Policy Booklet

Important information about health covers

- General terms and conditions
- Hospital cover
- Extras cover
- Ambulance cover
- Government initiatives

Read with your product information.
Effective 1 October 2026.

FREQUENT FLYER | QANTAS INSURANCE

Policy Booklet

About the insurer

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

About the Agent

nib has appointed Qantas Airways Limited ABN 16 009 661 901 (Qantas) as its authorised Agent to promote and distribute this health insurance on behalf of nib. Qantas is paid a commission by nib for promoting and arranging this insurance which includes an ongoing commission while you hold this Policy.

About this document

This document is issued by nib as the underwriter of this health insurance. This document summarises your and Our rights and obligations under the Fund Rules and is designed to help you understand what you will be Covered for and important limitations and Exclusions that apply. It should be read in conjunction with your Product Information which contains more information about your health Cover. It is of a general nature only and you should always make enquiries with Us before going to Hospital or undergoing a new course of Treatment. The information in this document is accurate and up to date as at the date of issue of this document, and may be amended from time to time. Please read this document and keep a copy for your records.

Contents

General terms of Cover **5**

Applying for a health insurance Policy 5
Who is Covered 5
Adding a dependant or Partner 6
Adding a newborn dependant 6
Commencement of Cover 6
Waiting Periods for newly insured Members 7
Waiting Periods when switching Funds or changing Products 9
Waiting Periods when splitting a Policy 10
Pre-Existing Conditions and Hospital Benefits 10
Waivers 11
30 day cooling off period 11
Who can view and change the Policy 12
Health Cover reviews 13
Policy suspensions 13
Resuming your Policy 14
Maintaining continuous Cover 14
Your Premiums 15
Your Member Card 20
Claims 21
Obligations if entitled to Compensation 24
Provisional payment of Benefits 24
Private Health Information Statements 24
Cancelling the Policy 25

General terms of Hospital Cover **27**

Partner Private Hospitals 27
What is Covered 28
What is not Covered 39

General terms of Extras Cover 41
Our Recognised Providers 41
First Choice Providers 41
What is Covered 42
What is not Covered 48

General terms of Benefits for ambulance 49
Our Recognised Providers 49
What is Covered 49
What is not Covered 49

Our obligations 50

Your obligations 51

Health insurance initiatives from the Australian Government 52
Medicare Levy Surcharge 52
Lifetime Health Cover 52
The Australian Government Rebate on Private Health Insurance 54

Glossary of important terms 56

Privacy statement 70

Feedback and complaints 73
How to resolve a complaint or dispute 73
Step 1: Talk to Us 73
Step 2: Contact Qantas Insurance Customer Resolutions 73
Step 3: Seek an external review of the decision 73

General terms of Cover

Applying for a health insurance Policy

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

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

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

Who is Covered

A health insurance Policy provides Benefits for the Policy Holder, any additional listed Partner, Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant. In regards to a Policy:

- Dependants who are aged between 21 and up to 31 years can be Covered if they are in full-time study and registered with Us as a 'Student Dependant'.

- We will allow a Dependant who is between 21 and up to 31 years and no longer studying to remain on their parents' Cover as a 'Non-Student Dependant' for an additional fee determined by Us *(not available on all Covers and under all circumstances – check your Product Information and call Us to learn more).*
- Child Dependants, Non-Classified Dependants, Student Dependants and Non-Student Dependants must be unmarried and not in a defacto relationship.
- To Claim for Hospital or medical Treatment, all those listed on the Policy must be Australian Citizens, Permanent Residents of Australia or entitled to an interim Medicare Card under Medicare, registered for Medicare and listed on an active Medicare card.
- Unless otherwise approved by Us, a person under 16 years of age is not eligible to be a Policy Holder.

Adding a dependant or Partner

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

Adding a newborn dependant

i. We need to be notified by the Policy Holder (or Partner with authority) to add a child to the health Cover. Immediate Cover is provided under a Policy for newborns if an Adult under the Policy notifies Us of the birth and requests the newborn become an Insured Person under the Policy within 2 months after the newborn's birth, where the parent/guardian upgrades from an existing Single or Couples Policy; or

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

Commencement of Cover

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

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

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

Waiting Periods for newly insured Members

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

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

No Waiting Period applies to Veteran Gold Card holders including when a Member joins within 2 months of ceasing entitlements to a Veteran Gold Card, that Member will not be required to serve any Waiting Periods in respect of Hospital or General Treatment.

Standard Ambulance Waiting Periods	
Approved ambulance transport	1 day
Standard Hospital Waiting Periods	
Pregnancy & birth	12 months
Pre-Existing Conditions	12 months
Hospital Psychiatric Services	2 months – Members may be entitled to waive this waiting period. For more information refer to 'Mental Health Waiver' on page 26
Rehabilitation or palliative care (whether or not a Pre-Existing Condition)	2 months
Other Conditions requiring hospitalisation (except those listed above) that aren't Pre-Existing Conditions	2 months
Accidental Injury Benefit	1 day
Standard Extras Waiting Periods	
Hearing aids & Cochlear speech processors	36 months
Health aids	12 months
Non-specialty orthodontia	12 months
Dental specialty services, dental prosthetic services, inlays, onlays, facings, orthodontia, periodontia, endodontia & oral surgery	12 months
Dentures, denture maintenance/ repairs & other prosthodontic services	12 months

Standard Extras Waiting Periods	
Periodontic surgical, root therapy & endodontic services by a dentist not registered as a specialist	12 months
Healthier Lifestyle	6 months
Optical appliances and repairs	6 months
All services and items except those listed above	2 months

Please refer to your Product Information for further detail relating to Service Limits and annual Benefits.

Waiting Periods when switching Funds or changing Products

We recognise the Waiting Periods you have already served from the last Previous Cover you held at the date of terminating with your Previous Fund.

On the new Product:

- Waiting Periods will apply only to services with higher Benefits, services not previously Covered or where a Member has not fully served Waiting Periods on the Previous Cover (the balance of the Waiting Period will apply with Us).
- For services already Covered at an equivalent level, no Waiting Period will apply.
- Lower Benefits or reduced Coverage on the new Product applies immediately.
- If the Hospital Excess on the new Cover is lower than the Previous Cover, the previous Hospital Excess will apply for the duration of the Standard Hospital Waiting Period that applies to a Benefit (regardless whether a Member is required to serve a Waiting Period in order to make a Claim for that Benefit).
- If the Hospital Excess on the new Product is higher it will apply straight away irrespective of a Pre-Existing Condition.
- A 30 day Cooling Off Period applies to all Product changes, providing no Claim is made on the new Product *(see 30 day cooling off period).*

- When switching Funds, there must be a gap of no more than 59 days between terminating your Previous Cover and joining Us to maintain continuity of Cover and avoid having to re-serve Waiting Periods.
- When changing Products with Us, there must be no gap between terminating your Previous Cover and joining another to maintain continuity of Cover and avoid having to re-serve Waiting Periods.
- If you have used part or all of your annual Benefits under your Previous Cover, We will adjust your available new Benefits accordingly.

Waiting Periods when splitting a Policy

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

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

Pre-Existing Conditions and Hospital Benefits

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

- No Benefits are payable for Hospital Treatment during the first 2 months of membership irrespective of whether the Condition is pre-existing (except for Accidents – (*see 'Waiting Periods' and 'Accidental Injury Benefit'*)).

A 2 month waiting period still applies to new members before being able to access the mental health waiver.

