Territory
HEALTH FUND

Hospital Cover

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!

1 JULY 2024

Welcome to Territory Health Fund

OUR PURPOSE

Territory Health Fund is a community and people focused health insurer, developed specifically for the Northern Territory. Our purpose is to provide Northern Australians a genuine, easy and value for money experience.

Territory Health Fund strives to meet the health insurance needs of people in the Northern Territory by:

- Improving the health and wellbeing of Members
- Maintaining competitive premiums
- Offering 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 difference with Territory Health Fund.

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Territory Health Fund is a community and people focused health insurer, developed specifically for the Northern Territory.

Why is private health insurance hospital cover for me?

Choose your **doctor**

With private hospital cover, decide whether you want to go to a private or public hospital and choose your own doctor if they're willing and able to treat you.

More choice when choosing your **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.

More choice as to when you're **treated**

Lock in your **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 peace of mind and the security of health care options and benefits not available today through the public health care system.

Plus... you won't have to worry about long waiting periods in the public system

But if you want to go private, you won't have to pay full price

Childbirth $10,374*

Hip replacement $27,446*

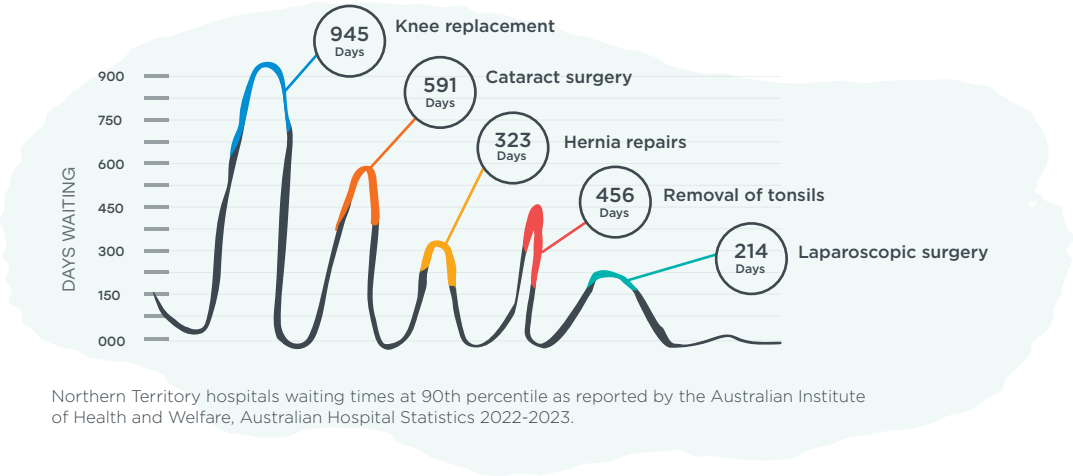
Knee replacement $27,003*

* Source: Queensland Country Health Fund claim records; average cost for procedures performed in a private hospital in 2023-2024.

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.

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

Data for 2022-2023 sourced from: www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery Table 4.7



Northern Territory hospitals waiting times at 90th percentile as reported by the Australian Institute of Health and Welfare, Australian Hospital Statistics 2022-2023.

WHY TERRITORY HEALTH FUND?

Member focused

At Territory Health Fund our primary focus is satisfying the needs of our Members. We invest heavily in making your experience personal 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

We understand your health care needs, and that you need to be covered wherever you go.

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.

Adult children also covered

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

In some circumstances, we can continue to cover adult dependents on your family policy up to and including 31 years of age. We have more information about our family policies on page 8.

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 people covered under a Territory Health Fund private hospital product* who reside outside of Queensland or Tasmania (nationwide emergency ambulance services for Queensland and Tasmanian residents are already 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.** 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 of our stand-alone Extras products which are Select and Young Extras.

PACKAGED COVERS

We have a simple but versatile product range, so you can choose health cover that meets any budget or need.

We keep it simple and easy to understand:

Choose from one of our two hospital cover options – Better Hospital (Silver+) or Vital Hospital (Bronze+)

Then **select an eligible excess** option (if applicable) that suits your budget.

