Your member guide.

Get the most from your health cover.

A-Z of health insurance.

All the tricky technical terms you need to know.

We know private health insurance can be difficult to understand. To help make things a little easier, here are some common terms you'll see throughout this guide.

Annual Limits
The maximum amount of benefits that can be claimed on a covered service within the calendar year, and may be subject to other limits.

Benefit
The amount you can claim back/the amount we'll pay towards a service, treatment or good.

Benefit Quote
A formal document outlining what we will pay towards an upcoming service.

Claim
The formal request you send to us to receive a benefit for a service.

Cooling off period
You have 30 days from the time you join or change your cover to decide whether it's right for you.

Co-payment
The fixed amount you'll pay towards the cost of treatment, per service.

Cover
Another word for insurance; a form of financial protection, where you pay a premium to HBF, and in exchange, we pay a benefit towards agreed health services.

Dependant
A child on a family, extended family, parent plus or extended parent plus policy. The dependant must be under 31 years of age and not married or in a de facto relationship.

Excess
The amount of money you agree to pay upfront when you're admitted into hospital for treatment. With HBF, you'll only pay the excess once per person, per calendar year, no matter how many times you are admitted to hospital.

Exclusions
Treatments, services or goods that HBF will not pay a benefit towards.

Inclusions
Treatments, services or goods that HBF will pay a benefit towards.

Inpatient
Someone who's been formally admitted to hospital for day or overnight treatment. For example, knee reconstruction surgery is considered an inpatient service.

Lifetime limit
The total benefit you can receive for a specified service (e.g. Orthodontics) in your lifetime. If you change your cover, or transfer from another fund, any lifetime limits that have been used under your previous level of cover will be carried over and considered when determining the lifetime limit available on your policy, even if you leave and re-join.

Medicare Benefits Schedule (MBS) and Fee
The Medicare Benefits Schedule (MBS) is a list of medical treatments and services that Medicare will pay towards. The MBS Fee is the amount Medicare will pay towards that service.

Out-of-pocket expense
The portion of a hospital or extras bill that you pay from your own pocket for which you won't be reimbursed – by either us or Medicare.

Outpatient
A patient who receives medical treatment without actually being admitted to hospital. For example, emergency ward care is considered an outpatient service.

Premium
The amount you pay for health insurance. Premiums are usually paid at a regular frequency, for example, monthly or yearly.

Provider
Someone who supplies health services, treatments or goods, for example, a specialist or doctor.

Restrictions
Treatments and services for which HBF will only pay the minimum default benefit. If a treatment or service is restricted, you'll generally have a large out-of-pocket cost.

Waiting period
A set amount of time during which you must continuously hold your level of health cover but cannot claim a benefit. When you've served your waiting periods, you can claim.

Contents

Why HBF?	2
Save on health insurance.	3
Take control of your health cover.	4
Making a claim.	5
Understanding waiting periods.	6
Accident cover.	9
Understanding Ambulance cover.	10
Urgent Ambulance	11
Non-Urgent Ambulance	11
Understanding Hospital cover.	12
What you can claim	13
How much you can claim	15
Understanding Extras cover.	19
What you can claim	20
How much you can claim	21
Managing your policy: FAQs	24
Our Privacy Collection Statement.	29
How HBF handles complaints.	33

Why HBF?

Here's why, since 1941, Australians like you have trusted HBF with their health cover:

We're not run by shareholders. That means we can focus on giving our members more back.

We have over 80 years' experience looking after Australia's health, so we know the health system better than anyone else.

We've negotiated great deals for our members at a range of hospitals and with health professionals across Australia. Choosing these 'Member Plus providers' over non-participating providers mean less or even no out-of-pocket expenses for you.

We offer a 30-day cooling off period to let you decide if your new health insurance policy is right for you. If it isn't, we will refund any premiums paid during this time, so long as you haven't made a claim.

HBF health members have access to a range of member discounts and special offers. Visit hbf.com.au/member-perks to find out more.

Save on health insurance.

Here are three ways to save with your private health insurance:

Understand government incentives and surcharges

To encourage Australians to get health insurance, the government introduced a rebate, a tax and a loading. Understanding these will help you save on health insurance.

a. The Australian Government Rebate on private health insurance

This is the government's way of helping make health insurance cheaper. The government pays for a percentage of your premium, with the amount they pay depending on your age and income.

You can claim the rebate at tax time or apply it directly to your premium (lowering the price you pay). If you would like to apply the rebate to your premium, simply nominate your rebate tier in myHBF.

b. The Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a levy paid by Australian taxpayers who earn above a certain income threshold and do not hold an appropriate level of private hospital cover. It aims to encourage individuals and families to take out private hospital cover and to use the private hospital system, in order to reduce the demand on the public health system.

MLS could be up to 1.5% of your income and is in addition to the Medicare Levy of 2%, which is paid by most Australian taxpayers. You may need to pay MLS if your partner or dependants do not hold an appropriate level of private hospital cover.

For the financial year ending 30 June 2026 the base income threshold for MLS starts for singles at $101,000 and for a family at $202,000. These amounts are reviewed annually.

It's important to note our HBF Overseas Visitor covers will not help you avoid the surcharge. Also, if your partner or one of your dependants are not covered, you will pay the surcharge.

c. Lifetime Health Cover loading

This is an extra cost on top of your hospital premium, which applies to people aged 31 or older who buy hospital insurance after the loading deadline. To avoid it, simply take out Hospital cover on or before 1 July following your 31st birthday.

Review your excess

To help reduce your premium, we offer a range of hospital excess options on our hospital covers that are available for sale.

You will only have to pay an excess once per member, per calendar year per policy.

On most HBF Hospital cover options, dependants won't pay an excess when they go to hospital. To see if you're eligible and for more details, see your product summary.

Pre-pay your premiums

You can pre-pay your health policy up to 18 months in advance, which could mean avoiding any increase to your health insurance premiums up to which you've paid. Contact us to pre-pay your premium. On select products, you may also be eligible for a discount by paying your premiums annually.

Take control of your health cover.

A quick guide to understanding and managing your membership.

With HBF, your health is in safe hands. Whether you're learning the ropes or you've been with us for a while, follow these steps to make the most of your membership.

Register for myHBF and download our App

You'll find everything you need to take charge of your cover in our handy online tools. In myHBF you can view your cover details, update your payment and contact details and submit claims. Just visit hbf.com.au/myHBF. If you're registering for the first time, your HBF member number is all you'll need to log in. Plus, you can also download our HBF Health App, available for Apple and Android.

Understand your cover in advance

Knowing what you're covered for and if a waiting period applies not only gives you peace of mind, it also helps minimise any out-of-pocket costs. Make sure to read your policy documents carefully and keep them close by, so you always know exactly what you're covered for. You can access your policy documents anytime in myHBF.

Get a quote before your treatment

Before you book hospital or other major treatments like dental work, contact us and we'll help you understand what you can claim, how much you can claim, and if any excess, co-payments or waiting periods apply. To ensure we give you accurate advice, please have a written cost estimate from your provider on-hand.

Choose a Member Plus provider

At HBF, we've negotiated great deals for our members at a range of hospitals and with health professionals across Australia. Choosing these 'Member Plus providers' over non-participating providers means you can reduce or avoid out-of-pocket costs. You can find a list of our providers at hbf.com.au/health-insurance/find-a-provider.

Use your HBF Member Perks

HBF health members have access to a range of member discounts and special offers. Visit hbf.com.au/member-perks to find out more.

Making a claim.

Claim benefits your way with our four easy options.

Claim on the spot at your provider

Many everyday health providers (such as dentists, physios and chiros) allow you to deduct your benefit from their fee immediately with electronic claiming. Simply swipe your HBF member card and pay the difference.

Submit your claim online

If your provider doesn't have electronic claiming, you can log into myHBF and submit a claim at any time. Just upload your bill or receipts and we'll do the rest.

