union health

IMPORTANT INFORMATION GUIDE



Effective 1 August 2026

This publication contains general information to help you understand your health insurance and make informed choices about your cover. Please read in conjunction with information on our website and the relevant product guide.

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Terms that are highlighted are explained further in the Terms, conditions and definitions section.

Information in this brochure is correct at time of printing and may be subject to changes, which may include premiums, closing a policy type and removing or restricting services or benefits. If any changes to our fund rules have a detrimental impact on your cover, we will provide you with notice in writing before the changes come into effect. Changes will apply regardless of whether premiums have been paid in advance.

You can change your cover at any time. For details and conditions, see Changing your level of cover.

Contact us if you'd like a copy of our fund rules.

A FEW THINGS YOU SHOULD KNOW ABOUT YOUR PRIVATE HEALTH INSURANCE POLICY

MEMBERSHIP

Your membership starts when you first purchase your Union Health health insurance policy. You'll be issued with a membership card, which you'll need when you make claims. So keep it handy, and contact us for a replacement if you lose it.

CATEGORIES

Single membership covers one adult only.

Single parent membership covers one adult and their dependants.

Couple membership covers two adults on a single policy.

Family membership covers two adults and their dependants.

THE POLICYHOLDER

If you are the policyholder, the membership is held in your name and you are legally responsible for the membership. Only the policyholder can terminate the membership or remove dependants under 18 years of age. See Spouse/ partner authority.

PAYMENTS

Your health insurance premiums are payable in advance and must be up-to-date when you make claims. There are several ways to pay:

- **Direct debit:** We can automatically debit payments from your financial institution or bank account on a fortnightly, monthly, quarterly, half-yearly or annual basis.
- **Automatic credit card charge:** We can charge your preferred credit card monthly, quarterly, half-yearly or annual basis.

If you are finding it difficult to make regular payments, please contact us to discuss your options. Your membership will automatically cease if your payments are outstanding for more than two months.

HOW TO CLAIM

You'll be able to claim benefits from Union Health once you've paid your first premium and met any relevant waiting periods, as detailed in the product guide.

We offer four easy ways to claim for your extras:

- Swipe your physical membership card or use the digital card on the Union Health app (Android users) at your HICAPS/Healthpoint participating health care provider to apply your benefit immediately.
- Claim through the Union Health mobile app, available on Google Play and the iTunes Store.
- Log into our member portal (via our website) and follow the instructions to submit your claim.
- Send your claim form and original accounts or receipts to PO Box 265, Fortitude Valley 4006, or email copies to online.claims@unionhealth.com.au.

If a benefit is payable to you, we will pay it directly into your nominated bank account. Adults on the membership may nominate account details other than the policyholder's for payment of claims made in their own name.

For information about hospital or inpatient doctor and medical claiming see Claiming and Access Gap Cover.

*Please retain your original accounts/receipts for 12 months after your claim has been paid, as they may be subject to audits. For more information, see Claiming.

We pay claims under the understanding that:

- The costs involved are not recoverable from a third party (eg. NDIS, workers compensation, or other insurance/ damages). If treatment costs are reimbursed by a third party you must repay any benefits we have paid for the claim.
- To ensure correct payment of benefits, we will use your personal information in accordance with our Privacy Policy. Unless you tell us otherwise, this may include contacting your health service provider to request information about the treatment you received and the charges raised.

For further details please contact us for a copy of our Fund Rules.

WANT TO CHANGE YOUR MEMBERSHIP?

As your situation changes throughout life, your health cover needs to change with it. We recommend you review your cover periodically and around any significant events. Getting hitched? Switch from single to couple membership. Welcoming your first child? Increase your level of cover and later switch to family membership. Kids over 21 years of age and still need cover? Get extended dependant cover. Kids all grown up and moving out? Remove them from your policy.

You can update most of these details on our website, or by downloading a Change to Membership Details form and posting it to us. Some details can also be updated on our member portal, in our mobile app or by calling us.

CHANGING YOUR LEVEL OF COVER

Waiting periods apply for:

- existing Union Health members who increase or upgrade cover, including changing to a different excess; and
- new Union Health members transferring from a lower level of cover at another fund.

The previous level of cover continues to apply until all appropriate waiting periods for the new cover have been served. Any increase to your excess will apply immediately. Years of membership with your previous fund are not recognised. Please contact us if you wish to discuss your individual circumstances.

If you reduce your level of cover, the lower benefits on your new cover will apply immediately if you have already served the required waiting periods.

To authorise your partner/spouse or other adult on the policy to operate the policy, please see Partner/spouse authority.

CHANGING WHO IS COVERED

Adding a new adult or dependant to your policy or removing someone from your policy (including a deceased person) may lead to a change of membership category or the premium payable, so please let us know as soon as you can.

CHANGING YOUR CONTACT DETAILS

You can change your contact details on our member portal, on our mobile app, or by calling us.

CHANGING YOUR PAYMENT PREFERENCES

You can change your payment method or frequency on our member portal, on our mobile app, or by calling us. See Payments.

ABOUT HOSPITAL COVER

WHAT IS COVERED?