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

Waivers

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

- If a waiver applies, Members will be able to Claim immediately for the Extras services to which the waiver applies.
- Waivers do not apply to Hospital Treatment, except for Hospital Psychiatric Services received in accordance with the Mental Health Waiver (see *'Mental Health Waiver'*).
- Waivers do not apply to any services which have a 12 month (or higher) Waiting Period.
- Members can confirm if a waiver applies to them by Us.

30 day cooling off period

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

- New Members can receive a full refund of Premiums if they decide to cancel the Policy within the first 30 days of membership – providing no Claims have been made during that time.

- Members who have changed their level of Policy can also revert to the Previous Cover within 30 days with no impact on Waiting Periods – providing no Claims have been made during that time.
- If a Claim is made within 30 days the Policy can only be cancelled or changed from the day after the date of service of the Claim.
- Despite the above rule, where Claims have been made within the first 30 days of the commencement of the Policy, We may on a case-by-case basis and in Our absolute discretion decide to refund all Premiums where the Member agrees to repay an amount equal to all Benefits received under that Policy.

Who can view and change the Policy

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

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

Health Cover reviews

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

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

Policy suspensions

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

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

- A Policy Holder who wishes to apply to suspend their Policy can do so by calling Us. The Policy Holder will also be required to supply Us with the following proof to complete the suspension application:
  - Proof of travel dates (e.g. a copy of boarding pass, travel itinerary or stamped passport).
  - We will accept Policy suspensions from the date of notification providing the application to suspend is accepted.
- A Policy must be financially up-to-date before it can be suspended.
- No Premiums are payable for the Policy during a period of suspension.
- No Benefits will be paid by Us during a period of suspension.
- Where Waiting Periods had not been fully served, the remainder of the Waiting Period must be served once the Policy is resumed.
- Once a Policy is resumed after a period of suspension, 12 months of continuous Cover must be maintained before the Member can apply to suspend again.

- Members listed on the Policy may be liable for the Medicare Levy Surcharge for any period of suspension *(see Medicare Levy Surcharge)*.
- If a Lifetime Health Cover loading applies to your Policy, your suspension period will not count towards your required 10 years of continuous Cover. Your Lifetime Health Cover anniversary date will be adjusted to factor in the period your Policy was suspended.

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

Resuming your Policy

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

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

Maintaining continuous Cover

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

- If the Policy falls into arrears, all Members on the Policy will be unable to Claim.
- After 2 months of non-payment the Policy will be cancelled.
- After more than 2 months without health insurance all Members listed on the Policy will have to re-serve Waiting Periods if they decide to re-join later.

- It will be at Our discretion to determine whether the Members listed on the Policy will be Covered for any Hospital, Extras or ambulance Claims required during a period of non-payment.
- If the Policy lapses, Members listed on the Policy may be liable for the Federal Government's Medicare Levy Surcharge and/or Lifetime Health Cover Loading *(see Medicare Levy Surcharge and Lifetime Health Cover Loading)*.

Your Premiums

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

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

Available payment method

- Direct debit from a bank, building society or credit union cheque or savings account.
- Phone Pay – make a credit card payment by calling **13 49 60**.
- Payment by BPAY payment is also accepted.

Available payment periods

Are set out below and must be paid in advance:

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

Direct Debit Service Agreement

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

- Any information about the account will remain confidential, except where required to complete direct debits, or in connection with a claim with your financial institution.
- When the due date is not a business day (NSW), We will debit the account on the first business day after the due date.

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

It is the Policy Holder's responsibility to:

- Ensure the nominated account can accept direct debits.
- Ensure there are enough Funds available in the account to make the payment on the due date.
- If there are insufficient funds to make payment on the due date, you may be charged fees or charges at the discretion of your financial institution.
- Tell Us if the account details change, or if the account is transferred or closed.
- Tell Us if payment is to be made by someone else.
- Arrange a different payment method if We cancel the debit arrangements.
- Ensure all account holders of the nominated account have authorised the direct debit request.
- Tell Us the new credit card expiry date.

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

- Stopping a payment.
- Deferring a payment.
- Suspending any future payments.

- Altering the direct debit nominated account details.
- Cancelling the debit arrangement.

If you believe that there has been an error in debiting *your account*, *you* should notify Us directly on **13 49 60** and confirm that notice is in writing with Us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up with your financial institution direct.

If *we* conclude as a result of our investigations that *your* account has been incorrectly debited we will respond to *your* query by arranging for *your financial institution* to adjust *your* account (including interest and charges) accordingly. *We* will also notify you in writing of the amount by which *your account* has been adjusted.

If *we* conclude as a result of our investigation that *your account* has not be incorrectly debited we will respond to *your* query by providing *you* with reasons and any evidence for this finding in writing.

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

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

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

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

Before you complete your Direct Debit Request, it is best to check account details against a recent statement from your financial institution to ensure the details on your Direct Debit Request are completed correctly. Ask your financial institution if you are unsure about your account details.

Please enquire of your financial institution, if you are uncertain when your financial institution processes an amount we draw under your Direct Debit Request on a day which is not a business day.

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

Policy Holders with direct debit inquiries, or those who believe a debit has been made incorrectly, should contact Us immediately on **13 49 60** or write to:

Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

Premium discounts

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

- We may offer a discount to Corporate Groups, Broker Groups, Association Groups or any other pre-defined Contribution Group at Our discretion.
- Closed Products may also be excluded from receiving the discount at Our discretion.
- Age-Based Discounts to eligible members.

Age-Based Discounts

Age-Based Discounting is a Federal Government initiative designed to encourage people to purchase Private Hospital Cover earlier in life. This means that when a person aged under 30 takes out Private Hospital Cover they may be eligible to receive a discount. Age-Based Discounts are calculated as 2% for each year that a person is aged under 30, up to a maximum of 10% for 18 to 25 year olds.

The discount is based on your age on the Discount Assessment Date, which is generally 1 April 2019, or the date you first took out an eligible Private Hospital Cover following 1 April 2019. It will apply to each person insured under the Policy who, on the Discount Assessment Date are:

- Aged between 18 and 29 (inclusive).
- Not a Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant under the Policy.

If you have a partner on the policy the total discount will be an average of your individual Age-Based Discounts.

The table below sets out the discount that may be applied to your Hospital premium:

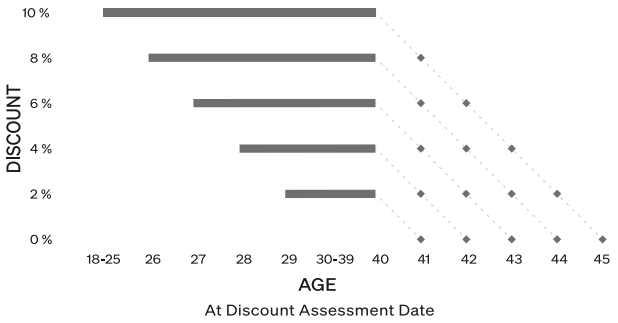
Age*	Applicable Percentage Discount
18-25 (inclusive)	10%
26	8%
27	6%
28	4%
29	2%

*Age as at the Discount Assessment Date.

You'll keep your Age-Based Discount until your 41st birthday unless:

- You transfer to a policy that does not provide for the Age-Based Discount to be retained; or
- The discount is discontinued on your policy.

When a person turns 41, the Age-Based Discount will reduce at the rate of 2% per year, so that no Age-Based Discounts are available after the age of 45.



Premium changes

Premiums may change as a result of:

- A change in Premiums approved under the Private Health Insurance Act.
- A change in Product.
- A change in Hospital Excess level.
- A change in state or territory of residence.

