Hospital Cover

Queensland Country Health Fund

1 July 2023

If you're concerned about public hospital waiting times and want to ensure that quality and timely care is available for you and your family by a doctor of your choice, then one of our hospital covers may suit you!

Contents

“Queensland Country Health Fund mirrors my passion to give back to regional Queensland. Their community focus and commitment to Member-centric benefits and affordability is why I am delighted to be their brand ambassador.”

Laura Geitz

Former Australian Netball Captain and Queensland Country Health Fund Member

Welcome to Queensland Country Health Fund

Our purpose

Queensland Country Health Fund exists to help people living in our communities live better lives through better health by:

- Assisting Members with access to their choice of medical services including doctors, therapists and hospitals in an affordable and timely manner
- Enabling Members to manage and improve their health
- Providing quality, affordable dental care
- Sharing relevant health education and advice
- Helping communities get active

Our history

Queensland Country Health Fund has been in the business of providing private health insurance cover to Queenslanders for over 46 years. Established in 1977 as the MIM Employees Health Society, the Fund was developed to help Members protect themselves against the financial burden of rising hospital and extras health care costs. In January 1999, we began trading as Queensland Country Health Fund, continuing the traditions of affordable and comprehensive health cover backed by superior, personalised and genuine service.

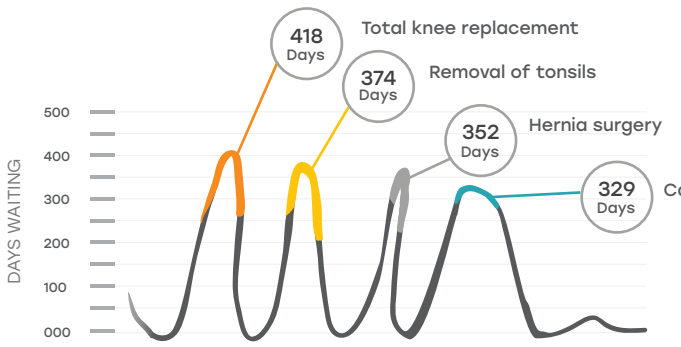
Whether you’re new to health insurance or thinking about making the switch, give us a call to find out how you can experience the Queensland Country Health Fund difference.

Why is private health insurance hospital cover for me?

I won't have to worry about long waiting periods in the public system

Some of the most common hospital procedures if provided in a public hospital can have lengthy waiting lists. Alternatively, if the medical treatment is provided in a private hospital the cost could easily be thousands of dollars if you don't have private hospital cover.

Data for 2021-2022 sourced from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery Table 4.7



With private health insurance, you avoid public hospital waiting times.

Queensland hospital waiting times at 90th percentile as reported by the Australian Institute of Health and Welfare, Australian Hospital Statistics 2021-2022.

I get more choice when choosing my hospital

Having private hospital cover generally gives you the choice of being treated in either a public or private hospital with more choice over the hospital you stay in.

I get to choose my doctor

With private hospital cover you can choose your own doctor and decide whether you will go to a public or private hospital that your doctor attends.

If I want to go private I won't have to pay full price

Childbirth
$10,283.35*

Hip replacement
$24,366.17*

Knee replacement
$24,198.54*

* Source Queensland Country Health Fund claim records; average cost for procedures performed in a private hospital in 2022.

I get more choice as to when I am treated

I'll lock in my Lifetime Health Cover age

Take out hospital cover before 1 July following your 31st birthday to avoid paying a Lifetime Health Cover loading.

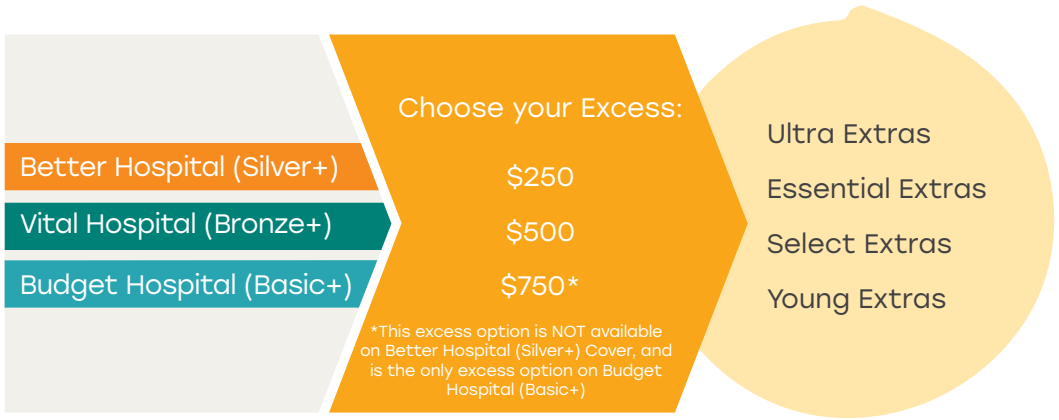
Peace of mind

Having private health insurance definitely has its rewards. It gives you the peace of mind and the security of health care options and benefits not available today through the public health care system.

Packaged covers

We have a simple but flexible product range, so you can choose health cover to meet your budget or needs.

We keep it simple and easy to understand:



Choose from one of our three hospital cover options – Better Hospital (Silver+), Vital Hospital (Bronze+) and Budget Hospital (Basic+).

You then select an eligible excess option, that you are comfortable with and that's your hospital cover locked in!

If you want to be covered for extras services as well, you can pair your hospital cover with the extras cover that best suits you or your family's needs. Choose between Ultra, Essential, Select or Young Extras Covers.

If you're not wishing to have hospital cover you can take Select or Young Extras as a stand-alone product.

It's that simple!

This brochure provides information about our Hospital Cover. For detailed information on our extras cover options, see our Extras Cover Brochure.

Have existing health insurance?

It's easy to switch!

At Queensland Country Health Fund, we believe private health insurance should be easy to understand, easy to claim on, but most of all it should be easy to join or switch to us in the first place.

If you switch from another Australian registered health fund, you're guaranteed portability of cover by law. This means that we'll recognise any waiting periods (or portions of waiting periods) that you've already served if you join us within 63 days of leaving your old fund, so you don't have to serve them again.

The only waiting periods that will apply when you transfer to us is when your Queensland Country Health Fund cover offers a higher level of benefits than your previous cover. But don't worry - while you serve these, we'll still offer you the same level of benefits you had under your previous cover.

If you transfer from a cover with a higher excess to one with a lower excess (for example, from a $500 excess to a $250 excess), this also counts as an upgrade to your cover. You may have to pay your previous higher excess until you've served the waiting period for the new, higher level of cover.

What we need

To complete the transfer, we'll request a Transfer Certificate on your behalf from your previous health fund. The Transfer Certificate confirms your health cover history, your Lifetime Health Cover (LHC) status and ensures you receive continuity of cover. We need this before any benefits can be paid.

We make switching easy – online, in person or on the phone!

Types of memberships

We have cover options for singles, couples and families. Some types of cover are better suited to families, and others to young singles or couples, or perhaps those families with adult dependents. Here's a quick guide to who's covered by each policy type.

Singles policy

Cover for only one person.

Couples policy

Covers the person who opens the policy (the policy holder) as well as their partner. The policy can be extended to cover dependents at no additional cost (a family policy).

Family policy

Covers the policy holder, as well as their partner and all dependents up to 21 years. Full-time students and apprentices can be covered under the family policy at no extra cost up to and including 31 years of age (as long as the dependent is not married or living in a de facto relationship).

Single Parent Family policy

Covers the policy holder as well as their dependents up to 21 years. Full-time students and apprentices can be covered under the single parent family policy at no extra cost up to and including 31 years of age (as long as the dependent is not married or living in a de facto relationship).