Submit your claim on our app

Use our HBF Health app (available for Apple and Android) to make a claim whenever you want, wherever you are. Simply take a photo of your bill or receipts and submit your claim.

Submit your claim at a local branch*

Present your HBF member card and original bill or receipts and our friendly team will help submit your claim for processing via the digital devices available.

If you have claimed from Medicare for in-hospital medical services, also bring the Medicare Statement of Benefit.

*Only available in WA.

Hospital claims

Claiming for hospital treatment can get a little complicated. Here are some tips to make the process as smooth as possible:

How to claim medical specialist bills

If we have an agreement with your chosen specialist, they'll submit their bill to Medicare and HBF on your behalf. If we don't, they'll bill you directly. In this case, you'll need to claim from Medicare first, then, send us the Statement of Benefit form that you'll receive when you submit your claim.

How to claim hospital bills

If you're treated at a Member Plus hospital, your bills will be sent directly to us. If you chose a non-Member Plus hospital you may be asked to pay the bill upfront and cover any out-of-pocket costs. If this happens, you can submit a claim to HBF afterwards to be reimbursed for some of the fees.

Remember

- You must make a claim within two years of the date you had the service, so don't delay.
- Set up direct credit in myHBF so we can automatically credit funds to your bank account as soon as your claim has been processed.

Understanding waiting periods.

A waiting period is a set amount of time during which you can't claim a benefit from HBF. Before you can claim, you may have to serve a waiting period.

Here's everything you need to know:

Waiting periods exist to discourage people from joining, claiming and leaving a fund soon after they've made a claim—this behaviour drives premiums up for all our other members.

Waiting periods may apply when you have:

- Never had private health insurance
- Changed your cover
- Joined HBF after a break in cover

Waiting periods vary between Hospital cover and Extras cover, and by service.

Hospital cover waiting periods

Service	Waiting periods
Rehabilitation	2 months
Palliative care	2 months
Psychiatric care	2 months
Pre-existing conditions	12 months
Pregnancy and birth services	12 months
Accident cover	1 day
All other services	2 months[1]

Extras cover waiting periods

Service	Waiting periods
Foot orthoses	12 months
Major dental (root canals, crowns, bridges) and Implants	12 months
Orthodontics	12 months
Hearing aids and appliances	2 to 12 months
All other services	2 months

Ambulance cover waiting periods

Service	Waiting periods
Urgent ambulance (by road)	7 days[2]
Non-urgent ambulance (by road)	30 days[2]

What is a pre-existing condition and how does it work?

- This is an illness or condition which, in the opinion of an independent medical practitioner (appointed by HBF), was known to exist, or where signs or symptoms were evident during the six-month period before you became an HBF member, including on the day you joined.
- This also applies if you transferred to a level of cover with higher benefits or reduce your excess level.
- If you proceed with a hospital admission without confirming what benefits you're eligible for and your condition is determined to be pre-existing, you will be required to pay all outstanding hospital and medical charges not covered by Medicare.
-

Talk to us before your treatment

Before going to hospital, we recommend you call us for a benefit quote to find out if you'll need to pay anything out-of-pocket and to get advice on keeping your costs down. To get a benefit quote, you'll just need the written estimate from your provider.

[1] If you hold an HBF Overseas Visitor cover, you will have different waiting periods. Please refer to your product summary for more information.
[2] If you hold a GMF cover, you will have different waiting periods. Please refer to your product summary for more information.

Things to keep in mind:

Joining HBF from another fund?

When transferring to HBF we'll ask your permission to request a document called a clearance certificate from your previous health fund/s. This lets us know how long you've held your cover for, the level of cover you held and the services you were covered for, plus any Lifetime Health Cover loading which may affect your premium. The clearance certificate allows us to honour any waiting periods you've already served with your previous health fund when you join HBF.

If you have any new services you weren't previously covered for waiting periods may apply.

If you've partially served waiting periods, you'll only need to complete the remaining time before you can claim.

If there are higher benefits or limits on your new HBF cover, you can claim benefits on a HBF cover that is comparable to your previous cover until the waiting period for the increase benefit or limits have been served.

If transferring to HBF with Extras cover, any claims you made in this calendar year with your previous health fund will be deducted from your annual claim limits for those services. Your claims limits will then reset on 1 January.

Without a clearance certificate, waiting periods will apply and HBF will only pay benefits once you've served your waiting periods.

Maintaining continuous cover

If you maintain continuous health cover, you won't have to re-serve waiting periods when you join us. HBF allows you to transfer within 2-months of leaving your last health fund to have your waiting periods recognised.

If you join HBF more than 2 months after leaving your last health fund or previous HBF policy, you will have a gap in cover. This means you will not have held continuous cover, and all relevant waiting periods will apply, including pre-existing waiting periods on hospital cover.

Please note that any gap in hospital cover can impact your status for Lifetime Health Cover purposes, and you may also be liable for the Medicare Levy Surcharge.

Planning to have a baby?

If you're planning to have a baby, just remember there is a 12-month waiting period for pregnancy and birth related services. You must hold your cover with pregnancy and birth related services for at least *12 months before your due date* to be eligible to claim as a private patient for pregnancy and birth related treatment.

Just had a baby?

You will need to add your newborn to your policy within three months of your baby's birth. This way, your baby will be covered from their birth and won't have to serve any new waiting periods, provided you have completed yours.

If you're currently on a Single or Couple policy and want your newborn to be covered, an increase to a Parent Plus or Family policy will apply from your baby's date of birth.

Need to upgrade your psychiatry cover?

If you need in-patient psychiatric treatments, and you upgrade your cover, you may be eligible for a Mental Health Waiver. This means that we'll give you access to your higher benefits immediately, rather than having to wait the standard 2-month waiting period. Just be aware that to access this one-time upgrade, you will already have to have served your 2-month waiting period for psychiatric treatment on your existing Hospital cover.

This waiver must be requested and is available once per person per lifetime and is subject to strict eligibility criteria.

*For Corporate cover, the full length of cover from the previous health fund is granted.

Accident cover.

What is accident cover and how does it work?

An accident is an unforeseen event, occurring by chance and caused by an external force or object that results in an injury to the body requiring admission to hospital for medical treatment.

To be eligible to claim benefits after an accident, you must be seen by a medical practitioner within 7 days of the accident. If you require hospital treatment as a result of the accident, HBF covers you as an admitted patient for admissions within 90 days of the accident or initial medical presentation after the accident.

HBF will not pay a benefit for hospital treatment as a result of an accident when:

- you did not seek any medical treatment within 7 days of the accident.
- the hospital treatment was for the treatment of an illness, condition, ailment, sickness or injury that was either known or should reasonably have been known to you at any time.
- The accident occurred as a consequence of your employment or professional duties. or if the treatment is claimable through a third party insurer.

Accident cover is only available on certain HBF covers.

Understanding Ambulance cover.

The information you need to avoid surprise ambulance costs.

Important information about Ambulance services

Urgent Ambulance is not available for sale to QLD or TAS residents.

Ambulance Care is not available for sale to QLD, TAS, NSW or ACT residents.

- If you live in TAS, you may be covered under your state based scheme for urgent and non-urgent ambulance services within your state.
- If you live in QLD, you may be covered under your state based scheme for urgent and non-urgent ambulance services nationwide.
- If you live in NSW or ACT you may be covered under your state based scheme for urgent and non-urgent ambulance services within your state if you hold an eligible hospital cover.

Concession card holders may have subsidised ambulance services depending on the state in which they live.

Ambulance cover with HBF is broken into two categories: Urgent and Non-Urgent Ambulance. Understanding how each works is the key to avoiding unexpected bills.

Urgent Ambulance

With Urgent Ambulance, you will be fully covered for the cost of urgent ambulance services by road.

The most common urgent ambulance service is a call-out that requires a trip to a hospital emergency department. Emergency or urgent treatment by paramedics at the scene, such as resuscitation, are also considered an urgent ambulance service.