With hospital cover (subject to any exclusions), you are covered for medically necessary inpatient treatment in Australian hospitals (see 'Hospital types'). Accommodation may be in a shared or private room. This is determined by the hospital. For eligible private inpatient services, Medicare will cover 75% of the Medicare Benefit Schedule (MBS) fee set by the government for doctors' charges. Union Health will cover the remaining 25%. Any amount above this will be paid by you directly to the doctor, see Access Gap Cover.

Your cover includes accommodation, theatre fees, intensive care, industry approved Medical Devices and Human Tissue Products (see Surgically implanted Medical Devices and Human Tissue Products), and hospital medication that health insurers can pay under the law.

You can also choose your own doctor and get quick access into almost all private hospitals in Australia. A current list of contracted hospitals is available on our website.

Some covers may have restrictions or exclusions, please refer to the product guide for details.

WHAT IS NOT COVERED?

We pay benefits in accordance with the law and with Union Health Fund Rules and policies. The items that we do not pay benefits for include, but are not limited to:

- hospital treatment that is not medically necessary
- hospital treatment that is not eligible for Medicare benefits
- cosmetic surgery
- outpatient treatment, GP visits, specialist consultations
- charges above the Medicare Benefit Schedule (MBS) fee
- some pharmacy items
- personal incidentals
- experimental procedures or therapies
- high-cost medications*
- robotic surgery consumables*
- medical devices not included in hospital theatre fee charges as determined by law
- treatment in an emergency department
- procedures or services that are excluded from your policy
- treatment while you are serving a waiting period.

*At our discretion and in accordance with the hospital contract, we may give special consideration for benefits toward high-cost medications, exceptional medical procedures or other extraordinary costs related to the health care of a Union Health member. Requests are considered on a case-by-case basis.

HOSPITAL TYPES

CONTRACTED PRIVATE HOSPITALS

We have contracts in place with an extensive network of private hospitals. Each contract sets out agreed rates and benefit schedules, enabling us to pay for the services included on your cover (less any applicable excess) in line with the Private Health Insurance Act. Please visit our website to search for contracted hospitals, or call us prior to hospital admission.

NON-CONTRACTED PRIVATE HOSPITALS

At non-contracted private hospitals, we only pay the default benefits as determined by the government. If you choose to be admitted to one of these hospitals, you may incur significant out-of-pocket costs.

PUBLIC HOSPITALS

You can be treated as a public patient in a public hospital at no charge, even if you have private health insurance. Union health has no contracts with public hospitals. If you choose to stay in a private room for an overnight stay, we'll pay the shared room minimum benefit. If the hospital accommodation charges are greater than the Union health benefit, you'll be required to pay the balance as an out-of-pocket expense. If you are admitted as a private patient, you may also incur out-of-pocket medical expenses and/or co-payments if you are a nursing home type patient. The hospital should let you know what these expenses will be before you elect to be a private patient. See Informed financial consent.

HOSPITAL EXCESS

See Excess.

INPATIENT/OUTPATIENT

You become an 'inpatient' when you are admitted to a hospital for treatment. You're an 'outpatient' if you receive medical services without being admitted into hospital, including specialist appointments, post-surgical follow-up consultations, prenatal visits, diagnostic imaging, pathology, or emergency department treatment.

Hospital benefits only apply for medically necessary inpatient treatment as determined by law. For medical services not related to inpatient treatments (outpatient treatment), Medicare will cover 85% of the MBS fee. The law does not allow for any benefit to be paid by health insurance.

ABOUT EXTRAS COVER

WHAT IS COVERED?

Your extras cover pays benefits toward a wide range of dental, optical, and allied health services, such as physiotherapy and remedial massage, amongst other things. Your product guide contains a list of benefits and annual limits that apply. The limits reset on 1 January, and you can check your usage on our website and the mobile app.

Benefits are paid for treatment by registered practitioners in private practice and recognised natural therapists approved by Union Health. Please contact us to check if your provider or natural therapist is recognised by Union Health, and to confirm the benefits you can claim.

WHAT IS NOT COVERED?

We pay benefits in accordance with the law and Union Health Fund Rules and policies. The items that we do not pay extras benefits for include, but are not limited to:

- services where a benefit is payable by Medicare
- treatments by providers not recognised by us for benefit purposes
- services that took place two years or more before the date you lodge the claim
- overseas products, treatments or services
- telephone and email consultations or letters of advice by providers (also see Telehealth - pl 14)
- pharmacy/vaccinations where the fee is less than the PBS amount or is not TGA-approved
- treatment by a provider who is a family member, including (but not restricted to) treatment by yourself or your partner, parent, sibling, child, or other insured person on the policy
- midwife services at a home birth
- vitamins and supplements.

Restrictions may apply for multiple treatments on the same day.

DEFINITIONS, TERMS AND CONDITIONS

ACCESS GAP COVER

We help to close the gap on in-hospital medical expenses for our members by including Access Gap Cover with all our hospital covers.

