Overseas Important Information Guide

Understanding private health insurance can be complex at the best of times, let alone in a new country. That's why we designed this handy guide to help make things a little easier whilst you're in Australia for work or a visit. We strongly recommend that you read this guide in conjunction with your *HBF product sheet*. If you require further information about your cover, please call us on 133 423 or drop in to your nearest branch.

About the Australian health care system

The Australian health care system is made up of two components – the public health system which is administered by the government and is called Medicare, and the private health system.

Medicare provides eligible Australian citizens and residents with free or subsidised treatment for:

- Treatment in a public hospital that is medically necessary
- Visiting a General Practitioner (GP) or specialist
- Medical tests and examinations
- Medicines covered by the Pharmaceutical Benefits Scheme (PBS)

However, there are a number of things that Medicare does not cover:

- Treatment in a public hospital that is not medically necessary
- Treatment in a private hospital
- Ambulance services
- Extra services such as dental, optical and physio

For more information, visit *Medicare*.

Can I access Medicare?

The Australian Government has agreements with certain countries, called Reciprocal Health Care Agreements (RHCA). Residents from these countries may be entitled to subsidised health services for emergency medical treatment while visiting Australia.

If you're from a non-RHCA country you will not have access to any Medicare benefits. Should you require medical attention in Australia, whether in an emergency or a non-emergency situation, you will be charged for all hospital, ambulance and doctor fees and have significant costs to pay. That's why as a visitor to Australia, it's worth having private health insurance so you can keep your health a top priority and have greater peace of mind.

Medicare Levy Surcharge and Visa requirements

The Medicare Levy Surcharge (MLS) is a tax designed to reduce the demand on the public health care system, Medicare. If you are entitled to Medicare and don't hold an appropriate level of private health insurance hospital cover, you may be charged the MLS if your taxable income is above the base income threshold.

Note: The MLS is not covered on Overseas products. Please check with the Australian Taxation Office or for more information, please refer to *Medicare Levy Surcharge*.

Immigration requirements

Some overseas visitors entering Australia will need to take a level of private health insurance which meets the Department of Immigration and Boarder Protection (DIBP) requirements. This is known as visa condition code 8501.

Note: Being enrolled with Medicare under a reciprocal health care agreement is sufficient to meet the health insurance requirements for visa condition code 8501.

If you are unsure if this requirement applies to you, please contact DIBP directly on 131 881 or refer to the *DIBP* website.

If your circumstances change or you become eligible for Medicare benefits, please notify us immediately and we'll review your level of cover.

General information about your HBF cover

It's important to know how your cover works and how to maintain it.

Policy categories

We have a range of policy categories to suit your needs:

- **Singles policy** – covers the primary policy owner.
- **Couples policy** – covers the primary policy owner and partner.
- **Family policy** – covers the primary policy owner, partner and all dependants up to the age of 25, provided they meet the criteria below.
- **Parentplus** – covers the primary policy owner and all dependants up to the age of 25, provided they meet the criteria below.

Dependants

On most Family or Parentplus policies your children will be covered until the end of the year they turn 18, unless they're married or in a de facto relationship. At HBF we also choose to continue to cover your children up to the age of 25, provided they're studying full time and aren't married, in a de facto relationship or earning more than $21,250 per calendar year.

Adding or removing people from your policy

Do you have a new partner in your life? Or is there a new baby on the way? Let us know if there's been a change and we'll amend your cover to best suit your needs.

To add a dependant you'll need to upgrade from a Singles or Couples policy to Family or Parentplus policy. If you do this **within 2 months** of your baby's birth, the child will be fully covered from their date of birth and won't have to serve any waiting periods. Please contact us if a child has been included in your family unit (for example through marriage or adoption).

Have your details changed?

To enable us to pay your benefits and provide a high level of service, it's essential we have your current contact details on record. To update your postal address, email address or payment details, please use our convenient self-service portal, myHBF, or give us a call.

Moving interstate?

HBF provides comprehensive cover across Australia. Premiums and some benefits (like Ambulance cover) vary from state to state, so we recommend you contact us to change your address and to see if your level of cover best suits your needs.

Will I be covered outside of Australia?

No. Australian health funds are not legally permitted to pay benefits for treatment or services provided outside of Australia, including general treatment such as dental and glasses, and any hospital or medical treatment.

Suspension of membership

If you're on overseas visitors cover you can have one period of suspension every three years, for any period from two to six months. So, if you want to return overseas for a short period of time, you can keep your current policy.

