Membership Terms and Conditions

Transport Health

Important information

Code of Conduct

Private Health Insurance Code of Conduct™ Transport Health abides by the Private Health Insurance Industry Code of Conduct which ensures that you, our member, receive clear and transparent information in both written and verbal correspondence with the Fund.

The code ensures that:

- Transport Health will provide easy to understand information in plain English to our members
- Transport Health continues to improve our practice standards and service for our members
- Transport Health will ensure our staff are adequately trained to provide up to date information to our members
- Transport Health will provide members will access to an internal dispute resolution procedure to ensure members are aware of their rights to escalate any grievance to the appropriate Government body

A copy of the Code of Conduct can be viewed at **www.transporthealth.com.au** or provided on request.

Internal dispute resolution & feedback policy

Transport Health continuously looks at ways to improve services to members. We comply with the Private Health Insurance Industry Code of Conduct. We have established an internal dispute resolution process to ensure disputes are managed effectively and efficiently, while ensuring privacy and professionalism at all times.

If you have an issue of concern, please contact one of our Member Service Consultants who will endeavour to resolve the issue promptly through our internal disputes resolution process. Health Insurance issues that cannot be resolved over the telephone should be lodged in writing to the General Manager Health who will respond within 5 working days. Unresolved disputes can be addressed to the Private Health Insurance Ombudsman (see below).

We appreciate any feedback that you may have in regards to the service or operations of the Health Fund and encourage members to contact us or follow the feedback procedure at **www.transporthealth.com.au**

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman (PHIO) has been set up by the Government to assist members with complaints where a member is not satisfied with an outcome provided by the Fund. Transport Health would encourage members to first contact the Fund and escalate any complaint through our own internal disputes resolution provision, however, the PHIO can be contacted on 1300 362 072 or you can write to:
The Private Health Insurance Ombudsman,
GPO Box 442 Canberra ACT 2601.

Private Patients' Hospital Charter

The Private Patients' Hospital Charter is a guide to what it means to be a private patient in a public hospital, a private hospital or day hospital facility.

It also sets out what you can expect from:

- the doctor(s) providing your treatment
- the hospital in which you receive your treatment, and
- your health insurance fund

The Charter was prepared by the Commonwealth Department of Health and Ageing and may be obtained from Transport Health on request.

TRANSPORT HEALTH INITIATIVES

Contracted providers

Transport Health has endeavoured to reduce or eliminate our members' out-of-pocket expenses for hospital, medical and general extras treatments by entering into agreements with providers. Transport Health only negotiates with those providers who are accredited and registered with the appropriate body and in private practice.

Hospital agreements are where the hospital has entered into a contract with the Fund and our members are only responsible for any excess or co-payment under their chosen level of cover, where the treatment has a Medicare Benefits Schedule item number and isn't excluded under their cover.

Access Gap is where the treating doctor charges more than the Medicare Benefits Schedule (MBS) fee and the Fund has agreed to pay an additional benefit to reduce or eliminate our members' out-of-pocket costs.

Preferred providers are generally extras providers who have entered into an agreement with Transport Health to charge a negotiated fee for their services. In most cases services are fully covered where the provider is a participant in this scheme.

Terms and conditions

Important Conditions

- Waiting periods ranging from 2 to 36 months apply to some services. Please refer to detailed information below.
- If you have a pre-existing ailment or condition, waiting periods must be served before benefits are payable.
- We encourage members to contact us prior to hospitalisation to obtain accurate information about their benefits and level of cover.
- Benefits are provided per calendar year (January - December) for the purpose of entitlements, excesses and co-payments.

A benefit replacement period (the period of time you will need to wait after claiming an item before you can receive further benefits to replace the item) applies for the following items:

Hearing aids	36 months
Dentures	36 months

If you received a claim benefit for a full set of dentures on 1/7/2011 you would not be eligible to claim on dentures again until after 1/7/2014.

- Hearing aids and denture replacement apply once every 3 years.

Claims – important conditions

Claims may be made by post, email, the mobile 'app' or by Fax.

In order to assess your claim and calculate your benefit Transport Health requires a fully itemised account, and if you have paid the account/s the original receipt/s.

A doctor's letter of recommendation is required to be lodged with the claims for the following services: blood glucose monitor, blood pressure monitors, nebuliser pumps, health appliances, CPAP Machine, pressure/compression garments, orthotics, braces and splints.