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 cover.

That's it. Easy as 1 - 2 - 3.

If all you need is extras cover, you can choose Select or Young Extras as a stand-alone product, without purchasing hospital cover.

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

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 age 31 (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 age 31 (as long as the dependent is not married or living in a de facto relationship).

EXTENDED FAMILY POLICY

Covers the person who opens the policy (the policy holder), their partner and all adult dependents up to and including 31 years of age (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.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 33 for more information about dependents.

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, you can 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.

ALREADY HAVE HEALTH INSURANCE?

It's easy to switch!

At Territory Health Fund, we believe private health insurance should be easy to understand, easy to claim on and it should be easy to join or switch 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 Territory Health Fund cover offers a higher level of benefits than your previous cover. 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.

AGE-BASED DISCOUNTS

Discounts for our younger Members

Younger people are now eligible for a discount on their private health insurance as per the government reforms that were introduced 1 April 2019. 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 aims to encourage more young people to take out private health insurance, a move that we have welcomed.

The provision of discounted products by insurers is voluntary but we took the opportunity provided by this legislative change to offer the discount to all eligible people 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 package covers are the only products eligible for the discount. **It is not available for a stand-alone extras cover.** As stated above, all of Territory Health Fund's hospital or hospital and extras packages provide this discount to younger people.

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.

AGE WHEN ELIGIBLE HOSPITAL POLICY IS PURCHASED	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 purchase a policy that offers these discounts.

Elegibility 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,

(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 Territory Health Fund when I am already eligible for an age-based discount?

You will retain the applicable discount percentage that applied to your previous cover at the time of transfer if where your previous health fund informs us that the policy you held was an age-based discount policy, and you transfer to any of Territory Health's retained age-based discount policies* within 63 days of terminating your previous cover.

* 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 Territory 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+)		
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 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 both Better Hospital (Silver+) and Vital Hospital (Bronze+) 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 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 Excluded services, 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 11 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 6. Full conditions are available in our Membership Guide.	✓		✓		
Accommodation benefits Accommodation benefit of up to $50 per night for Members travelling 300 kilometres or more return journey from their home address for hospitalisation. Conditions apply see Accommodation Benefit information on page 26 for further information.	✓		✓		
Surgically implanted medical devices and human tissue products Surgically implanted stents, screws and plates (for fractures) and pacemakers etc. Benefits as per the Government Prescribed List. No benefit payable on an excluded service.	✓		✓		
Access Gap Cover A benefit over and above the Medicare Benefits Schedule for participating doctors on inpatient services	✓		✓		
Intensive care	✓		✓		
Nursing home type patients This amount is determined by the Federal Government. Certification is required.	✓		✓		
Rehabilitation	✓		✓		
Palliative care	✓		✓		
Brain and nervous system	✓		✓		

* Clinical categories are defined by the Department of Health. More information about clinical categories can be found at www.privatehealth.gov.au/health_insurance/howitworks/clinical_categories.htm.

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 Territory 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+)		
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS				
Eye (not cataracts)	✓		✓		
Ear, nose and throat	✓		✓		
Tonsils, adenoids and grommets	✓		✓		
Bone, joint and muscle	✓		✓		
Joint reconstructions	✓		✓		
Kidney and bladder	✓		✓		
Male reproductive system	✓		✓		
Digestive system	✓		✓		
Hernia and appendix	✓		✓		
Gastrointestinal endoscopy	✓		✓		
Gynaecology	✓		✓		
Miscarriage and termination of pregnancy	✓		✓		
Chemotherapy, radiotherapy and immunotherapy for cancer	✓		✓		
Pain management	✓		✓		
Skin	✓		✓		
Breast surgery (medically necessary)	✓		✓		
Diabetes management (excluding insulin pumps)	✓		✓		
Blood	✓		✓		
Back, neck and spine	✓		✓		
Plastic and reconstructive surgery (medically necessary)	✓		✓		
Dental surgery	✓		✓		
Podiatric surgery (provided by a registered podiatric surgeon)	✓		✓		
Lung and chest	✓		✓		
Insulin pumps	✓		✕		
Implantation of hearing devices	✓		✕		
Pain management with device	✓		✕		
Sleep studies	✓		✕		
Cataracts	✓		✕		
Heart and vascular system	✓		✕		

* Clinical categories are defined by the Department of Health. More information about clinical categories can be found at www.privatehealth.gov.au/health_insurance/howitworks/clinical_categories.htm.