Cover for Urgent Ambulance is included on all Hospital and Extras covers. You can also get Urgent Ambulance cover as a standalone product.

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 urgent or emergency ambulance transport or on-site treatment, send it to us for processing.
- If you live in NSW or ACT and have Hospital cover, you need to return your bill to your respective state/territory ambulance levy scheme with your HBF member information. Alternatively, if you don't have Hospital cover, send your bill to us.

HBF won't pay a benefit for:

- Situations where the service is not classified as emergency or urgent and where you are not transported to an emergency department, including transport to medical appointments.
- Any transport not 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.

Urgent Ambulance is not available for sale to residents of QLD and TAS.

Non-Urgent Ambulance

With HBF, you can get cover for non-urgent ambulance services under our Ambulance Care add-on. If you aren't already covered for non-urgent ambulance, and you hold a HBF Hospital cover you can get Ambulance Care.

With Ambulance Care, you will be fully covered for the cost of non-urgent ambulance services (by road), provided by an HBF approved ambulance provider.

Non-urgent ambulance services include medically necessary transport from home to the hospital, and transfers between hospitals. Call-outs are also covered, regardless of whether you are transported to hospital.

Ambulance Care does not cover all ambulance services. Services not covered are: air ambulance services, transport between a public hospital to your home (including transport from a public emergency department to your home), and transport not provided in an ambulance.

Please note that some Emergency Departments affiliated with Private Hospitals such as Joondalup, Peel and St John of God Midland are classified as public hospitals. Transport from these Emergency Departments to your home is not covered under Ambulance Care.

Ambulance Care is not available for sale to residents of QLD, TAS, NSW or ACT.

Understanding Hospital cover.

The information you need to approach hospital treatment with peace of mind

We know that planning a hospital stay can be stressful. The following information will help you understand how Hospital cover works, the out-of-pocket costs you may face and some tips to avoid them.

What you can claim

Understanding what you can and can't claim is the easiest way to avoid surprise bills. Here's how your Hospital cover works:

Inclusions

Inclusions are the treatments that are covered by your Hospital insurance when you are admitted to hospital.

Inclusions vary depending on the level of cover you have, so be sure to check your product summary to find out which treatments are included on your Hospital cover.

When you've been admitted to hospital for treatment that is included on your cover, you'll be covered for private room accommodation and theatre fees (less any co-payment or agreed excess) for all agreed services in a Member Plus hospital.

We may also pay a benefit towards your specialist fees and other in-hospital services, if your treatment is covered by Medicare.

If you choose to be treated as a private patient in a public or non-Member Plus hospital, we'll pay a benefit towards your accommodation only, and you may incur out-of-pocket costs.

You'll have the option to request a private room, however please note that private rooms are offered based on medical need and availability.

Hospital boarders

All HBF Hospital cover options provide cover for hospital boarders in private hospitals. This means, if you need someone to stay with you while you're in hospital, we'll cover the cost of their food and accommodation, provided it's an agreed service with your hospital, the service you're receiving is covered on your Hospital insurance and the person staying with you is integral to managing your condition.

Talk to us before your treatment

Before going to hospital, we recommend you call us for a benefit quote to find out if you'll need to pay anything out-of-pocket and to get advice on keeping your costs down. To get a benefit quote, you'll just need the written estimate from your provider.

Restrictions

Restrictions are the treatments and services that HBF will only cover to a limited extent. Restricted services receive the minimum default benefit, which basically means if you try to claim on a restricted service, you'll probably have to pay for a large portion of your treatment out of your own pocket.

For restricted procedures, we'll cover the same amount as the cost of receiving treatment at a public hospital, staying in a shared room.

If you choose to receive treatment for a restricted service at a private hospital you'll have to pay the difference, which could be significantly more. To avoid this, we recommend going to a public hospital for treatments and services that are restricted on your level of cover.

Like your inclusions, whether a treatment or service is restricted depends on your level of cover, so be sure to check your product summary before you receive a treatment or service.

Additional information on restrictions

Dental surgery

Please note that some dental surgery treatments are not fully covered under HBF Hospital cover. For example, wisdom teeth removal and dental implant surgery. HBF won't pay a benefit for the oral surgeon's fees under your hospital cover, however you'll still be covered for the accommodation and theatre. To manage any out-of-pockets, you may be able to receive a benefit for these treatments if you hold an eligible Extras cover and waiting periods have been served. Contact us before your treatment to understand what out-of-pocket cost may apply.

Long stay patients

After 35 days of continuous hospitalisation (and if you no longer need acute care), the hospital must classify you as a *nursing home patient*. In this case, private health insurance legislation puts restrictions on the amount we can pay, and you'll be required to contribute towards the cost of your care, which could be significant if you're in a private hospital.

Podiatric surgery

Limited benefits will apply to podiatric surgery. This means that:

- HBF will pay a benefit towards accommodation and theatre fees where podiatric surgery is an included service on your cover.
- HBF may pay a benefit towards the anaesthetist and/or podiatric surgeon, however, you will incur out-of-pocket costs. To receive a benefit, your treatment must be provided by a HBF approved podiatric surgeon at a hospital where podiatric surgery is an agreed service. The maximum amount we'll also pay for anaesthetic services is outlined in the HBF Anaesthetic Schedule.
- If podiatric services are provided in a clinic, they are considered outpatient services, so unless you have Extras cover which includes those services, you'll have to pay the bill yourself.

Call us before any treatment to understand your level of cover and the out-of-pocket expenses that may be incurred.

Exclusions

Exclusions are the treatments and services that HBF *will not* pay a benefit towards. This means you could face a large out-of-pocket cost.

The services and treatments that are excluded depends on your level of cover, so check your product summary to find out which exclusions apply to you.

There are also some exclusions that apply to all HBF Hospital cover options, no matter what level of cover you have. HBF will not pay a benefit if:

- You receive a service or treatment that is excluded on your cover.
- You receive an outpatient service, such as emergency ward care.
- You receive hospital treatment that is not eligible for a Medicare benefit, such as cosmetic surgery. If you aren't eligible for Medicare, you may wish to consider HBF Overseas Visitor cover.
- Your premium payments are not up-to-date at the time of treatment or service.
- You receive a treatment or service during your waiting period.

- Your claim is not lodged within two years of the date of service.
- You have not received your treatment or service at the time you claim.
- Your treatment or service is provided outside of Australia.
- Your claim is covered by worker's compensation, third party or other legal right.
- Your employer or potential employer is required to provide your treatment or service as a condition of your employment.
- Another insurer is required to provide your treatment or service as a condition of your policy.
- You received treatment from a provider who is also a family member on the same policy.

How much you can claim

The amount you get back on a hospital claim depends on the type of agreement HBF has with your hospital and specialists. Here's how it works:

Medical specialist bills

When you're admitted to hospital for treatment, your medical specialists' bills are covered between Medicare, HBF and you. If there's a gap between what Medicare and HBF pay, and your final bill, you'll pay the difference.

In a private hospital, Medicare will pay 75% of the Medicare Benefits Schedule (MBS) fee, and we'll pay the remaining 25%. If your doctor charges more than the MBS fee, we'll cover none, some or all additional costs, depending on our agreement with your doctor.

Your doctor's fee will fall into one of three categories.

Western Australia

Full Cover
If your specialist participates in a Full Cover arrangement, they will only charge up to a certain fee, HBF will pay an additional amount above the MBS, leaving you with no out-of-pocket expense for their inpatient services.

Provider Choice
If your specialist participates in the Provider Choice agreement, they have the option to opt-in or opt-out of the arrangement on a case by case basis. If they choose to opt-in your specialist will only charge up to a certain fee, HBF will pay an additional amount above the MBS eliminating your out-of-pocket cost.

No Arrangement
If your specialist is not registered to participate in an arrangement (or opts-out of Provider Choice), their in-patient services will be covered up to the MBS fee. The difference between the MBS fee and the specialist's fee will be your out-of-pocket expense.

