Member Guide

Effective 1 July 2018

Version 1.0

Contents

Welcome!

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 and policies for all members.

For specific information regarding your level of cover, this *Member Guide* should be read in conjunction with the *CUA Health Product Sheet* for your policy. It's important that you fully understand your policy, so please read both of these documents carefully. You can get the latest versions of these documents online, by calling us, or visiting any CUA branch. If you have any questions please get in touch with us.

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@cua.com.au
Fax: 1300 797 066
Web: www.cua.com.au/health-insurance
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About this Member Guide: Your CUA Health cover is subject to the terms of our Fund Rules and your relevant policy. This *Member Guide* summarises the rules and policies as at the effective date noted on the front cover, and supersedes any previously published information. Your premiums, benefits, Fund Rules and policies can change from time to time.

I've joined: What do I need to know?

Who can be a member?

You're eligible to hold a CUA Health policy as long as you're not covered under an equivalent policy with another private health insurer.

However, if you do not hold or are not eligible for a green Medicare card, we may not be able to pay some or all of your benefits under your policy (see '

Medicare eligibility', page 6). If you are a non-resident, ineligible for Medicare or hold a Reciprocal Medicare Card (yellow), please contact us so we can ensure that you have purchased the appropriate cover.

CUA Member Discount

CUA Health is part of CUA Group, Australia's largest credit union. One of the benefits of being part of the group is a 4% discount on your CUA Health insurance premium when you pay your premiums as a direct debit from CUA transaction account (BSB 814-282). This discount is not based on your tenure with CUA Health, but helps members save on PHI premiums by passing on any cost savings when they pay CUA Health from a CUA transaction account.
To change your premium payment to direct debit out of a CUA transaction account visit:
https://www.cua.com.au/health-insurance/health-discount

Member card

You will receive a member card in your Welcome pack. Please check that the details on the card are correct - if they aren't, please call us on 1300 499 260.

You can use your member card to claim directly for some 'Extras' services. That's why it's important you keep your card safe and tell us straightaway if it's lost or stolen. We won't accept liability for the misuse of a lost or stolen card.

This card also has your member number, which you may need to quote when contacting us.

***Did you know*:** You can use your CUA member card to claim extras benefits on-the-spot at any recognised service provider that has the electronic claiming service.

Switching private health insurers

By law, you don't have to re-serve any waiting periods that you have already served with another Australian private health insurer. This means that you'll generally only need to serve waiting periods if:

- A treatment wasn't covered under your previous cover.
- You haven't fully served the waiting period under your previous cover.
- You've upgraded your level of cover.
- You've decreased your excess or co-payment.

In the last two circumstances, we'll cover you at a level comparable to your old level of cover during the applicable waiting period.

However, we may not pay benefits for some services until we have received a Transfer Certificate (also known as a Clearance Certificate) from your previous insurer. To make this process easier, you can authorise us to request this from your previous insurer on your behalf.

We also use the information on the Transfer Certificate to verify whether a Lifetime Health Cover loading (page 7) applies to you or anyone else on your policy, as this could affect your premiums.

Please note that switching private health insurers will not re-set limits on your Extras benefits. Any Extras benefits paid by your previous insurer during the current calendar year will be applied as already being used under the limits of your new cover.

TIP: We strongly recommend that you take steps to cancel any premium payment arrangements (Direct debit) you may have with your previous health insurer as your previous insurer's rules may not allow us to cancel payment arrangements.

Starting your cover

You can start or change your cover at any time, but we won't generally back date any cover to before you contacted us unless you are switching from another private health insurer.

If you switch to CUA Health within two months of leaving your previous health insurer, unless you ask us not to, we will back date your cover to the day after you left your previous health insurer to ensure you have continuous cover. This means:

- If you have Hospital cover, you'll have continuous cover for the purposes of the Medicare Levy Surcharge so you won't be penalised for tax purposes if you fall into the relevant income brackets. You'll need to make sure your Partner and any Dependent Children are covered as well.

- Any Waiting Periods already served on a comparable or lower cover will generally be recognised.
- You'll also retain your Lifetime Health Cover loading and the permitted days without Hospital cover.

If you don't want us to back date your cover, please let us know. Please be aware that you'll have a gap in cover and may need to re-serve some applicable Waiting Periods.

Understanding your cover

We offer a range of private health insurance policies. This *Member Guide* together with your *CUA Health Product Sheet and your CUA Health Brochure* contain a summary of the key terms and conditions which apply to your policy.
Details specific to your cover are contained in the following documents:

Standard Information Statements (SIS)

We are required by law to give you a Standard Information Statement (SIS) which provides an overview of key benefits and product features of your cover.

For a complete overview of your policy cover, you should review the SIS in conjunction with the relevant *CUA Health Product sheet* and this *Member Guide*.

We will send you a copy of your SIS at least once every 12 months. You can also visit **privatehealth.gov.au** or call us on 1300 499 260 to request a copy.

CUA Health Fund Rules

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 will let you know in writing a reasonable time before the change is effective. See also 'Changes to your policy' (page 29).

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

What's not covered?

This section sets out some general conditions which apply to all of our policies regarding the benefits we will pay. These should be read together with details of your specific cover as set out in the applicable *CUA Health Product Sheet*.

Please also see 'What's covered?' and 'What isn't covered?' under the Hospital Cover section_(see page 15) and Extras Cover section (see page 22).
Compensable claims
We don't pay benefits for a claim where you've received, or are entitled to compensation from a third party e.g. workers' compensation or third party insurance. This includes claims that relate to treatment of a condition caused by an accident where another party is at fault.

We may withhold benefits until you've settled your third party compensation claims. Alternatively, if we have paid benefits for treatment for which you subsequently receive compensation, you must use the compensation to first refund us the benefits we've paid for your treatment.

If you make a third party claim, you must provide us with timely information, including completing an Accident Report Form, which is available at **www.cua.com.au/health-insurance** or by contacting us.

Overseas claims

Your CUA Health cover doesn't cover you for any benefits for products, services or treatments purchased from, or provided by, practitioners overseas, whether you buy them in person, by mail, by phone or online

If you are travelling overseas, it's important to organise travel insurance that suits where you'll be going. Without adequate travel insurance you could find yourself paying a lot of money if you're hospitalised or need to visit a doctor overseas.

Other times we won't pay benefits

- Benefits relating to sport, recreation or entertainment unless they're part of an approved chronic disease management or a health management program.
- 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.

Cooling off period

If you change your mind, CUA Health provides a cooling-off period of 30 days from the start date of your policy.

If you wish to cancel, you'll need to advise us in writing during the first 30 days after joining and any premiums paid will be refunded in full, providing you haven't made a claim

Email: cuahealth@cua.com.au
Phone: 1300 499 260
Fax: 1300 797 066
Post: GPO Box 100, Brisbane QLD 4001

Medicare eligibility

Your eligibility for Medicare defines the type of hospital cover that is best suited for you. This is because private health insurance benefits for hospital treatments are linked to the payment of Medicare benefits. This means that we are generally able to provide cover to Green and Blue Medicare card holders. Blue Medicare cards have a validity of two years in most cases. Please call us to update your card details when your card has expired.

If you hold a yellow Medicare card or no card at all, this indicates that you have limited access to Medicare and can affect the benefits we can pay under your cover. In some instances, some benefits set out in your cover may not be paid, and you may end up with large out-of-pocket expenses to pay for your treatment yourself.

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 decide to purchase a Hospital cover 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 not pay any of the benefits under the cover as you are ineligible for Medicare (see '

Medicare eligibility', page 6).

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 in-patient medical services, if admitted to hospital.
- Comply with any health insurance specific visa requirement e.g. Specific cover type and a supporting letter to grant a sub class 457 or similar visa.

We will consider that you have made an informed decision to buy a Hospital cover with us, as an overseas visitor, after clearly understanding the implications. We strongly recommend that you call us if you do not have full Medicare eligibility to discuss your situation.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is levied on payers of Australian tax who do not have Hospital cover and who earn above a certain income. The MLS is in addition to the Medicare Levy. For further information regarding the MLS including when you may be exempt from the MLS and the applicable income thresholds, please refer to the Australian Taxation Office.

All of CUA Health's hospital policies meet the legislative requirements to exempt you from the Medicare Levy Surcharge.