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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 Territory 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+)		
	$250 EXCESS	$500 EXCESS	$250 EXCESS	$500 EXCESS	$750 EXCESS
	NOTE: DEPENDENTS AGED 12 YEARS AND UNDER DO NOT PAY AN EXCESS				
Dialysis for chronic kidney failure	✓		×		
Pregnancy and birth	✓		×		
Assisted reproductive services	✓		×		
Joint replacements	✓		×		
Hospital psychiatric services	R		R		
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. More information about clinical categories can be found at www.privatehealth.gov.au/health_insurance/howitworks/clinical_categories.htm.

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 Territory 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 below for further detail)

Vital Hospital (Bronze+):
- Choice of $250, $500 or $750 excess
- Exemption for dependents 12 years and under (see below 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 in a Membership Year*. However, 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'll be required to pay the remainder of your excess obligation. Your excess amount payable resets at the start of your next 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+) only	$750	$750	$1500

* Membership Year is defined on page 9.

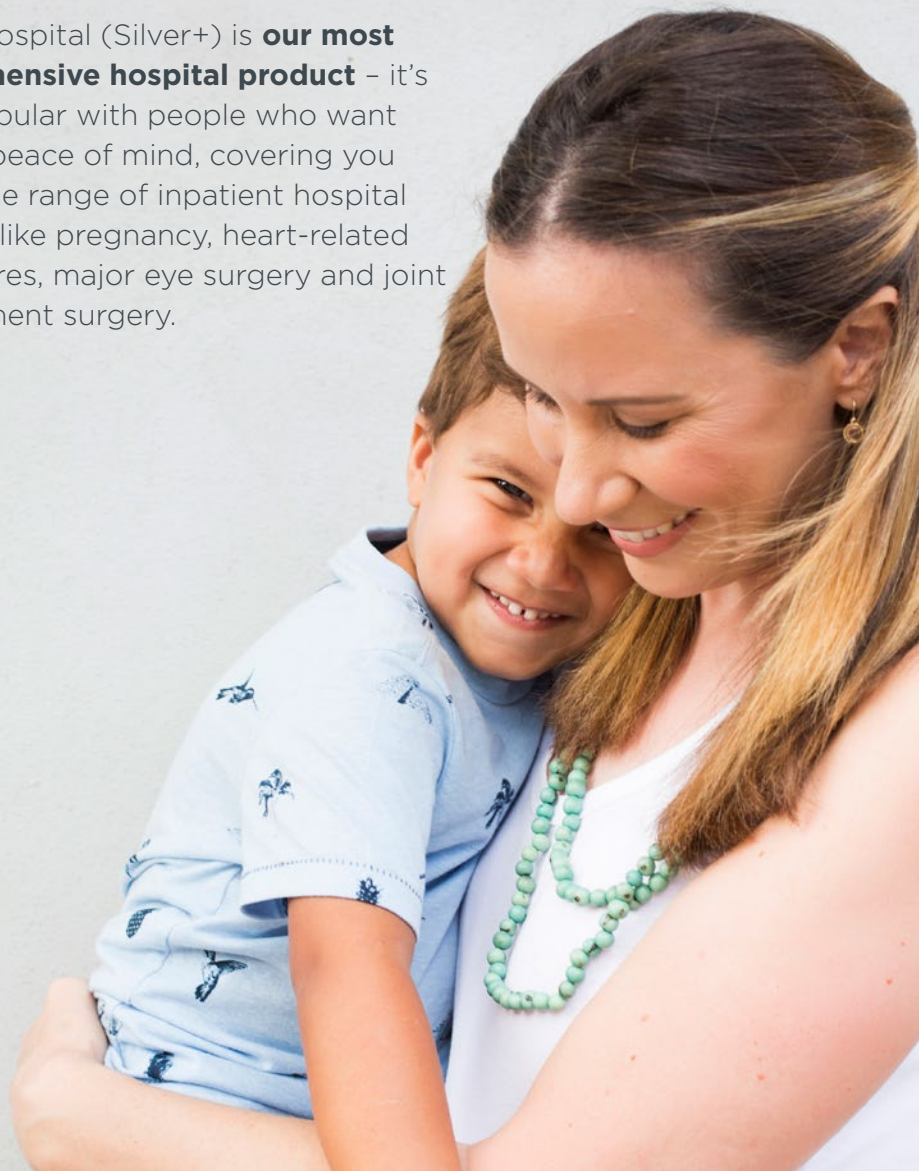
EXCESS EXEMPTION FOR YOUNG DEPENDENTS - ON ALL HOSPITAL COVERS

If your dependent aged 12 years and under is admitted to hospital for medical treatment, you will not be charged any excess with our hospital covers.

BETTER HOSPITAL (SILVER+)

our most comprehensive hospital product

Better Hospital (Silver+) is **our most comprehensive hospital product** – it's most popular with people who want greater peace of mind, covering you 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 a high level of hospital cover

Features:

- ✓ **Our highest level of hospital cover**
- ✓ **Cover for private hospital accommodation^**
- ✓ **Doctors' fees for services provided in a hospital^**
- ✓ **Cover for most major surgeries^**
- ✓ **Choice of a $250 or $500 excess**
- ✓ **Age-based discounts available for eligible policy holders***
- ✓ **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 below 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 11.