Find a full list of Full Cover specialists by searching under: Find a Provider at hbf.com.au/health-insurance/find-a-provider or call us on 133 423.

A note for members outside of WA

HBF participates in the Australian Health Service Alliance (AHSA) Access Gap Cover (AGC) arrangement for all states outside of Western Australia. If your specialist participates in the AGC arrangement, they have the option to opt-in or opt-out of the arrangement on a case by case basis. If they choose to opt-in your specialist will only charge up to a certain fee, HBF will pay an additional amount above the MBS, leaving you with a maximum out-of-pocket expense of $500 (or $800 for obstetric services). If your specialist chooses to opt-out of the arrangement or are not registered to participate in the AGC arrangement, their in-patient services will be covered up to the MBS fee. The difference between the MBS fee and the specialist' fee will be your out-of-pocket expense.

Informed financial consent

You're legally entitled to know how much your treatment will cost before you're admitted into hospital*. If your hospital stay involves any out-of-pocket charges, the hospital (whether public or private) and your specialist *must disclose the cost* and obtain your agreement in writing before your admission.

Your Informed Financial Consent form is a useful reference to match against your final bill, so be sure to ask your specialists and hospital about it before you're admitted for treatment.

* Except in a life-threatening situation, for example, if you have a heart attack.

Hospital bills

These include any costs related to your stay, such as accommodation and theatre fees. If the total cost of your hospital bill is more than the amount we cover, you'll have to pay a gap.

To help you avoid these gaps, we have arrangements with a large network of Member Plus hospitals across Australia. Choosing one of these hospitals means there'll be less–or even nothing–for you to pay.

You will still need to pay any excess or co-payment on your policy.

In-hospital pharmacy

When you're admitted into hospital you may be given medication as part of your treatment.

In a number of Member Plus hospitals, in-hospital non-Pharmaceutic Benefits Scheme (non-PBS) items are specified in the Hospital's Participating Hospital Provider Agreement. These items may be included in your hospital bills, which means you may have limited or no out-of-pocket costs to pay.

Where the agreement does not specify a benefit for non-PBS pharmacy items, the benefit is limited to $1,400 per hospital episode (any period of hospital stay or care), with a co-payment of $100. There's no limit on the number of patient episodes per year, however re-admissions within seven days may be considered continuous and therefore only one limit and co-payment applies. If the hospital does not have an agreement with HBF, no benefit is payable on non-PBS pharmacy items. Also, HBF will not pay a benefit towards PBS pharmacy prescribed whilst you are in hospital.

Speech and sound processor replacements

Some HBF hospital covers include benefits for speech and sound processor replacements.

Where the replacement is clinically necessary and provided as an outpatient service, such as at your audiologist or hearing clinic, and you satisfy the additional criteria below, we will pay the minimum benefit listed on the Federal Government's prescribed list for that device. If your specialist charges more than the minimum benefit listed for the device on the prescribed list you will have an out of pocket cost. We will not pay benefits towards the specialist's outpatient medical fees or for devices not included on the prescribed list If you have made a claim for a speech or sound processor under a hospital cover, we will not pay any benefits towards that device under any HBF extras product you may hold.

We will also not pay benefits:

- if it has been less than 5 years since the previous speech or sound processor was wholly or partly funded by HBF; or
- where you are eligible to receive any payment, compensation or benefit towards the repair or replacement of the device from a 3rd party, for example, if the device is within warranty or you are covered under a National Disability Insurance Scheme (NDIS) or similar.

Waiting periods may also apply if you have not held an eligible hospital cover for a minimum of 12 months. Not all hospital covers include benefits for these items and you should check your product summary to see if it's included.

If you are eligible, and would like to claim benefits, for a speech or sound processor replacement, you and your audiologist will need to complete a speech/sound processor replacement funding application available by calling us on 133 423, and submit it to HBF for approval. Benefits will only be payable if your application is approved by HBF. Any approval granted is valid for 30 days and is subject to you holding an eligible hospital product with premiums paid up to date on the replacement fitting date.

Travel and accommodation benefits

HBF's Gold Hospital Elevate includes benefits for travel and accommodation for you and your carer when traveling at least 200km (round trip) for an included hospital admission.

Benefits for travel costs only apply for travel from your usual place of residence to the hospital. This may include the cost of transportation tickets such as taxi, train, bus or plane tickets and the cost of fuel where you, or your carer, are driving your own vehicle.

Benefits for accommodation are only available for accommodation provided by a non-hospital, commercial accommodation provider. This may include hotels, motels, caravan parks and short-term rentals such as airbnb.

For benefits to be paid towards a carer's travel or accommodation, the carer must be required to either support you during your travel or be present as an integral part of the management of your condition.

HBF won't pay a benefit for:

- Costs associated with treatment received within 200km (return journey) of your usual place of residence.
- Costs associated with treatment where there is no hospital benefit payable for that treatment. This includes cosmetic treatment, outpatient treatment and treatment when you are admitted as a public patient.
- Costs covered by a State Government Scheme, worker's compensation, third party or other legal right.
- Costs associated with goods or services that are incidental to travel or accommodation, such as meals or parking.

To make a claim, please fill out the Travel and Accommodation Claim Form located at hbf.com.au/travelandaccommodation

For your claim to be processed, you will also need to submit all relevant receipts for your travel and/or accommodation costs with your form.

Your travel receipts will need to show the date of travel and details of the to and from locations. If your receipt is for fuel it must include a date within 7 days of your hospital admission or discharge. Your accommodation receipts must include the name of the provider and the relevant dates you stayed at the accommodation.

The benefits you can claim have a limit per hospital episode, check your product summary for further details.

Avoid surprise bills by understanding common hospital out-of-pocket costs. You will have an out-of-pocket if:

- You have an excess on your Hospital cover, you will need to pay it upfront when you're admitted to hospital for treatment. Your excess is paid once per person, per calendar year.
- Your policy doesn't cover a private room, but your selected hospital only has private rooms available. You will pay the difference between a shared room rate and a private room rate.
- Your treatment or service is restricted or excluded on your level of cover.

- Your treatment requires the use of robotic consumables and they are not specified as included in your cover on your product summary.
- Your specialist, anaesthetist, podiatric surgeon and surgical assistant are not fully covered.
- You need medication as part of your hospital treatment.
- You need recovery aids such as slings, crutches, compression stockings and they are not included under your Extras cover.
- A surgically implanted medical device and human tissue product that isn't on the government prescribed list.
- Depending on your level of cover, if you use sundries, such as pay TV, internet, phone calls and newspapers.
- A provider treats a family member (partner, dependant) who is on the same policy as the provider.
- You need plastic and reconstructive surgery which is medically necessary. You'll be covered up to the Medicare Benefits Schedule, even if your specialist has a HBF agreement.

A special note for our Overseas Visitors and reciprocal Medicare card holders

If you need medical or hospital care while you're here, and you're not entitled to Medicare, or have not purchased an HBF Overseas Visitor cover, you will need to pay the hospital and medical costs yourself.

The Australian Government has Reciprocal Health Care Agreements (RHCA) with certain countries which means that visitors from these countries are entitled to publicly funded medically-necessary care.

If you are from a RHCA country and do not have an appropriate level of HBF Overseas Visitors cover, you might also experience significant hospital and medical out-of-pocket expenses. See your product summary in myHBF for full details about your coverage or talk to us if you would like to take out HBF Overseas Visitor cover.

If your circumstances change or you become eligible for Medicare benefits, please get in touch as soon as possible and we'll review your cover.