Extended Family policy

Covers the policy holder and their partner and all adult dependents up to and including age 31 (or just the policy holder and adult dependents in the case of a Single Parent Extended Family policy). Extended Family Cover is available on our hospital covers, with the exclusion of Public Hospital (Basic+)*. The cost is slightly higher than a standard family or single parent family policy, but is more cost effective compared to the dependent taking out their own cover at the same level. See page 45 for more information about dependents.

*Public Hospital (Basic+) is no longer available for purchase.

Membership Year

Throughout this brochure we'll refer to your Membership Year. We're a bit different to other health funds, we maximise the time you get to use your benefits by starting your Membership Year from the day your policy begins.

Your yearly limits, excesses and benefits all reset on the anniversary of your join date each year.

Cooling off period

If you're not completely satisfied with your cover, we'll allow you to cancel your policy and receive a full refund within 30 days of joining or upgrading your policy, as long as you haven't made any claims.

The right cover

Before taking out any private health insurance products, you should read all documentation provided to you and make sure the product is appropriate for you. Please keep a copy of all documents for future reference.

Why Queensland Country Health Fund?

Member focused

At Queensland Country Health Fund, our primary focus is satisfying the needs of our Members. We invest heavily in making your experience unique and refreshing.

We're driven to design and deliver exceptional value private health insurance products, while maintaining a simple and satisfying experience for our Members!

We will always strive to improve our already highly regarded reputation for exceptional Member service to keep our Members smiling!

National coverage

Being the only health fund based in regional Queensland means we understand the health care needs of Queenslanders better than anyone.

If you work, move or play interstate, you can rest easy because we provide nation-wide coverage. Through our relationship with the Australian Health Service Alliance (AHSA), we have agreements with most private hospitals and medical practitioners throughout Australia.

You'll have cover for all eligible in-hospital services within Australia, giving you peace of mind wherever you may go.

Ambulance cover

You never know when an accident might happen and you need to be rushed to hospital in an emergency. We provide nationwide ambulance cover for all persons covered under a Queensland Country Health Fund private hospital product* who reside outside of Queensland or Tasmania (nationwide emergency ambulance services are provided for Queensland residents and statewide emergency ambulance services are provided for Tasmanian residents. These are covered by their respective State Governments).

You're covered for **one emergency ambulance transport service or one on-the-spot emergency treatment per person per Membership Year.** Cover is Australia wide. Conditions do apply and further information regarding ambulance coverage can be found in our Membership Guide. There is a **one day waiting period for emergency ambulance treatment.**

* Not available on any stand-alone extras products (Select and Young Extras)

Dependents also covered

Dependents can stay on a family policy up to 21 years of age at no extra cost.

We can also under some circumstances, continue to cover them on your family policy up to and including 31 years of age. We have more information about our family policies on page 10 and 11.

97% **of our Members are satisfied with their membership!***

Discounts for younger Members

As of April 2019 private health insurers have been able to offer premium discounts of up to 10% to 18-29 year olds taking out their own hospital cover.

Queensland Country welcomed this reform believing that it will assist younger people to participate in private health insurance by making premiums more affordable. The provision of discounted products by an insurer is voluntary but Queensland Country has taken the stance of providing the discount to all eligible persons across all of our hospital products.

For more information regarding eligibility to age-based discounts refer to page 16-17.

Home away from home

Most of our policy holders live in regional and remote areas of Queensland, so it's often necessary for people to travel to Townsville or Brisbane for essential medical treatment.

Trips like these can mean high accommodation costs for family accompanying the patient. We offer two-bedroom furnished apartments in Brisbane (close to the Wesley Hospital) and in Townsville (near the Mater Hospital) to give our Members a home away from home.

Once you've been with us for two months, we're able to offer accommodation at these apartments at concessional rates when you travel for hospital or medical treatment and medical appointments.

Care Navigation

Care Navigation is a service provided by Registered Nurses for our Members with Better Hospital (Silver+) Cover. The service is aimed at supporting Members who require assistance immediately after a stay in hospital or for those living with chronic diseases.

Care Navigation can be accessed after two years of continuous membership and based on a clinical assessment completed by the Care Navigation team, we may recommend a short-term program or offer ongoing education and support over the phone. The clinical assessment may include information about your recent hospital treatment, current medications and level of support at home. This will help our team determine the most appropriate program for you.

Care Navigation is part of our commitment to improving the long-term health and wellbeing of our Members.

For more information, visit queenslandcountry.health/carenavigation

*Source: January 2022 Member Satisfaction Survey, 70% were very satisfied and 27% were somewhat satisfied from 1,528 respondents.

continued...

Why Queensland Country Health Fund?

Sponsorships and community support

Queensland Country Health Fund is committed to supporting health in local communities. We're proud to sponsor and support the Townsville Running Festival and the Mackay River to Reef Charity Bike Ride.

We also provide support for local community groups through sponsorship of events and donations.

Your own dental practice

Queensland Country Dental is Queensland Country Health Fund's dental practice located in Townsville, Mount Isa and Mackay.

The practice offers a full range of general dental services and has a preventive focus with the aim of improving our Members' oral health.

All health fund Members can access high quality dental care. Members with Ultra Extras will have no or low out-of-pocket expenses on a range of diagnostic and preventive treatments, like checkups and scale and cleans.

For further information on the dental practice, visit queenslandcountry.health/dental

Age-based discounts

Discounts for our younger Members

Government reforms to private health insurance introduced from 1 April 2019 sees younger people eligible for a discount on their private health insurance hospital cover. Legislation previously prevented health insurers from offering discounts to people based on their age.

The Government's decision to allow private health insurers to offer discounts to younger Australians is designed to encourage more young people to take out private health insurance, a move that Queensland Country Health Fund has welcomed.

The provision of discounted products by insurers is voluntary but Queensland Country Health Fund took the opportunity provided by this legislative change to offer the discount to all eligible persons across all of our hospital products. These discounts are referred to as age-based discounts.

What policies is this discount available on?

Under the reforms an insurance policy must not provide an age-based discount unless the policy covers hospital treatment. This means that hospital only or hospital and extras packaged covers are the only products eligible for the discount. **It is not available for a stand-alone extras cover.** As stated above, all of Queensland Country Health Fund's Hospital or Hospital and Extras packages provide this discount to younger persons.

How much is the discount?

Insurers are able to offer premium discounts of 2% per year that a person is under 30 years of age when they first purchase insurance on an age-based discount policy to a maximum of 10% for 18-25 year olds. The discount rates are shown below.

Person's age when they become insured under a hospital policy offering the discount	Percentage discount that insurer may offer
18-25	10
26	8
27	6
28	4
29	2
30	0

How does it work?

The age-based discounts on hospital cover premiums are based on a person's age when they become insured under a policy that offers these discounts.

The eligibility to the age-based discount is based on a policy holder's discount assessment date. This date is critical for establishing the discount that applies to a person. This discount assessment date can be established in three ways:

(a) The date the person became insured under an age-based discount policy, or

(b) The date the person was first eligible for an age-based discount if the policy they purchased introduces an age-based discount at a date after the person became insured, or

(c) If a person transfers from a policy to a new policy which is stated to be a retained age-based discount policy*, the person's discount assessment date under the old policy applies

What if I transfer to Queensland Country Health Fund when I am already eligible for an age-based discount?

If your previous health fund informs us that the policy you held was an age-based discount policy and you transfer to any of Queensland Country Health Fund's retained age-based discount policies* within 63 days of terminating your previous cover you will retain the applicable discount percentage applying to your previous cover at the time of transfer.

