Product Disclosure Statement (PDS)

This Product Disclosure Statement (PDS) is and extract from the Health Partners Member Guide and is designed to help you understand what you will be covered for when you take out private health cover with Health Partners. It should be read in conjunction with Health Partners individual cover details. We recommend that you always make enquires with Health Partners before going to hospital or undergoing a new course of treatment. This PDS is effective 1 August 2018.

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Health Partners is a signatory to the
Private Health Insurance Code of Conduct.
Go to ahia.org.au/codeofconduct.

In addition to outlining the various different levels of private health insurance and benefits available through Health Partners, this Member Guide contains important information about the general terms of membership and cover with Health Partners, including who can be covered on a membership, items that have benefit conditions associated with them, our Privacy Policy, Resolution Process and health insurance initiatives from the Australian Government (this information is also available in our Product Disclosure Statement *extract* online). It is the policyholder's responsibility to understand what is and what is not covered by their health insurance policy, therefore this information should be read and retained in conjunction with individual cover details. A glossary of terms that might assist can be found on the Health Partners website, along with our Fund Rules. This information is correct at time of printing; however, we reserve the right to make changes to prices, cover/benefit specifications and other conditions relating to Health Partners products, programs and services at any time, with appropriate notice provided to members where required. Please contact us on 1300 113 113 or visit healthpartners.com.au prior to purchasing any health insurance products to make sure you have the latest information available.

Membership Information

Here you'll find information on the types of memberships available, how you can pay for your membership, waiting periods, claiming, as well as how to join and the great discounts you can receive once you're a member.

Applying for cover

Membership with Health Partners is open to all Australian residents. Any person wishing to claim hospital benefits with Health Partners must be eligible for full Medicare benefits.

Please note Health Partners does not offer private health cover to overseas visitors or students.

Applications can be made

Over the phone

1300 113 113

Our friendly and experienced team can help you find the right cover and complete your application over the phone.

Online

Get a quote and join at healthpartners.com.au.

Via a Membership Application form

A hard copy of the form is available at Health Partners centres, can be downloaded from the Health Partners' website, or posted upon request.

Membership categories

Health Partners health cover is designed to allow you to change between membership types to suit your life stage.

For example, if you have a single or couple membership and wish to add a child to your cover, you simply need to transfer to a family or sole parent family membership. To avoid waiting periods you must add the child to your cover within 60 days of the child's date of birth, with premiums paid from the child's date of birth (or from the date of obtaining legal guardianship in the case of adoption or fostering).

When applying for cover, you may select from the following types of memberships:

Single:

Yourself only.

Couple:

You and your spouse/partner (married or de facto).

Family:

A couple, plus all registered child dependants up to the age of 21 and registered student dependants up to their 25th birthday, who do not have a spouse/de facto or family of their own, but do not need to be living at home.

Family Focus:

A family, plus all registered child dependants from their 21st to their 25th birthday who are not studying full-time and do not have a spouse/de facto or family of their own, but do not need to be living at home.

Single/sole parent family:

You, plus all registered child dependants up to the age of 21 and registered student dependants up to their 25th birthday, who do not have a spouse/de facto or family of their own, but do not need to be living at home.

Single/sole parent Family Focus:

Sole parent family, plus all registered child dependants from their 21st to their 25th birthday who are not studying full-time and who do not have a spouse/de facto or family of their own, but do not need to be living at home.

Please note not all membership categories are available for all covers.

Who can be covered?

On applicable covers, Health Partners membership provides cover to the following:

Policyholder:

The person applying for cover, who will be responsible for ensuring premium payments are made and has full authority over the membership. Policyholders must be 18 years or older. Most correspondence will be addressed to this person.

The policyholder agrees to our Privacy Policy and to abide by our Fund Rules and policies on behalf of the whole membership, and agrees to let us know as soon as possible if any circumstances of anyone on the membership change or if any of the details we hold change or are incorrect.

Spouse/partner:

This is the married spouse or de facto partner of the policyholder, who can also make some enquiries and changes to the membership (refer to the *Delegation of Authority* section for more information).

Child and young adult dependants:

Includes all dependent children up to their 21st birthday (Family category) or young adult dependants up to their 25th birthday (Family Focus category), who do not have a spouse/de facto or family of their own and are not studying.

Student dependants:

Includes all dependent children from their 21st to their 25th birthday who are studying full-time, are registered with Health Partners as 'student dependants', and do not have a spouse/de facto or family of their own. Policyholders are required to register full-time student dependant status on them turning 21 and then annually; Health Partners will contact the policyholder when registrations are due.

Transferring from another health fund

Transferring couldn't be easier. Just include your membership details including member number when you apply and we will take care of the rest for you. And, if you switch to an equivalent level of cover you will not have to re-serve your waiting periods.

Commencement of cover

Your cover will commence automatically on the date that you apply, unless you have requested your membership to commence at a later date. Benefits are accessible once your first payment is received and any applicable waiting periods have been served.