Additional information

- If you are entitled to Medicare and don't hold an appropriate level of Hospital cover, you may be charged the Medicare Levy Surcharge (MLS) if your taxable income is above the base income threshold.
- Some overseas visitors entering Australia will need to take a level of private health insurance which meets the Department of Home Affairs requirements. This is known as visa condition 8501 and being enrolled with Medicare under a reciprocal health care agreement is sufficient to meet these requirements. If you are unsure if this requirement applies to you, please contact homeaffairs.gov.au

HBF Patient Pulse

We believe there is an important role for us to provide a voice to our members to share their hospitalisation experience and outcomes of their care.

After a hospital admission, eligible members in WA will receive an email inviting them to complete questionnaires about their hospital experience. Since we're also measuring recovery post hospital discharge, eligible members will receive a number of tailored surveys over a key period of recovery; the hospital treatment will shape the questions members receive and number of questionnaires.

HBF Patient Pulse is an optional survey. If you do not wish to participate, please opt out of receiving 'Ideas and Input' communications either through related correspondence or via the Member Communications Preference Centre in the MyHBF portal.

Understanding Extras cover.

The information you need to get the most out of your Extras cover.

Extras insurance covers you for everyday services like dental, physio and optical. These services are generally not covered by Medicare, so having Extras cover helps you keep your out-of-pockets down.

What you can claim

Understanding what is covered, isn't covered, or covered to a limited extent is the key to keeping your out-of-pockets to a minimum when you see your dentist, physio and other Extras service providers. Here's how your Extras cover works:

Inclusions

Inclusions are the services that are covered by your Extras insurance.

Inclusions vary depending on the level of cover you have, so be sure to check your product summary to find out which services are included on your Extras cover.

Restrictions

Extras services don't have 'restrictions' in the same way Hospital cover does. With Extras cover, a service is either covered (included) or not covered (excluded).

However, there are some situations where HBF will only pay a benefit if you meet certain criteria, such as with Dental. See the 'Dental benefits restrictions' note on the next page for more information.

Exclusions

There are some exclusions that apply to all HBF Extras cover options, no matter what level of cover you have. HBF will not pay a benefit if:

- You receive a service or treatment that is not included on your cover.
- You receive an Extras services where Medicare will pay a benefit.
- You purchase something online. However, you will still receive a benefit for pharmaceuticals, some appliances, and glasses or contact lenses from an HBF approved provider that operates in Australia, so long as you're covered for it.
- Your premium payments are not up-to-date at the time of treatment or service.
- You receive a treatment or service during your waiting period.
- Your claim is not lodged within two years of the date of service.
- You have not received your treatment or service at the time you claim.
- Your treatment or service is provided outside of Australia.
- You received treatment from a provider that is not approved by HBF.
- You received treatment from a provider who is also a family member on the same policy.
- Any good purchased on a gift card.
- You have reached your benefits limits for annual limits, lifetime limits and sub-limits.

How much you can claim

When you claim on an Extras service, like dental, the amount you get back depends on two things: your benefits and your annual limits.

Your benefit is the amount you get back at the time you claim. Your limit is the maximum amount you can claim within a certain period of time—most limits are based on a yearly calendar, known as 'annual limits'.

The amount you can claim back depends on the level of cover you select. Most Extras policies won't fully cover your services, which means you'll usually pay a portion of them yourself. To find out exactly how much you'll get back for an upcoming treatment, please contact us.

Understanding benefits

The amount you get back at the time you claim is called your 'benefit'.

With Extras services, like dental, you can find your benefits in your product summary. Your benefit depends on the level of cover you have—generally, the higher your level of cover, the greater your benefit.

Additional information on benefits

Dental benefit restrictions

There may be restrictions on what we'll cover if your dental service is performed with other specific dental services, or if a service is received more than once within a specified amount of time.

We'll also only pay for medically necessary bleaching and procedures undertaken in the surgery.

Call us for a benefit quote before you receive any dental work and we'll help you understand what we'll cover and any potential out-of-pocket costs.

Orthodontics

Two types of limits apply to orthodontic claims.

Annual limit: The maximum amount you can receive for orthodontic treatment within a calendar year.

Lifetime limit: The total amount of benefits you can receive for orthodontic treatment in your lifetime. Orthodontic benefits that you receive from all health funds count towards your Lifetime Limit.

Inclusions Commonly used services	**Waiting periods**	**Benefits**	**Annual limits**
Major Dental and Implants		All dental providers	
Crowns	12 months	70%	Length of Cover / Amount Up to 3 years $1000 3 - 4 years $1250 5 years and over $1500
Root Canal			
Dentures			
Bridges			
Implants			
Orthodontics		All dental providers	
Braces and sequential plastic aligners	12 months	100%	$800 $2400 Lifetime Limit

On your product summary, commonly used services and their benefits are listed against each service.

For some covers HBF pays a benefit per course of orthodontic treatment. A course includes the fitting, adjustment and removal of the appliance, along with any additional removable or fixed appliances. For these covers, HBF pays benefits up to your annual limit for that course on the date of diagnostics or fitting. The benefit is paid once. A lifetime limit may apply.

For other covers, HBF pays a benefit per orthodontic item. For these covers, HBF pays benefits up to your annual limit on your initial claim. If your orthodontic treatment continues across multiple calendar years and you maintain cover for Orthodontics, we may pay benefits each year up to your annual limit until your lifetime limit is reached.

Contact us to prior to treatment to understand how benefits will be paid and which limits are applicable to your cover.

Optical benefits

When buying glasses or contacts, your benefit applies to the calendar year on your invoice, not when you collect them. For example, if you order your glasses in December and receive them in January, your benefit will be calculated from last year's annual limit.

Appliance benefits

Benefits are payable for appliances that are:

- on the HBF approved list, and
- medically necessary.

We won't cover accessories or associated software for appliances, and unfortunately, we can't recognise appliances paid with a gift voucher.

To find out how much you'll get back, contact HBF.

Pharmaceuticals (non-PBS) benefits

HBF may pay benefits for medications including vaccines you purchase as an outpatient if it is included on your cover and meets HBF's eligibility criteria at the time the medication is dispensed including that:

- the medication is not listed on the General Schedule of the Government Pharmaceutical Benefits Scheme (PBS),
- the medication is lawfully prescribed to you and dispensed by an approved provider,
- the medication is listed on the Australian Register of Therapeutic Goods (ARTG) as active and approved for sale nationally,
- the medication is listed on the Therapeutic Goods Administration (TGA) Poisons Standard as a Schedule 4 or Schedule 8 drug,
- the cost of the medication is greater than the co-payment amount, and
- at least one active ingredient in the medication is listed on the HBF Pharmaceutical Schedule.

If the medication is listed on the ARTG with an approved use for male pattern hair loss, erectile dysfunction, contraception, weight management or weight reduction, no benefits will be payable.

A compounded medication with an active ingredient that has a pre-manufactured equivalent excluded by HBF will not be eligible for benefits. Other criteria may still apply for a benefit to be payable.

Before a benefit is payable on eligible medication, a co-payment amount reasonably determined by HBF is deducted from the cost of each script. As at 1 January 2023 the co-payment amount is $42.50. A co-payment may be deducted on prescribed vaccines depending on your level of cover. Some medications may receive a lesser benefit.

Contact HBF with your medication name, pack size and dosage amount to understand what benefits you may be entitled to.

Foot Orthoses benefits

We'll only cover your orthotics if they are custom and hand made by an approved HBF provider (podiatrist orthotist, medical practitioner, pedorthist or surgical boot maker). Some things are only eligible for a benefit if provided by a podiatrist. For more information, please contact us.

Understanding limits

There are several limits that may apply to your Extras cover and these will vary by product. Limits for commonly used services are available on each product summary. The following limits may apply so refer to your product summary for the specific limits that apply to the cover you hold.

Annual limit

The maximum amount of benefits that can be claimed on a covered service within the calendar year, and may be subject to other limits.

Per person limits

The maximum amount of benefits that can be claimed on a covered service by any one member on the policy within a calendar year, up to the policy limit.

Per policy limits

The maximum combined benefits that can be claimed on a covered service by all members on the policy within a calendar year, subject to per person limits.

