Basic Extras
Cover Summary

Affordable cover for General Restorative Dental, Optical and other essential services

Features

Affordable cover for commonly used services

$160 annual limit for Optical

No annual limit on Preventative Dental

As an HBF member you'll:

- ✓ Be part of a not-for-profit health fund that focuses on giving more back to members.
- ✓ Be able to check your limits, view usage, update your details and get a benefit quote with myHBF, our member service portal.

How to contact us:

Call 133 423
For call centre opening hours, please visit hbf.com.au/contact-us

Go to hbf.com.au

Find a location near you
Please visit hbf.com.au/find-a-branch

What am I covered for?

This is an overview of Basic Extras. This product sheet must be read in conjunction with the Membership Guide available at hbf.com.au/membership-guide

Benefits are payable up to your annual limit and only for services and programs approved by HBF and delivered by providers that are approved by HBF. Annual limits are per person per calendar year unless otherwise stated. Waiting periods may apply before benefits are payable.

Inclusions Commonly used services	**Waiting periods**	**Benefits**		**Annual limits** Length of Cover	Amount
Chiropractic					
Initial consultation	2 months	$22		Up to 1 year 1-2 years 2-3 years Over 3 years	$250 $300 $350 $400
Subsequent consultation		$17			
X-ray – 1 per calendar year		$64		Combined annual limits for Chiropractic, Osteopathy and Physiotherapy	
Dental					
Preventative		Member Plus dental providers	Non-Member Plus dental providers		
Oral examination (Item 012)	2 months	75% of schedule fee	$37	No limit	
Dental x-ray (Item 022)			$30		
Fluoride treatment (Item 121)			$18		
Scale and clean – first visit per calendar year (Item 114)		100% of schedule fee	$73		
Scale and clean – subsequent visit (Item 114)		75% of schedule fee	$73[1]		
General Restorative		All dental providers			
Extractions (Item 322)	2 months	$81		Up to 3 years 3-5 years Over 5 years	$350 $400 $450
Simple fillings (Item 521)		$54			
Healthy Living Programs					
Health check – 1 per calendar year	2 months	One fully covered health check when provided at select Member Plus pharmacies		One health check	
Flu vaccination – 1 per calendar year		100% and only when provided at select Member Plus pharmacies		Up to 3 years Over 3 years Sub-limits apply	$200 $300
Dose administration aids					
Health management services		Up to 100%			
Optical					
Frames and single vision lenses	2 months	100%		$160	
Frames and bi-focal or multi-focal lenses					
Contact lenses					
Osteopathy					
Initial consultation	2 months	$22		Up to 1 year 1-2 years 2-3 years Over 3 years	$250 $300 $350 $400
Subsequent consultation		$17		Combined annual limits for Chiropractic, Osteopathy and Physiotherapy	

[1] If a subsequent scale and clean is required to complete the same course of treatment (dental item 115), the benefit for this treatment may be lower

Inclusions Commonly used services	**Waiting periods**	**Benefits**	**Annual limits** Length of Cover	Amount
Physiotherapy				
Initial consultation	2 months	$27	Up to 1 year 1-2 years 2-3 years Over 3 years	$250 $300 $350 $400
Subsequent consultation		$21		
Group consultation		$8	Combined annual limits for Chiropractic, Osteopathy and Physiotherapy	
Urgent Ambulance				
Urgent Ambulance by road	7 days	100%	No limit	

More information about your health cover

Waiting periods

Where you have continuous extras cover, we'll honour any waiting periods you served on your previous cover, so you won't have to re-serve them.

If you are part-way through a waiting period, you will just have to serve the remainder before you can claim.

If there are services on this cover, that were not on your previous cover, you will have to serve the relevant waiting periods for the new services.

If there are higher benefits or limits on this cover compared to your previous cover, you will have to serve the relevant waiting periods for the increased benefits or limits.

Urgent Ambulance

With Urgent Ambulance, you'll be fully covered for ambulance transport by road and on-site treatment, for circumstances classified as emergency or urgent provided by an HBF approved provider.

The most common urgent ambulance service is a call-out that requires a transport to the nearest hospital emergency department. Emergency or urgent treatment by paramedics at the scene, such as resuscitation, are also considered an urgent ambulance service and will therefore be eligible for benefit under your cover.