TIP: To avoid incurring the Medicare Levy Surcharge, it's important to maintain Hospital cover. To find out how this affects you go to http://www.ato.gov.au/privatehealthinsurance

Australian Government Rebate

If you have a CUA Health product and hold a Medicare card, then you are eligible for the Australian Government Rebate (Rebate). However, your Rebate amount depends on your age and income. For some, this means that the rebate may reduce to $Nil. The Australian Government adjusts the Rebate every year on 1 April. This means that the amount of Rebate you receive will also change every year even if your other circumstances do not change.

You can receive your rebate either as a reduction in your premium, or as a tax offset in your annual tax return. If you wish to receive the Rebate as an automatic reduction to your premium, you'll need to complete and return to us the 'Application to receive Australian Government Rebate on Private Health Insurance' form (included in your welcome pack, or available on our website or by calling us on 1300 499 260). You can nominate to do this at any time during your membership.

The Rebate does not apply to any Lifetime Health Cover loadings (see 'Lifetime Health Cover', page 7).

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

***TIP*:** If you're receiving an increased Rebate because someone covered under your policy is aged 65 or older and you can call us on 1300 499 260 beforehand to discuss any potential impacts on your policy.

Lifetime Health Cover

The Australian Government's Lifetime Health Cover (LHC) initiative rewards people who get Hospital cover when they're young.

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 the base rate of your Hospital cover premium, up to a maximum of 70%, for each year (or part year) you're aged over 30.

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

After you take out cover, there are circumstances where you can have gaps in your Hospital cover without LHC being applied when you re-start your Hospital cover. This is known as '*permitted days without cover*'. You are permitted by law to have up to 1,094 permitted days without Hospital cover over your lifetime. However, you should be aware that you may be subject to the Medicare Levy Surcharge for periods when you do not have an active Hospital cover.

There are a range of circumstances where the LHC loading may not apply to you even if you did not take out a Hospital cover on 1 July after your 31st birthday. There are specific rules around each exemption, so we recommend that you contact your Accountant, Financial Advisor or the ATO on 13 28 61 for advice on your eligibility for any exemptions.

TIP: You can check your liability for Lifetime Health Cover loading on the LHC calculator at **https://www.privatehealth.gov.au/dynamic/lifetimehealthcover.aspx**

For more information on the Australian Government Rebate, Lifetime Health Cover or Medicare Levy Surcharge, visit one of the following websites:
www.ato.gov.au/privatehealthinsurance
www.health.gov.au
www.privatehealth.gov.au

Managing your cover…

Online Services Portal

Access our Online Services Portal through https://onlineservices.cuahealth.com.au
or Download our CUA Health app

You will be able to:

- Submit most Extras claims – see 'How to make a claim' (page 24)
- Check your Extras benefits balance - you can see how much you've claimed, how much you have left on your annual benefit limit, and then plan additional treatments before your claim limits are refreshed each year (1 January).
- Check specific details about your cover including any waiting periods or exclusions that might apply to services.
- Change your personal details.
- Manage your policy including setting up or updating direct debit or credit payment details, pay your premiums with a credit card and download your annual tax statement.

Who can manage my cover?

Type of change		Policy Holder	Partner	Dependent Children over 16 y/o
Personal details	P/holder details	✓	✗^	✗
	Partner details	✓	✓	✗
	Depend't details	✓	✗^	✓
Bank A/cc	Premium payment	✓	✓	✗
	Claims payment	✓	Own claims only^	✗
Change Policy	Change cover	✓	✗^	✗
	Cancel policy	✓	✗^	✗
Remove members	P/holder	✓	✗^	✗
	Partner	✓	✓	✗
	Depend't	✓	✗^	✓

^ Unless otherwise authorised by the Policy Holder

The Policy Holder is the member authorised to manage the cover. Other members on the policy may also be able to make changes depending on their status on the policy. The following is a summary of changes that members can generally request:

Third Party Authorisation

A Policy Holder can authorise a person who is not a member on the policy to do anything that the Policy Holder would be able to do on the cover. To do this, call us on 1300 499 260 or provide us with authorisation in writing. This will be registered on the membership until it is 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.

Adding/removing members

At different life stages, you may need to add or remove members on your cover. Generally, a Policy Holder or a person authorised by the Policy Holder can add or remove other members from the cover.

Members can generally only be added from the date you advise us. Anyone you add to your cover may need to serve Waiting Periods (see page 13), unless they've previously held cover for the same benefits and have no break in cover between their old cover and the current cover. For newborn babies, please see 'Having a baby?' (page 11). Please also read 'Who can be on my cover?' below.

Who can be on my cover?

Who can be on your cover depends on your cover type:

Cover type	Policy Holder	Partner	Dependent Children
Single	✓	✗	✗
Couple	✓	✓	✗
Single Parent	✓	✗	✓
Family	✓	✓	✓

Partner – a person who lives with the Policy Holder in a marital or de facto relationship.
Dependent Children – a child of the Policy Holder or their Partner:

- Who is under the age of 23 and not married or living in a de facto relationship; or
- Who is under the age of 25, not married or living in a de facto relationship and is a full time student. To qualify as a full time student, they must be enrolled for a course of study at a recognised Australian Educational Institution, with a full-time workload as determined by us.

Important: A person who is undertaking an apprenticeship will not qualify as a full-time student.

We cover a maximum of two adults (excluding Dependent Children) on a policy. Other adults living in the household, such as parents of the Policy Holder or Partner, cannot be covered on family policies.

Changing your cover

We recommend that you regularly review your cover to ensure that it remains appropriate as your life changes. If you'd like us to help you review your cover, call us on 1300 499 260.

Changing your level of cover could result in:

- Waiting Periods applying for any new or additional services not previously covered or that have an increased benefit (e.g. changing cover to reduce your excess).
- A change to the Excess payable by you.
- Additional premium being payable by you if your cover is increased. If your premiums reduce, then any surplus already paid will be applied against your future premium payments.
- Certain services ceasing to be covered or lower limits may apply.

Changing your cover will not re-set any limits on your Extras benefits. Any Extras benefits paid under your old cover during the current calendar year will be applied as already being used under the limits of your new cover.

Moving?

If you move or change any of your contact details, you can update your details through our Online Services Portal or by calling us on 1300 499 260.

Also, if you're moving interstate, let us know as soon as possible as this may affect your premiums. This is because your premium is determined by the State or Territory that you live in, even if you are only living there for a short time or if you have a house/PO Box in another State.

If you move interstate, your premiums will be adjusted as at the date of the move and you'll either be required to pay the higher premium, or if your premium is reducing any premiums paid in advance will be applied as additional cover on your policy.

Important: Don't forget to tell us if you change your phone number or email address as well. We'll generally send important information regarding your policy by email.

Suspending your cover

You can ask us to put your cover on hold for up to three years at a time if:

- you've been with CUA Health for over 12 months, and
- You're going overseas for more than two months.

You'll need to send us a completed suspension form in advance of your trip, along with a copy of your airline or travel agent issued itinerary and/or tickets which includes the dates of travel. You must pay your premiums up to the date of your departure.

No benefits will be paid during any period of suspension. Nor will you be able to access any services offered by CUA Health.

A suspension won't affect any Loyalty Limits you might have under your cover as the period of suspension will still count towards the years of continuous cover. However:

- The suspension time doesn't count against any applicable Waiting Periods, and
- You may be subject to the Medicare Levy Surcharge for the duration of your suspension. This is because the Australian Taxation Office sees you as not holding appropriate Hospital cover for the period your policy was suspended. Contact your Accountant, Financial Advisor or the ATO on 13 28 61 for more details and/or detailed advice.

We will automatically recommence your policy on the day of your advised return to Australia, with premiums payable from this date. If your return date changes, you'll need to contact us as soon as possible (but no later than 30 days) after your return to reactivate your cover and restart your premiums. You'll also need to send us proof of your new return date to Australia.

Cancelling your membership

Please call us on 1300 499 260 if you wish to cancel your membership. We may require you to give us written notice of your request.

If you make a claim after you ask us to cancel your membership, we will only assess any claims for services provided before your requested cancellation date. Any claims for services provided after the cancellation date will be rejected. Any premiums paid in advance of the cancellation date will be refunded, but CUA Health may charge an administration fee.

In most cases we will contact you to discuss the reason for your cancellation. If you still decide to cancel, we will work with you to find the best options for you including the best cancellation date so that your Lifetime Health cover status is not affected when cancelling your Hospital cover or explaining the impacts of Medicare Levy Surcharge as a result of cancellation.