Lifetime limit

The total benefit you can receive for a specified service in your lifetime. For example, Orthodontics can have a lifetime limit of $2,400. This means that if you change your cover, or transfer from another fund, any lifetime limits that have been used under your previous level of cover will be carried over and considered when determining the lifetime limit available on your policy, even if you leave and re-join HBF.

Combined limit

A combined limit is the maximum amount of benefits that can be claimed on a group of covered services. For example, Physiotherapy and Exercise Physiology can share a combined limit of $600 that can be used each calendar year across the two covered services. You may claim all or some of the limit on just Physiotherapy or Exercise Physiology, or you may use all or some of the limit on both Physiotherapy and Exercise Physiology.

Sub limit

This is the maximum benefit you can claim for a specific service or group of services within an annual limit. For example, Podiatry (which covers consultations and procedures, and Foot Orthoses) can have an annual limit of $400, and within that, Foot Orthoses has a sub limit of $250. This means that out of the $400 annual limit, we will pay a maximum of $250 per calendar year if you purchase Foot Orthoses.

Item/Service limit

The maximum number of times that the same service can be claimed on within a specific time period. For example, benefits for Flu Vaccination are limited to one vaccination per calendar year. This means that no benefit will be payable for any subsequent Flu Vaccination received after the first one in the same calendar year.

Additional information about your limits

Switching to HBF from another health fund

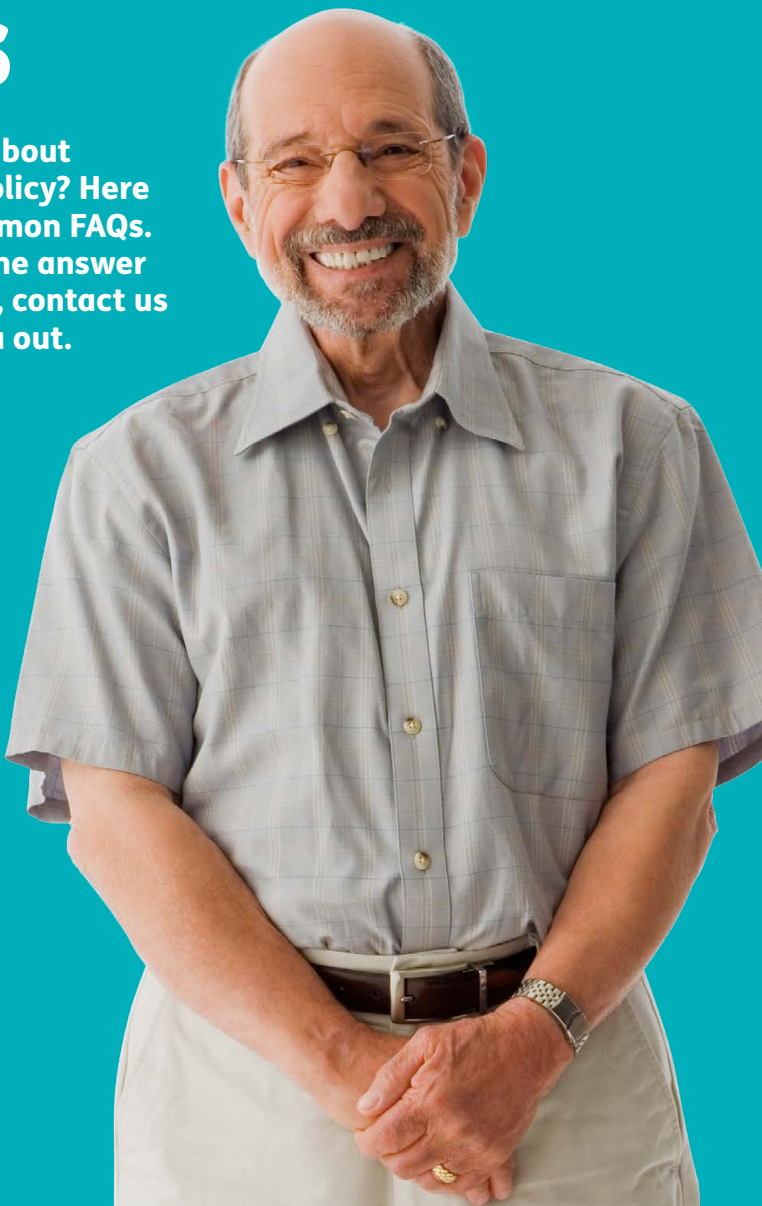
If you switch to HBF from another health fund and you've already claimed some of your benefits in the same calendar year, any claims you have made with your previous fund this calendar year will result in an adjustment of the annual limit you can claim with us for the rest of the calendar year. For example, if you have claimed $300 on Occupational Therapy with your current fund and you join an HBF cover with an annual limit of $400, you may be able to claim $100 with us this calendar year.

HBF member changing level of cover

If you are an HBF member and you want to change your level of cover and you've already claimed some of your benefits in the same calendar year, any claims you have made on your current cover this calendar year will result in an adjustment of the annual limit you can claim on your new cover for the rest of the calendar year. For example, if you have claimed $250 on Natural Therapies on your current cover and decide to move to a cover with an annual limit of $300, you may be able to claim $50 for the remainder of the calendar year.

Managing your policy: FAQs

Have a question about managing your policy? Here are our most common FAQs. If you can't find the answer you're looking for, contact us and we'll help you out.



How do I make changes to my cover?	You can log in to myHBF to update your personal details, such as updating your payment details or personal address. If you need to make a change to your level of cover, you will need to contact us. We'll be happy to discuss options and find a solution that suits you. To ensure our members can access affordable and effective health insurance, our products, benefits and terms and conditions may change from time to time. Don't worry – we'll always give you plenty of notice if we're planning a change.
How do I pay my premiums?	As an HBF member, there are a range of flexible payment methods available to you: • **Direct Debit:** Our most popular and most convenient option. Your premiums will be deducted fortnightly, monthly, quarterly, half yearly or yearly from your bank, building society, credit union or credit card account (MasterCard or Visa). It is your responsibility to ensure your direct debit details are up to date to avoid any problems down the line. • **Pay online:** You can quickly and securely pay your premiums online via myHBF. • **Telephone:** Call us on 133 423 to pay by MasterCard or Visa card over the phone. **Important information about paying your premiums** Please be aware if your premiums are more than two months late, you won't be able to claim any benefits and your policy may be cancelled.
How do I add or remove people from my policy?	Get in touch if you're planning to add a partner, dependant or baby to your policy and we'll tell you if you need to supply any extra information and if additional waiting periods apply. **Important information for new parents** Remember to add your newborn to your policy within three months of your baby's birth. This way, your baby will be covered from their birth and won't have to serve any new waiting periods, provided you have completed yours.
Who can be a dependant?	A dependant is a child on a family, extended family, parent plus or extended parent plus policy. The dependant must be under 31 years of age and not in a de facto relationship. If that dependant is 21 years of age or over, an adult member on the policy the dependant is covered on must declare if the dependant is studying full time so we can classify the dependant as a dependant student or dependant non-student.
How do I order a new card?	HBF member cards will be given to the policyholder and their partner. You can request cards for any dependants or replacement cards on myHBF.

What happens if I move interstate?

If you are planning on moving to a different state, contact us so we can review your cover as premiums vary by state. Additionally some covers are not available in all states.

If you have already moved interstate and you are yet to update your address, please contact us immediately.

Our contact information is listed on the back of this brochure.

Can I suspend my cover before travelling overseas?

If you're planning on going overseas for an extended period of time, you can put your cover on hold so you don't have pay for your health insurance while you're away, re-serve waiting periods or be affected by Lifetime Health Cover when you return.

You can suspend your cover if:

- You have the correct authority level to suspend the cover.
- You have held an eligible cover* with HBF for at least 12 months.
- Your membership is paid up until your departure date.
- You will be overseas for a minimum of two months.
- It has been at least 12 months since your last suspension.
- You have notified us of your suspension date before you leave.