* A retained age-based discount policy means an insurance policy that is not only an age-based discount policy but also states that it is a retained age-based discount policy. Persons transferring to a retained age-based discount policy from another age-based discount policy will retain their discount assessment date that applied under the old policy, and consequently the applicable discount percentage applying at the time of transfer. If a person transfers to a third or subsequent policy they retain their discount assessment date and applicable percentage, as long as each successive policy is stated to be a retained age-based discount.
All Queensland Country Health Fund Hospital Covers are retained age-based discount policies.

How long do I retain my discount for?

If as an eligible person^ you stay covered under an age-based discount policy you will retain the discount applicable to your discount assessment date until you turn 41 years of age. This is subject to you remaining on the same policy (and that the Fund continues to provide age-based discounts on this product) or subsequently transferring to another retained age-based discount policy.

On turning 41 years of age the discount reduces by 2% per year for each year until you are 45 years of age, when the discount will no longer apply. The table below demonstrates this.

Person's age	Phase out
41	Person's base percentage less 2%
42	Person's base percentage less 4%
43	Person's base percentage less 6%
44	Person's base percentage less 8%
45 or older	zero

^ In relation to an age-based discount policy, an eligible person is a person to whom a discount applies in accordance with their discount assessment date

Clinical category* and cover overview

	BETTER HOSPITAL (SILVER+)		VITAL HOSPITAL (BRONZE+)			BUDGET HOSPITAL (BASIC+)
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS					
Choice of doctor/hospital	✓		✓			✓
Public hospital accommodation as a private patient	✓		✓			✓
Private hospital accommodation For Better Hospital (Silver+), Vital Hospital (Bronze+) and Budget Hospital (Basic+) when admitted as an inpatient at a private hospital or day facility for any of the Restricted (R) services you will have a benefit entitlement to the default rate benefit only. This will likely lead to large out-of-pocket expenses if admitted under this level of hospital cover. No benefit is paid towards an Excluded service.	✓		✓			✓
Theatre fees For hospital services or treatments that have Restricted benefit or are an Excluded service, no benefit is paid towards the cost of theatre charges raised for inpatient services in a private hospital or day surgery.	✓		✓			✓
Age-based discount eligible policy Refer to page 16 for further information.	✓		✓			✓
Nationwide ambulance cover Ambulance benefits will be applied to emergencies only and limited to one per person per Membership Year, when provided by recognised providers. For more details see Ambulance Cover section on page 12.	✓		✓			✓
Accommodation benefits Accommodation benefit up to $50 per night for Members travelling 300 kilometres or more return from their home address for hospitalisation. Conditions apply see Accommodation Benefit information on page 38 for further information.	✓		✓			✓
Surgically implanted prostheses e.g. surgically implanted stents, screws and plates (for fractures) and pacemakers etc. Prostheses benefits as per the Government listing. No prosthesis benefit payable on an excluded service.	✓		✓			✓
Access Gap Cover A benefit over and above the Medicare Benefits Schedule for participating doctors on inpatient services.	✓		✓			✓

	BETTER HOSPITAL (SILVER+)		VITAL HOSPITAL (BRONZE+)			BUDGET HOSPITAL (BASIC+)
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS					
Intensive care	✓		✓			✓
Nursing home type patients This amount is determined by the Federal Government. Certification is required.	✓		✓			✓
Bone, joint and muscle	✓		✓			✓
Dental surgery	✓		✓			✓
Diabetes management (excluding insulin pumps)	✓		✓			✓
Hernia and appendix	✓		✓			✓
Joint reconstructions	✓		✓			✓
Kidney and bladder	✓		✓			✓
Lung and chest	✓		✓			✓
Miscarriage and termination of pregnancy	✓		✓			✓
Skin	✓		✓			✓
Tonsils, adenoids and grommets	✓		✓			✓
Palliative care	✓		✓			R
Rehabilitation	✓		✓			R
Back, neck and spine	✓		✓			✗
Blood	✓		✓			✗
Brain and nervous system	✓		✓			✗
Breast surgery (medically necessary)	✓		✓			✗
Chemotherapy, radiotherapy and immunotherapy for cancer	✓		✓			✗
Digestive system	✓		✓			✗

* Clinical categories are defined by the Department of Health and detailed in the Private Health Insurance (Reforms) Amendment Rules 2018. A copy of the clinical categories, detailing the scope of cover can be accessed at queenslandcountry.health/clinical-categories or on page 52-57 of this brochure.

R Restricted benefits: You will be covered for shared ward accommodation in a public hospital only. While you can choose to go to a private hospital or day surgery for the service or treatment, your admission is not fully covered and will likely result in large out-of-pocket expenses. Some private specialists may not operate in a public facility, please take this into consideration when making a hospital product choice.

✗ Excluded Services: Hospital or day surgery admissions for these services in either a public or private facility will receive no benefit from Queensland Country Health Fund. As well there is no benefit payable for services for which Medicare pays no benefit e.g. most cosmetic surgery.

Clinical category* and cover overview

	BETTER HOSPITAL (SILVER+)		VITAL HOSPITAL (BRONZE+)			BUDGET HOSPITAL (BASIC+)
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS					
Ear, nose and throat	✓		✓			×
Eye (not cataracts)	✓		✓			×
Gastrointestinal endoscopy	✓		✓			×
Gynaecology	✓		✓			×
Male reproductive system	✓		✓			×
Pain management	✓		✓			×
Plastic and reconstructive surgery (medically necessary)	✓		✓			×
Podiatric surgery (provided by a registered podiatric surgeon)	✓		✓			×
Assisted reproductive services	✓		×			×
Cataracts	✓		×			×
Dialysis for chronic kidney failure	✓		×			×
Heart and vascular system	✓		×			×
Implantation of hearing devices	✓		×			×
Insulin pumps	✓		×			×
Joint replacements	✓		×			×
Pain management with device	✓		×			×
Pregnancy and birth	✓		×			×
Sleep studies	✓		×			×

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	BETTER HOSPITAL (SILVER+)		VITAL HOSPITAL (BRONZE+)			BUDGET HOSPITAL (BASIC+)
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS					
Hospital psychiatric services	R		R			R
Care Navigation Provides assistance immediately following a period of time in hospital or for those living with one or more chronic diseases. See page 13 for eligibility.	✓		×			×
Hospital boarder Benefits up to $35 per day to a maximum of four days per person, where such accommodation is necessary for the wellbeing of the patient	✓		×			×
Weight loss surgery	×		×			×
Surgery or hospital treatment where Medicare does not pay a benefit e.g. elective cosmetic surgery, experimental treatment/procedures and laser eye surgery (LASIK etc.)	×		×			×

* Clinical categories are defined by the Department of Health and detailed in the Private Health Insurance (Reforms) Amendment Rules 2018. A copy of the clinical categories, detailing the scope of cover can be accessed at queenslandcountry.health/clinical-categories or on page 52-57 of this brochure.

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× Excluded Services: Hospital or day surgery admissions for these services in either a public or private facility will receive no benefit from Queensland Country Health Fund. As well there is no benefit payable for services for which Medicare pays no benefit e.g. most cosmetic surgery.

Choose your excess

An excess is the amount you agree to contribute towards the cost of hospital treatment if you're admitted as a private patient at a public or private hospital or a day surgery.

The higher your agreed excess amount, the lower your premium will be, because you're contributing more to the cost of your hospital visit.

In addition to your agreed excess, you may have other out-of-pocket costs associated with your hospital treatment, which are explained further in this brochure.

We offer a choice of excess options on our hospital covers, the options differ slightly between the two hospital products.