Medicare covers 75% of the Medicare Benefit Schedule (MBS) fee set by the government for eligible inpatient services. Union Health covers the remaining 25% of the MBS fee. But if your medical practitioner charges above the MBS fee, you'll need to pay an additional out-of-pocket amount, known as the 'gap'. See also Medical Gap.

If your practitioner chooses to participate in our Access Gap Cover scheme, you'll have lower or no out-of-pocket costs. In most cases, Union Health will receive the account, make Medicare claims on your behalf, and pay the practitioner directly.

Participation in this scheme is the personal choice of individual medical practitioners, so prior to treatment, please:

- request an estimate of costs from your doctor (see Informed financial consent)
- ask your doctor if they have chosen to participate in our Access Gap Cover scheme
- ask your doctor to confirm if any assisting specialists use Access Gap Cover.

ACCIDENTS

You're immediately covered for hospital treatment for accidents with no waiting periods to serve, providing you joined Union Health prior to the accident, have the appropriate cover for that treatment and your premium payments are up to date.

An accident is an unexpected incident that results in injury and requires treatment by a medical practitioner or dentist within 7 days. Benefits are payable for the initial inpatient hospital treatment for injuries resulting from the accident as well as ongoing inpatient hospital treatment where the services are provided within 180 days of the date of the accident. Accidents are not related to any other ailment, illness or condition.

If you have been involved in an accident and received compensation or damages from a third party:

- you cannot claim additional benefits in relation to this accident
- you must repay Union Health any benefits and associated costs we've already paid.

See Emergency departments.

ACTIVE HEALTH BONUS

The Active Health Bonus is a reward available to members with eligible levels of cover, when any adult other than an adult dependant completes the Health-e-Profile, our online health assessment, in each consecutive 12-month period. You may use the bonus to pay the out-of-pocket costs for extras treatments (up to the annual limit).

The Active Health Bonus limit is per policy, per calendar year. A six-month waiting period to receive the bonus applies from your join date.

The following are not claimable under the Active Health Bonus:

- co-payments for Pharmaceutical Benefit Scheme (PBS) prescriptions
- any difference between the Medicare Benefits Schedule fee and the doctor's charge for medical expenses
- any medical expense our Fund Rules or legislation prevents us from paying
- hospital excesses.

If you decrease/change your level of cover, you may receive a reduced or no Active Health Bonus.

AGE-BASED DISCOUNT

To help make private health insurance more affordable, we offer a discount of up to 10% for people who join selected hospital covers before the age of 30.

The discount applies to the full cost of Silver+ Family Hospital, Silver+ Hospital Essentials, Silver+ No Pregnancy Hospital, Bronze+ Young Choice, Bronze+ Hospital and Basic+ Hospital policies.

As long as you retain an eligible policy the discount applies until you turn 41, then decreases by 2% per year.

AGE-BASED DISCOUNT	
AGE UPON JOINING	DISCOUNT
Under 26	10%
26	8%
27	6%
28	4%
29	2%

AMBULANCE

Subject to the state-based terms below, ambulance is covered for both emergency and non-emergency situations.

Non-emergency situations include:

a) A call out or attendance by an ambulance where no transport occurs;

b) Admission to a hospital from home where transport is deemed medically necessary.

c) Discharge from hospital to home where transport is deemed medically necessary, and does not include inter-hospital transfers.

QLD RESIDENTS

All Queensland residents are covered by Queensland Ambulance Service (QAS) arrangements, including interstate travel. Any claims are to be submitted directly to QAS.

NSW AND ACT RESIDENTS

If you live in ACT or NSW, an ambulance levy to cover transportation or attendance by NSW ambulance is included in your hospital cover. If you receive a NSW Ambulance account, send it to us. If you require ambulance assistance in another state, you can only claim if you have hospital cover combined with extras cover.

When a dependant resides in NSW or the ACT, but the policyholder's residential address is in another state, they can only claim for ambulance on hospital covers combined with extras cover.

TAS RESIDENTS

All Tasmanian residents are covered by Ambulance Tasmania. If a Tasmanian resident requires services in QLD or SA, they're not covered by the state scheme and can only claim if they are on hospital covers combined with extras cover.

ALL OTHER STATES AND TERRITORIES

You are entitled to cover for ambulance transportation or attendance if you have hospital cover combined with extras cover. Benefits for air ambulance services are limited to a maximum of $6,000 per person per annum and are only payable for state-owned air ambulance services. A waiting period of one day will apply to air ambulance benefits. If you receive an ambulance account, send it to us for payment.

AMBULANCE SUBSCRIPTIONS

Members residing in South Australia, Northern Territory, Victoria or regional Western Australia who have an eligible stand-alone general/extras treatment cover may purchase an ambulance subscription with their ambulance service provider and then claim the cost of that subscription from us under the Health Management benefit (refer to your product guide for details of eligibility and annual limits sub-limits apply). Any subsequent ambulance transportation fees must then be reconciled with the ambulance service provider under the terms of your subscription.

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

The government provides a rebate on private health insurance premiums. The rebate you receive depends on your age (persons aged 65 and over receive a higher rebate) and your household income. You must be eligible for Medicare benefits to qualify for the rebate.

You can claim the rebate as a reduction of your premiums, or as a tax rebate when you lodge your annual tax return.

