Membership Guide

This should be read in conjunction with one or more of the following:

Hospital Cover Brochure
Extras Cover Brochure

1 April 2025

Queensland Country Health Fund

Welcome to Queensland Country

This Membership Guide has been designed to help simplify private health insurance, and allow you to better understand your membership entitlements and responsibilities.

This guide summarises Queensland Country Health Fund's rules and policies. It also provides useful information about your Membership Card, online services, claiming, managing your premiums, and much more.

Please take some time to read this guide carefully, particularly the sections on:

- Waiting periods, including the pre-existing condition or ailment rule (pages 16-18).
- Restricted and excluded benefits. This is important to ensure you understand what hospital services (if any) are restricted or excluded on your chosen level of hospital cover and explains how this may affect you financially if seeking treatment for these services (pages 18-19).

Please read all documentation carefully before making any decision to purchase a health insurance product and retain all documentation for future reference.

It is important to contact us to check your benefit entitlement if you or anyone else on the membership are going to need treatment. Our contact details are listed in the back of this guide.

And remember, as with all forms of insurance, you should review your health cover from time to time to ensure you continue to have the cover that is best suited to you.

The information in this Membership Guide is current as at 1 April 2025 and is subject to change.

Thank you for choosing Queensland Country Health Fund!

Contents

Before you get started...

Here is an explanation of some of the terms used in this guide:

'We', **'us' 'our'** and **'Queensland Country'** means HBF Health Limited ABN 11 126 884 786 trading as Queensland Country Health Fund.

'Member' means any person covered under a Queensland Country private health insurance policy.

'Membership' comprises all the Members covered under a Queensland Country private health insurance policy.

'Policy holder' is the person who 'owns' the Queensland Country private health insurance policy.

Closed products

Throughout this guide, we may refer to health insurance products that are no longer available for purchase by Queensland Country to new Members. These products are referred to as closed products.

Members covered by any of our closed products can be assured that we will regularly review the benefits paid under these products to ensure the benefits paid are aligned with the cost of treatment for the services covered.

A policy holder will still retain their cover under a closed product as long as they held this closed product cover prior to Queensland Country making this product no longer available for purchase. Our closed products include; Singles & Couples (Basic+) Combined Cover, Top Hospital (Gold) Cover, Intermediate Hospital (Basic+) Cover, Value Hospital (Basic+) Cover, Public Hospital (Basic+) Cover, Premium Extras Cover, Premium Care Extras Cover, Premium Support Extras Cover, Essential Care Extras Cover, Essential Support Extras Cover, Select Care Extras Cover, Select Support Extras Cover, Young Care Extras Cover, Young Support Extras Cover, Pure Care Extras Cover, Pure Support Extras Cover.

Responsibility for the membership

By joining Queensland Country Health Fund, you (as the policy holder) and your spouse or de facto partner included on the policy (where applicable) agree that you are responsible for the administration and maintenance of the policy and will:

- ensure that all information supplied to Queensland Country is true and correct for all persons on the policy
- keep the membership information up to date and notify us of any changes as soon as possible
- be the recipient/s of all correspondence for the policy
- be the only person/s who can add others to the policy
- have access to details of claims information for all persons on the policy except dependents aged 16 years and over (refer to the information contained under the heading 'Delegating Authority' in this guide). Claims information includes services claimed, date, provider and cost and benefit for each service.

Administration and maintenance of the policy includes:

- changing any details on a policy (e.g. contact details, debit and credit information)
- changing the level of cover
- adding eligible persons to the policy
- receiving benefits on behalf of other persons on the policy

The only exclusion to this authority applies to a spouse or de facto partner. They cannot:

- terminate the policy, or
- remove the policy holder from the policy.

It is the policy holder's sole responsibility to:

- ensure that all persons on the membership are aware of and abide by the terms and conditions of the health insurance policy purchased, including our Health Fund Rules, the information in this guide and our Privacy Policy; and
- make the minimum advanced premium payments required to keep the policy financial.

The policy holder can remove authority for their spouse or de facto partner to have administration and maintenance rights on their policy at any time by calling our Contact Centre on 1800 813 415.

Transfer of ownership

Queensland Country Health Fund will allow a policy to remain open in circumstances where the policy holder has elected to either be removed from the policy or to remain on the policy but not in the capacity as policy holder. Transfer of either ownership must be to an adult person that is currently listed on the policy, as either a spouse or dependent and have agreed to assume responsibility for the policy.

Examples of where this may need to occur are:

- The policy holder passes away and ownership transfers to the spouse/partner
- Where the spouse/partner's employer has a corporate discount arrangement with Queensland Country Health Fund and they are required to become the policy holder in order to receive this discount
- The policy holder and their spouse/partner separate, and the spouse/partner agrees to assume responsibility for the policy.

In order to facilitate this change to the policy the individual who is assuming responsibility for the policy as the policy holder must:

1. Agree to the terms and conditions of the health insurance policy, including the Queensland Country Health Fund Rules, Membership Guide, product terms and conditions and privacy policy;
2. Agree to accept responsibility for the policy including the financial management of the policy, by making the minimum advanced premium payments required to keep the policy financial; and
3. Ensure that all persons on the membership are aware of and abide by the terms and conditions.

Delegating authority

All persons under this policy aged 16 and over may delegate authority to a nominated adult person to:

- request policy details and other personal information
- change or update policy details, and
- submit claims.

All delegations of authority must be provided verbally or in writing by the person of authority.

A request to delegate authority can be submitted to Queensland Country by the Member, or a person appointed:

- as Attorney under a Power of Attorney
- as Administrator by an Order of the Queensland Civil and Administrative Tribunal (QCAT) or equivalent body if appointed outside Queensland (order must be registered by QCAT).

Please note: Once a dependent turns 16, their personal information relating to claims can only be disclosed to another person, including the policy holder or a parent/guardian, if the dependent has provided verbal or written authority.

Understanding and making the most of your membership

Setting up your membership

1

When you join us, you'll receive a welcome pack. This includes:

- **Your Certificate of Cover**
  This is a summary of your membership information, including your level of cover and your Australian Government Rebate on private health insurance entitlement.
- **Product summary of your hospital and/or extras cover**
  This is a snapshot of what you're covered for, along with applicable waiting periods and exclusions or restrictions that apply to your cover.
- **Private Health Information Statement (PHIS)**
  This is a high-level summary of your cover and is provided to you in accordance with private health insurance legislation. The benefits and premiums on this statement are indicative only, and your actual premium amount can be found on your Certificate of Cover.
- **Privacy Policy**
  In order to comply with our obligations under the Privacy Act we are required to provide you with a copy of our Privacy Policy.

We're here to help, so please give us a call if you have questions or queries about any of these documents.

2

Register for Online Member Services (OMS)
Visit members.queenslandcountry.health and select 'Register Online'. Once you have registered you are ready to go! Login to OMS using your Membership Number and chosen password.

You can also use these details to access our Mobile App!

3

Confirm your election to claim the Australian Government Rebate on private health insurance. Once you login to OMS, you'll be prompted to complete the rebate confirmation of the Australian Government Rebate Form if you haven't completed it already. Scroll to the bottom of the page, tick the declaration box and select View Form. To complete select Accept at the bottom of the page.

4

Email address
Make sure we have your email address so we can communicate with you quickly and easily. You can update your contact details through OMS and our Mobile App.