Transport Health does not cover:

- Claims made two years or more after date of service.
- When you or your dependants have the right to recover costs from a third party other than us, including an authority, another insurer (traffic accident schemes, workers compensation or public liability), or under an employee benefit.
- Treatment for pre-existing ailments or conditions within the first 12 months, excluding psychiatric, rehabilitation and palliative care which have a 2 month waiting period.
- Goods and services received during any period where your payment is in arrears, your membership is suspended or you are within waiting periods.
- Treatment that we deem inappropriate, after receiving independent medical or clinical advice.
- Services that are not delivered face to face, such as online or telephone consultations, unless you are participating in one of our health improvement programs.
- Costs for treatment in an Emergency Department in a Private Hospital
- Benefits for Hospital procedures not recognised for Medicare benefits purposes (such as cosmetic surgery)

Transport Health extras cover does not include:

- Psychological and developmental assessments. Where psychology is included in your cover, psychology treatment is only payable when Medicare Australia entitlements are exhausted
- Goods and services while a hospital patient except for oral surgery.
- Pharmacy items that are not on our Approved Pharmacy list, eg. Items listed on the PBS, items prescribed without an illness, items that are available without prescription, or items that are not TGA approved.
- Goods and services that have not been provided at time of claim eg. Pre-payment.

To claim on these pre-paid goods and services the claim cannot be made until the actual date of the consultation occurs, or the goods have been received.

- Fees for completing claim forms and/or reports.
- Costs incurred for hiring goods - crutches, mobility aids, etc.
- Goods and/or services received overseas or purchased from overseas including items sourced over the internet.
- More than one therapy service performed by the same provider in any one day.
- Co-payments and gaps for government funded health services eg. The co-payment for PBS items.
- Where a provider is not in private practice.
- Where a provider is not registered with an Australian Board or Association recognised by Transport Health.
- Dental procedures where a limit on the number you can have has been excluded.

Limited benefits

- Cosmetic surgery, sterilisation reversals or services not listed in the Medicare Benefits Schedule (MBS). Limited benefits are available but due to the complexity of these procedures, please contact us before commencing treatment.
- Non-contracted private hospitals – for details please contact the fund.
- Extras Cover Sub Limit Period – new members who are previously uninsured will be subject to a Sub-limit on extras benefits (excluding young singles & young couples cover). See below for more information on sub-limits.
- Access gap is not available for restricted or excluded services. Access Gap provides benefits for medical services charged in excess of the Medicare Benefits Schedule Fee, where the doctor chooses to participate. Refer to details on this page for a comprehensive description of access gap.

Waiting periods

When joining, or upgrading your level of cover, waiting periods must be served before any benefits are payable. If you are transferring from another health fund, waiting periods are waived for the services that were covered under your previous policy, provided you've served the equivalent waiting periods with your previous fund.

SERVICES	WAITING PERIOD
Emergency ambulance transportation	No waiting periods
Accidents requiring either hospital or ancillary treatment (excluding services detailed below)	
All services, except as specified below	2 months
Psychiatric, Rehabilitation and Palliative Care	2 months
Optical	6 months
Elective procedures	12 months
Appliances	
Orthodontic treatment	
Orthotics	
Major dental, ie: bridges, crowns, dentures & implants	
Pre-existing ailments (see definition)	
Pregnancy related conditions (except IVF/GIFT see definition)	
All services that refer to Benefit Limitation Periods for the insured level of cover	
Reproductive treatment, such as IVF/GIFT	
Hearing aids	24 months
Laser eye surgery	36 months
Replacement of dentures	

Sub limit – extras:

This applies to Top Extras, Healthy Choice Extras, Family and Single Parent Family by Design Extras. Benefits payable during the first 6 months of membership, and after serving the specified waiting periods, cannot exceed 50% of the full annual benefit limit entitlement. If further treatment is required in the subsequent 6 months, members are entitled to the balance of the annual limit. The overall benefit payable over 12 months is equal to the normal quoted annual limit but this amount cannot be claimed within the first 6 months of membership. Sub-limits do not apply to members who are transferring from other funds, providing they have held equivalent cover and served the required waiting periods.