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

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 Territory Health Fund. There is no benefit entitlement for hospital treatment for which Medicare pays no benefit e.g. **cosmetic surgery.**

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+)

a great value mid-level cover

Vital Hospital (Bronze+) 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 costs down by limiting cover on services you're less likely to need**
- ✓ **Choice of $250, $500 or $750 excess**
- ✓ **Age-based discount available for eligible policy holders***
- ✓ **Combine with any of our extras products**

* 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 11.

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

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 service on Vital Hospital (Bronze+) is:

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, spinal disc replacement.
- **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 for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. e.g. gastric banding, gastric bypass, sleeve gastrectomy.

There is no benefit entitlement for hospital treatment for which Medicare pays no benefit e.g. **most cosmetic surgery.**

If you need cover for any of the excluded services, we recommend upgrading to Better Hospital (Silver+) Cover^. (No benefits are payable however on Better Hospital (Silver+) Cover for weight loss surgery or cosmetic surgery).

^ If you would like to receive the full benefit entitlement for any of the excluded services under our Vital Hospital (Bronze+) you will need to upgrade your policy to one of our Better Hospital (Silver+) 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 either Vital Hospital (Bronze+) or Better Hospital (Silver+) Covers for weight loss surgery. Also, Hospital psychiatric services is a restricted service on both Vital Hospital (Bronze+) and Better Hospital (Silver+) Covers.

FEATURES OF HOSPITAL COVER
with Territory Health Fund

HOSPITAL NETWORK

Territory Health Fund has agreements with most of the participating private hospitals and day surgery hospital 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 Territory 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 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*.