Each state runs a little differently when it comes to Ambulance cover, so here's what you need to know when you get your bill:

- If you live in VIC, SA, WA or NT and receive a bill for emergency or urgent ambulance transport or on-site treatment, send it to us for processing.
- If you live in NSW or ACT, you need to return your bill to your respective state/territory ambulance levy scheme with your HBF member information.
- If you live in TAS or QLD, and are a permanent resident, you are covered under your state-based scheme for ambulance services within your state.
- If you hold a concession card, you may have subsidised ambulance services depending on the state you live in.

HBF won't pay a benefit for:

- Situations where the service is not classified as emergency or urgent and you are not transported to an emergency department, including transport to medical appointments.
- Any transport not provided in an ambulance by road, including air ambulance services.
- Situations where the benefit or cost is subsidised by a state scheme or is payable by a third party, including inter-hospital transfers.
- Any transport between public hospitals.

Healthy Living Programs

Health management services help members manage or improve their health and wellbeing, through early intervention services or programs. These services can change from time to time, for more information go to hbf.com.au/healthy-living-programs

Out-of-pocket costs

There may be an out-of-pocket cost if your provider charges more than the HBF benefit payable for that service. As benefits are only payable up to annual limits, an out-of-pocket cost may also apply if your remaining limit is less than the fee charged.

Member Plus providers

HBF has a range of Member Plus providers that offer Member Plus benefits to HBF members on eligible health covers. Choosing these 'Member Plus providers' over non-participating providers means you can reduce or avoid out-of-pocket costs. Member Plus benefits apply when the provider charges in accordance with the Member Plus schedule fee, if the provider charges above the schedule fee, you will have a larger out-of-pocket cost. You can find a list of our providers at hbf.com.au/find-a-provider.

Member Plus dental: When going to an HBF Member Plus dental provider, you will receive 100% back on your first scale and clean per calendar year and between 75% to 100% benefit depending on your cover for preventative dental services, subject to your annual limit.

Member plus dental arrangements available in WA, NSW, VIC, QLD and ACT only.

Member Plus optical: HBF has a large network of Member Plus optical providers to help members minimise out-of-pocket expenses associated with glasses and contact lenses. These providers offer fully covered glasses from the no-gap range. Additional benefits may include complimentary hard coating on all lenses, four week replacement warranty on frames and discounts on lens add-ons like reflective coating and tinting.

Member plus optical arrangements available in all States.

Member Plus pharmacy: When going to an HBF Member Plus pharmacy provider, you will receive 100% back on your first health check, a flu vaccination and dose administration aids each calendar year, subject to your Healthy Living Program annual limit.

Member Plus pharmacy arrangements available in all states excluding NT. Please note, some Member Plus pharmacies may not offer all services.

Definitions

Annual limit: The maximum amount of benefits you can receive for a treatment within a calendar year. When you change your level of cover or switch to HBF, any claims you made this calendar year will result in an adjustment of the annual limit you can claim for the remainder of the year.

Item/Service limit: The maximum number of times that you can claim on the same item or service within a specific time period.

Sub-limit: The maximum amount of money you can claim on a specific service or item within an overall annual limit.

Are there any exclusions on benefits?

There are some common situations where HBF won't pay a benefit:

- If you receive treatment that is not included on your cover
- Your premium payments are not up-to-date at the time of treatment
- Your claim is not lodged within two years of the date of service
- If you have not yet received your treatment at the time you claim
- Your treatment is provided outside of Australia
- For goods received directly or indirectly (eg. online ordering through marketplace websites) from providers operating outside of Australia
- Your claim is covered by worker's compensation, third party or other legal right
- For treatment where incompatible services are received
- For services received more than once in a specified period of time

See the **Membership Guide** for further exclusions.

Before receiving any treatment, you should contact us or go to hbf.com.au/myhbf for a health benefit quote so you know how much you're covered for, the benefits you'll receive and any out-of-pocket expenses.

HBF reserves the right to make changes to its products, benefits and terms and conditions from time to time. HBF will notify the policyholder a reasonable time in advance of any changes that might be detrimental to the member's interests.