- A change in Policy Category (single, couple, family, single-parent family, extended family).
- Adding Members onto the Policy who have a Lifetime Health Cover loading *(see Lifetime Health Cover Loading)*.
- Inclusion or removal of discounts.
- A change in Rebate tier *(see Health insurance initiatives from the Australian Government)*.
- Removal of Lifetime Health Cover loading in accordance with Lifetime Health Cover rules.
- Failure to complete the necessary application for Australian Government Rebate.

Your Member Card

By using the Member Card, you agree:

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

More important information about the Member Card:

- The card is not transferable.
- The card must not be left with any Provider or other party.
- The card is Our property – Members must return it if asked.
- Members must return or destroy the card if the Policy is cancelled.
- Members must notify Us immediately if the card is lost or stolen.

- If the card is forgotten the Member will need to pay for the Treatment in full, obtain an Official Provider Receipt, and Claim Benefits from Us later.
- If you require a replacement physical card, you can request one by calling Us.
- If any changes are made to the persons Covered on a Policy, a new card will be issued to reflect the Members Covered on the Policy.
- If you have a smartphone, you can access your digital Qantas Health Insurance card through the Qantas Wellbeing App.

Claims

- Benefits will only be paid for Claims which meet Our Fund Rules and criteria. If you're unsure what might be Covered we'd encourage you to contact Us before Claiming by calling **13 49 60**.
- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to Our Fund Rules and criteria.
- The Member number on the front of the Member Card must be quoted for all Claims.
- Members will not be paid any Benefits if their Policy is not financially up-to-date. If Premiums are in arrears We may cancel a Policy that is more than 2 months in arrears.
- Medical Benefits (e.g. for services provided by a specialist, or Pathology and radiology services) will only be paid if the services were administered whilst you were an admitted Private Patient in a Hospital.
- Claims for medical Benefits (e.g. for services provided by a specialist, or Pathology and radiology services) provided while you were an admitted Private Patient in a Hospital must be submitted to Medicare before you forward the Claim to Us.

Supporting documentation for Claims

Claims for Benefits must:

- Be made in a manner approved by Us; and
- Be supported by Provider invoices and/or receipts on the Provider's letterhead or showing the Provider's official stamp, and showing the following information:
  - The Provider's name, Provider number and address;

  - The Patient's full name and address;
  - The date of service;
  - The description of the service;
  - The amount(s) charged for the service in Australian Dollars $AUD;
  - That the amount(s) charged for the service have been paid in full; and
  - Any other information that We may reasonably request.
- Be accompanied by a Health Management Program Supporting Document form, which has been signed by your health professional (required only for Claims made for the Healthier Lifestyle Benefit).
- Unless otherwise agreed by Us, all documents submitted in connection with a Claim become Our property.

Time limit on Claims

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

Method of payment of Benefits

We may pay Benefits by electronic Funds transfer to a bank account with an Australian recognised banking provider in accordance with arrangements that We determine.

Benefits not payable

Benefits are not payable for:

- Services not Covered by the Product in accordance with the Fund Rules.
- Services provided during a Waiting Period.
- Services provided after the Annual Benefit Limit, Service Limit or Lifetime Limit has been reached.
- Policy applications or Claims where false or inaccurate information is supplied.
- Services that are for Treatments where a Member received or established a right to receive Compensation from a third party. Where rights to receive payments by way of liable third party/Compensation have not been determined, We may make provisional payments of Benefits pending the determination or settlement of the

Claim. We have the right to recover any such payments once a determination or settlement has been granted.

- Services other than wholesale material costs involved in the provision of the service rendered by a Provider to themselves, their spouse, de facto Partner or Dependants. Where the service includes an invoiced cost of materials, nib may consider payment of Benefits towards the cost of purchase and supply of those materials.
- Services rendered to a Member by their spouse, de facto Partner or Dependant. Where the services include an invoiced cost of materials, nib may consider payment of Benefits towards the cost of purchase and supply of those materials.
- Services like examinations for life insurance, health certificates, mass immunisation, health screens and other expenses incurred for services required by employers.
- Services that have already been Claimed from your annual limits under Previous Cover. If you have used all or part of your annual Benefits with your previous health Fund or your Cover with Us, We may adjust your new annual Benefits accordingly.
- Incomplete Claims.
- Consultations Covered by a Medicare Primary Health Care Plan, e.g. psychology or dental plans.
- Services performed by a medical practitioner, specialist, radiologist, radiographer, sonographer or pathologist when you were not an admitted Private Patient in a Hospital.
- Services by Providers not recognised by Us.
- Treatment (including goods) provided to a Member from outside Australia.
- Treatment (including goods) provided to a Member while the Member is outside of Australia.
- Goods purchased outside of Australia. When purchasing goods online, the company must have a physical business conducted in Australia and must be recognised by Us (cannot simply be a website ending in .com.au).

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

Obligations if entitled to Compensation

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

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

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

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

Provisional payment of Benefits

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

Private Health Information Statements

The Australian Government requires all health funds to provide information to consumers about their private health insurance policies in a format that is consistent across all

private health funds. This format is called a Private Health Information Statement.

We will:

- Provide a Private Health Information Statement to the Policy Holder on commencement of a Policy with Us, and at least once every 12 months after the commencement of that Policy.
- Maintain and make available Private Health Information Statements in accordance with the requirements of the Private Health Insurance Act.

To receive a Private Health Information Statement, call Us.

Cancelling the Policy

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

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

Refund of Premiums

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

Termination of a Policy

We may terminate a Policy:

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

Improper advantage or unacceptable behaviour

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

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

General terms of Hospital Cover

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

Always call Us before going to Hospital.

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

Partner Private Hospitals

To reduce the amount of Hospital charges you pay including Accommodation charges, operating theatre fees and to minimise Out-Of-Pocket Expenses, Members should attend a Partner Private Hospital for Hospital Treatment that is Covered by the agreement. For example, if a Member chooses to attend a Partner Private Hospital, they are Covered for Accommodation and operating theatre fees for services included in the Hospital agreement.

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

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

To check if the Hospital is a Partner Private Hospital call Us or visit Our website.

What is Covered

We will pay Benefits for Hospital Treatment only where the:

- Service is included under the Member's Product, in accordance with the Fund Rules;
- Service meets Medicare eligibility criteria for a Medicare benefit to be paid;
- Member has served all relevant Waiting Periods;
- Policy is financially up to date;
- Treatment is provided to an Admitted Patient;
- Other Conditions for the Claim have been met *(see 'Claims' under General Terms of Cover)*.

Hospital Excess

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

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

Informed Financial Consent

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

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

Included Services

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

- Hospital Accommodation (i.e. the Patient's bed and a Private Room if available).
- Operating theatre fees.
- Intensive care, coronary care, neonatal care and labour ward fees.
- Patient meals.
- Ward drugs and sundry medical supplies (e.g. bandages, non-prescription pain killers).
- Associated Treatments for Complications *(see requirements in Section 2)*.
- Associated Unplanned Treatments *(see requirements in Section 2)*.
- Common Treatments and support Treatments *(see further information below)*.

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

- Dressings, sutures, needles and other disposable items.
- Pharmaceuticals to the extent set out below.

Pharmaceuticals provided in Hospitals

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

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

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

- Approved by the Therapeutic Goods Administration and entered in the Australia Register of Therapeutic Goods (ARTG) for use in Australia as part of the standard Treatment; and
- Where the item is intrinsic to the Patient's Hospital Treatment.