Once you come back to Australia, you'll need to:

- Contact us within two months to pick up where you left off, and
- Provide proof of the dates you left and returned to Australia.

We accept boarding passes or an international movement record.

To be effectively covered, your premium payments will start on the day you arrive back in Australia, not the day you contact us.

You can suspend your cover for a minimum of two months and up to a maximum of three years.

For more information on suspensions, go to hbf.com.au/suspensions

*Excludes Overseas visitors cover and Urgent Ambulance.

How do I cancel my policy?

We want you to be happy with your policy, so you'll have 30 days from the time you join or upgrade to decide whether it's right for you. If you cancel your policy within this time, you'll receive a refund for any premiums you've paid, provided you haven't made a claim.

If you want to cancel your policy after the 30-day cooling off period, contact us and we'll be happy to help.

What does it mean to be on an HBF cover that is not available for sale?

From time to time we may remove an Extras or Hospital cover, excess level or add-on, from sale. If you held one of these covers as at the date it was removed from sale, you will remain covered under your policy. However, it's important to be aware of the following:

- We cannot open any new policies on a cover or excess level that is no longer available for sale.
- If you choose to transfer to a different cover and decide it isn't right for you after the 30-day cooling off period, we can't switch you back to your previous cover.
- This applies to all products, add-ons and excess levels that are closed for sale.
- If you cancel or transfer to another Fund, you cannot switch back to that level of cover even if it is within 30 days.

Who has authority on my policy?

Your privacy is important, and we will only disclose information to authorised parties. If you wish to update or remove parties that you have previously granted authority to, please contact us.

A principal policyholder (policy owner) has authority to view all policy information and make/request changes to the policy.

A partner also has authority to independently view a wide range of policy information and make/request a wide range of policy changes. There are certain changes that a partner does not have the authority to make/request.

Dependants have extremely limited authority to access or make/request changes on a policy they are on.

Additionally, other parties appointed by the policy owner, partner, or a legal body may have authority to act on behalf of the insured persons. There are different types of authorities that can be granted and their privileges are driven by the type of authority they hold. Some types of authorities can have an end date, while others can be revoked at any time, and other authorities will only cease when the insured person is deceased.

Contact us if you have any questions about authorities and who can access your information. Our Privacy Collection Statement details how we handle your personal information and is available on page 29.

How do I manage my communication preferences?	HBF may send you a range of communications including service, marketing, and research communications. Service communications include personalised information about your HBF cover such as claiming updates, payment notifications and changes to your policy. HBF marketing communications include tips on how to get the most value from our products and partners, along with timely content related to health and wellbeing. Research communications include opportunities to participate in surveys or interviews to improve the HBF experience. You may select the types of messages you receive, and the ways you receive them, or opt-out of receiving these messages completely by changing your communication preferences in your Member Portal at any time. You can also use the opt-out functionality in any message we send you to opt out of that type of message in the future. You may also choose to share your views on a range of issues related to HBF by opting into receiving HBF Opinion Panel communications in your Member Portal.
Where can I find a copy of the HBF Fund Rules?	To obtain the HBF Fund Rules visit hbf.com.au/fundrules or contact us.

Our Privacy Collection Statement.

We are HBF Health Limited ABN 11 126 884 786. At HBF, we exist to deliver for our members in the moments that matter. We achieve this by providing our members with products and services including private health insurance and health and wellness services. References to "HBF", "HBF Health", "we", "us" or "our" in this policy refer to HBF Health Limited and its related bodies corporate other than those entities that conduct the HBF Dental, HBF Physio and Life Ready businesses. To view the privacy policies of these businesses, please visit their respective websites.

As an Australian business, HBF is required to comply with the *Privacy Act 1988* (Cth) (**Privacy Act**) which includes the Australian Privacy Principles. We may also be subject to state and territory health records legislation when we deal with health information.

What is personal information?

"Personal information" is defined in the Privacy Act as information or an opinion about an identified individual, or an individual who is reasonably identifiable, whether the information or opinion is true or not, or is recorded in a material form or not. It includes, but is not limited to, your name, age, gender, address, contact details and sensitive information. Sensitive information includes, but is not limited to, health information, genetic information and some biometric information.

Collection and use of your personal information

HBF collects and uses your personal information to provide you with private health insurance and health and wellness related services, including to:

- verify your identity;
- assist you to ascertain if your existing cover is adequate for your current and foreseeable future needs and identify other opportunities or value you get from your membership;
- manage our ongoing relationship with you;
- process private health insurance premiums;
- pay private health insurance benefits;
- administer, process and audit private health insurance claims;
- assess your suitability for, enrol you in and administer patient surveys and health and wellness related services such as chronic disease management programs and health management programs;
- provide you with access to smartphone applications and website portals in relation to managing your health, your private health insurance membership and your relationship with us;
- conduct patient surveys, market research, marketing campaigns, targeted marketing and feedback campaigns to improve the health of members, the effectiveness of marketing activities, the member experience and the products and services HBF offers;
- contact you (via mail, email, phone or SMS) in relation to our community events, member initiatives and other products or services we think may be of interest to you, including the products or services of third parties during the period you have a relationship with HBF and after you cease purchasing any products or services from or through HBF, subject to relevant laws;

- manage, review and develop our private health insurance products and related services whether provided by us or other parties on our behalf;
- manage, review, develop and improve our business and operational processes, including training and systems, provided by us or other parties on our behalf;
- resolve any legal and/or commercial complaints or issues including compensation recovery;
- prevent, detect and follow up fraudulent or invalid claims or misrepresentations;
- ensure our records are consistent and accurate; and
- meet legislative requirements relating to private health insurers.

We may be required to collect personal information about you in order to comply with our obligations under the *Private Health Insurance Act 2007* (Cth) and other private health insurance laws and regulations.

We may collect your personal information from you, the person responsible for the management of your private health insurance membership (**Principal Policyholder**) or a person authorised to provide us this information on your behalf.

We may also collect your personal information from a third party such as a health service provider, broker or employer where doing so is necessary to provide you with private health insurance cover and pay you benefits. HBF also engages third parties to carry out functions on behalf of HBF (such as claims administration, patient surveys, membership management services, facilitators to organise and manage hospitals, doctors and health service providers, providers of claims advice and chronic disease management program providers) and they may collect your personal information from you and disclose it to HBF.

If you do not provide the personal information requested by HBF, we may be unable to provide you with private health insurance cover, pay you benefits, assess or waive lifetime health cover loading or apply an entitlement to the Australian Government rebate on private health insurance as a premium reduction.

Disclosure of your personal information

In order to carry out the activities described in this statement, HBF may disclose your personal information to persons or organisations such as:

- other companies in HBF Group;
- our brokers and agents who refer your business to us;
- our service providers (who may provide some services directly to you on our behalf) including mailhouses, market researchers and digital marketing partners, manufacturers of membership cards, claim administrators, claim auditors, claim advisers, our membership management service providers, the facilitators of our arrangements with health providers and IT support (including by way of cloud computing);
- other partners in connection with opportunities to improve your wellbeing and/or the value you get from your membership;
- our professional advisors;
- other health funds, service providers or other third parties who assist us in the detection and investigation of fraud;
- health and wellness service providers (such as hospitals, pharmacies, general practitioners, allied health providers, and chronic disease and health management program providers);
- the facilitators of our arrangements with doctors, health service providers and hospitals;
- payment system operators and financial institutions;
- service providers engaged by us or acting on our behalf to provide software or other IT services;
- persons authorised by you, including other persons covered by your private health insurance membership, and your agents and professional advisors such as legal practitioners;
- if you have a compensation claim, the insurer or statutory body responsible for paying your compensation claim or compensation recovery organisations;
- if you have an overseas visitors product, your educational institution, migration agent or broker;

- if you have a corporate private health insurance product, your employer (or their authorised representatives);
- regulatory bodies and government agencies (such as the Australian Taxation Office, Australian Government Department of Health and Aged Care, the Private Health Insurance Ombudsman and Medicare);
- potential or actual buyers of our assets or business; and
- other parties to whom we are authorised or required by law to disclose information.

