we handle complaints), and who we disclose your personal information to (including overseas disclosures). If you need further information, please contact us. Details about we managed personal information prior to 1 October 2021 is also available from **www.cuahealth.com.au/privacy-policy**.

If you have any queries regarding privacy, please contact us at:

Privacy Officer
Email: privacy@hbf.com.au
Post: Locked bag 2234, Brisbane QLD 4001

Medical terms and service descriptions

ACCIDENTS/COVER FOR ACCIDENT: An unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or injury to the body, which requires Treatment by a Medical Practitioner or a Hospital Emergency department (within 48 hours) This definition excludes unforeseen Conditions attributable to medical causes.

Covers which have services that are normally Restricted or Excluded will be treated as an included service where treatment is required for injuries sustained in an Accident that occurs after joining this cover, provided that the treatment is on the Medicare Benefits Schedule.

ALL IN-HOSPITAL SERVICES WHERE A MEDICARE BENEFIT IS PAYABLE: The Medicare Benefits Schedule (MBS) lists all the medical services subsidised by the Australian Government through Medicare. This includes thousands of in-hospital services that we pay benefits towards if this item is included on the cover.

ASSISTED REPRODUCTIVE SERVICES: Treatment provided to an admitted patient in hospital to assist with becoming pregnant. Includes the retrieval and implantation of eggs and collection of semen. In Vitro Fertilisation (IVF) treatment and Gamete Intra Fallopian Transfer (GIFT) are two of the most common procedures. Please note that major portion of these treatments is provided as an outpatient and does not attract any benefits. Benefits are only paid for the inpatient portion of the treatment.

BACK, NECK & SPINE (INCLUDING SPINAL FUSION): Hospital treatment for the investigation and treatment of the back, neck and spinal column. For example, sciatica, prolapsed or herniated disc and spine curvature disorders such as scoliosis, kyphosis and lordosis.

BLOOD CONDITIONS: Hospital treatment for the investigation and treatment of blood and blood-related conditions.

BONE, JOINT AND MUSCLE: Hospital treatment for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example, carpal tunnel, fractures, hand surgery joint fusion, bone spurs, osteomyelitis and bone cancer.

BRAIN AND NERVOUS SYSTEM: Hospital treatment and investigation and treatment of the brain, or spinal cord and peripheral nervous system. For example, stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease.

BREAST SURGERY: Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy. For example, breast lesions, breast tumours, asymmetry due to breast cancer surgery and gynecomastia. No benefits are paid for cosmetic breast surgery that is not medically necessary.

CATARACTS: Hospital treatment for surgery to remove a cataract and replace with an artificial lens.

CHEMOTHERAPY, RADIOTHERAPY AND IMMUNOTHERAPY FOR CANCER: Hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours. Surgical treatment of cancer is listed separately under each body system.

CHIROPRACTIC TREATMENT: this involves manipulation-Based therapy to treat conditions related to the nerves, skeleton and muscles. Osteopathic treatment includes manipulation of the body to promote mobility and balance. Chiropractors and osteopaths are useful for:

- back and neck pain
- sciatica
- frequent headaches
- joint pains and muscle strains
- work-related, repetitive strain & sports-related injuries

DENTAL SURGERY: Hospital treatment for surgery to the teeth and gums. For example, surgery to remove wisdom teeth, and dental implant surgery.

DIABETES MANAGEMENT (EXCLUDING INSULIN PUMPS): Hospital treatment for the investigation and management of diabetes. For example, stabilisation of hypo- or hyper-glycaemia, contour problems due to insulin injections. Provision and replacement of insulin pumps is listed separately under insulin pumps.

DIALYSIS FOR CHRONIC KIDNEY FAILURE: Hospital treatment for dialysis treatment for chronic kidney failure. For example, peritoneal dialysis and haemodialysis.

DIETETICS AND NUTRITION: Dietitians and Nutritionists educate people on appropriate diet, menu planning and preparation of food to enhance and maintain optimum health.

DIGESTIVE SYSTEM: Hospital treatment for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example, oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids.

EAR, NOSE AND THROAT: Hospital treatment for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes, and related areas of the head and neck. For example, damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer.

EXERCISE PHYSIOLOGY: Use of exercise (as prescribed by an Exercise Physiologist) as a treatment strategy in the physical rehabilitation of a patient. Exercise physiologists may assist with:

- disease prevention
- injury rehabilitation
- establishing and maintaining functional independence

EXTRAS BENEFIT: The amount you get back when you claim for the recognised provider service. This could be a dollar amount or a percentage of cost amount depending on your level of cover.

EYE: Hospital treatment for the investigation and treatment of the eye and the contents of the eye sockets. For example, retinal detachment, tear duct conditions, eye infections, and medically damaged trauma to the eye.

GASTROINTESTINAL ENDOSCOPY: Hospital treatment for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope.

GENERAL DENTAL: Diagnostic and other preventative procedures (not covered under Preventative dental) completed to help you keep on top of your oral health.

This is routine dental that includes:

- fillings
- basic extractions (excluding surgical extractions)
- x-rays

This does not include more complex treatments or procedures such as orthodontic work, most endodontic treatment (root canal therapy), crowns or bridges.

GROMMETS IN EARS: Surgical insertion of ventilation tubes in the ear drum to treat chronic ear infection.

GYNAECOLOGY: Hospital treatment for investigation and treatment of the female reproductive system. For example, endometriosis, polycystic ovaries, female sterilisation and cervical cancer.