No Benefits are payable for:

- Contraceptive drugs;
- Drugs issued for the sole purpose of use at home; or
- Pharmacy items charged in a Public Hospital.

High cost drugs

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

- *Received as an Admitted Patient* if the drug is included in Our agreement with the Hospital for your particular type of Treatment.

- *Received as an Outpatient* if your Extras Product includes the pharmaceutical prescriptions Benefit and it Covers these drugs.

Doctors and specialists fees

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

- 75% of the Medicare Benefits Schedule Fee for specialists.
- 75% of the Medicare Benefits Schedule Fee for scans and tests.

We will pay the remaining 25% of the Medicare Benefits Schedule Fee, subject to exclusions outlined in the '**What is not Covered**' section of this Policy Booklet. In the case of specialists who charge more than the Medicare Benefits Schedule Fee, We may be able to help Cover these costs too, providing the specialist agrees to participate in the MediGap Scheme. For Pathology and radiology service providers who charge more than the Medicare Benefits Schedule Fee, We may be able to help Cover these costs at select Pathology and radiology Group locations.

The MediGap Scheme means that We will agree to pay an extra amount in addition to the standard 25% for services Covered under the MediGap Scheme. We've built up a network of doctors and specialists who may charge Us directly and when they choose to participate in MediGap for your procedure, are committed to either not charging you an out-of-pocket expense for your procedure or charging a Known Gap of up to $500. However:

- Doctors can choose on a case-by-case basis if they are going to treat Our Member as a MediGap Patient (or not).
- Members are advised to ask the doctor if they can be treated as a MediGap Patient, and if other Providers who will be treating them (e.g. an anaesthetist) will also treat them as a MediGap Patient.
- MediGap will only Cover services provided during the Hospital stay.
- Any Consultations before and after the Hospital stay will not be Covered.
- Administration and booking fees are not Covered by the MediGap Scheme.

- We will only pay a Benefit for services provided by a doctor or specialist if those services were administered whilst you were an admitted Private Patient in a Hospital. If the GP or specialist does not agree to participate in the MediGap Scheme, you must pay the difference between what the GP or specialist's charge and the Medicare Benefits Schedule Fee.
- Items covered under the MediGap Scheme and benefits paid to Specialists under the MediGap Schedule of Benefits may change from time to time.

Practitioners may choose to leave the MediGap network from time to time. We recommend you check when booking if the practitioner participates in MediGap.

Government Approved Prosthetic Devices

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

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

Same day Hospital Patients

Benefits for same day Hospital Accommodation are payable only where the Member is an Admitted Patient. Same day Benefits are determined by the Patient classifications and guidelines issued by the Minister. Same day Outpatient services are not payable.

Multiple Treatments

Subject to the sections below regarding Associated Treatments for Complications, Associated Unplanned Treatments and common and support Treatments, where a Patient undergoes more than one type of Hospital Treatment during a Hospital Admission, We will only Cover Accommodation, theatre fees and procedures related to the Covered Treatment performed as part of that Admission. If one or some Hospital Treatments are Covered as a Restricted Service, We will pay Restricted Benefits toward any part of the costs associated with that Treatment. If one or some Hospital Treatments are Excluded, no benefits will be paid toward any part of the costs associated with the Excluded Treatment.

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

Associated Treatments for Complications and Associated Unplanned Treatments

Where a Patient undergoes Hospital Treatment that is Covered under their Product, We will also Cover any Associated Treatments for Complications that arise during that episode of Hospital Treatment.

Where a Patient undergoes Hospital Treatment that is Covered under their Product, We will Cover any Associated Unplanned Treatments that are provided as part of the planned surgery performed during that episode, providing it is, in the view of the medical practitioner who provides the unplanned Treatment, both medically necessary and urgent.

Common Treatments and support Treatments

Where a Patient undergoes Hospital Treatment that is Covered under their Product, We will Cover a number of MBS items that are identified as common Treatments. We will also Cover a number of MBS items that are commonly used and identified to support the provision of a principal Hospital Treatment.

Restricted Services

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

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

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

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

Benefit Limitation Period

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

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

Nursing Home Type Benefit

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

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

Emergency Admissions

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

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

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

Accidental Injury Benefit

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

- Not every health Cover has the Accidental Injury Benefit *(check your Product Information)*. Some of Our health Covers will Cover Accidents only in line with the Benefits provided by the Product (e.g. a Restricted Service remains Restricted irrespective of an Accident).

- To ensure a Member is Covered for the immediate necessary Treatment or procedures required as the result of an Accident, it will be necessary to provide evidence to Us that they presented for treatment to a Medical Practitioner (e.g. a General Practitioner) or Hospital/ Facility within 72 hours of the Accident. An Emergency Department attendance as an Outpatient service is not classed as an Admission and is not payable by the Fund.
- If the criteria for applying the Accidental Injury Benefit has been met, this Benefit may apply after the Member has been admitted as an inpatient. This can include being admitted initially and/or being sent home after an Emergency Department consult to be admitted at a later date (but within 90 days of the Accident).
- If further Treatment is needed in Hospital as an Admitted Patient, the Member must be re-admitted to a Hospital within 90 days of date of Accident. Further Treatment or procedures relating to the Accident will only be Covered if the initial Treatment or procedure was Covered by the Accidental Injury Benefit.
- Any additional Hospital Treatment (after the initial 90 days) will be paid as per the level of Benefits on the Member's level of Cover if applicable.
- If a Member suffers an Accident, they and the attending doctor in Hospital may be asked to complete an Accident Form (available from Us) or to contact Us.
- Benefits are not payable for expenses incurred in relation to an injury where Compensation may be Claimed for that injury.

Dental surgery in Hospital

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

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

IVF and other assisted reproductive Services in Hospital

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

Podiatric surgery (provided by a registered podiatric surgeon) in Hospital

Only a podiatric surgeon who holds a registration in the specialty of podiatric surgery under the relevant State or Territory registration requirements is recognised by Us. Not every health Cover includes podiatric surgery (provided by a registered podiatric surgeon) in Hospital. Coverage for Hospital Treatment for the investigation and Treatment of Conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, is limited to Cover for:

- Accommodation; and
- The cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules.

It is important to be aware that podiatric surgeon fees for services performed in Hospital are not Covered. We will not pay benefits for theatre fees and services performed by the podiatric surgeon, any medical practitioner, specialist, radiologist, radiographer, sonographer, or pathologist that may be provided during or associated with podiatric surgery (provided by a registered podiatric surgeon).

Chemotherapy, Radiotherapy and Immunotherapy for Cancer in Hospital

Not every health Cover includes chemotherapy, radiotherapy and immunotherapy for cancer in Hospital *(check your Product Information)*.

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

High cost drugs are sometimes requested for the Treatment of some cancers. Typically high-cost drugs are for newer Treatments that are not recognised by the Pharmaceutical Benefit Scheme (PBS) because the PBS considers them to be still under clinical trial and therefore experimental Treatments. Health insurance will not Cover high cost drugs for the same reasons (or may only Cover a small portion of the cost). It is the responsibility of the treating doctor, and Hospital, to inform Patients about the potential for large out-of-pockets as a result of high cost drugs *(see 'General terms of Hospital Cover' and 'High cost drugs')*. Surgical Treatment for cancer is listed separately to Chemotherapy, Radiotherapy and Immunotherapy for Cancer under each body system (check your Product Information). E.g. if Eye (not cataracts) is Excluded from your Cover, then surgical Treatment for cancer of the eye would also not be Covered.