If you are not the Principal Policyholder of your private health insurance membership, HBF may also disclose your Personal Information to the Principal Policyholder as part of administering the membership and paying benefits. This may include the disclosure of sensitive information about benefits claimed by you under your policy. If the Principal Policyholder has authorised their spouse/partner to administer the private health insurance membership, HBF may disclose the Principal Policyholder's Personal Information to their spouse/partner.

Disclosing your personal information overseas

HBF may disclose your personal information to overseas recipients in the circumstances set out in this document. At your request, HBF may provide a transfer certificate or claims history containing your personal information to an overseas insurer nominated by you.

Generally, HBF uses systems and customer teams located within Australia. However, HBF may also use service providers who store personal information overseas. This means personal information may be transferred as part of commercial arrangements between HBF and its service providers. Service providers located overseas may also be able to access your personal information which is stored in Australia. At the time of the publication of this statement, the countries which HBF discloses personal information to or from which personal information may be accessed includes the United States of America, the United Kingdom, Canada, India, Singapore, Germany, Ireland and the Philippines. A list of countries in which information may be located is available on our website at www.hbf.com.au/about-hbf/legal/privacy.

Marketing

HBF may use your personal information to contact you (including by phone call, SMS, direct mail, email and online advertising) in relation to other products or services we think may be of interest to you. This may include the products or services of other companies in HBF Group or the products or services of third parties. Personal information may be shared between companies in HBF Group who may use your personal information to contact you (including by phone, SMS, direct mail, email and online advertising) in relation to their products or services or the products or services of third parties.

In particular, HBF may contact you about:

- getting value from your HBF membership, including timely advice to help you get the most value from our products and partners;
- community and events, including invites to local events and updates on what's happening in your community;
- health and wellbeing, including lifestyle tips relevant to you;
- seeking your ideas and input, including to request that you share your thoughts and opinions by inviting you to complete patient surveys or taking part in research to help inform HBF product and service improvements, design development, marketing and more; and.
- service feedback, including asking you to provide feedback on your experience with HBF's customer service.

You may select the types of messages you receive, and the ways you receive them, or opt-out of receiving these messages completely by changing your communication preferences in your Member Portal at any time. You can also use the opt-out functionality in any message we send you to opt out of that type of message in the future. You may also choose to share your views on a range of issues related to HBF by opting into receiving HBF Opinion Panel communications in your Member Portal.

HBF or other companies in HBF Group may contact you about products and services we think may be of interest to you during the period you are a private health insurance member and after you cease your private health insurance membership. For example, if

you cease your private health insurance cover with us, HBF may contact you about its private health insurance offering under other brands. HBF may also use your personal information (in conjunction with social media platforms and other digital content operators) to market HBF digital content to you online.

Use of your personal information in general digital marketing campaigns (such as surveys, website analytics, online behavioural advertising) may depend upon the privacy settings selected within applications and devices you use to access websites and other online content.

You may opt-out of receiving some or all direct marketing information (including direct digital marketing) from HBF at any time by:

- calling us on 133 423
- emailing us on hello@hbf.com.au
- changing your preference at myHBF.com.au
- selecting the option to unsubscribe on a form when you apply for a product or service. Please allow five working days for your request to be actioned.

Service Related Communications

Where you provide us with an email address or use our member web portal myHBF, we send most service-related communications to you by email or by the member portal. Service-related communications are the essential things you need to know about your cover, like changes to premiums and policy details. You can manage how we communicate with you by contacting us as detailed in the previous section.

If you are the Principal Policyholder

As the Principal Policyholder, you must ensure that your spouse/partner and dependant children (if any) are aware of, and consent to, how their personal information is handled under this privacy statement and the HBF Privacy Policy which can be accessed at www.hbf.com.au/about-hbf/legal/privacy-policy (**Privacy Policy**). You and your spouse/partner and dependant children (if any) should not provide us with any personal information unless you and they consent to it being handled in accordance with this Collection Statement and the Privacy Policy.

By:

- taking out or maintaining your private health insurance policy; or
- providing your personal information to HBF, or you or your spouse/partner and/or dependant children (if any) providing their personal information to HBF, for whatever purpose.

You consent to, and warrant that your spouse/partner and/or dependant children have consented to, HBF collecting, using and disclosing your and their personal information, however collected by us, in accordance with this Collection Statement and the Privacy Policy.

Access to your information and contacting us

HBF will allow you to access and correct personal information we hold about you as required by law. If you have any queries about how HBF handles your personal information, or would like to request access to or correction of that information, please contact us:

- By mail – HBF Privacy Officer, GPO Box C101, Perth WA 6839; or
- By telephone – 133 423.

If you have any concerns or complaints about the manner in which your personal information has been collected or handled by HBF, please contact the Privacy Officer using the details above.

The HBF Privacy Policy (available at hbf.com.au/privacy) contains further information about how HBF generally handles your personal information including:

- how you can access and correct personal information we hold about you; and
- how you can submit a privacy complaint to HBF and how HBF will deal with your complaint.

How HBF handles complaints.

How your rights are protected

Our obligation to you under the Private Health Insurance Code of Conduct (the "Code").

We will endeavour to:

- work towards improving the standards of the practice and service within HBF,
- provide information to our members in plain language
- promote better informed decisions about our private health insurance products and services:
  - by ensuring that our policy documentation is full and complete;
  - by providing an effective and clear verbal or written explanation of the contents of the policy documentation;
  - by ensuring that our employees providing information on health insurance are appropriately trained
- provide information to members on their rights and obligations under their relationship with HBF, including information on the Code; and
- provide members with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner and advise them of their rights to take an issue to an external body such as the Private Health Insurance Ombudsman.

How the Code helps our members

Apart from promoting improved standards in clarity and usefulness of information given to members, the Code is designed to help solve problems between members and us. We have a complaints handling process for members who may have a dispute with HBF.

Examples of disputes include

- contents of advertising by HBF,
- representations made to the member when they purchase a product,
- features of their product, and
- benefits paid under their product

How HBF handles complaints

Here's what you should do if you have a complaint about HBF:

Tell us about your feedback. In many cases, your concerns can be quickly resolved by contacting us directly.

- Call us on 133 423
- Visit your nearest branch or kiosk
- Email us at memberexperience@hbf.com.au
- Write to us at HBF Head of Member Advocacy & Relations GPO Box C101, Perth WA, 6839

If we haven't been able to resolve your feedback in the first instance, you can request for your complaint to be escalated and we will be pleased to appoint a Case Specialist to review your complaint.

If you're not satisfied with the outcome you can request to have it reviewed by the Internal Dispute Resolution Panel. This is the final step of the internal review process and can take up to 15 business days for HBF to provide an outcome.

If a resolution is still not reached to your satisfaction you can

- Contact the Private Health Insurance Ombudsman,
  - Visit: ombudsman.gov.au
  - Mail: GPO Box 442, Canberra ACT 2601
  - Phone: 1300 362 072
- Forward the problem to a health care complaints commission or fair trading body in your state of residence, or
- Report HBF's behaviour to the Australian Competition and Consumer Commission.

For information about private health insurance, please visit privatehealth.gov.au

Private Health Insurance Code of Conduct

How can I get a copy of the Code?

A full copy of the Code is available at privatehealthcareaustralia.org.au/codeofconduct or by calling us.

We're here to help you understand and make the most of your cover.

Visit a branch (WA only)
For branch opening hours, please visit hbf.com.au/find-a-branch

Go to hbf.com.au

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

Postal address
GPO Box C101 Perth 6839

Stay in touch
Find us at HBF Health

HI-1297 HBF17652 05/02/2026