Agreement private hospital and day facilities

Transport Health has negotiated set benefit arrangements with 98% of private hospitals and day facility hospitals throughout Australia, eliminating or minimising out-of-pocket expenses for members according to their level of cover. Product excesses and/or co-payments still apply. For a detailed list of agreement hospitals please visit our website **www.transporthealth.com.au** or contact the Fund.

Associated hospital costs

Surgically Implanted Prosthesis – The Federal Government publishes a prostheses schedule that sets out the benefits health funds must pay towards these items. Additional out of pocket (gap payment) prostheses expenses may be incurred that are not covered. Members are advised to confirm if there are any out of pocket expenses with their treating doctor and/or the private/public hospital prior to admission. To limit your out of pocket expenses, ask your doctor which prosthesis is best for you and if there is a no-gap option available.

Drugs in Hospital – Drugs prescribed for discharge and drugs not approved by the Health Department are not covered by the Fund, all other inpatient approved drugs associated with the treatment for a condition are covered.

Restricted Services

Some Transport Health Hospital covers have restricted services. If you have a cover with restricted services and are planning to use a private hospital please call the Fund to confirm your eligibility and level of cover for the service. The Federal Government minimum benefit (also known as the Default Benefit) is the benefit that Transport Health would pay for restricted services in a private hospital or day procedure centre. This benefit is a payment towards the accommodation cost only and does not cover any other hospital charges including operating theatre/labour ward. Members should be aware that treatment for a restricted service in a private hospital or day procedure centre may leave substantial out of pocket costs. Access gap is also not available on restricted services.

Non-agreement private hospital and day facilities

Additional costs may apply together with your excess or co-payment where a hospital is not contracted. You should check with the Fund if being admitted to a non-agreement hospital. Members should also contact the Fund if treatment is to be provided in a doctor's room where a facility fee may be raised.

Medical Gap

Under all hospital covers, medical benefits are paid in accordance with the Medicare Benefits Schedule Fee for inpatient medical treatment. Medicare will cover 75% of schedule fee and Transport Health will pay the remaining 25% of the schedule fee up to the Medicare Benefits Schedule (MBS). If a doctor charges more than the MBS this is known as the 'gap' and is payable by the member.

Access Gap / participating doctors

To try and reduce your out of pocket expenses as much as possible when you are treated as a private patient in hospital. Transport Health offer a direct billing scheme "Access Gap", where Doctors who participate in Access Gap agree to a set fee for providing treatment to you. This allows the Fund to pay an additional benefit and eliminate or reduce your out-of-pocket costs.

This is a voluntary addition to medical gap cover and doctors may participate on a patient-by-patient basis and can opt in or out at any time. This in no way compromises or interferes with patient care. The onus is on the doctor to provide the patient with details of any out-of-pocket cost before commencing treatment; this is known as Informed Financial Consent.

For a listing of Doctors who use Access Gap please visit our website **www.transporthealth.com.au** or contact the Fund.

Preferred providers (extras)

Transport Health has negotiated arrangements with health care providers to participate in programs that eliminate or minimise out-of-pocket expenses for some extras treatments like physiotherapy, chiropractic and osteopathy

A full list of these providers can be obtained on our website at **www.transporthealth.com.au** or you can contact the Fund for details.

How to join

Joining is easy. Complete the application form and return it with your first month's premium by mail or in person to our office. If you require assistance in completing the form or wish to discuss any cover details please contact our Member Service Consultants.

Health fund premiums are payable in advance, weekly, fortnightly or monthly. The following page had a guide to the Lifetime Health Loadings that may be applicable to the base rate premium if you are over the age of 30 years and taking hospital cover for the first time.

Lifetime Health Cover loadings

YOUR AGE#	LHC LOADING	YOUR AGE#	LHC LOADING	YOUR AGE#	LHC LOADING	YOUR AGE#	LHC LOADING
30	0%	39	18%	48	36%	57	54%
31	2%	40	20%	49	38%	58	56%
32	4%	41	22%	50	40%	59	58%
33	6%	42	24%	51	42%	60	60%
34	8%	43	26%	52	44%	61	62%
35	10%	44	28%	53	46%	62	64%
36	12%	45	30%	54	48%	63	66%
37	14%	46	32%	55	50%	64	68%
38	16%	47	34%	56	52%	65+	70%

Age as at 1 July. For a detailed explanation of Lifetime Health Cover Loading please visit www.privatehealth.gov.au. Lifetime Health Cover Loading component does not attract a rebate under the Australian Government Rebate Scheme.