We will also keep you updated via our bi-monthly e-newsletter Health eBYTES and bi-annual digital Living Healthy magazine. Make sure you've opted in to receive your copy! If you would like to receive a hard copy of Living Healthy please advise us.

Your Membership Card

Your Membership Card is important. It identifies you as a Member of Queensland Country Health Fund when you go to hospital or make an electronic claim at an allied health service provider (e.g. dentist, optometrist, etc) displaying the HICAPS or HealthPoint logo.

Your Membership Card shows your membership number, who is covered and the date you joined, which is identified as your anniversary date. The importance of this date will be covered later in this Guide. If you add or remove people covered by the membership, we'll issue you with a new card.

Safeguard your Membership Card

Your Queensland Country Health Fund Membership Card enables your benefit to be paid directly to participating allied health service providers to cover part or all of your treatment cost. Here are a few tips to help you safeguard your Membership Card:

- Treat your Membership Card like a credit card and keep it in your wallet or purse.
- Advise us immediately if your card is lost or stolen.
- Never leave your card with a health provider.
- Always check the health provider's receipt carefully before signing.

Additional cards

As the policy holder, you can request additional Membership Cards for those listed on your membership who are 16 years of age or over.

Replacement cards

If your Membership Card is damaged or has been misplaced, you can order a replacement card.

To do this, log on to Online Member Service (OMS) on our website at queenslandcountry.health and order a replacement card yourself - it's that easy.

If you are not already registered for OMS, please refer to page 10 for details on how to register. Alternatively, you can contact us on 1800 813 415 or email info@queenslandcountry.health or access our Mobile App and we'll arrange a replacement card for you.

Membership Year

Queensland Country Health Fund is a bit different to other health funds – our policies operate on a unique and individualised Membership Year. The original establishment date of your policy represents the start date of this Membership Year. This start date is referred to as the Anniversary Date of your membership. The Anniversary Date is printed on your Membership Card for your convenience.

By using your Anniversary Date as the basis for your Membership Year, you get maximum access to your annual benefits under your level of cover in the first year of membership.

Your claim benefit limits and sub-limits are based on your Membership Year. To maximise the benefits available on your chosen cover, it is important to understand when your Membership Year starts and finishes. If you don't claim an allocated benefit during any one Membership Year, it does not accrue to the next Membership Year.

Your Membership Year also determines the requirement to pay a hospital excess (if applicable) when admitted to hospital for an inpatient service. Your chosen excess will apply to the first hospital admission^ per person, per Membership Year. Refer to page 19 of this guide for further information on membership excess.

^ If the excess contribution on your first visit is less than your chosen excess option, and you are admitted to hospital again in the same Membership Year, you will be required to pay the remainder of your excess obligation.

Please note: Where a new person is added to the policy or adding an Extras level of cover after the original membership start date, a different Anniversary Date will be applied for a period until any waiting periods that apply to joining, transferring or upgrading their cover have been served. Once served, their Anniversary Date will revert to that of the membership they joined.

Transferring from another fund (portability)

When transferring from another health fund you will not have to re-serve applicable waiting periods as long as:

- you join Queensland Country within 63 days of the date on which you ceased to be covered by another Australian registered health fund
- you have served the applicable waiting periods with that former health fund, and
- we have received your Transfer Certificate from that health fund showing your previous level of cover.

We won't pay benefits for any services during the lapse period between the date you ceased cover with your former health fund and the date you join Queensland Country. We are unable to backdate the membership join date.

If you've met these conditions on the date of joining, you won't have to serve the normal waiting periods when transferring to an equal or lower level of cover. However, if you choose to upgrade your cover, where additional benefits or better conditions are gained by an inter-fund transfer, normal waiting periods will apply to the additional or upgraded benefits and conditions.

If you're transferring from another Australian registered health fund and your previous policy didn't provide any benefit entitlement for certain hospital treatments or services, you'll need to serve the applicable waiting periods for that hospital treatment or service under your new cover with Queensland Country.

Any loyalty bonus or other similar entitlements (for example increased limits for orthodontics or package bonuses) built up with your former health fund will not transfer to Queensland Country. Where limits apply, including lifetime limits, any benefits paid under your previous cover are treated as if Queensland Country has paid them and this may affect the payment of benefits on items or services already claimed under your previous policy cover.

If you transfer to Queensland Country more than 63 days after your previous cover has ceased, you will have to serve all waiting periods applicable to your new cover.

Cooling off period

If for any reason you change your mind within the first 30 days of commencement of your new policy or upgrade of cover and have not yet made a claim, we will cancel your policy and refund any premiums you have paid in relation to this cover.

Medicare eligibility

Your Medicare Card indicates your eligibility for Medicare. Holding a reciprocal (yellow) Medicare Card, or no Medicare Card at all, will affect the benefits you're entitled to receive under private hospital cover. As a result, you could be left with very large out-of-pocket expenses if you receive hospital treatment.

If you or any person on the membership have limited or no access to Medicare, you should call us to discuss whether the cover you've chosen is the most suitable.

Online Member Services (OMS)

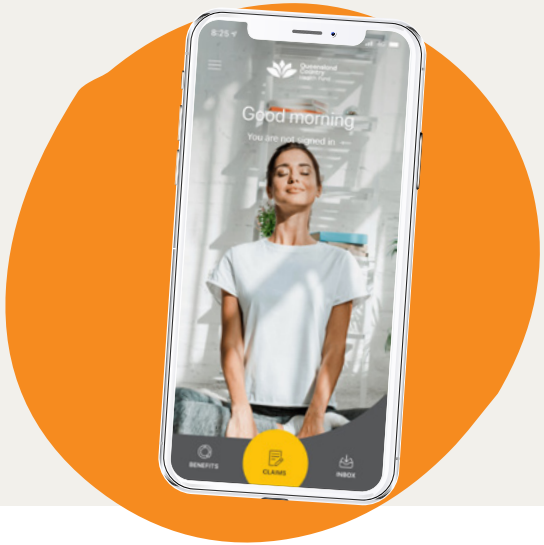
The Queensland Country Health Fund website provides you with the convenience of managing your membership online, anytime.

From the website, you can access online services, which allows you to:

- View your membership details
- View your cover details
- Update your address and contact details
- Add Dependents
- Lodge claims directly to our team by uploading a copy of your receipt/s you received from your service provider.
- View your claims history
- View your remaining limits
- View your payment details
- Set up direct debit for the automatic payment of your premiums
- Set up direct credit for receiving your benefit payments
- Change your password
- Make a contribution payment by credit card
- Order replacement Membership Cards

Registering is easy

To access Online Member Services (OMS), all you need to do is register by visiting members.queenslandcountry.health and selecting 'Register Online'. Once you have registered using your Membership Number and choice of password, click on the Login tab and enter your membership number and password. Now you're ready to go!



Once you've registered for Online Member Services you will be able to **download our Mobile App and claim on the go!**

Mobile App

The Queensland Country Health Fund Mobile App offers Members 24/7 access to your membership and is a convenient and secure way to manage your membership no matter where you are.