What is Covered for Chemotherapy, Radiotherapy and Immunotherapy for Cancer

- In-hospital cancer Treatments such as an initial chemotherapy cycle and some radiotherapy Treatments.
- Medications approved under the Pharmaceutical Benefits Scheme and delivered as part of in-hospital Treatment.

What is not Covered for Chemotherapy, Radiotherapy and Immunotherapy for Cancer

- Outpatient Treatments and associated expenses including, but not limited to, outpatient and home based chemotherapy, radiotherapy, immunotherapy, radiology, pathology, psychological support and physical therapy.
- High cost drugs not approved under the Pharmaceutical Benefits Scheme *(see 'High cost drugs').*
- Outpatient services performed by a doctor or specialist.
- Other Excluded Services listed in this Policy Booklet under General terms of Hospital Cover subheading *'What is not Covered'.*

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

Minimum Benefits are payable for Hospital Psychiatric Services, Palliative Care and Rehabilitation, if the Treatment for these services are not included on your policy.

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

Mental Health Waiver

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

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

To find out more, call Us on **13 49 60**.

Excluded Services

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

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

Excluded Hospital Services may be Covered in the event of an Accident – depending on the Member's level of Cover *(see Accidental Injury Benefit)*. Excluded Hospital Services may also be Covered in circumstances where the services are considered an Associated Treatment for Complications or an Associated Unplanned Treatment *(see Associated Treatments for Complications and Associated Unplanned Treatments in Section 2)*.

What is not Covered

- Any allowable Known Gap that is charged by a participating MediGap Scheme specialist.
- Any service listed as an Excluded Service for a Product under the Fund Rules on a Member's Policy.

- Any Hospital Excess.
- Procedures within Waiting Periods.
- In-hospital Treatment, drugs or disposable items not recognised for payment of Benefits by Medicare (for example, some items associated with robotic surgery or other new or experimental drugs/technologies).
- Cosmetic treatments to enhance appearance (including dental implants).
- Beauty services, phone calls, TV hire, car parking, luxury rooms and other Hospital Treatment that aren't directly related to a Patient's Treatment and care.
- Admission or booking fees charged by a specialist or the Hospital.
- Pharmaceuticals available under the PBS.
- Oral contraceptives.
- Services rendered in a nursing home.
- Private Room Accommodation for a same day procedure.
- Respite care.
- Take-home items.
- Experimental and/or Treatment not Covered by Medicare.
- Autologous blood collection and storage.
- Procedures performed in a doctor's surgery.
- Private Hospital emergency or Outpatient fees.
- Special nursing.
- Nursing care at home for Patients who have been discharged from Hospital early.
- Outpatient services performed by a doctor, specialist or other health professional.
- For Claims that do not meet Our General Terms *(see 'General terms of Cover' and 'Claims')*.

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

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

General terms of Extras Cover

This section outlines the general terms of Extras Cover and should be read in conjunction with your relevant Product Information. Not every health Cover includes Benefits for Extras Treatment.

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

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

A note about Benefit limits

It is not possible to transfer per person Benefit limits between Members on the same Policy, as our Fund Rules do not give Members this right.

Our Recognised Providers

We will pay Benefits for Extras treatments, Products or services if the Member attends a Provider recognised by Us.

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

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

First Choice Providers

Our First Choice network of Providers aims to offer greater predictability in Out-Of-Pocket costs and access to some no-gap services for eligible members. Dental, optical and physiotherapy Providers who have agreed to a set fee or discounted rate for our members. You may pay less for dental Treatment, your physiotherapy Consultation or your next pair of glasses by choosing a First Choice Provider.

- Set Treatment fees (for common dental treatments and physiotherapy individual/group consultations) or discounted rates (for select single vision glasses or contact lenses) apply to services covered by the First Choice Preferred Provider Agreement.
- Treatment fees and discounted rates are reviewed at least annually on 1st of April and may be subject to change.

- Practitioners may choose to leave the First Choice network from time to time.

In the case of First Choice Dental, Optical and Physio, members may also be eligible for a no gap arrangement if a member selects a Service that is within their level of cover, relevant waiting periods being served and, sufficient annual limits remaining. We recommend confirming with your practitioner at the time of booking that they are part of the First Choice Network.

What is Covered

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

- We will Cover the Extras included in a Member's Product in accordance with the Fund Rules.
- Normally only the cost of the Consultation will be Covered, unless otherwise stated.
- Services must be provided by one of Our Recognised Providers.
- If a Member sees the same Recognised Provider twice on the same day, only one Benefit will be payable.
- If a Provider performs multiple services within one Consultation (like remedial massage and acupuncture), the Treatment that attracts the higher Benefit will be paid.
- *See also 'General terms of Cover' and 'Claims'.*
- You can claim on Telehealth Consultations for the following services with a recognised provider:
  - Psychology;
  - Physiotherapy;
  - Dietetics;
  - Speech Therapy;
  - Occupational therapy;
  - Exercise physiology; and
  - Podiatry.

This is subject to your chosen level of cover, availability at your chosen clinic, policy Exclusions, waiting periods and service and annual limits. Telehealth Consultations may not be appropriate for all Consultations. Only individual Telehealth consultations are covered, groups and classes are currently

not funded for Telehealth. Approved chronic disease or health support programs may also be delivered digitally.

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

"Acupuncture" or **"Acupuncture Service"** means General Treatment that is:

(a) approved by Us; and

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

"Antenatal Classes" means General Treatment that is:

(a) approved by Us; and

(b) provided by a midwife or physiotherapist in Private Practice or an online course provider recognised by Us.

"Chiropractic" or **"Chiropractic Service"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is registered or licensed to practice and recognised by Us as a chiropractor.

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

"Dental Treatment" or **"Dental Service"** means General Treatment that is:

(a) approved by Us; and

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

Depending on your level of Cover, Benefits may be subject to the following conditions:

(a) Services provided by a First Choice network Provider will be paid at a percentage of the cost.

(b) Services provided by a Non-First Choice network Provider will be paid at a Set Benefit.

Teeth whitening and other purely cosmetic treatments are not Covered. We recommend you obtain a quote before undergoing major Treatment.

We require the dental item numbers before providing an estimate of the Benefits to be paid. Only certain items can be performed by a Dental Hygienist and we recommend calling Us for information on what is covered.

"Dietary" or **"Dietetic Services"** means General Treatment that is:

(a) approved by Us; and

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

"Digital Cognitive Behavioural Therapy (CBT)" means General Treatment that is:

(a) a form of psychological treatment delivered utilising structured programs that are internet-based (also known as iCBT) or computerised (also known as CCBT) and;

(b) approved by Us; and

(c) provided by a Digital CBT Provider who is recognised by Us.

"Exercise Physiology" means General Treatment that is:

(a) approved by Us; and

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

"First Choice Provider" means General Treatment Providers who are contracted with Us to provide services for members at either a set fee or discounted rate for items/ services covered by the terms of the First Choice Preferred Provider Agreement.

"Health Aids" means General Treatment that is:

(a) included on Our Schedule of approved health aids; and

(b) purchased from a Provider that is recognised by Us.

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

"Healthier Lifestyle" includes:

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

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

(c) fitness centre/gym or personal training services recognised by Us, where:

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

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

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

iv. the membership is not provided as part of a Corporate membership program.

(d) preventative tests recognised by Us.

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

"Hearing Aids" means:

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

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

Contact Us for details of specific benefits, restrictions and replacements.