Better Hospital (Silver+)

Choice of either $250 or $500 excess

Exemption for dependents 12 years and under (see page 23 for further detail)

Vital Hospital (Bronze+)

Choice of $250, $500 or $750 excess

Exemption for dependents 12 years and under (see page 23 for further detail)

Budget Hospital (Basic+)

This product is only available with a $750 excess

Exemption for dependents 12 years and under (see page 23 for further detail)

When you go to hospital, you'll pay your excess upfront on your visit. You only need to pay the excess on your first hospital visit within your Membership Year*, and your excess amount payable then resets at the start of your next Membership Year. If the excess contribution on your first visit happens to be less than your chosen excess option, you will be required to pay the remainder of your excess obligation if admitted to hospital again in the same Membership Year.

The most you'll have to pay in relation to an excess payment each Membership Year* if you choose a cover with a hospital excess is outlined below:

Excess type	Singles cover	Couples/Family/Single Parent cover	
	Maximum per Membership Year	Maximum per person per Membership Year	Maximum per policy per Membership Year
$250 Excess	**$250**	**$250**	**$500**
$500 Excess	**$500**	**$500**	**$1,000**
$750 Excess Vital Hospital (Bronze+) and Budget Hospital (Basic+)	**$750**	**$750**	**$1500**

Excess exemption for young dependents

On all hospital covers

With all hospital covers, you won't be charged an excess if your dependent up to and including the age of 12 years is admitted to hospital for medical treatment.

* Membership Year is defined on page 11.

Better Hospital (Silver+) Cover

Our most extensive hospital product

Better Hospital (Silver+) Cover is **our most extensive hospital product** – it's most popular with people who want greater peace of mind, paying benefits for a wide range of inpatient hospital services like pregnancy, heart-related procedures, major eye surgery and joint replacement surgery.

Best suited for

Couples, singles and families wanting our highest level of hospital cover

Features:

- ✓ **Our highest level of hospital cover**
- ✓ **Cover for private hospital accommodation^**
- ✓ **Benefits towards doctors' fees for services provided in a hospital^**
- ✓ **Cover for most major surgeries^**
- ✓ **Age-based discount available for eligible policy holders under the age of 30***
- ✓ **Choose from a $250 or $500 excess**
- ✓ **Access to our Care Navigation service^^**
- ✓ **Combine with any of our extras products**

^ Once all applicable waiting periods have been served. Some services are excluded or restricted on this level of cover; for these services there is no benefit payable (excluded services) or reduced benefit entitlement (restricted services). See page 26 for further details.

* Better Hospital (Silver+) is an age-based discount policy and also a retained age-based discount policy. For more information on eligibility to these discounts please refer to information on page 16.

^^ Care Navigation can be accessed after two years of continuous membership and benefit availability is pending the outcome of a clinical assessment by the Care Navigation Team. See page 13 for further details.

Some important things you need to know about Better Hospital (Silver+) Cover

Excluded services

Better Hospital (Silver+) excludes benefits for **weight loss surgery.** Weight loss surgery is hospital treatment that is designed to reduce a person's weight. Weight loss surgery includes gastric banding, gastric bypass, and sleeve gastrectomy. It includes replacements, repairs, adjustments and reversals. Surgeries to remove excess skin due to weight loss also fall under this clinical category and are also excluded services. Hospital or day surgery admissions for these services in either a public or private facility will receive no benefit from Queensland Country Health Fund. **There is no benefit entitlement for surgery or hospital treatment where Medicare does not pay a benefit** e.g. elective cosmetic surgery, experimental treatment/procedures and laser eye surgery (LASIK etc.)

Restricted services

Hospital psychiatric services - Mental health services or programs.

If a service is covered as a restricted benefit, **you will only be covered with your choice of doctor for shared ward accommodation in a public hospital. While you can choose to go to a private hospital or day surgery for the service or treatment, your admission is not fully covered and will result in large out-of-pocket expenses.** Restricted benefits are amounts set by the Government and are not enough to cover accommodation costs in a private hospital. Although cover with restricted benefits entitles you to your choice of doctor in a public hospital, your doctor may not be willing, or able, to treat you in a public facility.

Vital Hospital (Bronze+) Cover

A great value mid-level cover

Vital Hospital (Bronze+) Cover is a great value mid-level cover, ideal if you are young or a healthy person **who doesn't want to pay for hospital services you're less likely to need.** Vital Hospital (Bronze+) provides a lower cost hospital option to get you through to the next stage of life.

Best suited for

Singles, couples and young families

Features:

- ✓ **Cover for a number of common services in a private hospital or day surgery facility^**
- ✓ **Keeps premium costs down by limiting or excluding benefits on some services you may feel less likely to need cover for (see list on page 30)**
- ✓ **Age-based discount available for eligible policy holders under the age of 30***
- ✓ **Choice of $250, $500 or $750 excess option**
- ✓ **Combine with any of our extras products**

^ We will pay benefits for inpatient services in a private or public hospital where a Medicare benefit is payable, providing waiting periods have been served, except for restricted or excluded services where a lower or nil benefit entitlement exists.

* Vital Hospital (Bronze+) is an age-based discount policy and also a retained age-based discount policy. For more information on eligibility to these discounts please refer to information on page 16.

Restricted services

If a service is covered as a restricted benefit, you will only be covered with your choice of doctor for shared ward accommodation **in a public hospital. While you can choose to go to a private hospital or day surgery for the service or treatment, your admission is not fully covered and will result in large out-of-pocket expenses.** Restricted benefits are amounts set by the Government and are not enough to cover accommodation costs in a private hospital. No benefit is paid towards the cost of theatre charges raised for these services in a private hospital. Although cover with restricted benefits entitles you to your choice of doctor in a public hospital, your doctor may not be willing, or able, to treat you in a public facility.

The restricted services on Vital Hospital (Bronze+) Cover are:
Hospital psychiatric services^ e.g. mental health services

Excluded services^

Certain services are not covered at all under Vital Hospital (Bronze+). Excluded services mean you won't be covered in a public or private hospital and we won't pay benefits on that service.

The excluded services on Vital Hospital (Bronze+) Cover are:

- **Cataracts** e.g. Hospital treatment for surgery to remove a cataract and replace with an artificial lens.
- **Joint replacements** e.g. replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint.
- **Heart and vascular system** e.g. heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls.
- **Dialysis for chronic kidney failure** e.g. Hospital treatment for dialysis treatment for chronic kidney failure.
- **Pregnancy and birth** e.g. Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth.
- **Assisted reproductive services** Hospital treatment for fertility treatments or procedures. e.g. retrieval of eggs or sperm, IVF, and GIFT.
- **Insulin pumps** e.g. Hospital treatment for the provision and replacement of insulin pumps for treatment of diabetes.
- **Implantation of hearing devices** e.g. Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device.
- **Pain management with device** e.g. treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device.
- **Sleep studies** Hospital treatment for the investigation of sleep patterns and anomalies. e.g. sleep apnoea and snoring.
- **Weight loss surgery** Hospital treatment that is designed to reduce a person's weight. Weight loss surgery includes gastric banding, gastric bypass, and sleeve gastrectomy. It includes replacements, repairs, adjustments and reversals. Surgeries to remove excess skin due to weight loss also fall under this clinical category and are also excluded services.

There is **no benefit entitlement for surgery or hospital treatment where Medicare does not pay a benefit** e.g. elective cosmetic surgery, experimental treatment/procedures and laser eye surgery (LASIK etc.)