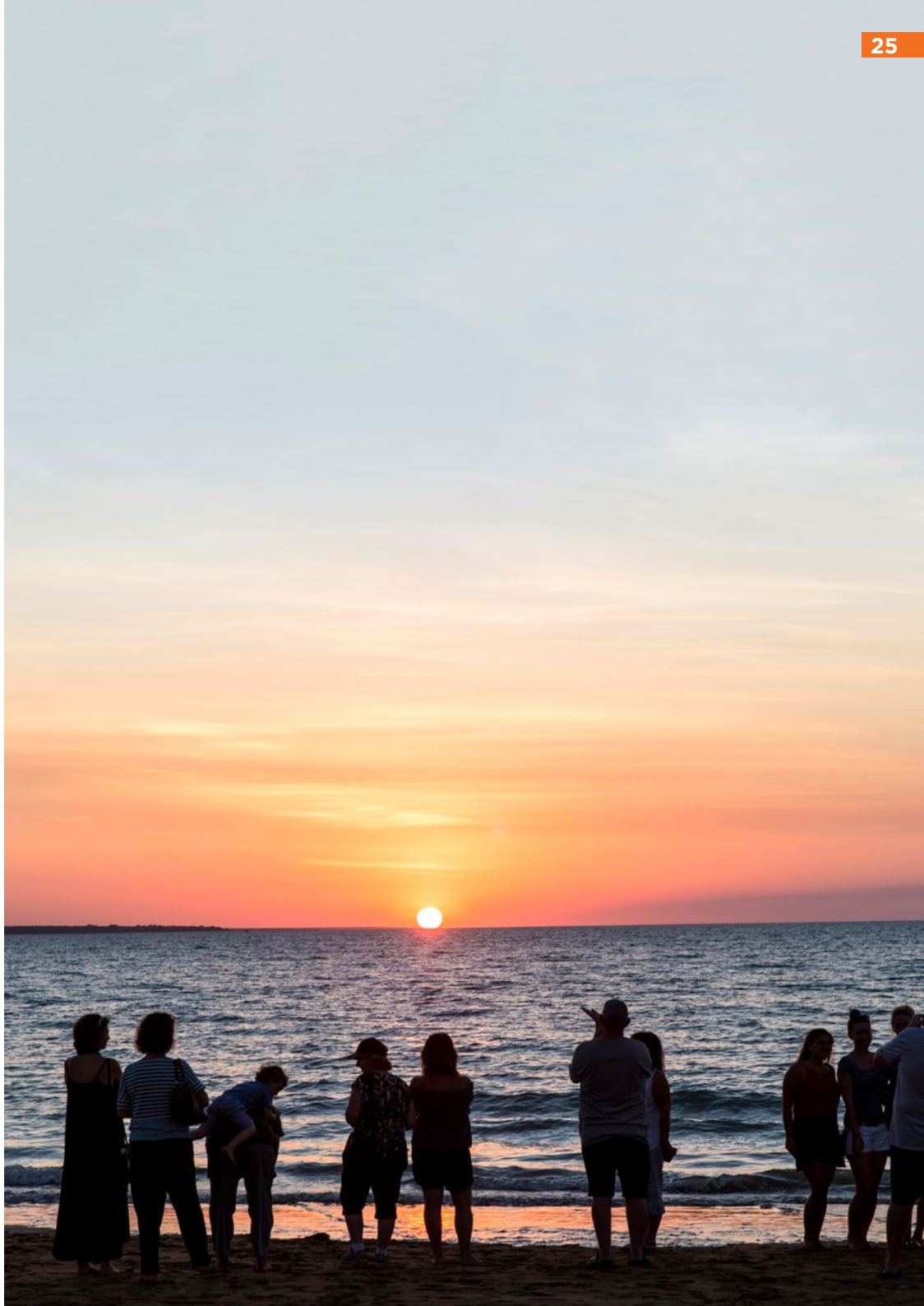
*Hospital substitute treatment allows patients the option subject to a doctor's approval, to complete their hospital recovery in the comfort of their own home or in community healthcare clinics e.g. wound care and IV therapy.

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, 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 or mail.

For more information on in-hospital pharmacy, please refer to our Membership Guide.

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.



FEATURES OF HOSPITAL COVER
with Territory 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 who are travelling away from home for their medical treatment, we provide accommodation benefits to subsidise the costs of their 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 Member (the patient) limited to the duration of the patient's hospital admission (as above).

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.