Key features:

- Online claiming - lodge claims directly to our team by simply taking a photo of your receipt/s and pressing submit
- Review your claims history
- View policy details including contribution details
- Check your annual benefit limits – it has never been easier to check your limits with a graph that clearly shows what is remaining
- View personal details and update your contact information
- Order new Membership Cards
- Make immediate payments by credit card
- Access membership communications through your personal inbox
- Upload a PDF document
- Provider search
- Learn more about your health insurance and how you can experience genuine value via our blogs and news
- Find your nearest Queensland Country Health Retail Centre
- Login in using biometric logins

Types of cover

Level of cover

A person may be admitted as a policy holder of Queensland Country to one of the following cover options:

- Any one level of hospital cover
- Any combination of one level of hospital cover and one level of extras cover
- Any combined product cover, such as Singles & Couples Combined Cover (no longer available for purchase), or
- Young Extras with no hospital cover
- Select Extras with no hospital cover

Who can be covered?

Policy holder – the person who 'owns' the Queensland Country private health insurance policy.

Partner - a person living with the policy holder in a marital or de facto relationship.

Child dependent – a child, adopted child, foster child, or stepchild of the policy holder or their covered partner who isn't married or living in a de facto relationship and is under the age of 21.

Student, apprentice or trainee – a child dependent of the policy holder or their covered partner who isn't married or living in a de facto relationship, who is receiving full-time education at a school, college, or university (including by participating in a recognised vocational education program comprising structured training and work), or is working as an apprentice, and is aged 21 to 31 (inclusive).

Adult dependent – a child dependent of the policy holder or their covered partner who isn't married or living in a de facto relationship and is aged 21 to 31 (inclusive).

As your circumstances change you may need to add or remove people on your policy. You must notify us if the status of anyone covered on your policy changes, for example, a student dependent is no longer studying full-time, as they may not be eligible to remain on the policy. Please refer to page 13 for more information.

Membership categories

Single membership – covers the policy holder.

Couple membership – covers the policy holder and their partner.

Family membership – covers the policy holder, their partner and any of their child dependents and/or student, apprentice or trainee dependents.

Extended family membership – covers the policy holder, their partner and any of their dependents (at least one of whom is an adult dependent). Refer to "Adult dependents under 32 years in the table below.

Single parent family membership – covers the policy holder and any of their child dependent and/or student, apprentice or trainee dependents.

Single parent family extended membership – covers the policy holder and any of their dependents (at least one of whom is an adult dependent). Refer to "Adult dependents under 32 years in the table below.

Dependents under 21 years	Student, apprentice and trainee dependents under 32 years
Your dependent can remain covered under your family policy up to and including age 20 years. The good news is that they can contact us and move straight across to their own single membership without having to serve any waiting periods, providing they have already been served on the family policy. The transfer must be arranged within 63 days of the termination date of the dependent from the family policy.	If your dependent is single and studying full-time at a school, college or university (including by participating in a recognised vocational education program comprising structured training and work) or working as an apprentice, they can remain covered under your family policy up to and including 31 years of age at no extra cost. To remain covered under your family policy, their Student, apprentice and trainee status must be confirmed at the start of each school or study year. Student, apprentice and trainee dependent status no longer applies when your dependent ceases study or training, defers or reduces to part-time or when the dependent enters into a married or de facto relationship.

Adult dependents under 32 years
If your dependent is aged between 21 and under 32 years and wishes to remain on your family policy (as long as they are not married or in a de facto relationship) our Extended Family Cover option will allow these eligible dependents to stay on your Extended Family policy up to and including 31 years. Extended Family Cover is available on all hospital covers, with the exclusion of Public Hospital (Basic+)* and if required, can also be packaged with any one of our extras products.

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

Adding or removing a person from your membership

Let us know if you would like to add or remove a person from your membership. Any person being added to the membership may have to serve waiting periods for benefits, depending on their previous cover or health insurance history. We will ensure that you continue to have the best level of cover for your needs if changes are made to your policy.

In situations where a person aged 18 years and over is being removed from a policy, it is a requirement that contact details of this person are provided by the Member or their spouse/partner so that the person being removed can be advised. This will provide them with opportunity to take out cover on a new policy without the requirement for them to re-serve waiting periods (providing the new policy is commenced within 63 days from removal from previous cover). Lapse duration may however vary from fund to fund.

If dependents aged under 18 years are to be removed from a policy both the Member and their spouse/partner will be required to be notified to provide an opportunity to make arrangements for these dependents to be covered on a separate policy if required. This will ensure that cover for this person/s can be maintained.

Adding a newborn baby

If you have a single membership type, to add a newborn baby to your policy, you will need to do this within two months from the date of their birth. The child will not have to serve any waiting periods* that you have already served, as long as the change is made to the policy within this time frame. The policy alteration will be backdated to the child's date of birth. This change of membership means that you will have higher policy premiums as the policy would then change to a single parent family cover.

If a newborn is added to the policy later than two months after their date of birth, the child will have to serve all waiting periods that apply to the new cover, commencing from the date they are added to the policy.

If you already have a couple or family membership and have held this for a period of 12 months, you can add your newborn by advising us of the baby's name and date of birth. Their cover will be immediate with no waiting periods or premium increases.

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

Suspending your membership

General conditions for all types of membership suspension:

- You must apply for a suspension of your cover before the suspension date and applications for suspension will not be processed retrospectively.
- The period of suspension does not count towards any accumulative benefit entitlement.
- All waiting periods must have been served on your membership at the time of suspension.
- The entire membership must be suspended.
- Benefits are not payable for treatment received, services provided or items purchased during the period of suspension.

- You will be unable to claim any Government incentive or rebate for the period of suspension.

Overseas suspension

If you're going to be absent from Australia for a period of more than 4 weeks but less than 24 months, you may apply for a suspension on your membership.

We may agree to your request based on the following criteria:

- The suspension date will be the day after departure from Australia.
- Your premiums must be paid at least one month in advance of the proposed date of suspension. The premiums paid in advance will be applied to your membership at the current rate applicable when your membership is reactivated.
- The suspension applies to all persons covered under your membership. There is no allowance for partial suspension.
- Written evidence must be provided with your application which includes your departure date from Australia and your intended return date. Written evidence can include a travel itinerary or e-tickets showing your travel dates.
- Your membership and payments will be automatically reactivated on the nominated return date unless you advise us of your change in travel plans.
- **For travel with an unknown return date** –
  - Proof of re-entry to Australia must be provided in the form of a boarding pass showing the date of your arrival back in Australia or alternatively an International Movement Record covering the period of suspension from the original date of departure from Australia. This information can be obtained from the Department of Immigration and Border Protection on 131 881. A Request for International Movement Records can be accessed on the Department's website at www.homeaffairs.gov.au
  - Proof must be provided to us within 30 days of returning to Australia.
  - If you do not provide the evidence required to reactivate your membership, premiums held will be applied to your membership and your membership will be terminated.
- A minimum period of six months must be served between the reactivation date of a membership and the commencement of another period of suspension for overseas travel.

Financial hardship suspension

If you're experiencing financial hardship you can apply for suspension of your membership. Upon receipt of supporting documentation, suspension applications will be considered on a case-by-case basis.

We may agree to your request based on the following criteria:

- The minimum suspension period is two (2) months and the maximum period of suspension is six (6) months.
- A Policy cannot be suspended under financial hardship where the 'paid to date' exceeds more than one (1) month.
- No more than one (1) period of suspension will be permitted during any 12 month period.
- Contract workers who work only part of each year (e.g. working 10 months out of 12 each year) will not qualify for a suspension of their membership on hardship grounds.
- To reactivate your membership you will be required to apply in writing, no later than one (1) week prior to the expiry of the suspension period.

- The date of reactivation of your membership will be the day following the expiry date of the suspension period nominated in your application.
- If you do not contact us to reactivate your membership, your membership will be terminated.