^ If you'd like full benefit entitlement for any of the excluded services under our Vital Hospital (Bronze+) Cover you will need to upgrade your policy to one of our Better Hospital (Silver+) Covers options at least 12 months in advance to be provided cover for hospital services that are listed as Excluded. Please note NO benefits are payable on Budget Hospital (Basic+), Vital Hospital (Bronze+) or Better Hospital (Silver+) Covers for weight loss surgery. Also, Hospital psychiatric services is a Restricted service on Budget Hospital (Basic+), Vital Hospital (Bronze+) and Better Hospital (Silver+) Covers.

Budget Hospital (Basic+) Cover

A valuable low-level cover

Budget Hospital (Basic+) Cover is a valuable low-level cover, ideal if you are young or a healthy person **who doesn't want to pay for hospital services you're less likely to need** earlier on in life. Budget Hospital (Basic+) is our lowest cost hospital option to get you through to the next stage of life.

Best suited for

Singles, couples and young families

Features:

- ✓ **Cover for a number of common services in a private hospital or day surgery facility***
- ✓ **Keeps premium costs down by limiting or excluding benefits on some services you feel less likely to need cover for (see list on page 34)**
- ✓ **Age-based discount available for eligible policy holders under the age of 30^**
- ✓ **Only available with a $750 excess option to assist in keeping premium costs as low as possible**
- ✓ **Combine with any of our extras products**

* We will pay benefits for inpatient services in a private or public hospital where a Medicare benefit is payable, providing waiting periods have been served, except for restricted or excluded services where a lower or nil benefit entitlement exists.

^ Budget Hospital (Basic+) is an age-based discount policy and also a retained age-based discount policy. For more information on eligibility to these discounts please refer to information on page 16.

Please Note: This product can only be purchased by speaking with one of our Product Specialists on 1800 813 415 or visiting one of our Retail Centres located in Ayr, Cairns, Mackay, Mount Isa, Rockhampton or Townsville.

Restricted services

If a service is covered as a restricted benefit, you will only be covered with your choice of doctor for shared ward accommodation **in a public hospital. While you can choose to go to a private hospital or day surgery for the service or treatment, your admission is not fully covered and will result in large out-of-pocket expenses.** Restricted benefits are amounts set by the Government and are not enough to cover accommodation costs in a private hospital. No benefit is paid towards the cost of theatre charges raised for these services in a private hospital. Although cover with restricted benefits entitle you to your choice of doctor in a public hospital, your doctor may not be willing, or able, to treat you in a public facility.

The restricted services on Budget Hospital (Basic+) Cover are:

- **Rehabilitation** e.g. inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation
- **Palliative care**
- **Hospital psychiatric services** e.g. mental health services

Excluded services^

Certain services are not covered at all under Budget Hospital (Basic+). Excluded services mean you won't be covered in a public or private hospital and we won't pay benefits on that service.

The excluded services on Budget Hospital (Basic+) Cover are:

- **Assisted reproductive services.** Hospital treatment for fertility treatments or procedures. e.g. retrieval of eggs or sperm, IVF, and GIFT.
- **Back, neck and spine** e.g. sciatica, prolapsed or herniated disc, spinal disc replacement and spine curvature disorders such as scoliosis, kyphosis and lordosis.
- **Blood** e.g. blood clotting disorders and bone marrow transplants.
- **Brain and nervous system** e.g. stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease.
- **Breast surgery (medically necessary)** e.g. breast lesions, breast tumours, asymmetry due to breast cancer surgery and gynecomastia.
- **Cataracts** e.g. hospital treatment for surgery to remove a cataract and replace with an artificial lens.
- **Chemotherapy, radiotherapy and immunotherapy for cancer**
- **Dialysis for chronic kidney failure** e.g. peritoneal dialysis and haemodialysis.
- **Digestive system** e.g. oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids.
- **Ear, nose and throat** e.g. damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer.
- **Eye (not cataracts)** e.g. retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye.
- **Gastrointestinal endoscopy** e.g. colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP).
- **Gynaecology** e.g. endometriosis, polycystic ovaries, female sterilisation and cervical cancer.
- **Heart and vascular system** e.g. heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls.
- **Implantation of hearing devices** e.g. hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device.
- **Insulin pumps** e.g. hospital treatment for the provision and replacement of insulin pumps for treatment of diabetes.
- **Joint replacements** e.g. replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint.
- **Male reproductive system** e.g. male sterilisation, circumcision and prostate cancer.
- **Pain management** e.g. treatment of nerve pain and chest pain due to cancer by injection of a nerve block.
- **Pain management with device** e.g. treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device.
- **Plastic and reconstructive surgery** (medically necessary) e.g. burns requiring a graft, cleft palate, club foot and angioma.
- **Podiatric surgery** (provided by a registered podiatric surgeon)
- **Pregnancy and birth** e.g. Hospital treatment for investigation and treatment of conditions associated with pregnancy and childbirth.
- **Sleep studies** e.g. hospital treatment for the investigation of sleep patterns and anomalies i.e. sleep apnoea and snoring.
- **Weight loss surgery** e.g. hospital treatment that is designed to reduce a person's weight. Weight loss surgery includes gastric banding, gastric bypass, and sleeve gastrectomy. It includes replacements, repairs, adjustments and reversals. Surgeries to remove excess skin due to weight loss also fall under this clinical category.

There is **no benefit entitlement for surgery or hospital treatment where Medicare does not pay a benefit** e.g. elective cosmetic surgery, experimental treatment/procedures and laser eye surgery (LASIK etc.)

^ If you'd like full benefit entitlement for any of the excluded services under our Budget Hospital (Basic+) Cover you will need to upgrade your policy to one of our other hospital options at least 12 months in advance to be provided cover for hospital services that are listed as excluded.

^ Please note NO benefits are payable on Budget Hospital (Basic+), Vital Hospital (Bronze+) or Better Hospital (Silver+) Covers for weight loss surgery. Also, hospital psychiatric services is a restricted service on Budget Hospital (Basic+), Vital Hospital (Bronze+) and Better Hospital (Silver+) Covers.

Features of hospital cover

with Queensland Country Health Fund

Hospital network

Queensland Country Health Fund has agreements with most of the participating private hospitals and day surgery facilities Australia-wide. In most cases, once you've paid your agreed excess (where applicable), your approved hospital accommodation charges will be covered in full. This means that you'll benefit from capped fees we've negotiated and convenient billing as your invoice will be sent directly to Queensland Country Health Fund.

Private hospitals and day hospital facilities that have not signed an agreement with us attract reduced benefits which will mean you may have out-of-pocket medical expenses for in-hospital treatment. Visit our website to find a hospital most convenient to you.

Depending on the hospital contract, a hospital may raise a charge for high cost drugs, non-PBS TGA approved exceptional drugs, custom-made prostheses or TGA approved prostheses not on the current Prostheses List, which may not be covered by the Fund.

PLEASE NOTE: Hospital services are paid based on the contract that exists between the Fund and the hospital provider. Default benefits will apply to services not included or if the contracted number of services is exceeded which includes hospital substitute treatment*.

Claiming for hospital services

Most hospital claims are settled directly with the hospital after your treatment once your appropriate excess has been paid, (excludes phone calls, TV hire/rental, newspapers, parking and discharge medication). If you need to submit a hospital claim to us, you can fill out a claim form available on our website and send it to us by email, mail or drop it into your local branch.

Irrespective of which hospital cover you have chosen, any ancillary service provided during your hospital stay or upon discharge, will not be able to be claimed against the fund, unless you have cover for these services under an extras product such as pharmacy, physiotherapy, dietetics and exercise physiology. For more information on in-hospital pharmacy, please refer to our Membership Guide.

*Hospital substitute treatment allows patients the option subject to a doctor's approval, to complete their hospital recovery in the comfort of their own home or in community healthcare clinics e.g. wound care and IV therapy.