To have the rebate deducted from the premium you pay, just complete the application form for the Australian Government Rebate on Private Health Insurance when you join Union Health.

Please visit privatehealth.gov.au for more information.

AUTHORISING A PARTNER/BACK-UP PERSON

If you'd like to enable a partner, relative or friend to manage your membership as well, all you need to do is complete and submit an authority form. The authorised person won't be able to remove you from the membership or cancel it, and you can withdraw their authorisation anytime.

BENEFIT

The amount you receive from Union Health when you make a claim. See your product guide for a list of benefits payable under your cover or please call us.

Benefits cannot exceed the fee for service incurred.

CALENDAR YEAR

A 12-month period commencing 1 January and ending 31 December.

CHRONIC DISEASE MANAGEMENT PROGRAMS

We offer a range of Chronic Disease Management Programs that are designed to decrease the risk of developing a chronic disease or to assist in the management of diagnosed chronic diseases. Product and clinical eligibility apply to these programs.

Current programs:

- **Disease Management Programs** - you must have held hospital cover for at least six months and clinical eligibility applies.

- **Healthy Weight for Life** - you must have held eligible hospital cover for at least 12 months and extras cover for at least six months and clinical eligibility applies.
- **Care Coordination** - you must have held eligible hospital cover for at least 12 months and extras cover for at least six months. Clinical eligibility applies.

CLAIMING

If a benefit is payable to you, it will be paid directly into your nominated account.

We offer four easy ways to claim for your extras:

- Swipe your membership card at your HICAPS/ Healthpoint participating health care provider to apply your benefit immediately.
- Claim through the Union Health mobile app, available on Google Play and the iTunes Store.
- Claim for eligible services on our member portal.*
- Send your claim form and original accounts or receipts to PO Box 265, Fortitude Valley 4006 or email copies to online.claims@unionhealth.com.au

Any account or receipt submitted must be on an official receipt or account, and bear the provider's official stamp. It must be legible and display the provider's name, provider number, practice address, ABN/ACN, the date of service, a description of the service, the name of the patient and the cost. Cash register dockets will not be accepted.

We will retain all documents unless you indicate otherwise.

To check if your claim is payable, we may request additional information, such as copies of clinical documents, from you or your health provider. If we don't receive this information, we may not pay a benefit for that claim.

For inpatient Medical Gap Cover treatment, the Medicare Statement of Benefits is required to process your entitlements. Your hospital should bill us directly and claims will be paid on your behalf. See Excess.

All claims are subject to private health insurance laws, Fund Rules and policies and procedures.

*Please retain your original accounts/receipts for 12 months after your claim has been paid, as they may be subject to audits.

COOLING OFF PERIOD

You have the right to a 30-day cooling off period if you change your mind about joining Union Health or changing your cover, provided there are no claims made during the period. The 30-day period commences from:

- the joining date;
- the date the level of cover increases; or
- the date the level of cover decreases.

For the latter two, the cover will revert back to the previous level of cover.

COSMETIC SURGERY

Cosmetic surgery refers to procedures performed that are non-medically necessary. We are unable to pay benefits for these procedures or the hospital costs associated with them.

To help us determine if your treatment is medically necessary, we may ask for further information from your treating practitioner before we can confirm your correct benefit entitlements. If in doubt, talk to your doctor and call us before committing to any treatment. See Plastic and reconstructive surgery.

DEFAULT BENEFIT

For any service that is restricted on your cover, only default benefits are payable.* This benefit is determined by the government and is the minimum amount funds must pay for accommodation costs in hospitals. Default benefits don't provide any benefit for labour ward or theatre fees. The default benefit covers the cost of:

- shared accommodation as a private patient at a public hospital;
- a reduced level of accommodation benefit as a private patient at a private hospital;
- Access Gap/Medical Gap Cover with participating doctors; and
- surgically-implanted Medical Devices and Human Tissue Products - we will cover the full cost of any government approved (no gap) Medical Devices and Human Tissue Products and the minimum benefit for gap permitted items.

Significant out-of-pocket costs may result if the treatment can only be claimed at default benefit rates so remember to check whether your cover suits your needs or, if applicable, choose a contracted hospital.

*Default benefits are also only payable for non-contracted hospitals.

DENTAL

The dental treatments you're covered for depend on the item number for that treatment. Some covers exclude certain procedures. Contact us for a quote on the item number or use the benefit quote function on our website or mobile app.

DENTAL PROSTHETISTS

Benefits are paid for treatment by registered dental prosthetists at 75% of the benefit which would be payable for treatment provided by registered dentists.

MAJOR DENTAL

Major dental includes all dental services relating to dentures, crowns, bridges, inlays, onlays, facings, dental implants, endodontia, periodontia, anti-snore devices and orthodontia.

Conditions apply for Mid Range Extras. Major dental is not covered on Basic Extras.

ORTHODONTICS

Benefits are paid for active treatment and annual limits may apply (refer to your product guide for your level of cover). Confirmation of continuing active treatment may be required to claim.