Please call us to discuss options if you're experiencing financial hardship.

Medicare Levy Surcharge (MLS) warning

While your policy is suspended, you may be liable for the Medicare Levy Surcharge (MLS) if your income for MLS purposes exceeds the relevant threshold and you are still a resident for tax purposes during the time you are away.

More information is available on the Australian Taxation Office website at www.ato.gov.au by searching "Medicare Levy".

Waiting periods

What is a waiting period?

A waiting period is an initial period of health fund membership, during which no benefit is payable for certain procedures or services.

Waiting periods can also apply to any additional benefits when you upgrade your health insurance cover.

Why do waiting periods apply?

If there were no waiting periods, people could take out cover or upgrade to a higher cover only when they knew they needed treatment, or suspected they might need treatment. Their treatment costs would then have to be paid by the long-term Members of the fund, leading to much higher premiums for all fund Members. This wouldn't be fair.

Therefore, when you join a health fund or upgrade your existing cover, you may have to wait a period of time before you can claim benefits.

When do waiting periods apply?

Waiting periods apply where a person:

- is insured for the first time or has not been insured within the previous 63 days
- upgrades to a higher level of cover (includes reducing an excess or co-payment), or
- transfers from another fund and has not completed their waiting periods for equivalent benefits or chooses to upgrade their cover when they transfer.

Note: When upgrading to a higher level of cover, you will be entitled to the benefits that applied to your previous cover while waiting periods are being served, for services or treatments that are included under both policies.

Waiting periods that apply to Queensland Country covers are:

Pre-existing conditions

12 months

Any pre-existing conditions (excluding rehabilitation, hospital psychiatric care and palliative care)#

Pregnancy and birth#

Treatment under major dental categories including:

- Periodontics - specialised gum treatments#
- Surgical extraction - includes wisdom tooth extraction#
- Endodontic services - includes root canal therapy#
- Crowns and bridges
- Orthodontics - braces etc#
- Prosthodontics - dentures#

Health aids and appliances#

Hearing aids#

Hearing aid maintenance, batteries and chargers#

Australian Hearing Services card#

Childbirth education#

Nursing services#

Mammograms and bone densitometry#

One day

Emergency Ambulance:
There is a one day waiting period for emergency ambulance treatment

2 months

All hospital treatments or services where there are no pre-existing conditions (excluding accidental injury**)

Rehabilitation - eg. inpatient rehabilitation, stroke recovery, cardiac rehabilitation#

Hospital psychiatric services#

Palliative care#

All other dental treatments including:

- Diagnostic - includes examinations and consultations
- Preventative - includes cleaning and scaling, fluoride treatment etc
- Simple extraction
- Restorative - composite and amalgam fillings
- General services - includes occlusal splints

Sporting accidents**#

School Accidents**#

Optical services

Extras therapies including:

- Acupuncture#
- Audiology#
- Chiropractor
- Foot orthoses and orthopaedic shoes#
- Massage therapy, myotherapy
- Osteopathy#
- Dietitian#
- Occupational therapy#
- Orthoptic therapy#
- Physiotherapy
- Exercise physiology#
- Podiatry
- Psychology#
- Speech therapy#

Healthy Living benefits

Pharmaceutical benefits

Not every health cover product provides benefits for these services/treatments. Please check the appropriate product brochure for benefit entitlement conditions for these services.

** Cover for an accident is immediate when arising from an accident that occurred after joining and is not recoverable from another source such as Workers' Compensation, third party or other liability provision. Sporting accidents sustained by sportspeople in activities relating to their full-time employment as a sporting professional, including training and competition have a two month waiting period.

What is a pre-existing condition?

A pre-existing ailment, illness or condition is one where, in the opinion of a Queensland Country appointed medical practitioner, signs or symptoms of that ailment, illness or condition existed at any time in the six months leading up to taking out or upgrading your cover.

It is not necessary that you or your doctor were aware of your condition, or that the condition had not been diagnosed. A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining a hospital table or upgrading your hospital cover.

Risk factors, including family history of an ailment or condition, are not signs or symptoms of a pre-existing condition. They will not be considered when deciding whether an ailment or condition is pre-existing.

Who decides if I have a pre-existing condition?

The only person authorised to decide whether you have a pre-existing condition is a medical or other health practitioner appointed by Queensland Country. The practitioner will consider the opinion of and evidence presented by your treating practitioner/s before making an informed judgement.

If you have had your current cover for less than 12 months and need treatment, you should confirm with Queensland Country whether the pre-existing condition waiting period will apply.

Queensland Country may require you and your long-term treating practitioner/s to complete a Medical Report Form in order to obtain facts about your illness. The practitioner appointed by Queensland Country to review your case will need a reasonable period of time to investigate and make an assessment.

Any fee charged by a Member's treating practitioner/s for completion of reports will not be paid by Queensland Country and will have to be settled privately by the Member.

Restrictions and exclusions

Restricted benefits

If a service is covered as a restricted benefit, this means you will only be covered for 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 an amount set by the Government and are generally not enough to cover accommodation costs in a private hospital and we do not pay benefits towards the cost of theatre charges raised for restricted services.

There are one or more restricted hospital services on all of our hospital products. This applies to products available for purchase as well as Closed products. Top Hospital (Gold) cover (Closed) is the only exception having no restricted hospital services. Please check the appropriate product brochure to determine your benefit entitlements for specific hospital treatments or services.

Excluded benefits

An excluded service means you will not be covered in a public or private hospital and will not receive a payment from Queensland Country for that service. If you think you may require treatment for any services not covered by Singles and Couples (Basic+) combined Cover*, Value Hospital (Basic+)*, Intermediate Hospital (Basic+)*, Public Hospital (Basic+)*, Budget Hospital (Basic+) or Vital Hospital (Bronze+) Covers, you may like to consider our Better Hospital (Silver+) cover. Please note some hospital services or treatments may not be covered on any of our hospital covers. Please check the appropriate product brochure to determine your benefit entitlements for specific hospital treatments or services prior to going to hospital or day surgery.

* These hospital covers are no longer available for purchase.

Excess

An excess is the amount you pay up front if you go to hospital or day surgery. The higher the excess, the less you pay for your regular premiums.

The excess applies to all Members covered and is applied to the full cost of hospitalisation, including dependents (excluding exempt dependents as provided below) in both public and private hospitals and day surgery facilities.

In addition to your agreed excess, you may have other out-of-pocket costs associated with your hospital treatment.

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

Better Hospital (Silver+):

- choice of either $250 or $500 excess
- exemption for dependents 21 years and under (see next page for further detail)

Vital Hospital (Bronze+):

- choice of $250, $500 or $750 excess
- exemption for dependents 21 years and under (see next page for further detail)

Budget Hospital (Basic+):

- this product is only available with a $750 excess
- exemption for dependents 21 years and under (see next page for further detail)

The calculation of the excess amount will apply to hospitalisations in the order they are processed by Queensland Country. If the excess contribution on your first visit is less than your chosen excess option, and you're admitted to hospital again in the same Membership Year you will be required to pay the remainder of your excess obligation.

Any excess or co-payments already paid on a hospitalisation under a previous cover will not be recognised by Queensland Country, nor will any such payments contribute towards the excess obligations payable on the new cover with Queensland Country.