"Home Nursing" means:

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

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

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

"Natural Therapies" or **"Therapies"** means General Treatment that is:

(a) not listed as a service in the Private Health Insurance Act for which We are prohibited from paying Benefits;

(b) approved by Us;

(c) listed as a Natural Therapy or Therapy Treatment in the Schedules; and

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

No Benefits are payable for ointment or medications required as part of the Treatment. No Benefits are payable for Excluded Natural Therapy Treatment received on or after 01 April 2019.

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

(a) dispensed by a registered pharmacy in private practice; and

(b) available on prescription; and

(c) not listed in the Pharmaceutical Benefits Scheme (PBS); or is listed on the PBS but used for an indication that is not recognised by the PBS; and

(d) published within the Poisons Standard as S4 or S8; and

(e) registered on the Australian Register of Therapeutic Goods (ARTG) (excludes Export Only medication under the Therapeutic Goods Act 1989); and

(f) for compounded drugs, at least one component must meet the conditions (a) to (d).

Benefits are not payable for:

(a) prescriptions dispensed to Hospital inpatients.

(b) items used for contraceptive purposes.

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

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

"Occupational Therapy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is registered, or licensed to practice, and recognised by Us to provide occupational therapy Treatment.

"Optical Appliance" or **"Optical Service"** means:

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

(b) a component of such an appliance, that has been prescribed during a Consultation with a Provider who is

recognised by Us as an optometrist, an ophthalmologist or optical dispenser.

Optical Benefits are not payable for:

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

(b) sunglasses;

(c) tinting, coating or hardening of lenses.

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

"Orthoptics" or **"Eye Therapy"** means General Treatment that is:

(a) approved by Us; and

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

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

Orthopaedic shoes/boots and Orthotic inserts must be custom made or medical grade (pre-fabricated foot orthosis are not covered).

"Osteopathy" means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation by a Provider who is registered or licensed to practice and recognised by Us as an osteopath.

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

"Physiotherapy" or "**Physiotherapy Service"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is registered, or licensed to practice, and recognised by Us as a physiotherapist.

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

"Podiatry" or "**Podiatry Service"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is registered, or licensed to practice, and recognised by Us as a podiatrist.

"Preventative Tests" means General Treatment that is:

(a) approved by Us; and

(b) used to help with the early detection of health Conditions.

"Psychology" or **"Clinical Psychology Service"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Psychologist who is registered, or licensed to practice, and recognised by Us to provide psychology Treatment.

No benefits payable for any associated diagnostics, testing, reports, books, DVDs, CDs, medications or supplements required as part of the treatment. Depending on your Cover Benefits may be payable for couple or group sessions (Contact Us before claiming to check if couple and group sessions are included in your Cover).

"Speech Therapy" or **"Speech Pathology Service"** means General Treatment that is:

(a) approved by Us; and

(b) provided during a Consultation with a Provider who is registered, or licensed to practice, and recognised by Us as a speech therapist.

Benefits are not payable for group speech therapy.

What is not Covered

- Extras benefits are not payable where Medicare, a Commonwealth Government authority, or third party provides a benefit.
- Extras already Covered, in whole or part, by Medicare (except for certain types of Hospital-Substitute Treatment).
- Providers who do not meet Our criteria.
- Providers who are not one of Our Recognised Providers.
- Extras or prescriptions provided to an Admitted Patient (these may be Covered under a Hospital Product).
- Extras Benefit entitlements accrued under another Fund's loyalty bonus scheme.
- Claims that do not meet with Our General Terms *(see 'General terms of Cover' and 'Claims').*

General terms of Benefits for ambulance

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

Our Recognised Providers

Ambulance transport provided by a State or Territory ambulance service.

What is Covered

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

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

What is not Covered

- Private ambulance and private transport services.
- Residents of Queensland and Tasmania who have ambulance services provided by their State ambulance schemes.
- Pension and health care card holders who have ambulance services provided by State ambulance schemes (check entitlements with Centrelink if unsure).
- Claims that do not meet Our General Terms *(see 'General terms of Cover' and 'Claims')*.
- Non-Emergency Ambulance Transportation or Treatment, e.g. Transportation to a General Practitioner clinic or from a Hospital to your home.

Also, you may not be Covered for:

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

Our obligations

We will:

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

Your obligations

By taking out a Policy with Us you agree to:

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

Health insurance initiatives from the Australian Government

Medicare Levy Surcharge

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

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

See below:

	Base Tier	Tier 1	Tier 2	Tier 3
Income level Singles	$105,000 or less	$105,001 to $123,000	$123,001 to $164,000	$164,001 or more
Income level Families	$210,000 or less	$210,001 to $246,000	$246,001 to $328,000	$328,001 or more
Medicare Levy Surcharge				
	0%	1%	1.25%	1.5%

Source: Australian Tax Office. These thresholds apply from 1 July 2026 to 31 March 2027. For families the thresholds increase by $1,500 for each Child Dependant or Non-Classified Dependant after the first. There are specific rules for calculating income for Medicare Levy Surcharge purposes. For more information go to **ato.gov.au**

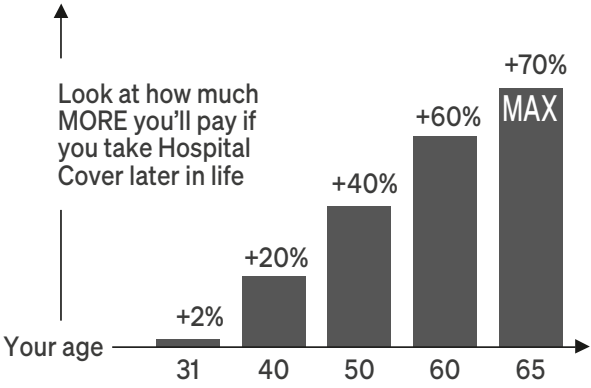
All of Our Hospital Products are suitable to help Members avoid the Medicare Levy Surcharge (and paying extra tax) providing they maintain their Cover for the entire financial year.

Lifetime Health Cover

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

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

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



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

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

The Australian Government Rebate on Private Health Insurance

To make private health insurance more affordable, the Federal Government provides Medicare holding Australians who meet the income requirements with a rebate, known as the Australian Government Rebate on private health insurance, when a member holds an appropriate level of private patient hospital cover from a registered health fund. The level of Rebate you could be entitled to receive is based on the age of the oldest person on the Policy and your taxable income (or combined family income for couples and families). The Rebate percentages are set annually on 1 April by the Australian Government. The Department of Health, Disability and Ageing provides a breakdown of the means testing requirements.

Each year the Government provides health funds with a rebate adjustment factor which will be applied to each member's premium (after any applicable discounts) and determined by their income tier and age. The rebate can be used to reduce your premiums or claimed when you lodge your tax return with the Australian Taxation Office. If you have a Lifetime Health Cover (LHC) loading, the Rebate is not Claimable on the LHC loading component of your Premium.

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

All Our Products are eligible to receive the Rebate.

To be eligible for the Rebate:

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

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

For more information about the Australian Government Rebate and to check the current thresholds, visit **privatehealth.gov.au** or The Department of Health, Disability and Ageing at **health.gov.au** or the Australian Taxation Office and Aged Care at **ato.gov.au**

Glossary of important terms

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

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

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

"ADA Schedule" means the Schedule of Dental Services published by the Australian Dental Association Incorporated.

"Addiction Medicine Specialist" means a specialist (within the meaning of the Health Insurance Act 1973) in relation to addiction medicine.

"Admitted Patient" means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. Treatment in the emergency room of a Private Hospital is not an Admission.