Benefits will only be payable if the dental treatment/service is completed as an in-person consultation with a registered orthodontist or dentist and not if the service is undertaken via:

- photo
- video
- telephone or
- online consultation.

DEPENDANTS

CHILD DEPENDANT

- A natural child, stepchild, legally adopted child, or child for whom the policyholder is the legal guardian or who is in the policyholder's legal custody.
- The policyholder's adult child, who is not married or in a de facto relationship and who is under 21 years of age.

STUDENT DEPENDANTS

Dependants who are full-time students or completing apprenticeships, traineeships or cadetships may remain on the family's policy until they complete their studies or until they turn 32 (whichever comes first) if they:

- attend a recognised education facility for the whole of the academic year; and
- are unmarried and not in a de facto relationship.

You must apply for student dependant cover on commencement of study.

Students are not covered if they cease or defer study during the year.

EXTENDED DEPENDANT COVER

Single parents and families with non-student dependants may purchase extended dependant cover to enable young single (i.e. not married or in a defacto relationship) adults to remain on their family's policy until they turn 32.

Available on all covers except Basic + Hospital (stand-alone or combined with an Extras policy). Additional loading applies.

EMERGENCY DEPARTMENTS

Hospital treatments which do not normally require admission as an inpatient (as determined by law), and all emergency department treatment at public or private hospital emergency departments, are not covered by private health insurance.

EXCESS

An excess is an amount you elect to contribute towards the cost of your hospital treatment (including same day surgery and procedures, such as chemotherapy and dialysis). Agreeing to pay an excess if you need hospitalisation reduces the amount of premium you pay. An excess is only payable once per adult per calendar year.

The hospital excess is not charged for dependants*.

*Note: Reducing your excess is considered to be upgrading your membership. We will charge your previous excess within the first two months of the upgrade, including for adults who are upgrading their level of cover by joining/re-joining as a dependant on a family membership.

EXCLUDED SERVICES

These are services for which no benefit is payable under some levels of cover. Examples of excluded services for some covers include:

- heart and vascular system
- pregnancy and birth
- weight loss surgery
- assisted reproductive services
- joint replacements
- cataracts
- dialysis for chronic kidney failure.

Please refer to your product guide for exclusions and restrictions that might apply to your cover.

GAP

See Medical gap and Access Gap Cover.

INFORMED FINANCIAL CONSENT

Before you receive treatment as a private patient in hospital, you are entitled to ask your doctor, your hospital and your health fund about any out-of-pocket costs you may incur.

Ask your treating doctor or specialist, wherever practical, how much their fee will be and if you'll need to pay a gap. For major treatment, this information should preferably be provided in writing. It's your right to ask for this information before you agree to a proposed treatment. In some circumstances, such as emergency admissions, it will not be possible for your doctor to obtain informed financial consent before the treatment is provided.

You may have more than one doctor involved in your treatment, such as a surgeon and anaesthetist. Your surgeon should be able to advise who else will be treating you and how you can contact the other doctors to seek fee information from them. See also Access Gap Cover.

LAW, LEGISLATION

The main law governing private health insurance is the Private Health Insurance Act 2007 and associated Rules. Union Health must also comply with its Fund Rules.

LIFETIME HEALTH COVER

Lifetime Health Cover is a government initiative designed to encourage people to join a private hospital cover early in life and to maintain membership. If you take out hospital cover after 1 July following your 31st birthday, your base premium will increase by 2% for each year you are over the age of 30 up to a maximum of 70%. This surcharge also applies to your partner if over 30. If you were born on or

before 1 July 1934 you will not be affected by the Lifetime Health Cover surcharge.

Any loading you pay is removed once you have paid the higher premium for a continuous period of 10 years.

Important: Having standalone extras cover will not exempt you from paying the Lifetime Health Cover loading.

LIFETIME MENTAL HEALTH WAITING PERIOD WAIVER

Policyholders can upgrade from a policy which offers restricted benefits for hospital psychiatric services to a policy which fully covers psychiatric services without having to serve the normal two-month waiting period.

This option is part of a government reform designed to make it easier for policyholders to access psychiatric services when they need it.

This exemption from the two-month waiting period can only be used once in a person's lifetime, regardless of whether you have transferred between insurers.

If you have not fully served the waiting period on your previous policy, the unexpired waiting period will still apply. If your previous policy had an excess, the excess provisions of the previous policy will apply for the first two-months of any upgrade.

The hospital admission must have been as a result of a referral by a consultant psychiatrist and the option to upgrade your policy must be taken within five working days of your admission to hospital. On upgrading, your premium will change to the rate of the upgraded policy.

LIMIT

ANNUAL LIMIT

The maximum amount payable per calendar year for an extras benefit. The annual limit is renewed on 1 January each year.

SUBLIMIT

A limit which is applied annually (or another specified period of time) on the benefit paid for a particular item or service within an overall category limit.

For example, with our Family Extras cover, you have an annual overall major dental limit of $2,000. Crowns and bridges have a sub-limit of $650 for your first year, so this is the maximum you can claim for these items. Your overall annual limit will then be reduced to $1,350 which you can use for other treatments within the major dental category.

MATERNITY

See Pregnancy and birth.