Terminating your membership

We will never terminate your membership on grounds of your health or claim status.

However, we may terminate a membership if:

- Any member listed on a policy has attempted to obtain an improper advantage, or committed or attempted to commit fraud or any other criminal act in relation to the operation of the private health insurer or CUA Health.
- Incorrect information or details were provided at the time of starting the membership or at any time since joining.
- A member has 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).
- Any member included on the membership has, in our opinion, behaved inappropriately towards CUA Health staff, providers or other members.
- If your premiums are in arrears for more than two months, your cover will lapse and your membership will be terminated.

We will give written notice of termination with a date of termination to the Policy Holder. Any premiums paid in advance past the termination date will be refunded.

Having a baby?

If you're planning to start a family within at least the next 12 months, it's important to make sure your cover includes Obstetrics related services. This is because there is a 12 month waiting period for these services. We will of course recognise any waiting period you've served with any previous cover – see 'Waiting Periods' (page 13).

Adding a baby to your cover

Once your baby is born, make sure you contact us to add them to your policy.

If you're on a single or couples policy, you'll need to change your policy to either a family or single parent policy from the day of the baby's birth in order for the baby to be covered.

If you already hold a family or single parent policy when your baby is born, all you need to do is to contact us to add your baby to your policy

Waiting periods for your baby

There are no waiting periods for the baby as long as they are added to the policy from their date of birth, and any relevant premiums are paid for the membership.

Hospital costs

Generally, a newborn isn't separately admitted to hospital as an in-patient 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 in their own right (e.g. a special care nursery or intensive care).

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 that your hospital Excess (see 'When do I have to pay an Excess?' page 17) will apply for the mother, but there are no excesses for Dependent Children in most cases. This means that if your baby is admitted as an in-patient for any reason, your Excess will not apply.

TIP: Talk to us when you're choosing your specialist and hospital so we can help you manage your out-of-pocket expenses (see page 17).

Doctors or Specialists costs

Medical services provided in hospitals by doctors, obstectrician, anaesthetists, radiologists and pathologists are charged separately from hospital-related services like accommodation and operating theatre fees.

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). This means that where a specialist charges fees in excess of the MBS, you may incur out of pocket expenses. Similarly if a specialist charges fees unrelated to in hospital services e.g. management of pregnancy, it is not covered under your Hospital Cover and has to be claimed through Medicare only

However, if your specialist participates in the Access Gap Cover scheme, we'll pay higher benefits for your medical procedure, up to certain limits. Refer to page 18 – Access gap Cover section for more details.

Assisted Reproductive Services

This includes any treatment provided to an admitted patient to assist with becoming pregnant. E.g.In Vitro Fertilisation (IVF) treatment and Gamete Intra Fallopian Transfer (GIFT).

In vitro fertilisation (IVF) is the most common form of assisted reproductive technology used to help couples who has been unable to conceive naturally.

What does CUA Health Cover?

IVF treatment may involve an admission to hospital or occur outside of a hospital admission. CUA Health will cover you for all services that require you to be admitted in-patient in a hospital or a day surgery. Medicare may contribute to the cost of medical services, whether or not they require a hospital admission. If IVF is included in your hospital cover and you've served your waiting periods, CUA Health will contribute to hospital and medical costs for IVF services that require a hospital admission.

Many IVF services do not require you to be admitted as an inpatient; however the type of IVF services provided to and number of cycles required by a patient will depend on individual circumstances and will be based on your fertility specialist's recommendations.

For more information about IVF and assisted reproductive technology, talk to your GP, who can refer you to a specialist.

Your premium

Your premiums must be paid in advance at all times and can be paid up to 12 months in advance.

Payment options

There are a number of ways to pay your premiums. A surcharge may apply for payments via Visa or MasterCard – call us on 1300 499 260 to find out more.

Direct debit

Choose your preferred frequency and day and we'll withdraw the premiums from your nominated bank account when the premiums fall due. Set this up through our Online Services Portal or by calling us on 1300 499 260.

Online

Make one-off payments with your Visa or MasterCard through our Online Services Portal.

Phone

Pay your premiums over the phone with your Visa or MasterCard by calling us on 1300 499 260.

Changes to your premiums

Generally, premiums are reviewed annually, subject to approval from the Minister of Health. We'll always write to you in advance if there is a change to your premiums.

If you've paid your premiums in advance, the new premium won't apply until your next payment is due. However, if you make any changes to your membership, such as your level or category of cover, reactivate your cover after a suspension or move to another state, the new premium will apply from the date of the change or the date you resume your membership. The date you have paid up to will then be adjusted accordingly.

Premium arrears

We won't pay you any benefits for items or services provided while your policy is in arrears.

The Policy Holder is responsible for ensuring that premiums are paid in advance at all times including ensuring that there are sufficient funds when direct debit has been requested.

If your premiums are in arrears for more than two months, your cover will lapse and your membership will be terminated. We'll try our best to attempt to contact you during this time to advise you of your policy being in arrears, and we'll also advise you in writing if the membership is terminated.

Refunds

If you cancel your policy, you're entitled to a refund of any premiums you have paid in advance. Your refund will generally be calculated from the date of cancellation, providing you have not made a claim after the cancellation date. An administration fee may apply.

***Did you know*:** As a CUA Health insurance member you receive a 4% discount on premiums when you pay your premiums as a direct debit from a CUA transaction account (BSB 814-282).
To change your premium payment to direct debit out of a CUA transaction account visit: **https://www.cua.com.au/health-insurance/health-discount**

Waiting Periods

There's a period of time you'll need to wait before you can claim certain services from us. This can relate to different situations:

- When you get health insurance for the first time in Australia, or you re-join after a period without health insurance.
- If you switch insurers and haven't fully served your waiting periods with your existing insurer.
- If you increase your cover whether with us or when switching to or from another private health insurer.

In the first two situations above, you won't be able to claim until your waiting period is served. However, if you've increased your cover (with CUA Health or when switching from another insurer) you'll be covered under your previous level of cover (or a CUA Health cover deemed similar to your cover with the previous fund if you are transferring) until you've served waiting periods for the new higher level of cover.

Below are some of the waiting periods that apply under our policies. Please note that depending on the cover you hold, you may not be covered for all of these treatments.

Hospital Waiting Periods

Waiting period	Service
1 day	• Accidents - an unforeseen and sudden event occurring by chance and caused by an external force or object, resulting in involuntary bodily injury requiring immediate treatment from a medical practitioner, which occurred after joining the fund. It does not include any condition that can be attributed to medical causes. • Ambulance transport (available only on some Hospital covers)
2 months	• All other hospital treatments, rehabilitation, Psychiatric services and Palliative care
12 months	• Pre-existing Conditions (see page 14) - excludes psychiatric, rehabilitation and palliative care • Obstetrics related services

Please note Australian Government's Mental Health Upgrade guarantee allows eligible members upgrade to a higher level of hospital cover without any waiting periods once in a lifetime. Contact us for more information.

Extras Waiting Periods

Extras Waiting Periods can vary depending on the cover you hold. Check your applicable *CUA Health Product Sheets* to see the Waiting Periods that apply to your cover. Generally, the waiting periods are as follows:

Waiting Period	Service
1 day	• Ambulance transport
2 months	• All other Extras services not mentioned in this section.
6 months	• Optical • Wellness Benefits
12 months	• Major dental • Orthodontics • Health Aids and Appliances • Podiatric Surgery • Orthotics and orthopaedic appliances

Important: If you purchased your policy **before 16 November 2016**, we strongly recommend that you check the waiting periods in your *CUA Health Product Sheet*. In some cases the waiting period may apply differently on those policies. For example, the waiting period may apply to Health Management Programs only as other aspects of wellness benefits may not be included under those policies or a higher waiting period may apply for some services. The information on the product sheet will always override the information provided here for those policies.

Pre-existing conditions

Pre-existing Conditions are subject to a 12 month Waiting Period from the time you join, switch or change to a higher level of cover.

What is a Pre-existing Condition?

A condition where signs or symptoms of your ailment, illness or condition – in the opinion of a medical practitioner appointed by us – existed at any time during the six months before you purchased your hospital cover or upgraded to a higher level of hospital cover. It is not necessary that you or your doctor knew what your condition was or that the condition was diagnosed.

How do we assess a Pre-existing Condition?

Our appointed Medical Practitioner is the only person authorised to decide if an ailment, illness or condition is pre-existing. They must consider any information that was provided by the medical practitioner who treated (or is treating) the ailment, illness or condition and may ask for additional information or seek clarifications.