Australian Government Rebate Medicare Eligibility

Your eligibility for Medicare depends on your residency and other factors. People who live in Australia are eligible for Medicare benefits if they:

- Are Australian or New Zealand citizens
- Are permanent residents
- Have applied for permanent residency (excludes application for a parent visa) and meet certain other criteria

Any enquiries about Medicare Eligibility can be made at any Department of Human Services service centres or by phoning 13 2011 for the cost of a local call.

Payments

Direct Debit – The easiest way to pay your premiums is through a regular direct debit from your nominated Bank account or credit card. This ensures that your premiums are up to date. Direct debits can occur on a fortnightly, monthly, quarterly, half yearly or yearly basis.

Premiums can be deducted from your account on any day of the month nominated.

Pay by phone – call Transport Health on 1300 806 808 to make a credit card payment over the telephone

BPAY – use the BPay facility of your financial institution

Mail – payments can be made by cheque, money order or credit card. Please do not send cash in the mail

Pay online – Simply visit **www.transporthealth.com.au**, log into the Transport Hub and make a secure payment with your credit card.

Membership conditions and glossary

As with all insurance, there are certain aspects relating to Membership and the payment of benefits with which you should be familiar.

Adult – dependant cover

Persons are considered dependants of the contributor in the following instances:

- Unmarried children between the age of 21-25 and are not full-time students and not eligible for cover under the family membership as detailed under the definition of "dependant children"
- Singles up to the age of 25 and not living in a de facto relationship

Adding a dependant

Expectant mothers on single memberships must change to a family membership or single parent family membership 3 months prior to the expected due date to ensure cover for newborns, for all covers except Young Couples which is 6 months.

An adopted or foster child must be added to your membership within two months of joining the family unit in order to avoid additional waiting periods. Documentation supporting guardianship and date of birth must be provided at time of request.

Ambulance

Entitlements to Ambulance Services can vary from State to State. When a member is not covered by their State Ambulance Services, Transport Health may pay a benefit for Emergency Transportation only.

Benefits are not payable:

- When an ambulance is called to attend to a patient but following treatment, they are NOT transported to a Hospital (Call Out Fee)
- When ambulance costs are fully covered by a Third Party, e.g. Traffic Accident Schemes, workers compensation, public liability or Ambulance Subscription schemes
- When patients are transferred between public hospitals as an admitted patient
- For ambulance transfers (patient transport) once patients have been discharged from hospital.
- Transport for regular treatment (patient transport) e.g. Chemotherapy
- Transport from the admitting hospital to another hospital for treatment

NSW, ACT

If you contribute to a Hospital cover Transport Health pay a state levy on your behalf and you are fully covered for ambulance transport. If you contribute to an Extras only cover you have limited cover for emergency only transportation.

TAS

Ambulance Tasmania provides a free service to Tasmanian residents. The only chargeable cases are those related to motor vehicle or workplace accidents where insurance arrangements cover costs.

QLD

All Queensland residents receive free ambulance cover, both in Queensland and elsewhere across Australia. No Transport Health benefit is payable if you are entitled to full cover for ambulance services under your State Government scheme.

VIC, SA, NT & WA

Under Transport Health Hospital and/or Extras covers you are covered for emergency Ambulance transportation only.

Cancellation of membership / cooling off period

Under fund rules members can cancel their membership in writing at any time. Cancellation of membership cannot be backdated, however, new members have a 30 day cooling off period where all premiums paid in advance of their joining date can be refunded. This is provided claims have not been paid during this period. In this instance the cancellation will occur after the date of the last claim paid.

Change of cover

Members who choose to change their level of cover need to do so in writing, the application form in this brochure serves as a Change of Membership request or members can download a form from our website. Once a change is actioned members will receive written confirmation from the Fund within 5 days of the date of the change.

Increased limits or changes to benefits: members upgrading their cover/limits will have a general 2 month waiting period before benefits are claimable at the new insured level for most services. Members with pre-existing conditions should read the definition of 'pre-existing conditions' as there may be additional waiting periods before benefits are paid.

Claiming

Benefits are payable only for services rendered by providers with appropriate qualifications and recognised by Transport Health.