Features of hospital cover

with Queensland Country Health Fund

Accommodation benefits

We understand that substantial travel is sometimes required for our rural and regionally based Members when they are seeking treatment for a medical condition.

So for Members not accessing the Queensland Country Health Fund accommodation units in Townsville or Brisbane or perhaps for those who are travelling to a different location for their medical treatment, we provide accommodation benefits to subsidise the costs of your stay.

We will pay an accommodation benefit related to hospitalisation where the patient is required to travel 300 kilometres or more return from their home address. Where a parent or carer travels with a dependent aged 12 years and under (the patient), there is no minimum travel distance required.

The accommodation benefit is up to $50 per night and will apply to every night for the duration of the hospitalisation required including the night prior to admission and also the night of discharge.

Benefits will extend towards the accommodation costs for a carer, partner or parent/s of a dependent who accompany the Member (the patient) and is limited to the duration of the patient's hospital admission. The accommodation benefit is limited to $50 per night i.e we will only pay up to $50 per night towards the accommodation costs for either the carer or the patient. The $50 benefit will not be paid for both parties accommodation respectively for the same date.

Accommodation benefits only apply to policy holders of our hospital products providing the treatment or service you or your family are being admitted for is actually covered by your current hospital cover. This accommodation benefit will not be available for policy holders of our stand-alone extras cover. This accommodation benefit is not claimable if you are staying in the Fund's accommodation units in Brisbane or Townsville.

Reduce your medical costs

Your doctor, surgeon and anaesthetist all charge for their services separately to your accommodation costs. Their fees are known as medical expenses.

These medical expenses are assessed against the Medicare Benefits Schedule (MBS), which is set by the government. When you go into hospital, the MBS is the amount you're guaranteed will be covered when you have private health insurance with us - Medicare covers 75% of the MBS fee, and we cover the other 25%.

Some doctors, however, charge more than the MBS fee. We try and make treatment more affordable by offering Access Gap Cover, if your doctor participates in what's called the Access Gap scheme.

Access Gap Cover

Access Gap Cover is a major feature of our hospital cover. Because some doctors charge more than the MBS fee, we offer Access Gap Cover to make treatment more affordable for you.

If your doctor participates in the Access Gap Scheme, there is an agreed maximum amount we'll pay up to for your doctor's services, this is known as the Access Gap Benefit. Your doctor may choose to accept this amount as full payment for your treatment which means no out-of-pocket expenses for you. Alternatively, they may choose to charge an allowable known gap (limits apply) under the Scheme. If your doctor's fee is higher than the agreed Access Gap Benefit amount, you'll have out-of-pocket expenses to pay.

Some doctors don't participate in the Access Gap Scheme at all while some participate on a patient-by-patient basis. In the instance your doctor doesn't participate, we'll only be able to cover the 25% between the Medicare rebate and MBS fee.

To make sure you're aware of all fees to be charged prior to treatment, we recommend contacting your treating doctor to find out if they will participate in the Access Gap Scheme and discuss all fees up front. We want you to be fully prepared and aware of any out-of-pocket expenses before you go to hospital. If your treating doctor doesn't participate in the Access Gap Scheme, or won't agree to participate for your treatment, you can find doctors who may participate by visiting our website.

Visit queenslandcountry.health/provider-search/medical-specialist

How to pay contributions

Queensland Country Health Fund offers a variety of payment options to choose from, and you can pay weekly, fortnightly, monthly, quarterly, six monthly or yearly. If you choose to pay by EFTPOS, BPAY® or credit card and your payment frequency is quarterly or greater, we'll send you a courtesy reminder notice.

It is your responsibility to ensure that the payment amounts are correct and made in advance. This avoids claims being rejected from being in an unfinancial status.

Your policy starts on the day you apply, or a future date that you nominate. You'll receive your Membership Card by mail within 14 days of your application. Members have the option of pre-paying their premiums to take their paid-to-date up to two years in advance from the date of payment.

Direct Debit

Pay by direct debit from a bank account or credit card.

Mobile App

Make immediate credit card payments through our Mobile App.

Online Member Services (OMS)

Make a credit card payment online or update your details by logging into OMS and accessing Membership > Contribution account.

Our biller reference code is 91082 and the reference number for your policy can be provided on request.

Phone

Call us on 1800 813 415 and pay by phone by speaking with a Member Service Officer.

EFTPOS

Pay by EFTPOS at any of our Health Fund Retail Centres located in Ayr, Cairns, Mackay, Mount Isa, Rockhampton and Townsville.

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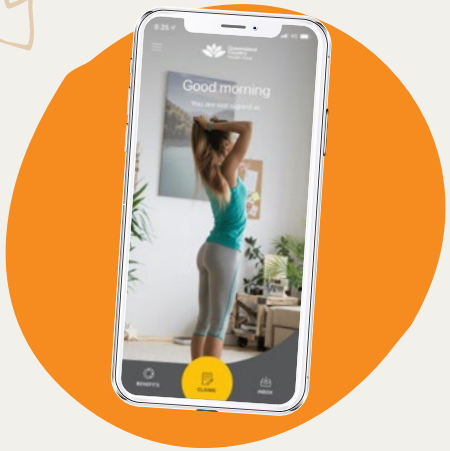
Online Member Services

Online Member Services (OMS) is your online portal where you can access your policy and membership details. If you have one of our extras covers, you can claim online for a range of services.

Once you've registered for Online Member Services you will be able to

download our Mobile App and claim on the go!



Here's what you can do:

- ✓ **Get to know your cover**
  Access your cover details including Anniversary Date, people covered and see what's remaining on your annual benefit limits.
- ✓ **Make changes in your own time**
  View and update your contact details, address information and order a new Membership Card.
- ✓ **Manage your payments**
  Set up or change your account details for direct debit premium payments and direct credit benefit payments. You can also make a contribution payment by credit card.
- ✓ **Access correspondence in your online portal**
  Access Private Health Insurance Statements (tax statement) and other important information documentation about your membership.

Important benefits information

This brochure outlines some of the important information that you should know and consider before taking out a hospital product with Queensland Country Health Fund.

Our Membership Guide contains a more comprehensive listing of rules and conditions that apply to your membership. All the documentation should be read carefully before any decision is made to purchase a health insurance product. Ensure you retain a copy of all documentation for future reference.

Waiting periods

Waiting periods apply when you join any health fund for the very first time, or when you upgrade to a higher level of cover.

If you're transferring from another health fund, or you're coming off your parents' policy onto your own, and you've switched to an equivalent level of cover, you won't have to serve waiting periods again providing you have fully served the waiting period prior to transferring.

Waiting periods are necessary to keep health cover fair. Without waiting periods, people may join, claim for something planned and then leave. Having waiting periods aims to protect our existing policy holders who contribute to a fund over a long period of time for when they need cover.

Always make sure you have served the waiting period that applies to your service before claiming, otherwise you may not be covered.

If you want to upgrade your extras cover to a higher level, you'll only have to serve waiting periods on the increased benefits.

Newborn babies and waiting periods

If you're thinking of starting a family and currently have a single policy, you'll need to convert your policy to a family or single parent family policy and add your newborn baby within 2 months of their date of birth for the baby to be covered. The baby will not have to serve any waiting periods* provided they have been served by the policy holder, and you make this change within the time frame.

*For policy holders with no previous cover, the pre-existing condition waiting periods may apply to the baby within the first 12 months.

Pre-existing conditions

A pre-existing ailment, illness or condition is one where signs or symptoms of that condition would have been present in the six months leading up to taking out or upgrading your cover. The presence of a pre-existing condition is determined by a medical or health care practitioner appointed by Queensland Country Health Fund, based on evidence.