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 Cover scheme for your treatment, 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. Below is a list of possible scenarios when it comes to the doctor's charges and your out-of-pocket expenses for inpatient hospitalisation:

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

"No-gap" scenario
MBS fee + Territory Health Fund benefit Your doctor participates in Access Gap

"Known-gap" scenario
MBS + Territory Health Fund + 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.

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 the AHSA website at www.ahsa.com.au/web/doctors/information/doctor_search

HOW TO PAY CONTRIBUTIONS

Territory 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.

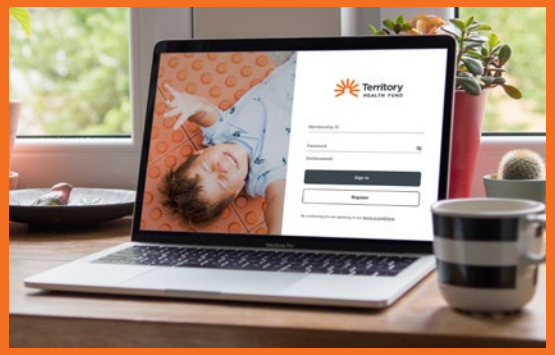
BPAY

Our biller reference code is 269308 and the reference number for your policy can be provided on request.

Phone

Call us on 1800 623 893 to pay over the phone by speaking with a Member Service Officer.

® Registered to BPAY Pty Ltd ABN 69 079 137 518



Your online portal

ONLINE MEMBER SERVICES

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

MOBILE APP

You can do all of the features of OMS and more through our convenient Mobile App.

You must be registered with OMS to access the Mobile App. To register for OMS go to members.territoryhealth.com.au. Once you have completed your registration you'll be ready to login to the App.

Download from:

Download on the App Store

GET IT ON Google Play

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 Territory Health Fund.

Our Membership Guide contains a more comprehensive listing of rules and conditions that apply to your membership. All this documentation should be read carefully before any decision is made to purchase a health insurance product. Ensure you retain a copy of the 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 which could impact on premium prices for the wider membership. 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 two 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.

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 services

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).

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 Territory Health Fund, based on evidence.

Benefit conditions

Territory Health Fund will only pay benefits when:

- Goods and services are provided in Australia
- 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 Territory Health Fund
- 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 Territory Health Fund
- 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 Territory Health Fund has already paid benefits by way of provisional payments and, where compensation has been paid in respect of an injury, the insured person must repay to the health fund benefits received in relation to the injury, upon settlement of the claim for compensation.
- 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 or appliance.

Recognised providers

We will only pay benefits for ancillary, dental and nursing services where the service is provided by a practitioner that is recognised by Territory 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 Territory 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 21 years of age.

We still have options for covering your dependents even once they turn 21, 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)# Cover 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 and if required, can also be packaged with any one of our 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 as long as their own cover starts within 63 days of leaving the family policy.*

The Extended Family Cover option is not available on stand-alone extras products.
* As long as all appropriate waiting periods were served under the family policy.

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 index 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 (2% of taxable income) that affects all Australian taxpayers.

The MLS won't apply to any Territory Health Fund policy holder who holds hospital cover (including all applicable family members).

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

Territory 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 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 on request by contacting us on 1800 623 893.

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 at times, 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 623 893
Website:	territoryhealth.com.au
Email:	info@territoryhealth.com.au
Address:	Shop K10, Gateway Shopping Centre 1 Roystonea Avenue Yarrawonga NT 0830