Benefits cannot exceed the fee charged. In some instances benefits are not payable:

- For services or treatment where you may have an entitlement to receive compensation and/or damages
- When claims are made 2 or more years after receiving treatment
- For treatment received when a Membership is unfinancial or suspended
- For services provided by a family member

Claim forms are available from the office or the website. Members also have the option to nominate a bank account and paid claims submitted by the member can be processed and directly credited into the account.

- Hospital – Hospital costs are usually billed directly to the Fund by the hospital, so members only need to pay applicable excess or co-payment (if any) on discharge.
- Medical – Medical Practitioners bill their services separately and claims need to be lodged by members through Medicare or by completing a two-way Medicare form with Transport Health. The two-way claiming arrangements between Medicare and Transport Health ensure that claims lodged with either will be processed and benefit cheques issued promptly for the appropriate amounts.
- Medical Practitioners providing associated hospital services who participate in our Access Gap Cover Scheme will bill the fund directly. Members will only need to pay the doctor any agreed gap payment. This amount is usually billed by the doctor prior to treatment.
- Claim forms can be downloaded from **www.transporthealth.com.au** or posted/emailed by contacting us on 1300 806 808. For paid accounts claims can be paid directly to the member by cheque or direct credit into a nominated bank account. For unpaid accounts, where possible, benefits will be paid directly to the practitioner or otherwise forwarded to the member for payment.

- HICAPS – HICAPS is available for selected Extras claims with many practitioners now offering this facility, making claiming quicker and easier. The practitioner swipes your plastic membership card and the appropriate benefit for your level of cover is automatically credited to the practitioner. You only need to pay the difference (if any) between the service cost and benefit direct to the practitioner at the time of service.

Co-payments

Co-payments under Top Hospital cover are an amount payable by the member and applicable to each hospital admission during a calendar year. Top Hospital with Co-payment has a daily co-payment of $100 per night, capped at $500 per person, per calendar year. This is also capped annually at $500 per person to a maximum of $1000 per couple / family per calendar year. Co-payments do not apply to same day accommodation.

Healthy Choice Hospital has a daily co-payment of $100 for overnight accommodation capped at $500 per person with a family maximum of $1000 in any calendar year. There is also a daily co-payment of $150 for day stays / day procedures excluding in-patient dental treatment.

Cosmetic surgery

Benefits are only payable for cosmetic surgery or services where it is required for a medical purpose and for which Medicare benefits are payable.

CPAP (Continuous positive airway pressure) Machine

Benefits can only be claimed from either a hospital or extras table but not from both. Benefits are payable for replacement parts i.e. masks.

Delegated authority

The member has the option to nominate a spouse, partner or representative to have access to the membership. This allows Transport Health to release membership details and other personal information to that person. They are also authorised to update membership details and other personal information.

The member must complete the section on the application form at the time of joining or contact Transport Health for a delegated authority form at any time. This information is recorded. Transport Health will confirm the authorised representative's details before quoting details or processing any changes requested.

The delegated authority can be revoked by the member at anytime by notifying Transport Health in writing.

Dependant children

Persons are considered dependants of the contributor in the following instances:

- Unmarried children between the ages of 21 and 25, who are full-time students in an approved apprenticeship / study course
- Unmarried children up to the age of 21

Dispute resolution & feedback policy

Transport Health continuously looks at ways to improve services to members. We comply with the Private Health Insurance Industry Code of Conduct. We have established an internal dispute resolution process to ensure disputes are managed effectively and efficiently, while ensuring privacy and professionalism at all times.

If you have an issue of concern, please contact one of our Member Service Consultants on 1300 806 808 or by emailing **enquiries@transporthealth.com.au** who will endeavour to resolve the issue promptly through our internal disputes resolution process.

Further information about this process is available on request.

Health Insurance issues that are not resolved through the usual processes (refer Internal Dispute Resolution & Feedback Policy) can be addressed to the Private Health Insurance Ombudsman.

The Ombudsman's office can be contacted on 1300 362 072 and via the website **www.ombudsman.gov.au**

Disclaimer

Transport Health encourages its contracted providers to offer high-quality products and services. The relationship Transport Health has with these providers does not construe an endorsement as to fitness for purpose and is not a recommendation or warranty of the services. Transport Health does not assume any responsibility for the product or service provided and members should rely on their own enquiries and seek assurances directly from the provider.