Once you return to Australia, you'll need to contact us within 2 months to resume your cover from the date of arrival. Hold onto your boarding passes and airlines tickets as you'll need to provide us with proof of your return date. For more information please read our ***brochure***.

Cancellation of policy/cooling off period

Changed your mind? No problem. We want you to be sure that you've chosen the policy that best suits your needs, so you have a 30-day cooling-off period from the start date of your new policy.

If you're an existing HBF member you have a 2 month cooling off period. This means you can return to your previous level of cover, and provided you haven't made a claim, you'll receive a full refund for any premiums you've paid.

Nominate an authorised person

If you would like a partner, friend or relative to manage your policy on your behalf, you can add them as an authorised person and select their level of authority. Based on their authority, an authorised person can make policy changes, submit claims or cancel the policy. If your circumstances change and you wish to amend or remove an authorised person, please call us on 133 423.

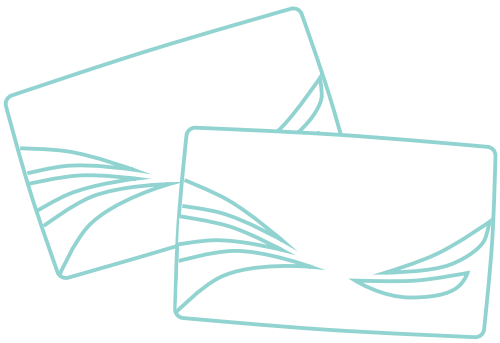
Additional member cards

HBF cards will be given to both you and your partner (for Couples and Family policies). You can request additional cards for any dependants listed on your policy. Likewise, if you lose your HBF card, you can order a free replacement via myHBF or by calling us on 133 423.

Payment methods

HBF offers a range of flexible payment methods including:

- **Direct Debit –** our most popular, convenient solution. Your premiums are 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, as failure to do so may deem your policy unfinancial.
- **Prepay online –** You can quickly and securely pay your premiums online via ***myHBF*** or our ***online payment tool.***
- **Telephone –** Call us on 133 423.



General information about your hospital cover

What's covered?

Please refer to your *product sheet* for what is covered on your policy.

What's not covered?

In general, there are a few circumstances where HBF won't pay a benefit, such as:

- If your membership is unfinancial at the time of treatment or service.
- Claims covered by Workers' Compensation, third-party or other legal right.
- Treatments or services provided outside of Australia.
- Care and accommodation in nursing homes.
- Treatments before your waiting periods are served.
- If a claim is not lodged within two years of the date of service.
- Hospital treatments that don't have a Medicare item number aren't eligible for a Medicare benefit, such as cosmetic surgery.
- Procedure room fee.
- Excluded treatments. For details, refer to your *product sheet*.

All about medical fees

Depending on your level of cover, HBF will pay benefits towards medical services that are listed under the Medicare Benefits Schedule (MBS) and are provided in or out of hospital. The two components are:

Inpatient medical fees

- These are fees charged by your doctor, surgeon, anaesthetist or specialist for any treatment given to you when you are admitted to hospital as an inpatient for the day or overnight. Treatment received in an emergency ward of a hospital without a formal admission does not qualify as an inpatient.

Outpatient medical fees

- These are fees for any treatment you receive out-of-hospital (i.e. not admitted) and include medical specialist's consultations or treatment provided at the hospital premises or clinic.

Be aware of the medical gap

Inpatient

The MBS fee is the amount set by the Australian Government for each medical service covered by Medicare. Some specialists (doctors, surgeons, anaesthetists) can choose to charge more than the MBS fee. To help manage this gap, it's important to understand which category your specialist falls into:

- Fully-covered: You can keep your out-of-pocket costs low by selecting a fully-covered specialist.
- Known-gap: These specialists have agreed to charge a fixed amount above the MBS fee. HBF pays some of this 'known gap' but you'll need to pay the remaining balance yourself.
- No agreement with HBF: These specialists have opted not to participate in any gap agreement and you'll pay all the costs charged above the MBS fee.

Outpatient

You will be entitled to different MBS benefits based on your level of cover. For more details, please refer to your HBF Product Sheet.

Choice of Hospitals

Public Hospital

If you are admitted to a public hospital, you are covered as set out below for any treatment recognised by Medicare unless it is excluded or restricted under your cover. But remember, you won't always avoid public hospital waiting lists, get a private room, or have continuity of care with the same doctor.