Hospital cover waiting periods

2 months
Hospital:
For all hospital treatments or services where there are no pre-existing conditions (excluding accidental injury^)
Hospital psychiatric services
Rehabilitation
Palliative care
12 months
Pre-existing conditions (excluding Rehabilitation, Hospital psychiatric services and Palliative care)
Pregnancy and birth
One day
Emergency ambulance treatment

^ The two month waiting period is waived for treatment arising from an accident that occurred after joining (excluding sporting accidents sustained by professional sportspeople in activities relating to their employment, including training and competitions).

Benefit conditions

Queensland Country will only pay benefits when:

- You have been charged for the treatment or service
- The service is medically necessary and clinically relevant
- Services are part of a course of treatment recognised by Queensland Country
- The service is provided in person
- The service is provided to a person on the membership
- The service or treatment has been provided by a practitioner or therapist recognised by Queensland Country
- The treatment or service is covered under your level of cover
- The conditions of the level of cover have been met
- For inpatient hospital treatments or services and the associated medical costs (doctor's fees), benefits are only payable where Medicare also provides a benefit entitlement
- A claim for a service is submitted within 24 months of the date of service
- The waiting period for that service has been served

- Benefits are not claimable from another source, e.g. Medicare Australia, workers compensation, motor vehicle accident insurance or third party liability. If Queensland Country Health Fund has already paid benefits by way of provisional payments and the insured person receives a compensation payment for the injury, they must repay to the health fund benefits received in relation to the injury.
- The amount received as a benefit for a service under your cover is calculated on the cost of the treatment or aid you receive, taking into account any allowances or discounts given by the provider.
- No benefit paid by us can exceed the actual charge for the service.

Recognised providers

We will only pay benefits for ancillary or dental services where the service is provided by a practitioner that is recognised by Queensland Country Health Fund. We don't pay benefits for overseas hospitalisation or ancillary care.

Recognition of providers is only for the purpose of determining the payment of benefits. It should not be taken as or considered an approval of, or any recommendation of the qualifications and skills of the provider and their services.

Recognition is subject to change without notice.

You should check with Queensland Country Health Fund that your practitioner is recognised before commencing treatment.

Dependents

Our family cover options provide coverage for dependents, which include children and stepchildren, legally adopted children or foster children under the age of 21.

We still have options for covering your dependents even once they turn 21 and up to and including 31. If your dependent is a full-time student at a school, university or college, or is working as an apprentice they can stay on your family policy at no extra cost, as long as they're not married or in a de facto relationship.

If they're aged between 21 and 31 years inclusive and not a student, or an apprentice we offer a cover type called Extended Family Cover#, where they can stay on your family policy (as long as they're not married or in a de facto relationship). The Extended Family (or Single Parent Extended Family)# premium will be a bit higher than a standard family policy to cover the extra adult, but it's cheaper compared to taking out their own cover at an equivalent level.

Extended Family Cover is available on our hospital covers, with the exclusion of Public Hospital (Basic+)* and if required, can also be packaged with any one of our open for sale extras products.

If they're wishing to be independent, once they turn 32 or once they marry or enter into a de facto relationship, they can also take out their own policy – the good news is that they'll move straight onto their own single membership and won't have to serve any waiting periods already served under the family policy, as long as their own cover starts within 63 days of leaving the family policy.

The Extended Family Cover option is not available for stand-alone extras products.
* Public Hospital (Basic+) is no longer available for purchase.

Government initiatives

Australian Government Rebate on private health insurance

The Australian Government Rebate was introduced by the Federal Government to help Australians by reducing the premium costs of their private health cover. The government recognised that Australians with private health insurance not only make a substantial contribution to their own health care, but also to Australia's health care system by taking pressure off the public system.

Both the age of the oldest policy holder and income* determine the amount of rebate assistance. When you join, you must nominate an appropriate rebate tier (based on your age and income).

The Australian Government Rebate on private health insurance applies to the base hospital and extras component of your premium. It does not apply to any Lifetime Health Cover loading component of the hospital premium.

Your options for claiming the rebate include:

- **You can choose to claim the appropriate rebate upfront to lower your policy premium.**
- **You can nominate to claim a lower rebate than your entitlement, and claim the difference at tax time.**
- **You can claim no rebate at all, and reconcile this when lodging your tax return.**

Most people with private health insurance who are eligible for the rebate claim it upfront as a reduction in their policy premiums.

If you're eligible for the rebate, the rebate percentage you receive today will be reduced every year if insurers increase their premiums more than the Consumer Price Index (CPI). This is because the Australian Federal Government now indexes the rebate either by the CPI or by the actual average increases in premiums charged by consumers, whichever is the lesser.

Premiums quoted by the Fund will take into consideration all of these variables, once you've nominated your rebate tier.

*For information on the income, including the calculation method for this income known as income for Medicare Levy Surcharge purposes, please see the advice of your tax agent, financial advisor or contact the Australian Tax Office (ATO) Help Line on 132 861 or visit their website at https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/

Lifetime Health Cover loading

Lifetime Health Cover (LHC) is a Federal Government initiative designed to encourage people to take out hospital cover earlier in life and maintain this cover.

For each year you delay taking out private health insurance after you turn 31, you'll pay a 2% loading on top of the base rate of the hospital component on your premium (or your share of a couple or family premium), up to a maximum loading of 70%.

If you're turning 31, you must join before the 1st of July following your 31st birthday to avoid the loading.

If you're over 31, by taking out hospital cover as soon as possible, you can stop the continuous increase and your loading will be frozen at the age you joined (we call this your Certified Age of Entry, or CAE). As long as you maintain your hospital cover, your loading will stay locked at this level.

Once you've held private hospital cover for 10 continuous years (and keep it), you'll stop paying the loading on your cover as a reward for commitment to the private health system. Please be aware that the loading may be reapplied if you stop holding hospital cover and re-join again later. If you took out hospital cover before 1 July 2000 and have maintained this cover, you'll pay a base rate premium regardless of age.

People born before 1 July 1934 can take out hospital cover at any time and only pay the base rate.

Transferring from another fund

If you're transferring hospital cover from another registered fund, we need your CAE, rather than your current age, to calculate the correct premium. This information can be found on your Transfer Certificate provided by your previous fund.

Under the Federal Government's LHC legislation, the 2% loading does not apply to extras cover.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) applies if you earn above a certain income and don't hold hospital cover. The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private hospital system to reduce the demand on the public health system.

If your income for MLS purposes is higher than the thresholds set by the ATO, you'll pay a surcharge between 1.0% and 1.5%. This is on top of the standard Medicare levy (e.g. 2% of taxable income) that affects all Australian taxpayers.

The MLS won't apply to any Queensland Country Health Fund policy holder who holds hospital cover.

If you take out hospital cover part-way through the financial year, you'll still avoid the surcharge but only for the period you held hospital cover.

Private Health Insurance Code of Conduct

Queensland Country Health Fund is a signatory to the Private Health Insurance Code of Conduct ('the Code'). The Code was developed by the health insurance industry and aims to promote the standards of service to be applied throughout the industry.

A full copy of the Code is available at www.privatehealth.com.au/codeofconduct

Summary of rules

The information contained in this brochure provides only a summary of the fund rules. The full terms and conditions of membership and liability under the fund are set out in the Complete Rules of the Health Benefit Fund.

These rules are available for inspection at
Queensland Country Centre,
Level 1, 333 Ross River Road,
Aitkenvale QLD 4814.

Private health insurance complaints

If for any reason you're not happy with something, we want to hear about it.

While we're absolutely committed to providing you with the best possible service, we are only human and sometimes we may make mistakes or see things differently from our Members, so we have processes in place to make sure you're absolutely satisfied.