The most you'll have to pay each Membership Year for your excess payment 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+) only	**$750**	**$750**	**$1500**

Excesses for dependents 21 years and under

If you have a dependent up to and including the age of 21 years, who needs to be admitted as an inpatient of a hospital or day surgery facility, you will not be required to pay an excess, regardless of your chosen hospital excess level or hospital cover.

Going to hospital

Inpatient vs outpatient

Hospital cover provides benefits when you are treated as a private inpatient. An inpatient is someone who is admitted to hospital to receive medical care or treatment.

Services that are provided where you are not admitted to hospital are called outpatient services. Outpatient services include things such as visits to an emergency department, a general practitioner (GP) or a specialist. Under government legislation, Queensland Country is not allowed to pay benefits for outpatient services. This is why we will not pay any benefits when you are not admitted to hospital. A rebate may be claimable from Medicare for outpatient services.

As a Member of the Australian Health Services Alliance (AHSA), Queensland Country has negotiated Purchaser Provider Agreements with most of the participating private hospitals and day hospital facilities Australia-wide. Visit queenslandcountry.health to find a hospital most convenient to you.

Informed Financial Consent

Before going to hospital it's important to ask your doctor/s and the hospital about any potential out-of-pocket expenses you may incur. This information should be provided in writing before your treatment or hospital admission and is known as Informed Financial Consent.

If you're admitted in an emergency, there may not be time for the hospital or doctor/s to seek your Informed Financial Consent. Information about your out-of-pocket expenses should be provided as soon as possible after you receive treatment.

Going to hospital

It's important to be aware that your hospital cover may not fully cover all of the costs associated with hospital accommodation.

If your hospital stay was subject to any waiting periods and/or involved the payment of an excess or any personal expenses (e.g. telephone calls, newspapers etc.) you will be responsible for the expense and the hospital may require settlement on discharge.

Hospital accommodation benefits do not include other things such as TV hire, telephone calls, newspapers, parking and take-home items. Queensland Country will not pay benefits for these (or similar) items and services. The hospital should discuss any charges with you.

Ancillary services 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 items, physiotherapy, dietetics and exercise physiology.

Hospital network

Queensland Country 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 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.

Private hospitals and day hospital facilities that have no signed 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 that is the most convenient for you.

Depending on the hospital contract, a hospital may raise a charge for high cost drugs, non-PBS TGA approved exceptional drugs, custom-made medical devices and human tissue products or TGA approved medical devices and human tissue products not on the current Prescribed 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*.

*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.

Length of stay

All Queensland Country hospital covers provide Members with cover for as long as they require hospital treatment. You must obtain certification of ongoing acute care after 35 days of continuous hospitalisation. A lower benefit will be paid if this certification is not provided.

Doctors' fees and Access Gap Cover

Where your doctor/s charges more than the Medicare Benefit Schedule (MBS) fee, you will be left with an out-of-pocket expense you'll need to pay. This is commonly referred to as the 'gap'. To help you reduce or eliminate the gap, Access Gap Cover is available on all of our hospital covers in relation to eligible services.

The maximum allowable gap for Access Gap Cover is capped at $500 per doctor per medical episode*, except for obstetrics which is capped at $800.

* Definition of episode: The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.
Example: If a patient changes care type (in the same or different hospital), e.g. Acute to Rehabilitation then back to Acute this would be three separate episodes. This would apply even if there has not been more than a seven day break between two acute episodes as there was a separation between each care type.

If your doctor won't participate in our Access Gap Cover scheme for your treatment, you have the right to find a doctor who will. Access Gap accounts are sent directly to us by the doctor. All other medical accounts should be sent to Medicare first and then forwarded to us with the Medicare statement.

In summary, there are a number of possible scenarios when it comes to the doctor's charges and your out-of-pocket expenses for inpatient hospitalisation:

Please note: These scenarios relate to medical costs only. You may have to pay an excess or other costs associated with your hospital stay.

"MBS fee only" scenario
Doctor/s only charges the MBS fee You pay $0.

"No-gap" scenario
MBS fee + Queensland Country benefit Your doctor participates in Access Gap.

"Known-gap" scenario
MBS + Queensland Country + you pay a known-gap Your doctor participates in Access Gap and the most you will be out-of-pocket is the allowable known gap for the treatment you receive as an inpatient.

"Doctor not participating" scenario
MBS fee + unlimited doctor's charges As the doctor is not participating in Access Gap you will pay the difference between the MBS fee and the doctor's fee or their service.

In-hospital pharmacy

Pharmaceutical supplies associated with a Member's admission and treatment, specific to the care provided during the admission will be covered under most hospital contracts.

Medications that are unrelated to the care provided during the admission will be the responsibility of the patient.

Depending on the hospital contract, the hospital may raise a charge for High Cost Drugs and non-PBS TGA approved exceptional drugs which may not be covered by the Fund.

Medical Devices And Human Tissue Products

Many hospital procedures include the use of surgically implanted medical devices and human tissue products (e.g joint, cataract, or heart device). The Federal Government regularly issues the Prescribed List of Medical Devices and Human Tissues Products to health funds. An industry group of clinical experts review all items on the Prescribed List.

There will be at least one prosthetic item for every relevant procedure that is listed in the Medicare Benefits Schedule (MBS) that is fully covered by your hospital cover (a no gap item).

In some circumstances, you and your surgeon may feel it is more appropriate to your individual medical needs to use a different item from the Prescribed List instead of the no-gap item. Where the cost of the recommended prosthetic item is above the minimum benefit listed on the Prescribed List, you will be responsible for paying the additional amount.

It is recommended that prior to your surgery you discuss with your surgeon the cost of the surgery including any out-of-pocket expenses associated with either the surgery and/or the recommended medical device or human tissue product.

Benefits are not payable for any medical devices and human tissue products associated with an excluded service under your hospital cover.

Health Aids and Appliances

We offer benefits on a wide range of health aids and appliances under our open for sale Ultra Extras product and some of our closed for sale products (please refer to your Product Summary to confirm benefit entitlement). Benefits for some items are restricted to hire only for a maximum period of three months.

A benefit replacement period applies to certain aids and appliances. This means once you've been paid a benefit for a particular item, you'll need to wait a period of three years from the date of purchase of the item before you're entitled to a benefit for the replacement of that item. Benefit replacement periods apply per person.

When claiming for these items, a letter from your doctor or relevant practitioner is required and, in some circumstances, only after an inpatient hospitalisation. Prior to purchase or hire of any health aid and appliance, please contact us to check the conditions of claiming the benefit.

Benefit replacement period	Items
3 years	Blood glucose monitors (glucometer) Blood pressure monitor C-pap machine and humidifier and initial mask and tubing (only covered on some products, please contact us to confirm benefit entitlement) Tens machine (not circulation booster)

Claiming for hospital treatment

In most cases, if you are covered for your treatment or procedure under your level of cover, you've served the appropriate waiting period and paid the excess that applies to your hospital cover, your claim will be settled directly between Queensland Country and the hospital. If you receive an invoice from the hospital, you can forward this to Queensland Country for payment.

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.

For Members that choose not to access our Townsville and Brisbane unit accommodation 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 a hospitalisation:

- Where the patient has to travel 300 kilometres or more return journey 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 patient limited to the duration of the patient's hospital admission (as above).
- A benefit won't be paid towards accommodation for both the patient and carer for the same dates. e.g. the benefit is limited to $50 per night and is not claimable by the patient while admitted.
- 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 a stand-alone extras cover.
- This accommodation benefit is not claimable if you are staying in the Fund's unit accommodation in Townsville or Brisbane.