HBF Member Plus hospitals

To help you get the best value, HBF has special arrangements with a large network of private hospitals across Australia, known as Member Plus hospitals. By going to a Member Plus hospital, you'll be covered for accommodation and theatre fees for all agreed services on your policy, plus have peace of mind knowing that potential out-of-pocket costs will be minimised or eliminated. Search for a Member Plus hospital or contact us for details.

Common out-of-pocket expenses

While every hospital works a little differently, remember there'll always be some expenses you'll incur. To ensure there are no surprises, be aware that you may have to pay for the following:

- If applicable, an excess for your hospital stay.
- A private room - if you're not covered for private accommodation but your selected hospital only has private rooms available, you may need to pay the additional cost.
- Pharmaceuticals.
- Pathology and radiology tests.
- Aids for recovery, such as slings, crutches or compression stockings.
- Personal expenses such as pay TV, internet, phone calls and newspapers.
- Some surgically implanted prostheses, which aren't government approved or cost more than your health insurance benefit.
- Medical fees for surgical assistants or anaesthetists that aren't fully covered by HBF or eligible for a rebate from Medicare.
- There are restrictions for medically necessary plastics and reconstruction procedures.
- Robotic consumables.
- Services and recovery aids after you're discharged from hospital. Your out-of-pockets depend on the product you are on, please refer to your Product Sheet for more information. We recommend that you call us before going to hospital, so you can be confident your level of cover and choice of hospital gives you full cover.
- Non-urgent ambulance transport.

To keep your out-of-pocket costs low, select a **fully-covered** specialist. Find hundreds of HBF fully-covered specialists *here*.

Waiting periods

Waiting periods protect our members by preventing new members from making large claims shortly after joining or upgrading their cover and then dropping their membership, which would result in increased premiums for all members. Waiting periods will apply if you're new to private health insurance or if you've upgraded to a higher level of cover. If you have transferred from another Australian registered health fund, we may honour the waiting periods that you've served so you won't need to re-serve them.

Hospital waiting periods

- Psychiatric, rehabilitation and palliative care - 2 months.
- Maternity and assisted reproductive services – 12 months.
- Pre-existing conditions – 12 months.
- All other treatments or services – no waiting period.

Pre-existing ailments or conditions

A 12-month waiting period applies for pre-existing conditions. 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 in existence during the 6 months preceding and including the day you joined HBF, or upgraded your level of cover. This rule applies to all private health insurers. 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.

Other useful hospital cover information

Exclusions

An exclusion means you won't receive any benefits towards your hospital or medical costs. If you're worried you might need to have a procedure that's listed as excluded, you should think about changing your level of HBF cover. Waiting periods and pre-existing conditions will apply.

Hospital boarders

If you need someone to stay with you while you're in hospital, we'll fully cover the cost for a hospital boarder whose presence is necessary for the management of your condition.

Inclusions

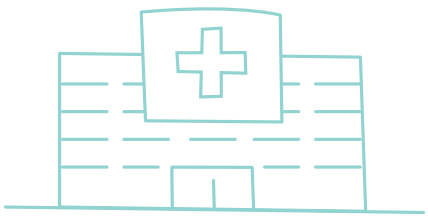
Inclusions are the types of procedures and services you'll be covered for in a public or private hospital. The higher your level of cover, the more procedures and services you'll have in your inclusions.

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. If this happens, due to private health insurance legislation, we can only pay a small portion of the fee incurred per day and you'll be required to contribute towards the cost of your care. If you're in a private hospital these costs may be substantial.

Restrictions

Some policies include restricted services and procedures. Check your product sheet to see what restrictions may apply to your policy. For restricted procedures, HBF will pay the Minimum Benefit which is equivalent to the amount a public hospital would charge a private patient for a shared room. If you have treatment in a private hospital you'll have to pay the difference which could be a significant out-of-pocket cost.



Useful tips to help you save

Informed financial consent

Remember, you're legally entitled to know what useful tips to help you save your costs might be before going into hospital, except in a life threatening situation. If your hospital stay involves any out-of-pocket hospital charges, the hospital (whether public or private) and your specialist must disclose the cost and obtain your agreement in writing before your admission. This could include fees from anaesthetists, assistant surgeons, pathologists or radiologists.