Excess

The excess is an amount payable by the member on making a hospital claim. The excess, as in Top Hospital with Excess cover is $250 per person, on the first overnight admission, per calendar year. A single membership has a maximum excess of $250 annually. A family membership has an excess of $250 up to a family maximum of $500, for overnight admissions, per calendar year.

Young Singles cover has a $250 excess payable on overnight and/or day stays per admission. This excess is capped annually at $500.

Young Couples cover has a $250 excess payable on overnight and/or day stays per admission. This excess is capped annually at $500 per person, per calendar year.

Excluded services

Excluded services, as detailed in Healthy Choice Hospital, Young Singles cover and Young Couples cover, are not covered. Transport Health does not pay benefits for hospital treatment on any of these conditions when you elect to be treated as a private patient. You are, however, covered by the public system under your Medicare entitlement, only when treated as a public patient by hospital appointed doctors in a public hospital.

Extras cover – sub limit period

New members who were previously uninsured will be subject to a Sub-limit on Extras benefits during the first 6 months of membership. This applies to Top Extras, Healthy Choice Extras and Family / Single Parent Family by Design. Benefits payable during the first 6 months of membership and after serving the specified waiting periods, cannot exceed 50% of the full annual benefit limit entitlement. If further treatment is required in the subsequent 6 months, members are entitled to the balance of the annual limit. **The overall benefit payable over 12 months is equal to the normal quoted annual limit but this amount cannot be claimed totally within the first 6 months.** Sub-limits do not apply to members who are transferring from other funds, providing they have held equivalent membership and served the required waiting periods.

In general, sub-limits apply to those who were previously uninsured. After 12 months of membership (or the stated waiting period for the service – whichever is the greater), members are entitled to unrestricted benefits as stipulated in our brochure.

Loyalty reward

The loyalty reward offers you the option, after 24 months continuous membership of Young Couples cover, to upgrade to a Top Cover plan for pregnancy and birth-related services with no further waiting periods applying.

Membership

- A single membership provides cover for an individual.
- A single parent family membership provides cover for an adult contributor and dependant children. See earlier definition of dependant children.
- A Couple membership comprises an adult contributor and their partner.
- Family / couples memberships comprise an adult contributor with a partner and/or dependant children. See earlier definition of dependant children.
- Family adult membership comprises of one adult contributor with a partner and/or spouse with children up to the age of 25 who do not qualify for benefits under the category of 'dependant children'.

Only residents of Australia are eligible to join the Fund.

Newborns

When a newborn baby is in hospital with the mother a separate accommodation charge is not usually raised for the child during the hospital stay, unless the newborn baby becomes an admitted patient in their own right.

Single cover should be changed to family or single parent family at least 3 months prior to the birth. Single Parent Family or Family cover is required to cover accommodation costs for:

- Newborns admitted to hospital and/or neo-natal intensive care units or
- The second or later child of a multiple birth

Overseas suspension

Members may suspend their cover whilst travelling overseas after 12 months of continuous membership. The minimum period of suspension is 30 days and the maximum period is 12 months. Members must contribute to hospital and/or hospital and extras cover to be eligible. Extras only cover cannot be suspended.

- Members who pay their contributions through payroll will need to ensure that their membership is financial at the date of departure.
- Members must notify the Fund of their return to Australia within 7 days of their arrival. A copy of written confirmation, boarding pass or passport is required for reinstatement of membership.
- Any waiting periods not served prior to departure will be applicable when the membership is reinstated.
- Further overseas suspensions are only permitted once the member has held continuous membership for a further 12 months following re-instatement.

Premiums

Health fund premiums are payable in advance, weekly and fortnightly (payroll deductions only) or fortnightly, monthly, quarterly, half yearly and yearly. Transport Health's rate guarantee policy ensures that contributions paid in advance are protected against the rate change until the earlier of; the next due date of the contribution payment or for a period of 12 months from the effective date of the new rate.

Pre-existing ailments

A pre-existing ailment (PEA) is any ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical or health practitioner appointed by Transport Health (not your own doctor) were in existence during the 6 months preceding the day you joined Transport Health or upgraded your level of cover.

The pre-existing ailment rule applies to all hospital and extras tables.

Benefits are not payable during the first 12 months of membership for treatment of a pre-existing ailment (excluding psychiatric, rehabilitation and palliative care which have a 2 month waiting period)

When a cover is upgraded, benefits at the higher level of cover will not be paid at the insured level within the first 12 months of membership for treatment of a pre-existing ailment. However, benefits are payable at the previous insured level of cover during this 12 month period, providing that appropriate waiting periods have been served.