MEDICAL GAP

Medicare covers 75% of the Medicare Benefit Schedule (MBS) fee set by the government for eligible inpatient services. Union Health covers the remaining 25% of the MBS fee. If your doctor charges above the MBS fee, you'll need to pay an additional out-of-pocket cost, known as the 'gap', unless it is covered by our Access Gap Cover.

MEDICAL PRACTITIONER

A person registered or licensed as a medical practitioner under a law of a state or territory that provides for the registration or licensing of medical practitioners, in accordance with the Health Insurance Act 1973.

MEMBERSHIP CARD

We'll send your membership card by mail shortly after you join. Android users can also use a digital version on the Union Health mobile app. You will need either your physical or digital card for on-the-spot extras claim and may need it for hospital admissions, so please keep it safe and handy. If you lose your card please let us know immediately. You can order replacement cards via our member portal. Note: For your security, the old card will be cancelled once a new card is ordered.

The card remains the property of Union Health and you will be liable for any costs incurred as a result of invalid claims which are carried out by you, or by another person with your knowledge.

MEMBERSHIP ELIGIBILITY

To qualify for membership with Union Health, you must be aged over 18 and meet either of the eligibility criteria below:

- A current or former member of any Australian union.
- A family member of a current or former union member, or a Union Health member. This includes parent, partner or former partner, dependent child, adult child (and their partner), grandchild, brother or sister (and their partner and dependent children).

MEDICARE BENEFITS SCHEDULE

The benefits you receive from Medicare are based on a schedule of fees for medical services set by the Australian Government. The Medicare Benefits Schedule (MBS) lists a wide range of consultations, procedures and tests, and the schedule fee for each of these items. Benefits are only payable for hospital procedures that are listed in the MBS and/or meet the eligibility criteria for Medicare benefits. You can look up a service or item number at mbsonline.gov.au, or by asking your medical practitioner.

NURSING HOME TYPE PATIENTS

Non-acute certified admissions exceeding 35 days may be defined as a Nursing Home Type Patient. A co-payment may apply, please contact us for more information.

OUT-OF-POCKET COSTS

HOSPITAL

Possible hospital out-of-pocket costs include:

- hospital treatment that is not medically necessary or treatment which is not eligible for Medicare benefits
- cosmetic surgery
- outpatient treatment
- charges above the Medicare Benefits Schedule (MBS) fee
- some pharmacy items

- personal incidentals (e.g. toiletries, newspapers, tv, etc.)
- experimental procedures/therapies
- high cost medications*
- robotic surgery consumables*
- medical devices not included in hospital theatre fee charges as determined by law.

*we may give special consideration for benefits toward high cost medications, exceptional medical procedures or other extraordinary costs related to the health care of a Union Health member at our discretion in accordance with the hospital contract. Requests are considered on a case-by-case basis.

Access Gap/Medical Gap Cover is limited to treatment provided during inpatient hospital admission.

For more information, please refer to the Commonwealth Ombudsman's brochure 'Doctors' Bills' which you can download from ombudsman.gov.au. Alternatively, you can contact us and we'll send you a copy.

EXTRAS

An extras out-of-pocket cost is the difference between the amount a service provider charges and the benefit we pay. For example, if a physiotherapist charges $70 for a visit and we pay a benefit of $32, the out-of-pocket cost would be $38.

Visiting a preferred service provider may reduce the out-of-pocket costs you are required to pay. See our website for a list of Union Health's preferred dental and optical providers.

OVERSEAS PRODUCTS, TREATMENTS AND SERVICES

We do not pay benefits for services provided or products purchased overseas, including internet purchases where the goods are provided from an overseas supplier. This is to ensure you receive the high level of consumer protection and quality of service that is provided under Australian standards and health conditions.

OVERSEAS TRAVEL

Private health insurance does not cover you for medical/hospital/extras treatment received while travelling overseas or while on a cruise ship in Australian waters. We recommend you obtain travel insurance for all overseas travel.

PHARMACEUTICAL BENEFITS SCHEME (PBS)

The PBS is run by the Australian Government to subsidise prescription medicines for Australians who have a Medicare card. If a medicine is subsidised under the PBS, you pay a lower price for the medicine, and the government pays the rest. For more information, see pbs.gov.au.

If your cover includes pharmaceutical, you are able to claim the amount above the PBS fee up to the benefit amount.

Benefit excludes medicines or medications which are:

- prescriptions less than PBS co-payment
- available without a medical practitioner's prescription
- not approved by the Therapeutic Goods Administration
- prescribed for contraceptive purposes.

PLASTIC AND RECONSTRUCTIVE SURGERY

Plastic and reconstructive surgery refers to the evaluation and treatment to correct functional impairments caused by trauma or congenital abnormalities. Plastic surgery can be performed to approximate a normal appearance, for example, a breast reconstruction following a mastectomy or skin grafting following burns.

Plastic and reconstructive surgery is not cosmetic surgery. Cosmetic surgery is performed for non-therapeutic purposes and no benefit is paid by Union Health.