Cover Details Statement

This statement is a summary of your membership and issued when you join Health Partners or change your level of cover.

It includes details such as your member number, cover choice, contact details, persons covered on your membership, Lifetime Health Cover loading (if applicable), premium amount and payment method (including banking details if provided).

Please read it carefully and if any of the details are incorrect, please contact Health Partners immediately on 1300 113 113.

Payment options

When joining, please select from the following payment options:

Direct debit

This option entitles you to a 3% discount on your premiums. Your premiums may be deducted from a nominated bank account or credit card.

Account notice

Account notices will be posted to you and you can pay using any of these methods:

- BPAY, Australia Post Billpay, Visa, Mastercard, American Express and EFTPOS.
- Online via Members Online.
- 24 hour Australia Post BillPay phone service 131 816 (Visa and Mastercard only).

Payments via the above methods may take up to 48 business hours to be loaded on to your membership.

- Calling Member Care on 1300 113 113.
- In person at any Health Partners centre.

Payroll

This option is only available for payroll groups registered with Health Partners. Please enquire with your employer or call us for details.

Payment frequency

The following options are available:

- Fortnightly*
- Monthly#
- Quarterly
- Half-yearly
- Yearly

**Fortnightly payments are only available for payroll or direct debit deductions from a bank account on Fridays.*

#Monthly payments can only be paid via direct debit deductions (from a bank account or credit card). You can choose from the 1st, 8th, 15th or 22nd of the month.

Membership Information
continued

Direct Debit Request Service Agreement

The following is a summary of our Direct Debit Request Service Agreement, outlining the responsibilities of both Health Partners and you, the member, to ensure the smooth and secure operation of our direct debit agreement. For a copy of the full agreement, please contact us on 1300 113 113. The full agreement is also on the back of the Direct Debit Request form available at healthpartners.com.au or upon request.

Health Partners responsibilities

We will only deduct premiums from your chosen account. Your Cover Details Statement shows the amount and how often we have agreed to deduct it. We assure you that we will not disclose your bank details to anyone else, unless you have agreed in writing that we can, or unless the law requires or allows us to do this. If the scheduled payment date is a weekend or a public holiday, we may debit your account on the next business day. Where you consider the debit is incorrect in either the amount or frequency, or both, you should contact Health Partners on 1300 113 113. If the name of the bank account/credit card account you nominated for premium payments differs to the name of the policyholder, Health Partners are obligated to obtain authorisation from the account holder to use their account prior to any funds being debited. This account holder can also cancel these payments at any time by contacting Health Partners. We will then contact the policyholder to arrange an alternative payment method to ensure continuity of their membership.

Your responsibilities

Before sending us your account details, please check with your bank or financial institution that direct debit deductions are allowed on the account you have chosen. Please make sure that you have enough money in your account to cover the payment of your premiums when due. Your bank or financial institution may charge a fee if the payment cannot be met. You are required to pay any arrears that arise on the membership due to a direct debit payment not being deducted.

Changing your payment details

You may cancel or change your direct debit deductions at any time. Such requests must be received by us at least fourteen (14) days prior to the nominated debit date. If you request more than three (3) changes in a twelve (12) month period, we reserve the right to amend your payment method. This may include removing the direct debit option which revokes the 3% discount provided specifically for direct debit payments, therefore affecting your premiums.

Paying your premiums

To ensure you maintain continuous cover and access to benefits, premium payments must be up-to-date. If premiums are overdue and no prior arrangement is made with us, your membership may lapse (become 'unfinancial'). Please note that electronic claiming (e.g. HICAPS) will not be available and benefits will not be payable whilst your membership is unfinancial. Waiting periods will also need to be re-served if your membership lapses.

To discuss payment options call us on 1300 113 113.

Review period

We offer a 30 day review period (also known as 'cooling-off period') which applies to all Health Partners health covers.

If you are a new member and not satisfied with your cover, you will receive a full refund of premiums paid if you cancel your membership within 30 days of application and no claims have been made.

If you are an existing member who has changed your level of cover, you may revert back to your previous level of cover without affecting your waiting periods and the difference in premiums will be credited to your account (if applicable).

If a claim has been made during the 30 day review period, the membership can only be cancelled (or changed) from the day after the date of service of the most recent claim, and refunds are also calculated from that date.

Moving interstate?

Premiums and some benefits may vary slightly from state to state. If you are moving interstate, you need to advise us of your new address within 14 days so that we can adjust your premiums.

Members Online

Members Online is accessible to the policyholder via the member login page at healthpartners.com.au. Once registered, you can securely log in and access, view and update various membership details. Correspondence is also accessed from Members Online (unless you have advised us otherwise).

By providing an email address when applying for cover, you will automatically be registered for the service and you will receive a confirmation email from Health Partners, including a user name and temporary password.

Terms and conditions of the service are available on the Members Online homepage at healthpartners.com.au.

Existing members not already registered for this service can easily do so via the Members Online homepage at any time.