Lower your premium by adding an excess

To help you pay a lower premium, we offer a range of Hospital excess options. This means that you only pay the excess if you're admitted to a private hospital. The excess is only paid once per member per calendar year (to a maximum of twice per Family policy), no matter how many times you may have been hospitalised. If you're moving from a level of cover with an excess to one without an excess, you'll still need to pay the excess if you're admitted to hospital during the waiting period.

There may be an excess for dependants or for day procedures.

Request a health benefit quote from HBF

hello

We strongly suggest you call us before receiving any significant treatment or going to hospital. We'll check all details including any waiting periods, restrictions, minimum benefits and if any excess co-payments or out-of-pocket payments apply. To ensure we give you accurate advice, please call us with your written cost estimate from your provider. Benefit quotes are valid for three months and are subject to change if treatment is not received, or changes to a treatment are made in that time. You can also request a benefit quote online in *myHBF*.

General information about your extras cover

Extras cover provides benefits for a wide range of day-to-day health treatments such as dental, physio, chiro and optical.

Benefit

The amount you'll get back when you claim for a recognised service.

Annual Maximum

This is the maximum amount of benefits you can claim in a calendar year. Each person on your policy will have their own annual maximum. Contact us to check your annual maximum status.

If you're switching from another fund, and you've already used some of your benefits, we'll adjust the balance of your annual limits to reflect this. If you're unsure of your remaining annual maximum, please contact us before you use your cover.

Rewarding member loyalty

To reward our long-standing HBF members, some annual maximums are based on the length of your membership, which means you may see an increase after your first year. For more information, please view your product sheet.

Waiting periods

Waiting periods protect our members, by preventing new members from making large claims shortly after joining or upgrading their cover and then dropping their membership, which would result in increased premiums for all members. Waiting periods will apply if you're new to private health insurance or if you've upgraded to a higher level of cover. If you've transferred from another fund, we'll honour the waiting periods that you've served so you won't need to reserve them.

Extras waiting periods:

- Major dental – 12 months.
- Hearing aids and appliances – 12 months to 36 months, depending on cover.
- Ambulance services – 7 days.
- Foot orthoses – 12 months.
- All other Extras services – 2 months.

Are there any exclusions on benefits?

- If your membership is unfinancial at the time of treatment or service.
- For treatment or services provided outside of Australia.
- Before a treatment or service has been received.
- If a claim is not lodged within two years of the date of service.
- On internet purchases, unless for pharmaceuticals, some appliances, glasses or contact lenses from an HBF approved provider that operates in Australia.
- For Extras services where Medicare would pay a benefit.

Other useful extras cover information

Ambulance Cover

We'll provide cover for urgent ambulance treatment or transport by road when provided by the state or territory government ambulance organisation.

NSW & ACT members who have a hospital product as part of their policy are covered for ambulance transports under their state/territories levy scheme. If you receive an account for ambulance transport, simply send it to us and we'll endorse and arrange for processing of the payment through the relevant ambulance provider.

HBF won't pay a benefit under the following circumstances:

- If the transport originates from a hospital.
- For attendance to booked medical appointments.
- Air ambulance services.
- Where the benefit or cost is subsidised by a state scheme.

Differences across Australia: VIC, SA, WA and NT members will receive cover for recognised emergency ambulance transport.

HBF Member Plus dentists

In WA, we have agreements with dental providers aimed to keep your out-of-pocket expenses as low as possible – we call them HBF Member Plus. Depending on your level of cover, you'll receive 60% – 90% back (up to your annual maximum) and a fully-covered scale and clean each calendar year. Of course, you can visit any HBF approved dentist you choose and still receive benefits. If you visit a non-Member Plus provider, you'll receive the dollar amount in line with the HBF dental schedule. Please call us for a quote before receiving treatment.

HBF Member Plus optical

We have agreements with optical providers across Australia aimed to keep your out-of-pocket expenses as low as possible – we call them HBF Member Plus. A selection of frames are available at a guaranteed no gap. Of course, you can visit any HBF approved optical you choose and still receive benefits. If you visit a non-Member Plus provider, you'll receive the dollar amount in line with your product sheet.

Orthodontic benefits for banding

A benefit is not paid for orthodontic treatment commenced during the waiting period. The benefit for banding is for the full course of treatment and includes all associated treatment (such as removable appliances) following the fitting of the appliances.

Dental benefit restrictions

The benefit we pay on some dental items may be restricted if performed in conjunction with other specific dental services, or if a service is received more than once in a specified period of time.