Ambulance cover

You never know when an accident might happen and you need to be rushed to hospital in an emergency.

Who is covered?

We provide nationwide ambulance cover for all persons covered under a Queensland Country hospital product* who:

- reside outside of Queensland and Tasmania (nationwide emergency ambulance services for Queensland residents and statewide emergency ambulance services for Tasmania residents are already covered by these respective State Governments).

*Not available on any stand-alone Extras product.

What's covered	What's not covered

• 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 when provided by an organisation recognised by us (see below).
• An emergency is an unplanned event where you need immediate medical treatment.
• Benefits are only available for an **emergency ambulance transport service** where, in the opinion of a medical officer, a person requires immediate medical treatment in circumstances where there is a serious threat to a Member's life or health.
• For your transport to the hospital to be classed as an emergency, the ambulance account must be coded and invoiced as emergency transport by a recognised state ambulance authority.
• **On-the-spot emergency treatment** is where an ambulance is called to provide immediate professional attention but transport by ambulance in the opinion of the attending medical officer is not required.
• The following providers are recognised by us:
  • ACT Ambulance Service
  • Ambulance Service of NSW
  • Ambulance Victoria
  • Queensland Ambulance Service
  • South Australia Ambulance Service
  • St John Ambulance Service NT
  • St John Ambulance Service WA
  • Tasmanian Ambulance Service
	Situations when you will NOT be covered include:
	• Non-emergency ambulance transport
	  • Transportation from a hospital to your home, nursing home or another hospital for ongoing medical treatment (where you have been admitted to the transferring hospital first) or,
	  • Transportation from your home, a nursing home or hospital for ongoing medical treatment, e.g. chemotherapy or dialysis.
	• Air services (including helicopter services)
	• Road transport services that are **not operated** by a state or territory government or an organisation recognised by us
	• Where your state Government provides an ambulance benefit (e.g. Queensland and Tasmania) or where you are covered through a state based reciprocal arrangement
	• When you hold your own ambulance subscription with your state ambulance service
	• Where compensation, damages or benefits may be received from another source e.g. compensation, third party or other liability provision.

Waiting periods

Emergency – There is a one day waiting period for emergency ambulance treatment.

How to claim for extras

Easy on-the-spot claiming

You can claim on-the-spot for most extras services before you even leave your provider. Your Queensland Country Health Fund Membership Card enables your benefit to be paid directly to participating allied health service providers who display the HICAPS or HealthPoint logo. After the services have been provided, your Membership Card will be swiped and your claim processed in seconds. The appropriate benefit for your level of cover is automatically credited to the health care provider, so you only need to pay the difference (if any) between the service cost and benefit. It's fast, convenient and there are no claim forms to fill in.

Major dental item benefits may not be able to be claimed through HICAPS or HealthPoint in the first 12 months of membership with Queensland Country. Orthodontic benefits will not be able to be claimed at all through the HICAPS or HealthPoint systems.

Fast online claiming

It's easy to claim online for a wide range of services when on-the-spot claiming isn't available through your provider. Simply go online using your PC or tablet. Log in to Online Member Services (OMS) through our website and upload a copy of your receipt/s you received from your service provider, it's that easy!

Eligibility:

- Hold an extras product
- Policy is financial (paid up to date)

Mobile App

Claim easily from your phone simply by logging into our convenient Mobile App and uploading a photo of your receipt.

You'll need to be registered for Online Member Services to log in to our Mobile App and check your benefit limits and claims usage.

Download it from the Apple App Store or Google Play Store today. For more details visit queenslandcountry.health/mobileapp.

Direct claims payment service

Access your benefits quickly and easily with our direct claims payment service. Once we receive and process your claim, your benefits will be deposited into your nominated bank, credit union or building society account.

To register an account for direct claims payment:

- call or email the details of your preferred direct claims payment account
- complete the account crediting information section on our claim form, or
- log in to Online Member Service (OMS) or our Mobile App and add or change your bank account details.

By email

You can email us a completed claim form and associated invoices or receipts.

By mail

To claim your benefit by mail, complete a claim form, attach your original invoices/receipts, and mail them to us.

In person

If you wish to lodge your claim in person you can visit one of our Health Fund Retail Centres. Contact details for all of the above methods can be found in the "Contact Us" section in the back of this guide.

Obtaining a claim form

Claim forms are available for download from our website, by phoning 1800 813 415 or from your local Health Fund Retail Centre, locations can be found on page 43.

Paid accounts

If you have already paid the health care provider, we can credit your benefit payment directly into your nominated bank, credit union or building society account.

Unpaid accounts

When you submit a claim directly to Queensland Country for a service where the account is unpaid, benefits will be paid directly to the provider.

Where your provider submits a claim directly to Queensland Country or you send in an Access Gap Cover endorsed account, we will also pay your provider directly.

Things to remember when claiming

- A claim for benefits must be lodged within two years of the date of the service. Benefits will be refused if a claim is lodged after this period.
- For Queensland Country to assess your claim all invoices or receipts must be originals (or provider endorsed duplicates) and include the:
  - appropriate item number or full description of the service or product
  - patient's name
  - date of service
  - fee charged
  - provider's name, qualifications, practice address, provider number (if applicable), and a valid Australian Business Number (ABN)
  - tooth numbers are required on dental accounts where treatment has taken place on individual teeth.
- Benefits and limits are assessed having regard to the date on which the services were rendered or product supplied, except for courses of orthodontic treatment.
- Services must be provided by approved practitioners or therapists recognised by Queensland Country in private practice, or salaried doctors in public hospitals.
- The treatment or service is covered under your level of cover and the conditions of the level of cover have been met, including the waiting period for such treatment or service has been served.
- 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.
- For ancillary (extras) health care services, benefits are either to be paid by the health fund or by Medicare; a person cannot claim benefits for the same service/treatment from both sources.
- There is no entitlement to a Medicare benefit under an Allied Health Service program.
- All documents submitted in connection with a claim become the property of Queensland Country, unless otherwise agreed, by the health fund.
- Benefits are not payable for claims for services rendered while premiums are in arrears or the membership is suspended.
- Benefits are not payable, or may be payable at a reduced rate, during any applicable waiting periods.
- Benefits are not payable for goods or services where the business or individual supplying the goods or service cannot supply a valid Australian Business Number (ABN) matching details on the tax invoice issued.
- Benefits are not payable for claims for services rendered outside Australia or, for items purchased or hired from overseas suppliers.
- Benefits are not payable if a charge hasn't been raised for the treatment or service.
- Benefits are not payable if the service is not medically necessary and clinically relevant.
- Benefits are not payable unless a service forms part of a course of treatment recognised by Queensland Country.
- Benefits are not payable unless the service is provided in person to a person on the membership.
- The amount received as a benefit for a service under a level of cover is calculated on the cost of the treatment or aid/appliance that is received, taking into account any allowances or discounts given by a provider.
- No benefit paid by Queensland Country can exceed the actual charge for the service or aid/appliance.
- Benefits are not payable for treatment rendered by a provider to the provider's partner (spouse or de facto) or dependents or partner's dependents if a legally enforceable debt is not raised.
- Benefits for gym membership, personal training and aquatic exercise/rehabilitation* under Healthy Living benefits will only be payable on referral by your health care professional for you to participate in this health management program where it is to address or improve a specific health or medical condition. Supporting documentation in the form of a Health Management Program Benefit Approval Form is to be completed by your health care professional and is required to be lodged along with a completed claim form.