Assuming that we receive all the information required from your treating medical practitioner(s), we'll need up to ten working days to make the assessment, so 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 subsequently determined to be pre-existing, you'll be required to pay any hospital and medical charges not covered by Medicare.

What happens if I have a Pre-existing Condition?

If the ailment, illness or condition is considered pre-existing:

- New members with pre-existing conditions must wait 12 months for any hospital benefits. For psychiatric care, rehabilitation or palliative care, the maximum waiting period is two months (even if the condition is pre-existing), and
- Policy Holders transferring or upgrading to a higher Hospital cover must wait 12 months to get the higher hospital benefits, but you'll be covered up to your previous level of cover provided you've served the applicable waits under your old cover.

What if I need urgent treatment?

If you're admitted to hospital for an emergency, we may not have time to assess whether the admission relates to a pre-existing condition. This means that during the waiting period, you may have to pay for all or some of the hospital and medical charges if you are admitted as a private patient, and your condition is later determined to be pre-existing.

The waiting period applies if:

- you've held your current Hospital cover for less than 12 months; or
- you've changed your cover to include additional treatments and haven't been covered for that treatment for 12 months; or
- You have reduced an excess or increased annual limits

Important: Please Note Australian Government's Mental Health Upgrade guarantee allows eligible members upgrade to a higher level of hospital cover without any waiting periods once in a lifetime. Contact us for more information.

Hospital Cover

Hospital cover policies help cover the cost of in-patient hospital treatment by a doctor/specialist and hospital costs such as Accommodation and theatre fees.

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% of the MBS fee. Where a doctor or specialist charges in excess of the Medicare Schedule fee, you'll incur an out of pocket expense unless they participate in the Access Gap Cover scheme (see 'Access Gap Cover Scheme', page 17).

Your policy only covers treatments which are:

- Included on your level of Hospital cover. For example, obstetrics and gastric-band related services may not be covered under lower levels of cover.
- Deemed medically necessary and clinically relevant (we don't cover cosmetic surgery).
- Delivered as an in-patient service.

We won't cover any treatments where a Medicare benefit isn't payable (see 'Services not covered by Medicare', page 17).

***Important*:** Make sure you call us on 1300 499 260 before you receive any treatment so that we can help you understand whether your treatment is covered by your policy, whether any waiting periods or Excess applies, and what your potential out of pocket expenses might be.

If you need to be admitted to a hospital, you can choose to be treated under the public system (Public Hospital) or in the private system (choice between Private or Public Hospitals). If you have Private Hospital cover, you'll also have a number of choices that you wouldn't otherwise have.

Accommodation Type	Choice of hospital	Choice of doctor	Public Waiting Lists
Public Patient in a Public Hospital	✗	✗	✓
Private Patient in a Public Hospital	✗	✓	Sometimes reduced
Private Patient in a Private Hospital	✓	✓	✗

This section explains what is included in your Hospital cover as well as the type of coverage available for different services.

Important terms to understand in this section
In-patient – someone who is admitted to a hospital as an overnight or same day patient.
Outpatient **–** a person who receives treatment outside hospital, such as visits in a specialist's room, or in an accident and emergency room, or as a non-admitted patient in a hospital.
Default Benefit **–** an amount set by the Federal Government as the minimum amount that a private health insurer must contribute towards hospital accommodation charges for an Included or Restricted service or treatment. Where a Default Benefit applies a member may have significant Out-of-pocket expenses. This is also known as a Minimum Benefit or Minimum Default Benefit by some Health insurers.

What's covered?

This depends on what cover you have. Check product information for your specific cover in the applicable *CUA Health Product Sheet* for a list of services and procedures or treatments included in your cover.

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

- Agreed charges for accommodation in private or shared room.
- Same day admissions.
- Intensive care.
- Theatre fees.
- Doctors' fees for in-hospital medical services.
- Surgically implanted prostheses (see 'Prostheses charges', page 15).
- PBS medications prescribed while you are an in-patient (see 'Benefits for pharmaceuticals', page 16).
- Medical gap for doctors' and surgeons' in-hospital medical fees if they participate in Access Gap Cover scheme (see 'Access Gap Cover Scheme', page 17).

The hospital and doctors treating you should tell you about their costs before you go to hospital, so it's important to ask before you are admitted. This will enable you to provide informed financial consent.

Prostheses charges

A prosthesis is an artificial or substitute component, such as a pacemaker, defibrillator, cardiac stent (for coronary arteries), grommets or titanium plates and screws, cochlear implant or joint replacement that is surgically implanted.

As long as the service is covered on your policy, we'll cover you up to the minimum benefit listed on the Government's Prostheses List.

There may be more than one clinically appropriate prosthesis available for your procedure, including some that cost more than the minimum benefit. You should talk to your doctor prior to your treatment so that you can make a fully informed decision about the cost of your treatment.

If you choose a prosthesis that costs more than the minimum benefit, you'll have to pay the difference between the minimum benefit and the prosthesis charge. We won't pay benefits for prostheses not included on the Government's Prostheses List.

Benefits for pharmaceuticals

The Pharmaceutical Benefit Scheme (PBS) is a Government scheme that subsidises the cost of prescription medicine. The PBS sets the amount a patient pays towards the cost of a subsidised drug. We'll pay the PBS amount if you're an in-patient and the drug is prescribed for your treatment.

Restricted Services

If 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 (see 'Prostheses charges', page 15).
- Doctors' fees for in-hospital medical services when you're treated as a private patient.
- Medical Gap for doctors' and surgeons' in-hospital medical fees if they participate in Access Gap Cover scheme (see 'Access Gap Cover Scheme', page 17).

Please note, any Excess applicable to your cover will be charged even where only Default Benefits are paid (see 'When do I have to pay an Excess? page 17).

Nursing home type patients

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 we'll pay a lower benefit towards the daily hospital accommodation charge which could result in significant Out-of-pocket expenses.

What isn't covered?

If a service is excluded on your cover it means that we won't pay any benefits towards it and you'll be responsible for all the costs including accommodation, theatre fees, intensive care, prosthesis, medication, allied health and medical gap. You'll be significantly out-of-pocket if you choose to be treated as a private patient. Check your applicable *CUA Health Product Sheet* for a list of services and procedures or treatments that are excluded from your cover.

In addition, we will not pay benefits under your Hospital cover for:

- Outpatient services (see page 16).
- Services where a Waiting Period has not been fully served (see 'Hospital Waiting Periods', page 13).
- Overseas claims (see page 5).
- Any period when your premiums are in arrears or your membership has been suspended.
- Services which can be claimed by way of compensation or damages from a third party (see 'Compensable claims', page 5).
- Benefits relating to sport, recreation or entertainment unless they're part of an approved chronic disease management or a health management program.
- 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.

Outpatient services

Outpatient services include check-ups and other treatment considered an outpatient service e.g. Radium, treatment in an Emergency ward, and services relating to IVF or other reproductive assistance that don't require hospital admission.

Medicare covers 85% of the MBS fee when you receive medical services outside hospital, such as GP visits, visits in a specialist's room, or in an accident and emergency room, or as a non-admitted patient in a hospital.

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

Out of pocket expenses

The benefit we pay towards in-hospital medical services is based on the fees set by the Australian Government under the Medicare Benefits Schedule. The amount we cover towards the cost of hospital accommodation and theatre fees depend on whether or not you are admitted to an Agreement hospital (see 'Agreement hospitals', page 18).

This means that you will incur out of pocket expenses where:

- the services are not covered by Medicare (see 'Services not covered by Medicare', page 17);
- your doctor or specialist's fees exceed the Medicare Benefits Schedule (MBS) fee, unless your doctor participates in the Access Gap Cover Scheme (see 'Access Gap Cover Scheme', page 17);
- you are admitted to a non-agreement hospital (see 'Agreement hospitals', pg 18);
- you receive treatment for a Restricted service (see 'Restricted Services', page 16);
- you receive treatment in a private hospital during a Benefit Limitation Period (see '', page 16;
- you take home consumables such as bandages, dressings or any medication;
- You receive treatment from service providers such as physiotherapists who aren't directly employed by the hospital you're treated in. You may be entitled to receive a benefit towards these services if you have an Extras cover;
- you require medication which is not covered under your policy (see 'Benefits for pharmaceuticals', page 16);
- you require a prostheses (see 'Prostheses charges', page 15);
- you utilise any items of a personal nature, including TV rental or phone calls, that are not part of the agreed hospital charges;
- services are not invoiced by the hospital to CUA Health;
- An Excess applies to your cover (see 'When do I have to pay an Excess?', page 17.