If you have any complaints, and we hope you don't, then please contact us immediately.

Call: 1800 813 415

Website: queenslandcountry.health

Email: info@queenslandcountry.health

Address: Queensland Country Centre
Level 1, 333 Ross River Road
Aitkenvale QLD 4814

We take all complaints very seriously. Your health and wellbeing is our number one priority and if you're not completely happy with our service we would like to know about it. Our staff are here to answer your questions and understand your concerns.

If after we've done all we can to rectify the situation, you're still not satisfied with the outcome, you have every right to contact the Private Health Insurance Ombudsman. The Ombudsman is an independent body formed to help resolve complaints and to provide advice and information to members of private health funds.

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

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

Alternatively, the Ombudsman can be contacted by phone on **1300 362 072**.

Privacy Policy

We're committed to managing all personal information in accordance with our Privacy Policy. Our Privacy Policy is available on our website at queenslandcountry.health, or from any of our Retail Centres, locations can be found on page 59.

Information

Please ensure that you read all documentation provided to you before any decision is made to purchase a health insurance product and ensure you retain a copy of the documentation for future reference.

Clinical categories

Clinical categories are defined by the Department of Health and detailed in the Private Health Insurance (Reforms) Amendment Rules 2018.

Clinical category	Scope of cover
Rehabilitation	Hospital treatment for physical rehabilitation for a patient related to surgery or illness. For example: inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.
Hospital psychiatric services	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.
Palliative care	Hospital treatment for care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.
Assisted reproductive services	Hospital treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In vitro Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT). Treatment of the female reproductive system is listed separately under Gynaecology. Pregnancy and birth-related services are listed separately under Pregnancy and birth.
Back, neck and spine	Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion. For example: sciatica, prolapsed or herniated disc, spinal disc replacement and spine curvature disorders such as scoliosis, kyphosis and lordosis. Joint replacements are listed separately under Joint replacements. Joint fusions are listed separately under Bone, joint and muscle. Spinal cord conditions are listed separately under Brain and nervous system. Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Blood	Hospital treatment for the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants. Treatment for cancers of the blood is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Clinical categories cont.

Clinical category	Scope of cover
Bone, joint and muscle	Hospital treatment for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and bone cancer. Chest surgery is listed separately under Lung and chest. Spinal cord conditions are listed separately under Brain and nervous system. Spinal column conditions are listed separately under Back, neck and spine. Joint reconstructions are listed separately under Joint reconstructions. Joint replacements are listed separately under Joint replacements. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon). Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Brain and nervous system	Hospital treatment for the investigation and treatment of the brain, brain-related conditions, spinal cord and peripheral nervous system. For example: stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease. Treatment of spinal column (back bone) conditions is listed separately under Back, neck and spine. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Breast surgery (medically necessary)	Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy. For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia. This clinical category does not require benefits to be paid for cosmetic breast surgery that is not medically necessary. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Cataracts	Hospital treatment for surgery to remove a cataract and replace with an artificial lens.
Chemotherapy, radiotherapy and immunotherapy for cancer	Hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours. Surgical treatment of cancer is listed separately under each body system.
Dental surgery	Hospital treatment for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery.

Clinical category	Scope of cover
Diabetes management (excluding insulin pumps)	Hospital treatment for the investigation and management of diabetes. For example: stabilisation of hypo- or hyper- glycaemia, contour problems due to insulin injections. Treatment for diabetes-related conditions is listed separately under each body system affected. For example, treatment for diabetes-related eye conditions is listed separately under Eye. Treatment for ulcers is listed separately under Skin. Provision and replacement of insulin pumps is listed separately under Insulin pumps.
Dialysis for chronic kidney failure	Hospital treatment for dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.
Digestive system	Hospital treatment for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids. Endoscopy is listed separately under Gastrointestinal endoscopy. Hernia and appendicectomy procedures are listed separately under Hernia and appendix. Bariatric surgery is listed separately under Weight loss surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Ear, nose and throat	Hospital treatment for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer. Tonsils, adenoids and grommets are listed separately under Tonsils, adenoids and grommets. The implantation of a hearing device is listed separately under Implantation of hearing devices. Orthopaedic neck conditions are listed separately under Back, neck and spine. Sleep studies are listed separately under Sleep studies. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Eye (not cataracts)	Hospital treatment for the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye. Cataract procedures are listed separately under Cataracts. Eyelid procedures are listed separately under Plastic and reconstructive surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Clinical categories cont.

Clinical category	Scope of cover
Gastrointestinal endoscopy	Hospital treatment for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP). Non-endoscopic procedures for the digestive system are listed separately under Digestive system.
Gynaecology	Hospital treatment for the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer. Fertility treatments are listed separately under Assisted reproductive services. Pregnancy and birth-related conditions are listed separately under Pregnancy and birth. Miscarriage or termination of pregnancy is listed separately under Miscarriage and termination of pregnancy. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Heart and vascular system	Hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Hernia and appendix	Hospital treatment for the investigation and treatment of a hernia or appendicitis. Digestive conditions are listed separately under Digestive system.
Implantation of hearing devices	Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device. Stapedectomy is listed separately under Ear, nose and throat.
Insulin pumps	Hospital treatment for the provision and replacement of insulin pumps for treatment of diabetes.
Joint reconstructions	Hospital treatment for surgery for joint reconstructions. For example: torn tendons, rotator cuff tears and damaged ligaments. Joint replacements are listed separately under Joint replacements. Bone fractures are listed separately under Bone, joint and muscle. Procedures to the spinal column are listed separately under Back, neck and spine. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).

Clinical category	Scope of cover
Joint replacements	Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint. Joint fusions are listed separately under Bone, joint and muscle. Spinal fusions are listed separately under Back, neck and spine. Joint reconstructions are listed separately under Joint reconstructions. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).
Kidney and bladder	Hospital treatment for the investigation and treatment of the kidney, adrenal gland and bladder. For example: kidney stones, adrenal gland tumour and incontinence. Dialysis is listed separately under Dialysis for chronic kidney failure. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Lung and chest	Hospital treatment for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Male reproductive system	Hospital treatment for the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Miscarriage and termination of pregnancy	Hospital treatment for the investigation and treatment of a miscarriage or for termination of pregnancy.
Pain management	Hospital treatment for pain management that does not require the insertion or surgical management of a device. For example: treatment of nerve pain and chest pain due to cancer by injection of a nerve block. Pain management using a device (for example an infusion pump or neurostimulator) is listed separately under Pain management with device.
Pain management with device	Hospital treatment for the implantation, replacement or other surgical management of a device required for the treatment of pain. For example: treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device (for example an infusion pump or neurostimulator). Treatment of pain that does not require a device is listed separately under Pain management.

Clinical category	Scope of cover
Plastic and reconstructive surgery (medically necessary)	Hospital treatment which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma. Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is listed separately under Skin. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Podiatric surgery (provided by a registered podiatric surgeon)	Hospital treatment for the investigation and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, but limited to cover for: • accommodation; and • the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules, as in force from time to time.
Pregnancy and birth	Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth. Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory conditions are covered under Lung and chest. Female reproductive conditions are listed separately under Gynaecology. Fertility treatments are listed separately under Assisted reproductive services. Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.
Skin	Hospital treatment for the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin-related condition is also included. For example: melanoma, minor wound repair and abscesses. Removal of excess skin due to weight loss is listed separately under Weight loss surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.
Sleep studies	Hospital treatment for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.
Tonsils, adenoids and grommets	Hospital treatment of the tonsils, adenoids and insertion or removal of grommets.
Weight loss surgery	Hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.

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