* Aquatic exercise/rehabilitation includes pool entry and exercise classes (excludes swim classes/lessons)

Registered providers

It is a requirement that any practitioner is registered and recognised by us before benefits will be paid. Queensland Country will only pay benefits for therapies, optical, dental and other extras services if rendered by a provider or practitioner that is recognised by us. We reserve the right to refuse payment for services rendered by a provider who does not satisfy the criteria of Queensland Country.

Recognition of providers is for the purpose of determining the payment of benefits. It should not be taken or considered in any way as approval of or any recommendation as to the qualifications and skills of or services provided by a practitioner or therapist. You should check with Queensland Country that your practitioner is recognised before commencing treatment.

Multiple services in one day

Where a Member has two or more consultations for the same type of service on the same day, benefits will only be payable where the consultations relate to two separate conditions.

Where a Member has two consultations with the same provider on the same day, benefits are payable where:

- two different types of services are provided, and
- the provider is qualified to perform both types of service.

Where two services are required to be performed on the same day, the health fund may ask for clinical evidence of the requirements for this prior to payment of any benefits.

Compensation and damages

Benefits are not payable in respect of services provided to a Member as a result of an accident, illness, injury, condition or other incident for which there exists in the opinion of Queensland Country, a right to claim compensation or damages from a third party or authority at law or under any insurance or scheme of arrangement.

Where Queensland Country has paid benefits, whether by way of provisional payments or otherwise and the insured person has received compensation in respect of the injury, the insured person must repay to the Health Fund all benefits received in relation to the injury, upon the determination or settlement of the claim for compensation.

The liability of the Member to repay shall apply regardless of whether the Member continues to be a Member of Queensland Country.

Claims paid in error

In the event that a benefit has been paid incorrectly or in error, Queensland Country will be entitled to recover any amount that should not have been paid under the Fund Rules within 24 months of making the erroneous payment.

If a claim is paid in error, Queensland Country is entitled to recover the funds through offsetting against and/or deducting from monies that would otherwise be paid by Queensland Country at that time or after.

Paying your premiums

Premiums must be paid in advance

As a policy holder, it's your responsibility to ensure that your contribution amounts are correct and made in advance. This ensures the efficient processing of claims and hospital eligibility checks. 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.

Premium reviews

All health funds undertake an annual review of their policy premiums after a careful review of operating costs and in particular cost of benefits. Each fund makes a submission to the Minister for Health to request a premium increase for the following year. This review is necessary to ensure the continued sound financial standing of the Fund.

This rate change takes effect on 1 April each year. A written notification of any change to the premium payable is sent to all Members prior to this date, in accordance with the requirements of the Private Health Insurance Act 2007.

Paying your premiums

Queensland Country offers a range of payment options, including:

- **Direct debit:** This is the most popular and convenient method of payment. Under a direct debit arrangement, your premium payments are automatically deducted from your nominated bank, credit union or building society account on the contribution due date. You can choose to pay weekly, fortnightly, monthly, quarterly, half yearly and yearly.
- **Credit card*:** Payments can be deducted as a direct debit payment in accordance with your chosen payment frequency. Your first payment on joining will be deducted on the day your policy is loaded or on the future start date of cover.
- **Pay by phone:** You can also choose to pay your health insurance premiums over the phone by contacting our Call Centre on 1800 813 415. Payments can be accepted from a debit or credit card only*.
- **EFTPOS** facilities are available at any of our Health Fund Retail centres (locations listed in back of this guide).
- **Online Member Service (OMS):** If you're registered for OMS, you can log in and pay your premium contributions via credit card*.
- **Mobile App:** Immediate payments can be made through our Mobile App via credit card*.
- **BPAY®** allows you to pay your health insurance premium via internet or phone banking. The BPAY biller code and your reference number appear on all statements. If you require the biller code and reference number please contact us. This option is not available to eligible participants in a Corporate Health Plan.

  Please note: Your BPAY payment needs to reach us on or prior to your policy's paid-to date, to ensure availability of benefits under your chosen cover. Payments made via BPAY by 2pm Monday to Thursday will be processed the next day. If a payment is made via BPAY by 2pm on a Friday, a weekend or public holiday, the payment may not be processed until the next business day. Please check your financial institution's processing deadlines to avoid being without cover.
- **Payroll deduction** for Members who are eligible participants in a Corporate Health Plan.

Memberships in arrears

A membership is in arrears whenever the 'paid-to date' is earlier than the current date. Benefits are not payable for any treatment provided during a period of arrears.

It is important to keep us up to date whenever you change your contact details so we can contact you should your membership fall into arrears.

Maximum period of arrears

When a membership is more than 63 days in arrears, Queensland Country will terminate the policy. Notification of the arrears on the policy will be sent to the address on file prior to cancellation of the policy.

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*We do not accept payments via American Express or Diners Club

Age-based discounts

From April 2019, private health insurers can offer discounts 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 insurers is voluntary but Queensland Country has taken the stance of providing the discount to all eligible persons across all of our hospital products^.

^What type of covers are eligible for the discount?

Under the reforms an insurer must not provide an age-based discount unless the policy covers hospital treatment only or is a hospital and extras packaged cover. It is therefore not available for a stand-alone Extras cover. As stated above, all of Queensland Country's Hospital and Hospital and Extras packaged covers are eligible for the age-based discount.

I am still covered under my parents cover; will the discount apply to me?

The age-based discount does not apply to dependents who are still covered under their parent/s or guardian/s family policy.

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. A policy providing age-based discounts is referred to as an **age-based discount policy**.

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.

*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 policy.)

All Queensland Country Hospital Covers are retained age-based discount policies.

How much is my discount?

Insurers are able to offer premium discounts on hospital covers of 2% for each year that a person is under 30 years of age when they first purchase hospital 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

What happens if it is a couple or family policy?

On a couples or family policy the total age-based discount that applies under an age-based discount policy is equal to the sum of the applicable discount to which each eligible person who is insured under the policy is entitled for that period, divided by the number of adults.

e.g. Sally and Jack have a couples age-based discount policy together. Sally has a 6% age-based discount; Jack has a 10% age-based discount, the applicable discount for the total policy while both adults remain covered would be 6%+10%=16%/2=8%

Any Lifetime Health Cover loading or alternatively any other discount (e.g. corporate discount) is not taken into consideration when calculating an age-based discount policy premium.

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.

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

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 insurance 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.

The amount of rebate assistance provided is determined by both:

- the age of the oldest policy holder, and
- income* level.

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 premiums they pay to us for their health insurance cover.

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/

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 is higher for MLS purposes 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 (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 including eligible dependents covered on your policy. For more information about who is considered an eligible dependant for MLS purposes, you can refer to the Australian Tax Office's. Medicare Levy Surcharge page www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge.

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.

Lifetime Health Cover

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 for you. This can be found on your transfer certificate from your previous fund.