PRE-EXISTING AILMENTS OR CONDITIONS

All hospital claims in the first 12 months of membership for new members, members upgrading to a higher level of hospital cover or transferring from another fund are subject to the pre-existing ailment or condition rule. This rule refers to an ailment, condition or illness, the signs or symptoms of which existed at any time during the six months before a member joined Union Health or upgraded to a higher level of cover, even though a diagnosis may not have been made.

Our appointed medical adviser will decide if a condition is pre-existing based on medical notes and standard medical practice. If your claim is deemed pre-existing you will receive the benefits relating to your previous lower level of cover, or will not receive any benefit if no previous hospital cover was held.

Please allow five days for all the information to be received and assessed by the medical advisor.

A waiting period of 12 months is standard practice within the private health insurance industry to receive benefits for a pre-existing ailment. Two months apply to palliative care, psychiatric services and rehabilitation.

PREGNANCY AND BIRTH

Some covers exclude services related to pregnancy and birth. Please refer to the relevant product guide to see if you have the correct cover. Please be aware a 9-month waiting period applies.

By law, Union Health is unable to pay any expenses relating to visits to your obstetrician, gynaecologist or other doctors (including scans and doctor's management fees) either before or after you are hospitalised. Medicare will usually pay a benefit on these services.

To ensure your baby is covered from birth, members on single and couple cover must transfer to family or single parent membership within 12 months of your child's birth and ensure the additional premium is paid from the date of the baby's birth.

Visit our website for detailed information about pregnancy and pregnancy-related benefits.

Paediatric services provided to your baby in hospital are only claimable if the hospital deems it medically necessary and admits your baby as an inpatient.

RATE PROTECTION

You may pay your membership for up to twelve months in advance at the rate that applies at that time. This means that you will not have to pay extra for the period covered by your premium payment if premiums increase during the period for which you have paid. Rate protection will cease if you change your cover or suspend membership. Any amount paid in advance of the date of the cover change or suspension will be applied at the rate that is current at that time.

REBATE

See Australian Government Rebate on Private Health Insurance.

REMOTE TRAVEL AND ACCOMMODATION

A benefit is payable towards accommodation for the person requiring medical treatment or, in the case of hospitalisation, the accompanying person who must also be covered under the membership. This benefit is only payable where a tariff is charged by a registered accommodation facility and valid receipts are provided. Under this benefit members travelling over 200 kilometres return are also able to claim for travel expenses incurred to a maximum of one claim only per family per trip. Members travelling for appointments at the TUH Health Hub will be paid a benefit for over 300 kilometres return. The benefit paid is calculated at 15c/km based on the most direct route on Google maps and additional kilometres are not paid to avoid tolls.

RESTRICTED SERVICES

For services listed as restricted (for specific covers), we will pay the default benefit for hospital accommodation as determined by the Government for restricted services. Examples of restricted services for some covers include:

- hospital psychiatric services
- rehabilitation.

Refer to individual product guides for services with restricted benefits. Any excess applicable to your cover will be charged even where a default benefit only is paid.

The default benefit does not cover theatre or labour ward fees.

SURGICALLY-IMPLANTED MEDICAL DEVICES AND HUMAN TISSUE PRODUCTS

A surgically-implanted Medical Device and Human Tissue Product is a piece of equipment that is implanted into the body during a hospital procedure, such as artificial hip, a pacemaker, a cardiac stent, screws and plates. Most government-approved surgically-implanted Medical Devices and Human Tissue Products are covered by your hospital cover, however, some will require a patient contribution to be paid if the supplier charges above the listed benefit. If a gap amount applies to your Medical Devices and Human Tissue Products, your surgeon/hospital will arrange for you to complete an informed financial consent form.

SUSPENSION OF COVER

FINANCIAL HARDSHIP

If you are experiencing financial hardship and have been a financial member of Union Health for at least 12 months, we may allow you to suspend your membership for a minimum period of two months to a maximum period of 12 months. Suspension will be approved for an initial period of six months with an option to extend to a maximum period of 12 months. Multiple suspensions are allowed, however, 12 months must be served between consecutive suspensions. No claims can be made while your membership is suspended or for treatment that occurred while your membership was suspended.

OVERSEAS TRAVEL

If you are travelling overseas and have been a financial member of Union Health for at least 12 months, you may suspend your membership for a minimum period of two calendar months to a maximum period of three years. Premiums must be paid up to the date after you depart Australia, i.e. your suspension date plus one day.

Further suspensions can be requested once the policy has been active for a minimum of three consecutive months following a previous suspension. Complete a Membership Suspension Request from our website. No claims can be made while your membership is suspended.

Travel information to verify departure and return dates will be required at the time of application for suspension, unless you have a one-way ticket, in which case verification of return date will be required on resumption.

Please refer to the conditions that apply to suspension of membership, which are available on our website.

The remainder of any waiting periods not completed prior to suspension will continue when the membership is resumed.

TELEHEALTH SERVICES

Some extras services can be delivered effectively by phone or video instead of face-to-face.

WHAT CAN YOU CLAIM?