Also, benefits are only paid for medically necessary bleaching and procedures undertaken in the surgery; we don't pay a benefit for home bleaching.

Optical benefits

Please note that when purchasing glasses or contacts, your HBF benefit applies to the calendar year when you order them, not when you collect them. For example, if you order your glasses in December 2015 but don't receive them until January 2016, your benefit will be calculated from your 2015 annual maximum, so you'll be able to claim for glasses again in 2016.

Pharmacy benefits

The government subsidises the cost of some pharmaceuticals under the *Pharmaceutical Benefits Scheme* (PBS). You can claim benefits for prescriptions and repeats for non-PBS medications listed on the HBF Pharmacy Schedule, which means you may only need to pay a co-payment.

GapSaver- put a little away and pay less on the day

To assist with eligible out-of-pocket expenses, HBF offer a service called GapSaver that lets you put aside a little extra money to cover these gaps. GapSaver benefits accure quarterly and you can use the benefits you've accrued for as long as you have HBF health cover (they don't expire each year). If you're eligible for the Australian Government Rebate, you can accrue more GapSaver benefits than you'll pay in premiums. This makes GapSaver a great way to reduce your healthcare costs for your extras services.

Note: GapSaver can only be used while you're an HBF health member. It is important to note that the benefit is not refundable.

GapSaver can help cover:

- Out-of-pocket expenses for Extras services such as dental, physio and remedial massage.

GapSaver can't be used for:

- Any procedures or services not covered on your extras policy.
- Any out-of-pocket expenses incurred after your maximum entitlements have been reached.
- Services for which you haven't completed the standard waiting periods.
- Hospital services or treatments.

Easy ways to claim

Managing your cover is simple

We've made it easy to manage your health cover and claim online. In our secure online portal, myHBF, you can:

- Make a health claim and view your history.
- Get a benefit quote.
- Update your personal and payment details.
- Access important documents such as your cover details and tax statement.
- View exclusive member discounts such as discounted movie tickets.

To access myHBF, simply jump online and go to ***hbf.com.au/myHBF***

Electronic claiming

Most hospitals and medical practitioners bill HBF directly. But if you need to make a hospital claim, just contact us and we'll be able to help. You can claim on the spot for many Extras treatments, such as optical and dental. Simply present your HBF member card after your appointment, before paying for your treatment. Your benefit will be automatically processed and deducted from the provider's total bill and you just pay the difference. If you forget your card on the day of your appointment, you can present your card to the provider within 7 days of the service.

Claim online

Claiming online is simple. Just login to ***myHBF*** then click on 'Submit health claim' and upload your original account or receipt as a photo. If you've claimed from Medicare for in-hospital medical services, please also include the Medicare Statement of Benefit.

Manual claim form

Download a claim form online at hbf.com.au

Complete it and post to: HBF, GPO Box 1440, Perth WA 6839

Direct credit payment

Don't forget to enter/confirm your bank account details, so we can credit your benefits directly to your nominated account. If we don't have your bank details, we'll issue a cheque. To setup or confirm your bank account details, go to ***myHBF***.

Time limits

We only pay for claims made within 2 years of the date you had the service, so don't delay.

Privacy Policy

At HBF, we respect the privacy of your personal information. For more information on how we collect, hold, use and disclose your personal information, please refer to our ***privacy policy***. We also believe you should have access to your rights and obligations. For information on how we operate, please refer to our private health insurance ***Code of Conduct***.

Apart from promoting improved standards in clarity and usefulness of information given to members, the Code of Conduct is designed to help solve problems between members and us. Here's what you should do if you have a complaint about HBF.

- Call us on 133 423 or address your complaints to: HBF Dispute Resolution Manager, GPO Box C101, Perth WA 6839 or memberexperience@hbf.com.au
- If a resolution is still not reached to your satisfaction you can contact: Private Health Insurance Ombudsman, GPO Box 442, Canberra ACT 2601

We're here to help

Call us on 133 423

Drop in to a local branch

Log in to myHBF at hbf.com.au/myHBF

Email hello@hbf.com.au

Webchat at hbf.com.au

We speak your language

If English is not your first language, our multilingual team is fluent in many languages including Mandarin, Cantonese and Hindi. Call us on 1300 735 137.

HBF Health Limited **ABN** 11 126 884 786

The information in this guide is correct at 1 July 2016.

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