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

Direct debit request service agreement

Definitions

- "Account" means the account held at your financial institution from which we are authorised to arrange for funds to be debited (which will decrease the available balance in the account).
- "Agreement" means this Direct Debit Request Service Agreement between you and us.
- "Business day" means a day other than a Saturday or Sunday or a national public holiday.
- "Debit day" means the day that you have authorised us to arrange for funds to be debited from your account (which will decrease the available balance in your account).
- "Debit payment" means a particular transaction where a debit is made.
- "Direct debit" refers to the process whereby you provide us with the Direct Debit Request which authorises us to arrange for funds to be debited from an account held with your financial institution (which will reduce the available balance in that account).
- "Direct Debit Request" means the Direct Debit Request between you and us.
- "Your financial institution" is the financial institution nominated by you on the Direct Debit Request at which your account is maintained.
- "You" means the customer who signed the Direct Debit Request
- "We", "our" or "us" means HBF Health Limited ABN 11 126 884 786 trading as Queensland Country Health Fund

Debiting your account

- By signing the Direct Debit Request or providing us with a valid instruction, you have authorised us to arrange for funds to be debited from your account (which will reduce the available balance in your account). You should refer to the Direct Debit Request and this Agreement for the terms of the arrangement between us and you.
- We will only arrange for funds to be debited from your account (which will reduce the available balance in your account) as authorised in the Direct Debit Request.
- If the debit day falls on a day that is not a business day, we may direct your financial institution to debit your account on the following business day. If you are unsure about which day your account has or will be debited, you should ask your financial institution.

Changes by us

We may vary any details of this agreement or a Direct Debit Request at any time by giving you at least 30 days' written notice.

Changes by you

If you wish to stop or defer a debit payment or terminate this agreement, you must notify us in writing or telephone us on 1800 813 415 at least seven business days before the next debit day.

Your obligations

- It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the Direct Debit Request.

- If there are insufficient funds in your account to meet a debit payment:
  - you may be charged a fee and/or interest by your financial institution
  - you may also incur fees or charges imposed or incurred by us; and
  - you must arrange for the debit payment to be made by another method or arrange for sufficient cleared funds to be in your account by an agreed time so that we can process the debit payment.

Payment disputes

- If you believe that there has been an error in debiting your account, you should notify our Contact Centre on 1800 813 415 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly.
- If we conclude, as a result of our investigations, that your account has been incorrectly debited, we will arrange for your financial institution to adjust your account (including interest and charges) to correct the error.
- We will also notify you in writing of the amount by which your account has been adjusted.
- If we conclude, as a result of our investigations, that your account has not been incorrectly debited, we will respond to your query by providing you with reasons and any evidence for this finding in writing.

If we cannot resolve the matter or you are not satisfied with our proposed resolution, you can still refer it to your financial institution which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

Accounts

You should check:

- with your financial institution whether direct debiting is available from your account as direct debiting is not available on all accounts offered by financial institutions;
- your account details which you have provided to us are correct; and
- with your financial institution before completing the Direct Debit Request if you have any queries about how to complete the Direct Debit Request.

Confidentiality

We will keep any information (including your account details) in your Direct Debit Request confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about you:

- to the extent specifically required by law; or
- for the purposes of this agreement (including disclosing information in connection with any query or claim).
- We may provide a copy of the Direct Debit Request to another financial institution in the event any payment that is made in accordance with the Direct Debit Request is disputed.

Notice

- If you wish to notify us in writing about anything relating to this agreement you should write to:
  Queensland Country Health Fund
  PO Box 42
  AITKENVALE QLD 4814
- Any notice will be deemed to have been received on the day that it would have arrived in the ordinary course of the post or next business day following that day.

Privacy Policy

Queensland Country has a legal obligation to comply with the Commonwealth Privacy Act 1988 and the Australian Privacy Principles. Our Privacy Policy and collection notices informs you about how your personal information will be collected, held, used and disclosed, how you may gain access to that information and how you may complain about possible breaches of privacy.

A copy of the latest version of our Privacy Policy may be obtained from our website at queenslandcountry.health/privacy.

Fund Rules

All Members are bound by the Fund Rules of Queensland Country Health Fund.

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 Fund Rules change from time to time. A copy can be obtained by contacting us on 1800 813 415.

Compliments and complaints

Queensland Country values your feedback on our products and services which helps us to monitor our policies, procedures and systems to ensure we are meeting the needs of our Members.

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.

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

Call:	1800 813 415
Email:	info@queenslandcountry.health
Website:	queenslandcountry.health
Address:	Queensland Country Centre, Level 1, 333 Ross River Road Aitkenvale QLD 4814

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**.

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.

Under the Code, Queensland Country agrees to:

- work towards improving the standards of practice and service in the private health insurance industry;
- provide information to you in plain language;
- promote better informed decisions about our private health insurance products and services by:
  - ensuring that policy documentation is full and complete
  - providing clear explanations of the contents of our policy documentation when asked by you
  - ensuring that persons providing information on health insurance are appropriately trained
- ensure information exchanged between you and Queensland Country Health Fund is protected in accordance with privacy principles;
- provide information to you on your rights and obligations under your relationship with Queensland Country Health Fund, including information on this PHI Code of Conduct;
- provide you with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner and advise you of your rights to take an issue to an external body such as the Private Health Insurance Ombudsman.

A copy of the Code of Conduct may be obtained from www.privatehealth.com.au/codeofconduct.

Intermediary remuneration

Queensland Country pays remuneration to insurance intermediaries when we accept a policy the intermediary has arranged or referred to us. The type and amount of the remuneration varies and may include commission and other payments. If you require more information about remuneration we pay your intermediary, you should ask your intermediary.

Clinical categories

Details of the clinical categories are set out in Schedule 5 of the Private Health Insurance (Complying Product) Rules and are available at www.privatehealth.gov.au/health_insurance/howitworks/clinical_categories.htm.

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.

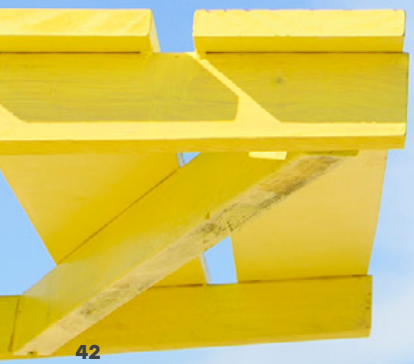
Contact

Townsville Contact Centre

Phone: 1800 813 415

Email: info@queenslandcountry.health

Web: queenslandcountry.health



Head Office

Queensland Country Centre
Level 1, 333 Ross River Road
Aitkenvale
Post: PO Box 42
Aitkenvale Qld 4814

Townsville Retail Centre

Queensland Country Bank
333 Ross River Road
Aitkenvale

Cairns Retail Centre

Queensland Country Bank
514-516 Mulgrave Road
Earlville

Rockhampton Retail Centre

Queensland Country Bank
103 Bolsover Street
Rockhampton

Mount Isa Retail Centre

Queensland Country Bank
70 Camooweal Street
Mount Isa

Burdekin Retail Centre

Queensland Country Bank
186 Queen Street
Ayr

Mackay Retail Centre

Queensland Country Bank
Caneland Central
Shopping Centre

Northern Territory Retail Centre

Gateway Shopping Centre
Shop k10, 1 Roystonea Ave
Yarrawonga

Queensland Country Dental

Queensland Country Centre
333 Ross River Road
Aitkenvale

How to contact us

If you have any questions or need more information, please contact us:

Retail Centre	Visit our website for a listing of all our Retail Centres
Post	PO Box 42 Aitkenvale Qld 4814
Phone	1800 813 415
Website	queenslandcountry.health
Email	info@queenslandcountry.health
	Queensland Country Health Fund

Queensland Country Health Fund is a registered business name of HBF Health Limited ABN 11 126 884 786

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