Services not covered by Medicare

Generally, we'll only pay a hospital benefit if Medicare pays a benefit for the service. In order to assess a claim, we'll need a Medicare statement that informs us of their payment. If you go into hospital to have a procedure that isn't covered by Medicare, we will not pay any benefits towards medical costs, theatre fees or intensive care fees.

Common services not covered by Medicare include:

- Podiatric surgery. However, some surgeries done by Podiatric Surgeons may be covered under your Extras cover. Please contact us for more details.
- Cosmetic treatment. This is any treatment which is not medically necessary and aims to revise or change the appearance, colour, texture, structure or position of normal bodily features;
- breast augmentation (except following a mastectomy);
- laser eye surgery to remove the need for glasses
- blepharoplasty (eyelid reduction)
- Dermabrasion (abrasive therapy, chemical face peels).

Important: Cosmetic surgery is excluded from coverage on all CUA Health Products, and we don't pay benefits for a Cosmetic procedure even if Medicare has paid any benefits towards the service.

When do I have to pay an Excess?

An Excess is an upfront lump sum payment that you agree to pay towards the cost of your hospital stay or day surgery on admission. Having an Excess can help reduce the premium that you pay.

If an Excess is applicable, it applies to each adult person on your policy and is capped at once per person per year. The Excess does not apply to any Dependent Children listed on the policy.

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

Important note for members on 'Private Hospital 500 + Co-Payment' and 'Private Hospital 65%' policies: your upfront lump sum payment works differently to above. Please refer to your *CUA Health Product Sheet* for details.

Access Gap Cover Scheme

Medical services provided in hospitals by doctors, surgeons, anaesthetists, radiologists and pathologists are charged separately from hospital-related services like accommodation and operating theatre fees.

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). This means that where a specialist charges fees in excess of the MBS, you may incur out of pocket expenses.

However, if your specialist participates in the Access Gap Cover scheme, we'll pay higher

benefits for your medical procedure, up to certain limits. In return, your doctor agrees to charge a lower amount. The Access Gap Cover Scheme will reduce or in some instances remove your out-of-pocket expenses for specialist care you receive while in hospital.

By seeing doctors and specialists who participate in the Scheme, you'll either:

- have no out-of-pocket expenses, or
- Be provided with an estimate of out-of-pocket costs before your treatment.

These doctors can also bill us directly. So, not only does your hospital treatment cost you less, but the billing system is made easier for you too.

Talking to your doctor about Access Gap

Before you go to hospital, you and your doctor should take the time to discuss the costs of your treatment, and any out-of-pocket expenses that you may need to pay. You may also find that it will be the receptionist, business manager or practice manager who will discuss costs with you. While it can be uncomfortable to discuss costs, ensuring you understand all costs is just as important as the conversation you have about your condition, treatment options or hospital procedure.

Your doctor or specialist may choose to use the Scheme on a patient-by-patient basis. Of course, whether or not your doctor or specialist participates in the Access Gap Cover Scheme will not affect the treatment you receive.
Your doctor has an obligation to advise you of any out-of-pockets, and you have the right to ask if they will participate in Access Gap.

How Access Gap benefits your doctor

Here are some of the great reasons why it can be beneficial for them as well as you:

- We pay your doctor directly so it simplifies the claims process;
- Improves cash flow in the doctor's practice with claims paid within 21 days;
- Doctors have the ability to opt in and out on a patient by patient basis;
- Adds value for private patients – giving patients another reason to choose them;
- Access Gap fees are indexed annually to encourage doctors' ongoing participation in the program.

Search for an Access Gap Cover doctor

Access to a list of doctors and specialists participating in the Access Gap Cover scheme is available at:

https://www.cua.com.au/health-insurance/faqs/information-for-policy-holders

Because doctors can opt in and out of the scheme on a patient by patient basis, it's important to double check with the doctor or specialist directly that they will participate in the scheme for your procedure.

Agreement hospitals

You can choose where you're treated and whether you're treated in a private hospital or as a private patient in a public hospital, in conjunction with your doctor or specialist. However, whether your chosen hospital is an 'agreement hospital' or not will impact on your potential out of pocket expenses.

We have agreements in place with the majority of private hospitals and day surgeries throughout Australia. These agreements detail agreed theatre and accommodation charges for included services under your cover. You are generally covered without gaps for hospital costs, if you're treated as a private patient in these hospitals. This doesn't apply to Restricted or Excluded Services.
If you receive treatment for a Restricted Service in an agreement hospital, we'll only pay Default Benefits and you may be significantly out-of-pocket. If you receive treatment for an Excluded Service, no benefits will be paid.

To find an agreement hospital visit: **https://www.cua.com.au/health-insurance/faqs/information-for-policy-holders**

Non-agreement hospitals

There are a few private hospitals and day surgeries with which we don't have an agreement. These are referred to as non-agreement hospitals.

If you receive treatment for a service that's Included or Restricted on your cover at a non-agreement hospital we'll only pay the Default Benefit (see the boxed text 'Important terms to understand in this section', page 15) and you'll be significantly out-of-pocket. If you receive treatment for an Excluded Service no benefits will be paid.

Please call us before being treated to clarify your benefit entitlements.

Going to hospital

Going to hospital can be a stressful experience so this section contains some important things for you to consider. And don't forget to call us before you go to hospital so we can confirm what benefits you're entitled to and help you work out your out of pocket expenses.

Doctors' admitting rights

Not all doctors have admitting rights to all hospitals. Your doctor will be able to tell you if they have admitting rights to the hospital of your

choice. When choosing your preferred hospital, you should consider whether it is an Agreement Hospital (see page 18) to minimise your out of pocket expenses.

Before you go to hospital

Some things to discuss with your GP/Specialist:

- Your choice of hospital. If it's not an Agreement Hospital (see page 18), you'll be significantly out-of- pocket.
- How long will you be in hospital for?
- Who will be treating you and will they participate in the Access Gap Cover Scheme (see page 17)?
- What other costs are involved, including any out of hospital treatment?
- Will there be any other specialists involved (e.g. assistant surgeon or anaesthetist)?
- Will you need any prostheses (see page 15)?
- What are the total costs involved? Your specialist should be able to provide you with an estimate of medical fees prior to your treatment so that you're fully aware of what you'll have to pay.

Understand your treatment

Make sure you ask:

- For a full explanation of the procedure and any likely complications.
- Whether you'll need any prostheses.
- About other treatment options.
- How long you'll take to recover.
- How long you'll have to wait for test results.
- How long you'll have to stay in hospital (if at all).

Call us to check your cover and benefits

We recommend that you call us on 1300 499 260 to check:

- if you're covered for the procedure
- whether any Restrictions or Benefit Limitation periods apply
- you have served your Waiting Periods (including the 12 month Waiting Period for Pre-existing conditions)
- what (if any) Excess applies to your cover
- your possible out of pocket expenses

Going to hospital in an emergency

In an emergency situation, you'll generally be taken to the nearest public hospital Accident and Emergency Department equipped to deal with your needs.

All Medicare cardholders are entitled to free treatment at a public hospital Accident & Emergency Department. Patients in emergency departments are treated as out-patients and private health insurance funds are not allowed by law to cover these treatment costs. We will only pay for your hospital expenses if you are admitted to hospital as an in-patient.

Out of hospital treatment

If you need additional hospital care after your initial assessment, the doctor may have you formally admitted to the hospital as an in-patient. In this situation, all Medicare cardholders can be treated as a public patient in a public hospital at no charge to them or their private health insurer. You can also choose to be treated as a private patient at a public hospital, though you may not receive any additional benefits over other patients admitted through the public system, and you may incur additional costs.

After hospital

Before you leave hospital, your doctor will determine that you are well enough to leave and that you have all the necessary information to ensure a smooth recovery at home.

For more information about being admitted as a private or public patient see 'going to a public hospital: know your rights' on page 20

Your recovery

When you are discharged, check that your doctor or the hospital has given you the following information:

- How do I know if my recovery is on track?
- How long will my recovery take?
- What symptoms should I look out for if I think there's a problem?
- Who should I contact if I need help?
- What medication do I need to take?
- When can I drive/exercise/return to work?
- Are there any specific instructions for my recovery?
- Will I need physiotherapy or other rehabilitation services?
- When should I make follow-up appointments with my GP/specialist?
- Is there any food or drink I should avoid?