"Adult" means a person Insured under a Policy who is not a Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant.

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

"Age-Based Discount Policy" means an insurance Policy that provides Age-Based Discounts (check your Product Information).

"Annual Benefits Limits" means the maximum amount of Benefits payable for a specific good or service as set out in the Schedules.

"Annual Service Limit" or **"Service Limit"** means the number of times during any Calendar Year that a Benefit will be paid for a particular Service.

"Associated Treatment for Complications" means Treatment that is provided during an episode of Covered Hospital Treatment to address a complication that arises during that episode.

"Associated Unplanned Treatment" means unplanned Treatment that is provided during an episode of Covered planned surgery that is, in the view of the medical practitioner who provides the unplanned Treatment, medically necessary and urgent.

"Base rate" means the Premium for a Policy, prior to any applicable discount, Lifetime Health Cover loading or Australian Government Rebate.

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

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

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

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

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

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

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

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

"Consultant Psychiatrist" means a specialist (within the meaning of the Health Insurance Act 1973) in relation to psychiatry.

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

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

"Contribution Group" means a group of Policy Holders approved by Us.

"Corporate" means a Product type available to a person who is an employee or member of a company, business, association, charity or other organisation that has an agreement with Us.

"Corporate Group" means an employer sponsored group of employee Members, or group of Members belonging to Us or a particular group, which constitutes a Contribution Group.

"Couples Policy" means a Policy that Covers the Policy Holder and their Partner.

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

"Customer" has the same meaning as Member.

"Day Service Limit" means the number of times during any one day that a Benefit will be paid for a particular service or associated item number.

"Default Benefits" or **"Restricted Benefits"** means the Minimum Benefit Payable under a Hospital Product for a particular Hospital Treatment in a Hospital that is not a Partner Private Hospital under the Private Health Insurance Act 2007.

"Dental Practitioner" means a person registered or licensed to practise as a dental practitioner under a law of a State or Territory that provides for the registration or licensing of dental practitioners or dentists.

"Dependant" means a Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant of the Policy Holder or their co-insured Partner.

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

(a) **"Child Dependant"** is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Policy Holder or Partner and who:

   i. is aged under 18 years of age; and

   ii. does not have a Partner; and

   iii. includes a Foster Child (as defined in the Fund Rules), legally adopted child or stepchild.

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

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

i. is aged 18 to 20 (inclusive);

ii. does not have a Partner; and

iii. includes a Foster Child (as defined in the Fund Rules), legally adopted child or stepchild.

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

(c) **"Student Dependant"** is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Policy Holder or Partner who:

i. is aged 21 to 30 (inclusive);

ii. is receiving full-time education at a school, college or university; and

iii. does not have a Partner.

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

(d) **"Non-Student Dependant"** is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Policy Holder or Partner who:

i. is aged 21 to 30 (inclusive);

ii. is not in full-time study;

iii. does not have a Partner; and

iv. who the Policy Holder has nominated to stay on the Policy for a fee.

"Discount Assessment Date" means, in relation to a person who is insured under an Age-Based Discount Policy, whichever of the following is applicable:

(a) the date the person became insured under a policy that provided an Age-Based Discount;

(b) the date the person was first eligible for an Age-Based Discount if the policy provided an Age-Based Discount after the person became insured under that policy; or

(c) the person's discount assessment date under their old policy, provided that:

i. the person transferred to the new policy from their old policy which was an Age-Based Discount Policy; and

ii. continuous Hospital Cover was maintained and the new policy is stated to be a retained Age-Based Discount Policy (check your Product Information); and

iii. the person was not a Child Dependant under their old policy.

"Emergency Ambulance Transportation" means ambulance transportation where the ambulance provider describes the transportation as an 'Emergency'. Benefits are not payable for ambulance transportation that is not described by the provider of the services as 'Emergency'.

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

"Excluded Natural Therapy Treatment" means any of the following Treatments:

(a) Alexander technique

(b) Aromatherapy

(c) Bowen therapy

(d) Buteyko

(e) Feldenkrais

(f) Western herbalism

(g) Homeopathy

(h) Iridology

(i) Kinesiology

(j) Naturopathy

(k) Pilates

(l) Reflexology

(m) Rolfing

(n) Shiatsu

(o) Tai chi

(p) Yoga

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

"Extended Family Policy" is a Policy with one or more Non-Student Dependants (not available on all Covers and under all

circumstances – check your Product Information and call Us for more information).

"Extras"– *see General Treatment*.

"Facility" means a Hospital, or medical facility which substitutes for a Hospital emergency department, excluding General Practitioner clinics.

"Family Policy" means a Policy comprising the Policy Holder, their Partner and one or more Child Dependants, Non-Classified Dependants and/or Student Dependants.

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

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

"General Product" means a Product for General Treatment.

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

(a) Treatment (including the provision of goods and services) that:

  i. is intended to manage or prevent a disease, injury or condition; and

  ii. is not Hospital Treatment; and

(b) any Treatment listed as permissible in the Private Health Insurance (Health Insurance Business) Rules for the purposes of General Treatment; and

(c) despite subsection (a)(ii), General Treatment includes Benefits for Travel and Accommodation relating to Hospital Treatment; and

(d) despite subsections (a), (b) and (c), the following is not General Treatment;

  i. the rendering in Australia of a service for which a Medicare Benefit is payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise;

  ii. any Treatment, listed as not permissible in the Private Health Insurance (Health Insurance Business) Rules for the purposes of General Treatment.

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

"Health Insurance Act" means the Health Insurance Act 1973 (Cth).

"Health Insurance Business" has the meaning given to that term under the Private Health Insurance Act.

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

"Hospital" means a Facility for which a declaration under section 121-5(6) of the Private Health Insurance Act is in force.

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

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

(a) some or all Hospital Treatment; and

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

"Hospital Psychiatric Services" means Hospital Treatment for the Treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example, psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.

"Hospital Treatment" means Hospital Treatment as defined in section 121-5 of the Private Health Insurance Act.

"Hospital-Substitute Treatments" means General Treatment as defined in section 69-10 of the Private Health Insurance Act.

"Immunisations" means vaccines that are listed on the National Immunisation Schedule.

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

"Influenza (flu) Vaccine" means a vaccine that:

(a) is approved by the Therapeutic Goods Administration and entered in the Australia Register of Therapeutic Goods (ARTG) for use in Australia;

(b) is not registered on the Pharmaceutical Benefits Scheme;

(c) is administered via injection to improve the immune response to an influenza (flu) virus;

(d) is supplied and administered by a Provider who is a registered pharmacy in private practice; and

(e) the member is not eligible to claim through the National Immunisation Program.

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

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

"Known Gap" means the ability of specialists to charge above the MediGap network benefit limit of up to $500 per episode, paid by the Patient, resulting in a Known Gap. This Known Gap must be accompanied by an informed financial consent, acknowledged by the Policy Holder in writing, prior to the Treatment.

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

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

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

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

"Medicare Levy Surcharge (MLS)" is a Commonwealth Government initiative to encourage higher income earners to take out Australian health cover. Under Australian taxation law, anyone who holds a Medicare Card or who is entitled to hold a reciprocal Medicare Card and does not have Australian domestic health insurance, may have to pay an additional 1% to 1.5% in tax if their income exceeds the MLS thresholds.

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

"MediGap Scheme" is a scheme to reduce or eliminate Out-Of-Pocket Expenses for Patients where specialists charge above the Medicare Benefits Schedule Fee for eligible In-patient Hospital Treatment.