Pregnancy & birth-related services

Pregnancy & birth-related services include, but are not limited to, antenatal and postnatal care and management of labour and delivery.

Proof of identity and/or age

Transport Health requires you to provide proof of identity and/or age, when joining Transport Health for all adult members on the membership.

Podiatric surgery

Where the surgeon is accredited by Medicare for in-patient podiatric surgery and where the Member has hospital cover, benefits for the surgeon's fees are payable. Contact the fund in relation to podiatric surgery prior to treatment.

Transferring from another fund

Provided you join Transport Health within 1 month of your financial date-paid-to with the other fund, and you have served all your waiting periods, you are immediately entitled to equivalent benefits when you transfer your membership to Transport Health from the next day of your date-paid-to with your previous insurer. If transferring to a higher level of cover, appropriate waiting periods will need to be served before you become eligible for the higher benefits. However, you will be entitled to equivalent benefits to those covered by your previous insurer during the waiting period. Transferring members must provide Transport Health with a completed Transfer Certificate request, or provide a Transfer Certificate and claims history to Transport Health, to confirm any Lifetime Health Cover loadings applicable, Paid Hospital Days and confirmation of previous cover.

If you transfer to Transport Health, any benefits paid under your previous cover may be taken into account in determining the benefits payable under your new cover with regards to annual limits, excesses and co-payments.

Online Member Services

Manage your membership online:

- Join the fund
- View membership details
- Download brochures and forms
- Order a replacement membership card
- Print your annual tax statements
- Update contact details
- Make credit card payments
- View payment details
- View newsletter

Policies

Privacy policy

Members' personal information will be used only for approved purposes, such as processing claims. We are required by law to protect your privacy and personal information. We comply with all Victorian and Federal legislation relating to privacy and confidentiality.

A copy of Transport Health's Privacy Policy can be viewed at our website **www.transporthealth.com.au**. Our privacy policy informs individuals of all relevant and required matters under Australian Privacy Law. Contact Transport Health on 1300 806 808 if you have any queries.

Security policy

As part of our security & privacy policy, Transport Health can provide membership details to the member only, unless advised otherwise. In the instance of a family membership and where approved by the member, the spouse and dependants over 18 years of age can only obtain information about their own records. Our staff are required to ascertain that they are speaking to a member when contacted. Members may request to establish a password.

Information collection policy

You have the right to obtain access to any information held by Transport Health about you as an individual but not for any other member. The information collected by us is used for the purpose of processing claims and will only be released to a third party when a written request is received from you, however we may need from time to time to release information in the following circumstances:

1. As required by law to a Government organisation such as the Department of Human Services or the Department of Health and Ageing.
2. A hospital, medical or paramedical provider when processing a claim for services provided to you.
3. Paid benefit confirmation to the membership holder.
4. Organisations that may assist us with electronic transactions, claims or system data.

Direct Debit service arrangement

This section sets out your rights, our commitment to you and your responsibility to us, and where you should seek assistance in relation to your direct debit arrangement with Transport Health.

In the terms of the Direct Debit Request arrangement between us and signed by you we undertake to periodically debit your nominated account in accordance with your signed authority.

If the drawing falls due on a non-business day it will be deducted on the next business day following that date. We will give you at least 14 days notice when we intend to make changes to the initial terms of this arrangement.

If you require changes to the arrangement please notify us in writing at least 2 business days prior to your next scheduled payment.

If you have a dispute regarding a direct debit arrangement or payment please contact the fund immediately. In the event of an unsatisfactory outcome you should follow our disputes resolution policy or contact your financial institution.

It is your responsibility to ensure that sufficient cleared funds are in the nominated debiting account on the date payments are due. For returned unpaid transactions Transport Health will notify you in writing and will outline the procedure to follow. Any transaction fees payable by us in respect to the above may be passed on to you.

Receiving marketing material

From time to time Transport Health may provide you with information about products and services that we consider of potential benefit to you and your family.

At all times Transport Health will give you the opportunity to "opt-out" of receiving any further marketing correspondence. You can opt-out at any time from receiving marketing information by calling us Monday - Friday on 1300 806 808 (8.30am to 5.00pm AEST).

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