Your doctor should also be able to answer any questions that you have about your recovery.

Making a claim

If you're treated at an Agreement hospital for a service that is included in your cover, the hospital will send the bill directly to us.

If your doctor/specialist participated in Access Gap Cover Scheme, they'll also send their bill directly to us. This means that you don't have to worry about filling in any claim forms.

If your doctor didn't participate in Access Gap Cover Scheme, they will send the bill to you. You'll need to take this to Medicare to claim from them

first, and then fill in a claim form and send it to us with the Medicare Statement of Benefits attached. This is the quickest way for your claim to be processed. CUA Health will cover the difference between the Medicare rebate and the MBS fee, and any amount above the MBS fee will need to be paid by you.

To assist in your recovery, your doctor may recommend that you see other healthcare providers after you have left hospital.

Out of hospital treatment such as physiotherapy isn't included in CUA Health's Hospital covers, however you may be able to claim benefits if you have an Extras cover.

Going to a public hospital: know your rights

Under Medicare, 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 pays for your accommodation, meals, medical and nursing care, theatre and other fees related to your treatment.

This means that 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, you should consider whether you are being offered the benefits of private treatment. This can include:

- Choice of doctor – do you get to choose who treats you or are you being treated by a hospital appointed doctor.
- Choice of where treatment is provided – is it your choice of hospital? Will you get your own room (if available)?
- Will you have to wait on a public wait list for your procedure if you don't elect to be treated privately?

In many cases, particularly in an Emergency situation, using your private health insurance may not grant you any better or special medical treatment. It may also result in you incurring out of pocket expenses. You should know exactly what you're covered for and be aware of any out-of-pocket expenses you may need to pay. It's best if you can make decisions about your care and payments before you get to hospital, so that when you arrive you can focus solely on your surgery and recovery.

You should not feel pressured into using your private health insurance cover. It is your choice whether to be treated as a private or public patient. Regardless of the type of hospital you choose to attend, it's important to be informed at every step of the way. You can choose to be treated as a public patient at any stage during your treatment if you feel you have not had the choice to choose your doctor or your accommodation status is no different from other public patients. Public system is funded through your taxes and you pay premiums for your private health insurance, so the choice should be about your health needs when it comes to a decision about where you want to be treated. Should you decide to go private, CUA Health will always be there to cover your expenses if your policy includes coverage for treatment you are having.

You can always call us and discuss your situation with our team who will provide you all the information you may need to make an informed decision.

We've prepared this table to help you understand what benefits we'll pay under our Hospital covers

		Agreement Hospital (Private)	Non Agreement Hospital (Private)	Public Hospital
Accommodation and 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 expense**: Any hospital excess (or co-payments) applicable to your cover	**CUA Health pays** a fixed benefit for Accommodation and ICU services **Your Out of pocket expense**: Any charges above that fixed benefit and any hospital excess (or co-payments) applicable to your cover	**CUA Health pays** the Default bed fees set by the Federal Government **Your Out of pocket expense**: Any charges above the default bed fees and any hospital excess (or co-payments) applicable to your cover
	Restricted Service	**CUA Health pays** the Default bed fees set by the Federal Government **Your Out of pocket expense**: Any charges above the default benefits and any hospital excess (or co-payments) applicable to your cover		
	Included service	**CUA Health pays** as per our agreement with hospital **Your potential Out of pocket expenses**: Should be limited to Excess (or co-payments) as per your cover only	**CUA Health pays** a fixed benefit for Theatre fees **Your Out of pocket expense**: Any charges above that fixed benefit.	**CUA Health will not pay** any benefit **Your Out of pocket expenses**: will be all charges by the hospital for theatre related fees.
Theatre Fees	Restricted Service	**CUA Health will not pay** any benefit **Your Out of pocket expenses**: will be all charges by the hospital for theatre related fees.		

		Agreement Hospital (Private)	Non Agreement Hospital (Private)	Public Hospital
Surgically Implanted Prostheses	Included and Restricted service	**CUA Health will pays** the minimum benefits set out in federal government's prosthesis 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 Diagnostics (Blood tests, CT scans & others)	Included and Restricted service	**CUA Health pays** 25% of Medicare Benefit Schedule (MBS) fee. (Medicare pays 75% of MBS fee) **Your Out of pocket expenses:** Any charge above the MBS fee per service or full charge if the service not listed on MBS		
In-hospital Doctors fee (Surgeon, Assistant Surgeon, Anaesthetist & Others)	Included and Restricted service	**CUA Health pays** 25% of Medicare Benefit Schedule (MBS) fee. (Medicare pays 75% of MBS fee) or Access Gap agreed fees if your doctor participates in 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		

Extras Cover

Extras cover helps with the costs of services and items that are not covered by Medicare, like dental, prescription glasses, podiatry or physiotherapy. There are various types of limits that may impact how much you can claim on your policy.

What's covered?

Services covered and benefits paid depend upon the level of Extras cover you have. Benefits are also subject to limits and waiting periods. Please check product information for your specific cover in the applicable *CUA Health Product Sheet*.

Consultations

We'll pay benefits for face-to-face consultations for services covered under your policy, as long as it's provided by a private healthcare practitioner who is a member of a professional association recognised by us. If you're unsure if the provider you have selected is recognised, please call us on 1300 499 260 for confirmation.

Initial and Subsequent consultations

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

Emergency Ambulance

Our Extras covers include cover for Emergency Ambulance services (see 'Ambulance Cover', page 26).

What isn't covered?

You will not be covered for treatment including:

- Services able to be claimed by way of compensation or damages (see 'Compensable claims', page 5).
- Items or services not included under your cover or in excess of any applicable Limits.
- Services provided by a family member.
- Any treatment considered an outpatient service, e.g. Radium (see 'Outpatient services', page 16).
- Benefits for products, goods, services or treatments purchased from or provided by practitioners overseas, whether you buy them in person, by mail order or online (see 'Overseas claims', page 5).
- Benefits in relation to sport, recreation or entertainment unless they are part of a CUA Health approved chronic disease management or a health management program or wellness plan.
- A service claimed together with at least one other service which is not covered under the policy and the services are supplied within a 2 hour period by the same provider to the same member.
- Benefits for products, goods, services or treatments if false or misleading information is provided.
- Extras cover services for which a Medicare benefits is payable, except as allowable as hospital substitute treatment.
- Telephone or video consultations.
- Treatment, goods or services provided during a waiting period.
- Treatment, goods or services provided at a public hospital or other publicly funded facility.
- Treatment, goods or services provided by a family member.

Cancelled or missed appointments

Your CUA Health Extras cover will not pay benefits towards missed appointments, so if you've been charged for not attending or cancelling an appointment, you won't be able to claim for it.

Limits that apply to your Extras cover

Annual limits

Benefits are subject to 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.

When changing cover (or insurer), limits that have been used under your previous cover will be taken into account in determining the first year's limit that will apply on your new cover.

Per person limits

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 other members on the cover.

Per family limit

This is the total amount that can be claimed by all members on your cover if you are on Single Parent, Couple or Family cover types.

Lifetime Limit

A lifetime limit is the total benefit you can claim for this service in a lifetime. When changing cover (or insurer) Lifetime limits that have been used under your previous cover will be taken into account in determining the Lifetime limit that will apply on your new cover.

Loyalty limits

Some of our covers include loyalty limits as a way of rewarding you for staying with us. The annual limit increases for the first three years by

a set amount. These loyalty limits are calculated using the anniversary of you joining the Extras cover.

Additional Extras benefits

Member discounts from optical retailers

CUA Health members who have Extras cover get additional discounts and free services, assessments or fitting sessions at leading Optical providers including Luxottica (OPSM, Laubman & Pank), OPSM Direct, Specsavers, Eyebenefit, VPS Global and others.

Refer to www.cua.com.au/health-insurance or the CUA Health brochure for details of discounts available at each provider.

Bonus Dental Check-ups

On Total & Classic extras covers, you will receive additional general dental benefits to help reduce or eliminate the cost of dental care. For routine dental services (comprehensive examination – item 011, periodic oral examination - item 012, scaling/cleaning – item 114, and fluoride – item 121) there will be no out of pocket expenses up to a total value of $250 per visit, for the first visit every year for adults and for two visits every year for dependants under 23.
Dependants under 23 can also claim one mouth guard item – 151 every year.