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

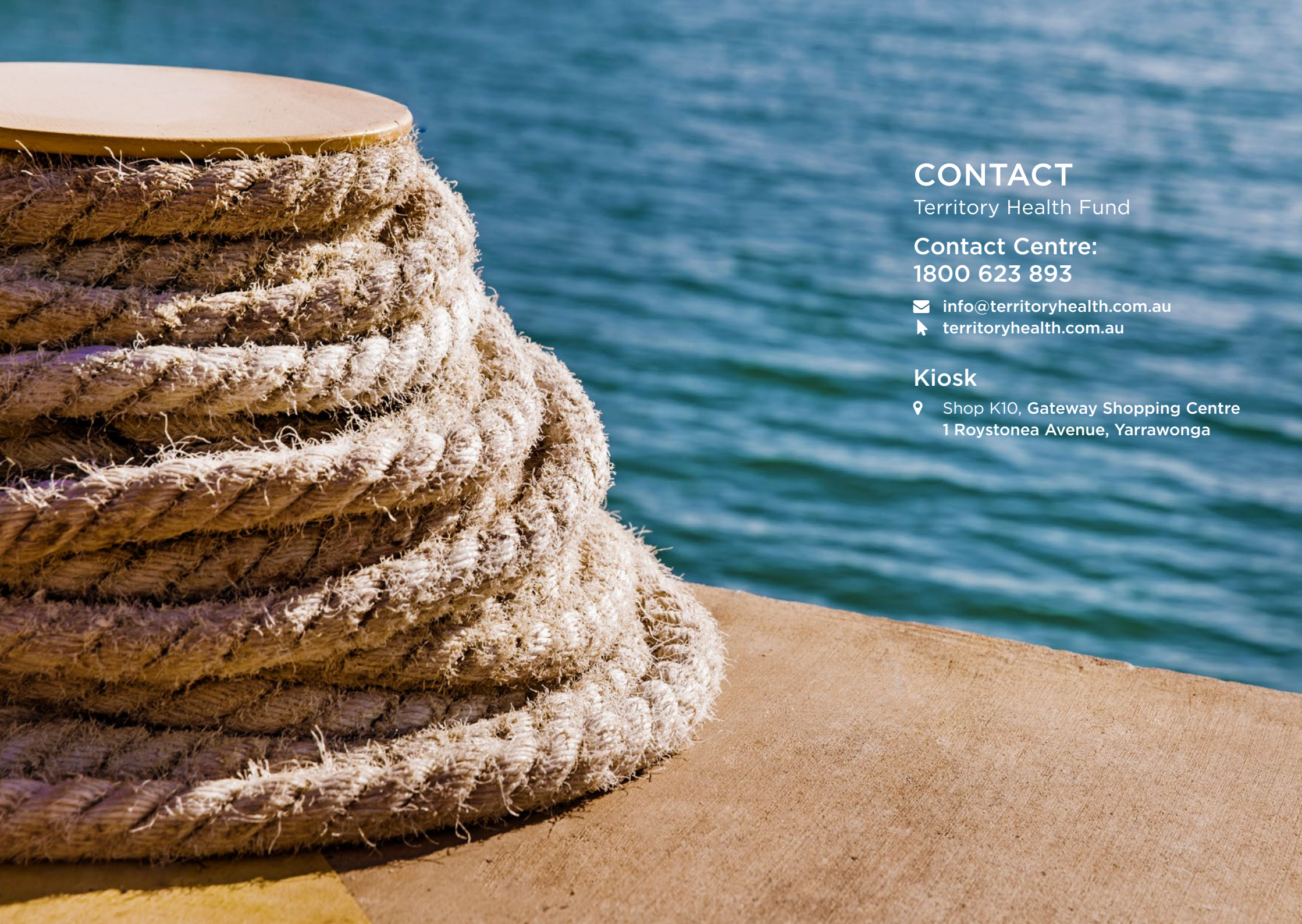
Alternatively, the Ombudsman can be contacted by phone on 1300 362 072.

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 territoryhealth.com.au/privacy.

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

Territory Health Fund

Contact Centre:
1800 623 893

info@territoryhealth.com.au
territoryhealth.com.au

Kiosk

Shop K10, **Gateway Shopping Centre**
1 Roystonea Avenue, Yarrawonga

HOW TO CONTACT US

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

territoryhealth.com.au

info@territoryhealth.com.au

1800 623 893

Shop K10, Gateway Shopping Centre,
1 Roystonea Avenue, Yarrawonga

Territory Health Fund

Territory Health Fund is a registered business name of
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