"Member" means any Policy Holder or person (including Adults and Dependants) insured by Us under a Policy.

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

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

"nib's First Choice network" or **"First Choice network"** means the network of Recognised Providers that have a contracted arrangement with Us to provide Treatment at set or discounted rates.

"Non-First Choice network" means the Recognised Providers that do not have a contracted arrangement with Us to provide Treatment at set or discounted rates.

"Non-PBS Pharmaceutical" means a pharmaceutical that is not listed on the PBS or is listed on the PBS but is prescribed and dispensed for a purpose outside of the provisions specified by the PBS.

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

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

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

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

(c) the date of service;

(d) the description of the service;

(e) the amount(s) charged; and

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

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

"Outpatient" means medical Treatment provided to a Member which does not require an Admission to Hospital to receive Hospital Treatment. Outpatient services may be provided at a Hospital, within Doctor's consulting rooms, walk in clinics or within the community.

"Partner" means a person who lives with a Policy Holder in a marital or de facto relationship.

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

"Partner Private Hospital" means a Hospital with which We have negotiated a Hospital purchaser Provider agreement.

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

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

(a) includes a new born child who:

  i. is admitted to an intensive care Facility in Hospital; or

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

(b) excludes:

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

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

"PBS" means the Pharmaceutical Benefits Scheme.

"PBS Pharmaceutical" means a pharmaceutical that is listed on the PBS and prescribed in accordance with the provisions specified by the PBS.

"Pharmaceutical Benefit" means General Treatment provided in the form of the supply of a medicine or drug that is prescribed and dispensed to the Member in accordance with these Rules (including the Schedules to these Rules).

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

"Pharmaceutical Schedule" means any list or schedule of pharmaceuticals adopted by Us from time to time for the purpose of determining eligibility for Benefits relating to the supply of Non-PBS Pharmaceuticals.

"Policy" means a Policy of private health insurance between a Policy Holder and Us issued under a Product.

"Policy Anniversary" means each anniversary of the date when the first Premium in a continuous period of Premiums to Us is paid by, or on behalf of, the Policy Holder under the Policy in relation to any Hospital Product.

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

"Policy Category" means the following groups:

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

(b) only two persons who are Adults (one being the Policy Holder) – a Couples Policy;

(c) only one Adult (being the Policy Holder) and at least one Non-Classified Dependant, Child Dependant and/or Student Dependant – a Single Parent Family Policy;

(d) only one Adult (being the Policy Holder) and any number of Non-Classified Dependants, Child Dependants and/or Student Dependants and at least one Non-Student Dependant – Extended Family Policy;

(e) only two Adults (one being the Policy Holder) and at least one Non-Classified Dependant, Child Dependant and/or Student Dependant – a Family Policy; and

(f) only two Adults (one being the Policy Holder) and any number of Non-Classified Dependants, Child Dependants and/or Student Dependants and at least one Non-Student Dependant – Extended Family Policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Private Room" means a room in a Hospital which:

(a) is purpose built and suitable for no-one other than a single admitted adult patient;

(b) holds one single sized bed; and

(c) has a dedicated ensuite.

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

"Product Information" is the material that relates to your Qantas Health Insurance Policy, such as Private Health Information Statements, Policy Statements and Product Information Sheets.

"Provider" – *see Recognised Provider.*

"Public Hospital" means a Hospital declared by the Minister as a Public Hospital.

"Purchaser-Provider Agreement" means a Hospital purchaser-provider agreement or a Medical Purchaser-Provider Agreement between Us and any other Provider.

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

(a) Hospitals; and

(b) General Treatment Providers that:

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

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

  iii. are in Private Practice; and

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

"Rehabilitation" means Hospital treatment for physical rehabilitation for a patient related to surgery or illness.

For example, inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.

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

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

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

"Set Benefits" or **"Fixed Amount"** means a fixed dollar amount that We pay towards an eligible service or Treatment, which may vary depending on your Cover.

"Single Parent Family Policy" means a Policy comprising the Policy Holder and one or more Child Dependants, Non-Classified Dependants and/or Student Dependants.

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

"Telehealth" means Treatment provided by any form of technology as an alternative to face-to-face consultations, including videoconferencing, internet and telephone, but excluding the use of technology during a face-to-face consultation.

"Transfer Certificate" means a certificate issued by a registered health insurer, in a form approved under the Private Health Insurance Act, detailing full health insurance cover details and claims histories of a person transferring from the fund operated by that insurer.

"Treatment" means:

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

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

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

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

Privacy statement

nib collects your personal information, including sensitive information (such as health information), from you and if necessary from third parties such as other health insurers, health service Providers and third parties who provide analytics services to Us. By purchasing and maintaining a Policy, you authorise Us to request and receive personal information about you. This includes, for example, health information in connection with your health insurance policy, audits of health provider records from health service Providers, and predicted health outcomes from third parties who provide analytics services to Us.

We will use the information We collect to:

- process your application for a Policy with Us.
- provide Benefits for health and related services, including My Account.
- determine your eligibility to receive or participate in health related programs, Products or services.
- offer and provide personalised health information, support and services.
- promote and market nib's current and future health and related services.
- promote and market existing and future other co-branded Products and services.
- conduct research (including but not limited to Member surveys) concerning nib's current and future health and related services.
- recommend updates to insurance policies to ensure adequate coverage for services beneficial to you.
- manage Our relationship with you.
- as otherwise authorised or required by law.

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

From time to time you may receive direct marketing or research communications from Us by mail, telephone, email or sms. You may at any time request to stop receiving these communications by opting out of the communications at the time of receiving them through the link provided, or contacting nib's Privacy Officer by calling **13 14 63** or emailing **privacyofficer@nib.com.au**. To opt out of your information being used for analytics purposes for Us to provide personalised health information and related Products and services, please contact nib's Privacy Officer by calling **13 14 63** or emailing **privacyofficer@nib.com.au**.

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

- The named Policy Holder who has your authority.
- Any other authorised individual.
- Other nib companies.
- Health service Providers including private and Public Hospitals, doctors and medical specialists and their state registration boards and professional associations.
- Private health insurers and government agencies.
- nib's contractors and service Providers who perform services such as data analytics, marketing, market research, mail-house services and Product research and development.
- nib's existing and future strategic partners in respect of co-branded Products and services.
- If you are part of a corporate plan to your employer, organisation or broker.

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

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

The nib Privacy Policy is available at nib.com.au or from your local nib branch.

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

nib reserves the right to change the nib Privacy Policy from time to time.

Changes will take effect when Our updated Privacy Policy is posted on Our website.

Feedback and complaints

How to resolve a complaint or dispute

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

Step 1: Talk to Us

The first thing you should do is talk to one of Our consultants about your concern. Phone Us on **13 49 60**.

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

Step 2: Contact Qantas Insurance Customer Resolutions

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

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

Phone: **13 49 60** and request to speak with the Customer Resolutions Team.

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

Step 3: Seek an external review of the decision

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

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

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

Phone: **1300 362 072**

Notes

Going to Hospital?

Contact Us before you go to Hospital or undergo a new course of treatment to make sure you are covered under your policy.

Need help?

Call Us on **13 49 60**
Mon to Fri: 9am – 7pm (AEST)
or go to **qantas.com/healthinsurance**

This health insurance is issued by nib health funds limited ABN 83 000 124 381 (nib) a registered private health insurer and is arranged by Qantas Airways Limited ABN 16 009 661 901 (Qantas) as an authorised Agent of nib for which Qantas receives commission.

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