On Essential extras only dependants under 23 receive no out of pocket expenses up to a total value of $250 per visit for the first two visits every year for routine dental services (comprehensive examination – item 011, periodic oral examination - item 012, scaling/cleaning – item 114, and fluoride – item 121).

On all the above covers, this benefit is paid out if the general dental benefit.

Healthy Start Bonus

Each person covered under Healthy Start Package receive a $100 credit every year, which can be used to offset any gaps on the Extras services till it has been used up. A new $100 bonus is available every year and any unused portion does not roll over into next year. This benefit is only available under the Extras component of 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 and/or to prevent an illness or condition. Wellness Benefits are only available on Products purchased after 16 November 2016. If you are on an Extras Policy that was purchased before that date, you may have limited or no cover for Wellness benefits. Please refer to your *CUA Heath Product sheet* for details.

Services covered include:

Quit smoking – You can claim benefits towards hypnotherapy and nicotine replacement therapy (patches, gum, lozenges and inhalers) to assist in quitting and reducing smoking to help improve or prevent an associated health condition, when such services aren't claimable under the PBS.

Health association fees & subscriptions – You can claim benefits of 50% of association 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 doctor's health checks and Healthy Heart checks 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 - provided by an Austswim® or Swim Australia accredited swim school or instructor. A medical practitioner or doctor's recommendation to undertake swimming classes due to a specific health condition needs to be provided to us.

Travel expenses – You can claim benefits when a hospital admission is required for a policy holder, or a dependant covered on the policy outside their usual place of residence and the return distance trip is greater than 400 km. 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 not claimable under a Medicare rebate.

Mammograms – Benefits can be claimed for mammograms when not covered by the Medicare rebate.

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 where the treatment is intended to improve a specific health condition or conditions. A letter from a medical practitioner referring the program may be needed clearly stating that the referred program is to manage the condition that has been diagnosed and its 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 benefit approval form renewal is required every year.

Goods or services that are primarily for the purpose of sport, recreation or entertainment are not eligible for benefits. For example, you can't claim for any sports club membership, gym membership or sporting equipment, footwear or clothing. You'll need to provide us with a health management program benefit approval form, along with:

- A tax invoice from the program provider.
- all Extras claims under $500 need to be paid in full before claiming

Sub-limits apply for each of the wellness benefits listed above.

How to make a claim

Before you claim, please remember:

- All Extrras claims under $500 need to be paid in full prior to claiming
- You'll need to serve the relevant waiting periods
- 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 CUA Health for assessment. Please read the claim form carefully and sign the form. If your policy requires you to pay an excess then you'll need to pay this directly to the hospital.

Medical Claims

The federal government has a schedule of fees for medical services (i.e. doctor's and specialists services) known as the Medicare Benefits Schedule (MBS). For privately insured patients, Medicare pays 75% of the fee for a medical service provided in hospital, and CUA Health pays the remaining 25%. If the doctor charges in excess of the MBS, a gap payment is required. This is in addition to any contributions that are applicable to the cover you have selected.

If your doctor participates in the 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.

On-the-spot claiming

After visiting your healthcare provider, simply swipe your CUA Health card for on the sport claiming. All you pay is the difference between your account and the benefit paid for the service.

Online

Claim benefits online at cua.com.au/health-insurance for the following services, provided you've already paid for the services:

- General dental
- Optical
- Physiotherapy
- Chiropractic & osteopathic
- Occupational therapy
- Dietitian
- Podiatry
- Speech therapy
- Exercise physiology

Extras claims of up to $300 are assessed online immediately, so you'll know straight away how much you'll get back from your claim.

Claim by Mail or in-Branch

Claim forms are available by visiting our website cua.com.au/health-insurance, through your CUA Branch or by contacting us on 1300 499 260. Once you've completed a paper claim form, attach the account and invoice and post it to us, fax it or drop it off at your local CUA branch.

Benefits payable will be credited to your nominated bank account, or a cheque will be posted to you.

Mail to:

CUA Health Insurance
GPO Box 100
Brisbane 4000 QLD

If you've already paid the provider fee, the benefit will be deposited in your bank account or a cheque will be posted to you.

If you haven't yet paid the provider (claims over $500 only), we'll send you a cheque payable to your service provider and you'll need to send this, along with any additional amount owing to the provider.

Can't find your original receipt? You'll need to ask your service provider for replacement copies before you can submit your claim.

Mobile claiming

With the CUA Health Mobile Claiming 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 it with just the click of a button - you don't need to fill out any paperwork.

Our app is free to download and works on iPhones, Android phones and most tablets.

To download the app, just head to the App store or Google Play and search for 'CUA Health'.

Declined claims

If we decline cover for your claim, we will send you a written notification to explain the reason for rejection of the claim.

We may also ask you for additional details in order to assess your claim.

Ambulance Cover

We will only provide ambulance benefits, in accordance with your level of cover, when 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.

State Ambulance schemes

Most State schemes cover their respective residents within their state of residence only. However, some States have entered into reciprocal agreements that allow you to be covered for ambulance services when you travel outside your state of residence. You should check with your state ambulance provider for when these reciprocal arrangements apply and the level of cover offered.

- **NSW and ACT:** If you reside in New South Wales or the Australian Capital Territory and you have Hospital cover, you pay an ambulance levy as part of your premium. This entitles you to free emergency ambulance transport under the State Government ambulance transport schemes. When you receive an account for ambulance transport, simply send it to us and we'll endorse it for you to send back to the appropriate ambulance transport scheme.
- **QLD and TAS:** If you reside in Queensland or Tasmania, you are covered under your state service scheme as well as for any reciprocal arrangements under that scheme.
- **VIC, SA, WA and NT:** If you reside in Victoria, South Australia, Western Australia or the Northern Territory you will receive cover for recognised emergency ambulance transport and on-the-spot treatment from us. This is as long as you don't have an ambulance subscription with your State ambulance service or cover through a state-based arrangement

Government Concession Card holders

Health Care Concession Card and Pensioner Concession Card holders are entitled to free ambulance transport services. Additionally, in NSW, Commonwealth Seniors Health Card holders are also entitled to free ambulance transport services.

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

When will CUA Health cover me?

If you fall outside your state-based arrangement (including any reciprocal agreement) and are not covered for emergency ambulance services, you'll be covered by CUA Health as long as:

- the services are provided by a recognised provider, and
- You hold any of our Extras covers, or one of our hospital products which includes Ambulance cover (check your applicable *CUA Health Product Sheet* to check your cover).

Emergency Ambulance

If you have Extras cover you're only covered for Emergency Ambulance services provided by a CUA Health approved ambulance provider. This means a sudden or unexpected need for hospitalisation where the only practical way of getting to a hospital is by ambulance.

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).

Recognised Ambulance Providers

We will only pay benefits towards ambulance services when they are provided by recognised providers including:

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

CUA Health also pays benefits for Ambulance Services provided by another provider where the service is provided on behalf of and invoice by one of the above State Ambulance Services.

Tip: We recommend that you take out an ambulance subscription with your recognised State Ambulance Provider if it's available in your state (VIC, SA, NT and some rural postcodes in WA). This will provide you with certainty of an ambulance coverage in all scenarios – Emergency & Non-emergency. Some States require additional cover to be effective nationally.

Important Information

Communicating with you

Our preferred way of communicating with you is by email. We'll use the email address you nominate at the time of joining to communicate all information about your CUA Health cover, except the first Welcome letter which will include your Member Card. You can update your email address at any time on our Online Services Portal or by calling us on 1300 499 260.

This means that we'll email you important notifications like any changes to your cover or to send you important documents like your tax statements or Standard Information Statements.

If you'd prefer us not to use email as our primary method of communication, please call us on **1300 499 260**.

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 www.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 insurance fund.
- 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 fund 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 fund is protected in accordance with national and state privacy principles.

A copy of the code is available online at www.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 29) 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
- agrees that, unless we are advised otherwise, if you're switching to CUA Health from another health insurer and you left your previous insurer less than 30 days before commencing cover with us, we'll automatically amend the date you joined to the date after you left your previous fund and you'll have to pay the premiums for that adjustment. For more on what this means, see 'Starting your cover', page 4.