- Physiotherapy (individual consultations only)
- Exercise physiology (individual consultations only)
- Psychology (individual or group consultations)
- Dietetics (individual consultations only)
- Occupational therapy (individual or group consultations)
- Speech therapy (individual or group consultations.)
- Lactation consultations (individual consultations only)
- Approved chronic disease management programs
- Approved health management programs
- Counselling (individual or group consultations)

HOW TO CLAIM

Please check your provider has included telehealth in the description of the service before submitting your claim.

You can submit your claim directly to us via the mobile app or member portal. HICAPS on-the-spot claiming is not available as no card can be presented in person.

TRANSACTION AUTHORITY

For any persons, other than your spouse/partner, to make transactions on your policy a Power of Attorney is required. For enquiries about the policy a Third Party Enquiry form must be completed. See also Spouse/partner authority.

TRANSFERRING TO UNION HEALTH

HOSPITAL COVER

When you transfer to Union Health from another fund, you will receive continuity of equivalent cover providing you join Union Health within two months of leaving your former health fund. If any waiting periods have not been served (at all or in part) with your former fund, you will be required to serve the balance of the waiting period before you can claim those benefits from Union Health. Where your new cover has higher benefits (including a lower excess or fewer excluded/restricted services), waiting periods will apply.

In the case of a lower excess, you'll need to pay the previous higher excess for a hospitalisation in the first two months of cover.

EXTRAS COVER

When you transfer to an equivalent level of cover with Union Health, you will receive the first year benefits and limits (for covers that have annual limits that increase with years of membership) for all services, provided all waiting periods have been served with the previous fund.

Credit will be given for waiting periods partially served with your previous fund or on a previous level of cover if you are upgrading. If you transfer to a cover that provides services not covered by your previous fund, all relevant waiting periods for these services must be served with us.

Any benefits paid by your previous fund will be deducted from the Union Health annual or lifetime limits. Continuity of membership will only be taken into account if you join Union Health within two months of ceasing membership with your previous health fund.

WAITING PERIODS

For all new memberships and upgrades of cover (where your new cover has higher benefits, lower excess or more services), including transfers from another fund, the following waiting periods will apply:

- two months for all hospital services*, extras services, and home care programs unless specified otherwise
- two months for palliative care, hospital psychiatric services*, rehabilitation and home care programs
- 6 months for Active Health Bonus and optical.
- 9 months for pregnancy and birth
- 12 months for pre-existing ailments or conditions (excluding palliative care, hospital psychiatric services and rehabilitation) and prostheses
- 12 months for assisted reproductive services (including the benefits that apply to IVF treatments)
- 12 months for major dental, orthodontia, orthotics, hearing aids and health devices/health appliances (except compression garments, which have a two-month waiting period)
- two years for refractive laser eye surgery

If you have transferred from another health fund on a comparable level of cover and have served waiting periods you will be able to claim straight away.

There are no waiting periods for accidents that occur after you join Union Health.

Some services do not apply to all covers. See your product guide for details on services available on your cover.

*Refer to Lifetime mental health waiting period waiver for details on circumstances where the waiting period for hospital psychiatric services may not apply.

WORKERS COMPENSATION

Claims for work-related injuries must be submitted directly to WorkCover or the workers compensation authority in your state. In the event that your state workers compensation authority rejects your claim, Union Health may make payment relevant to your level of cover. We require fully itemised accounts/receipts with a copy of the authority's letter stating that you are not entitled to compensation benefits.

OUR COMMITMENT TO YOU

CODE OF CONDUCT

Union Health is accredited under the Private Health Insurance Code of Conduct. This industry code stipulates a standard of service to promote communication and understanding between private health insurers and their members.

The code ensures we;

- continually work towards improving the standards of service we offer to our members
- provide information in plain language about our products and services
- provide easy access to our internal dispute resolution procedures
- keep your information confidential in accordance with privacy principles.

Accreditation is a significant achievement and confirms Union Health's commitment to excellence in delivering quality products and services to our members.

For further information visit the Code of Conduct website: www.privatehealthcareaustralia.org.au/codeofconduct

RESOLUTION OF PROBLEMS

Union Health has a resolution process to ensure your concerns are dealt with in a timely, professional and consistent manner to our mutual satisfaction where possible. When we receive a complaint, we'll look into the matter and get back to you within two working days. If we need more time to investigate the matter further, we'll get back to you and let you know how long it will take.

PRIVACY POLICY

unionhealth.com.au/node/26

CONTACT US

Address: 438 St Pauls Terrace, Fortitude Valley QLD, 4006

Post: PO Box 265, Fortitude Valley QLD 4006

Phone: 1300 661 283

Email: enquiries@unionhealth.com.au

UNION HEALTH

Complaints Officer

Phone: 1300 661 283

Email: customerrelations@unionhealth.com.au

If you remain dissatisfied with the way we've managed your concern, you may contact the Commonwealth Ombudsman.

COMMONWEALTH OMBUDSMAN

The Commonwealth Ombudsman's role is to assist with enquiries and complaints about any aspect of private health insurance. The Ombudsman is independent of private health funds, private and public hospitals. For information or complaints about health insurance please contact the Ombudsman's office.

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

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

Phone: 1300 362 072