HEALTH AIDS AND APPLIANCES: Includes benefits for Aids and appliances that help to maintain good health and diagnose and prevent medical conditions including Hearing Aids, Blood Glucose monitors, Blood Pressure pumps, pressure therapy garments, braces, splints, orthoses, post-mastectomy brassieres and external mammary prostheses amongst others.

HEART AND VASCULAR SYSTEM: 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 and removal of plaque from arterial walls.

HERNIA AND APPENDIX: Hospital treatment for the investigation and treatment of a hernia or appendicitis

HOSPITAL PSYCHIATRIC SERVICES: Hospital treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example, psychoses such as schizophrenia, mood disorders and addiction therapy.

IMPLANTATION OF HEARING DEVICES: Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device.

INSULIN PUMPS: Hospital treatment for the provision and replacement of insulin pumps for treatment of diabetes.

JOINT RECONSTRUCTIONS: Hospital treatments for surgery for joint reconstructions. For example, torn tendons, rotator cuff tears and damaged ligaments.

JOINT REPLACEMENTS: Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of protheses. For example, replacement of shoulder, wrist, finger, hip, knee, ankle or toe joint.

KIDNEY AND BLADDER: Hospital treatment for the investigation and treatment for the kidney, adrenal gland tumour and incontinence.

LUNG AND CHEST: Hospital treatments for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example, lung cancer, respiratory disorders such as asthma, pneumonia and treatment of trauma to the chest.

MAJOR DENTAL: Complex dentistry procedures including but not limited to:

- crowns and bridges
- root canal therapy
- removal of wisdom teeth
- dentures
- implants

MENTAL HEALTH UPGRADE: The waiver of the 2-month waiting period on Psychiatric Services for an upgrade to a higher level of Hospital cover for an eligible member. This can only be used once in a member's lifetime across any private health insurer.

NATURAL THERAPIES: Treatments that work on the physical and emotional body to relieve pain and improve health and wellbeing. Some services include:

- Remedial massage
- Acupuncture
- Chinese Herbalism

NERVE TREATMENT: Surgery to any part of the nervous system and can include Insertion of a device or injection to manage severe movement disorders or chronic pain, also includes carpal tunnel release surgery.

OCCUPATIONAL THERAPY: Therapy which assists people to overcome limitations caused by injury or illness, emotional or psychological difficulties, developmental delay or the effects of aging. This can include:

- rehabilitation in skills of self-care
- physical rehabilitation
- cognitive and memory assessment
- stress management and relaxation

OPTICAL: Correction of visual impairment such as long or short sightedness. Examples of treatment include:

- prescription glasses
- contact lenses

ORTHODONTICS: A form of specialty dentistry focusing on realigning teeth and bites as well as procedures to help with the correction & alignment of the teeth and jaw.

PALLIATIVE CARE: Hospital treatment for care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.

PHARMACY: No benefits will be payable where the cost of the PBS listed drug is less than the current PBS co-payment. Benefits are only payable per script.

Benefits are only payable for scripts that are not available under the Pharmaceutical Benefits Scheme (PBS) and are approved by Therapeutic Goods Administration (TGA) for the condition being claimed for and are usually classified as S4 or S8 type medication.

Any other Pharmacy items, including any clinical trials are not claimable under any of CUA Health's Extras policies.

PLASTIC & RECONSTRUCTIVE SURGERY: Hospital treatment which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example, burns requiring a graft, cleft palate, club foot and angioma.

PODIATRIC SURGERY: Provided by a registered Podiatric Surgeon, the hospital treatment for investigation and treatment of conditions affecting the foot and/or ankle, but limited to cover for; accommodation and the cost of a Prosthesis as listed in the Prostheses List set out in the Private Health Insurance (Protheses) Rules, as in force from time to time.

PODIATRY AND ORTHOTICS: Diagnosis, treatment and prevention of conditions affecting the toe, foot and ankle to help with good foot hygiene and posture. Orthotics are devices prescribed by a podiatrist that are placed into the shoe to control or correct abnormal lower limb motions and alignment. Conditions treated by a podiatrist include amongst other treatments:

- complications with arthritis affecting the legs and feet
- skin and nail disorders
- corns and calluses
- ingrown toenails

PREGNANCY AND BIRTH: Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth.

PSYCHOLOGY: Group or individual consultations with a psychologist. Psychology services are commonly sought for:

- marital, family or relationship problems
- stress or pain
- fears, phobias, anxiety and panic attacks
- sexual difficulties
- eating and weight control problems

REHABILITATION: Hospital treatment for physical rehabilitation for a patient related to surgery or illness. For example, inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.

SKIN: Hospital treatment for the investigation and treatment of skin, skin related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin related condition is also included. For example, melanoma, minor wound repair and abscesses.

SLEEP STUDIES: Hospital treatment for the investigation of sleep patterns and abnormalities. For example, sleep apnoea and snoring.

SPEECH PATHOLOGY: The diagnosis, management and treatment of people who are unable to effectively communicate or who have difficulty with feeding and swallowing. Speech pathologists help a range of people, including:

- children who have difficulty in verbal communication
- those who stutter
- stroke sufferers

TONSILS, ADENOIDS AND GROMMETS: Hospital treatment for the investigation of the tonsils, adenoids, and insertion or removal of grommets.

WEIGHT LOSS SURGERY: Hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of bariatric procedure. For example, gastric banding, gastric bypass, sleeve gastrectomy.

Got Questions?

We're here to help you understand and make the most of your cover.

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HEALTH INSURANCE

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