Complaints

If you have any complaints or concerns, please call us on 1300 499 260 or email us at cua.health.correspondence@cua.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 insurers via the following contact details:

Private Health Insurance Ombudsman
Phone: 1300 362 072
Email: phio.info@ombudsman.gov.au
Web: www.ombudsman.gov.au
Post: GPO Box 442, Canberra ACT 2601

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 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 CUA Health membership or a new product through the CUA Group (comprising Credit Union Australia Limited, CUA Health Ltd and Credicorp Insurance Pty Ltd).

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

- Joint policy holders.
- Referees nominated by you.
- Your employer(s).
- 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 other CUA Group companies.

If you provide us with personal information about another person (for example a referee 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 policy, and that they can gain access to that information in accordance with this 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. These generally include:

- Assessing and processing your application for the products and services we offer.
- Establishing and providing our systems and processes to provide our products and services to you.
- Executing your instructions.
- Charging premiums.
- Processing claims.
- Uses required or authorised by law.
- Maintaining and developing our business systems and infrastructure.
- Research and development.
- Managing our rights and obligations regarding external payment systems.

The CUA Group may also use your information so that we can provide you with information about other products and services which is offered by the CUA Group including products which we distribute on behalf of other organisations (refer to the section 'Marketing' below). You can tell us at any time if you do not wish to receive information about other products and services.

If you start an online application form but do not submit it or you submit an application (whether electronically or otherwise) but do not proceed with the application, we may use your information to contact you regarding your application. We may also use it for research purposes but only after the information has been de-identified.

Marketing

The CUA Group 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. In order 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, visiting any CUA branch, or by 'unsubscribing' from our email 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 external and related service providers (including Credit Union Australia Limited), such as organisations which we use to verify your identity, payment systems operators, mailing houses, printing service providers, information technology service providers (including core administration systems

support), debit card suppliers and research consultants.
- Our professional advisors, such as accountants, lawyers and auditors.
- 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 CUA Group.
- Courts and external dispute resolution schemes,
- Government and regulatory authorities including taxation authorities, Medicare, Centrelink, the police, or AUSTRAC where required or authorised by law.
- Social media sites and organisations (e.g. Facebook) and other virtual communities and networks where people create, share or exchange information.

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 www.ahsa.com.au for complete details about how they comply with the Privacy Act.

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

Our privacy policy

The CUA Group respects the privacy of our members' personal information. Our CUA Group APP & Credit Information Policy ("privacy policy"), available at www.cua.com.au, sets out important information including:

- How we handle your personal information, including your credit-related information.
- How you can request access to and correction of your personal information.
- What you can do if you think that we have breached your privacy.

If you have any queries regarding our Privacy Policy, please contact us at:

Privacy Dispute Officer
Email: privacydisputes@cua.com.au
Phone: 07 3552 4744
Post: GPO Box 100, Brisbane QLD 4001

Description of services included under our covers

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.

Appendix removal (Appendectomy) or Appendicitis treatment: Surgery to remove an inflamed appendix. May include admission to hospital for a suspected inflamed appendix (appendicitis) and where appendectomy is not required.

Brain Surgery: Surgery to treat conditions of the brain or skull. This may include:
- removing a brain tumour
- bleeding (haemorrhage) in the brain
- blood clots (hematomas) in the brain
- weaknesses in blood vessels (brain aneurysm repair)
- craniotomy.

Cardiac & Cardiac related procedures: Medical and surgical admissions to investigate, diagnose, monitor and/or treat heart-related conditions.
May include services such as open heart and bypass surgery, invasive cardiac investigations and procedures such as angiograms, angioplasties and stent insertions.

Cancer treatment: Surgery to diagnose or remove cancer and in-hospital cancer treatments which are approved under the Pharmaceutical Benefits Scheme for the specific type of cancer being treated. This may include:
- surgery
- radiation (radiotherapy)
- chemotherapy

Cataract and Eye lens procedures: Surgery to treat vision loss caused by cataracts, as well as other major eye-related hospital admissions.

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.

Cover for accidents: 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.

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

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.

Eye Therapy (opthoptics): Eye Therapy involves detecting, assessing, diagnosing and performing non-surgical (and non-medical) management of eye movement disorders and abnormalities. Orthoptists exclusively specialise in treating conditions such as:
- lazy or turned eyes
- double vision
- vision impairments caused by trauma.

Gastric Banding and Weight Loss Surgery: Surgery to the stomach which aims to aid weight loss in order to reduce the health risks associated with obesity. Surgery may involve reducing the size of the stomach (gastric banding or stapling), removing a portion of the stomach (sleeve gastrectomy) or bypassing the stomach (gastric bypass). It also includes subsequent surgery such as reversal or adjustment.

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 wisdom teeth)
•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.

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.

Joint Replacements: Surgery to replace a hip, knee, shoulder, elbow or ankle joint with a prosthesis. It includes surgery after fracture as well as joint deterioration and revision of previous replacement surgery. Any prosthesis provided must be on the Australian Government Prostheses List for benefits to be payable.

Joint (Shoulder and knee) reconstruction surgery & investigations: Reconstructions to repair ligament tears, remove loose tissue and to treat other damage. This is most common type of sports injury to joints. Please note this is different from a Joint replacements.

Major dental: Complex dentistry procedures including but not limited to:
•crowns and bridges
•root canal therapy
•removal of wisdom teeth
•dentures
•implants.

Minor Gynaecological Surgery: Minor surgery to treat conditions of the female reproductive system. Most minor gynaecological surgeries are usually (but not always) carried out as same day procedures. Excludes IVF

Mental Health Upgrade: The waiver of the two 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 Pricate Health Insurer.

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.

Natural Therapies: Treatments that work on the physical and emotional body to relieve pain and improve health and wellbeing. Services include:
•remedial massage
•acupuncture
•naturopathy
•homeopathy
•Chinese or western herbalism
•Myotherapy and more.

Obstetrics-related services (pregnancy): Services and treatment provided to an admitted patient in hospital for care during pregnancy and childbirth. Includes vaginal and caesarean delivery and in-patient diagnostic imaging, as well as treatment of pregnancy-related complications.

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: Health care that offers support to people with a life-limiting illness. Its aim is to comfort and to relieve pain and distress for people who are dying.

Pharmacy: This benefit only covers Pharmaceutical scripts that are not part of the Pharmaceutical Benefits Scheme, are approved by Therapeutic Goods Administration (TGA) for the condition being claimed for and are usually classified as S4 or S8 type medication. You will have to pay an amount equivalent to the current PBS contribution before benefits are payable.

Psychiatric treatment: The diagnosis and treatment of a wide range of mental health conditions, including addiction. For benefits to be payable, treatment needs to be provided at a CUA Health recognised psychiatric provider.

Plastic & reconstructive surgery: Surgery which is medically necessary to treat a physical deformity that is either acquired (through an accident, infection, changes in body shape) or congenital (present from birth). It may include the removal of excess fat or tissue (breast reduction, abdominoplasty), correction of nose deformities, or removal of a scar – where these conditions lead to a medical condition that requires treatment. CUA Health does not pay for cosmetic treatment.

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

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

Renal Dialysis: Treatment to assist or replace the function of the kidneys by ensuring the appropriate balance of chemicals in the blood. It can include both haemodialysis (circulating the blood through a machine) and peritoneal dialysis (infusing and draining a sterile solution into the abdomen).

Stroke Treatment: Stroke Treatment for a stroke. A stroke or CVA is the rapid loss of brain function(s) due to disturbance in the blood supply to the brain. This can be due to lack of blood flow (ischemia) caused by a:
• blockage (thrombosis, arterial embolism)
• haemorrhage

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

Spinal Fusion: Surgery to join two or more vertebrae to reduce pain and improve function arising from disorders of the spinal column.
It may include treatment of conditions such as chronic low back pain, spondylolisthesis, spondylosis and degeneration of the spine. It does not include treatment of developmental deformities such as scoliosis or kyphosis.

Surgical removal of wisdom teeth: The surgical removal of wisdom teeth in hospital in order to alleviate symptoms such as pain and infection associated with wisdom teeth. Includes benefits towards hospital accommodation and medical charges raised by doctors (e.g. anaesthetics) only where a Medicare benefit is payable. No benefits are payable under Hospital covers towards charges raised by dentists.

Surgical removal of Tonsils and/or Adenoids: Surgery to remove tonsils and/or adenoids.

Vascular Surgery: Vascular surgery is a surgical subspecialty in which diseases of the vascular system, or arteries, veins and lymphatic circulation. This relates to diagnosis and management of diseases affecting all parts of the vascular system. This also includes surgery for removal of varicose veins.