Your membership card

A membership card will be automatically issued to the policyholder and spouse/partner of a new membership, once financial. Additional cards for child dependants may be requested. Replacement cards can be requested via Members Online or by calling 1300 113 113.

Important information:

- The card is not transferable.
- The card gives you access to electronic benefit payment systems, such as HICAPS or HealthPoint (providing your membership is financial).
- At many extras providers utilising electronic claiming, all you need to do is swipe your card on the day of treatment for on-the-spot benefits*. If you forget your card you will be required to pay for your treatment in full, obtain an itemised receipt/account from the provider and then submit your claim to Health Partners for payment of benefits.
- The card must be presented at Health Partners Participating Pharmacies at the time of purchase to claim pharmacy benefits and the 20% participating pharmacy discount (refer to *Member Discounts* section regarding the latter).

  If you forget your card, you will be required to pay for your prescription items in full, obtain an itemised receipt/account from the participating pharmacy and then submit your claim to Health Partners for payment of benefits. The 20% discount will also not be available to you.
- Health Partners Participating Pharmacies have the authority to confiscate cards and return them to Health Partners if they suspect misuse by a customer who is not on the membership.
- The card must not be left with any health care provider or other third parties.
- The card remains the property of Health Partners.
- Members must notify Health Partners if the card is lost or stolen.
- Members must return or destroy their membership card if their membership is cancelled.

** Please note not all claims are payable via electronic claiming (e.g. orthodontic claims).*

Waiting periods explained

Waiting periods are the initial periods after joining or upgrading your private health cover during which you cannot claim on certain goods, treatments and services. The length of a waiting period depends on the type of service you wish to claim and whether or not you have already served waiting periods on previous cover.

Waiting periods may not apply for accidental injury if treatment is required immediately after the accident and is not related to a pre-existing condition. Membership must have been processed and be financial, and treatment required is not listed as an exclusion.

An accident form must be completed and approved by Health Partners.

Waiting periods when you join without current Australian cover

If you are taking out Australian* private health insurance cover for the first time or you have been without Australian cover for 30 days or more, you must serve waiting periods for all services on your selected level of cover.

If you have an eligible cover, after two months you can claim benefits for all extras services available on your level of cover, except for the following, where the respective waiting periods apply:

Major dental	12 months
Endodontics	12 months
Periodontics	12 months
Orthodontics	12 months
CPAP apparatus *(loyalty benefits also apply)*	12 months
Other aids and appliances	12 months
Laser eye surgery	36 months

Not all benefits are available on all covers.

After two months you can claim benefits for all hospital services available on your level of cover, except for the following, where the respective waiting periods apply:

Pre-existing conditions *(excludes in-patient psychiatric, rehabilitation and palliative care services which only attract a 2 month waiting period)*	12 months
Pregnancy and birth-related services, including IVF/GIFT	12 months
Home nursing	12 months
Home sleep studies	12 months
Insulin pumps (initial) Insulin pumps (replacement) *(loyalty benefits also apply)*	12 months 36+ months
Speech/sound processor (initial) Speech/sound processor (replacement) *(loyalty benefits also apply)*	12 months 36+ months

Not all benefits are available on all covers.

It's always best to contact Health Partners prior to any hospitalisation to ensure you are covered for your procedure.

**From the list of eligible funds at www.privatehealth.gov.au.*

Membership Information
continued

Waiting periods for pre-existing conditions

With hospital cover, a 12 month waiting period applies for pre-existing conditions.

A pre-existing condition is one where signs or symptoms of an ailment, illness or condition, in the opinion of a medical practitioner appointed by the fund, existed at any time during the six months preceding the date on which you purchased or upgraded your hospital cover. This does not apply to psychiatric conditions, palliative care and rehabilitation which have a 2 month waiting period (level of benefits may vary depending on the cover you purchased).

Waiting periods when you transfer from another Australian fund

If you transfer from another Australian fund with *an equivalent level of cover*, and have served the relevant waiting periods, you can obtain immediate access to all services on your selected level of cover. A 12 month waiting period applies to any higher limits on your new Health Partners cover for items such as orthodontic, laser eye surgery, some appliances or other services/items not previously covered. During this time you will receive the same benefits and pay the equivalent excess for hospital cover (and the co-payment applicable on some older covers) as your previous level of cover.

If you transfer to a *higher level of cover,* waiting periods apply to the additional benefits available on the higher level of cover. During this time you will receive the same benefits and pay the same excess for hospital cover (and the co-payment applicable on some older covers) as the Health Partners equivalent of your previous level of cover. Limits and benefits already claimed will count towards yearly/ lifetime limits.

Where your previous cover *had excluded or restricted benefits*, applicable Health Partners waiting periods will apply for these specific services.

If you have only *partially served waiting periods* with your previous fund, the remainder of the waiting period will be served with Health Partners.

Any loyalty bonuses or accrued entitlements with your former fund are not transferable to Health Partners.

When you transfer, we will explain to you which benefits you can claim immediately and any waiting periods that may apply (if any).

Waiting periods when you change your cover

For current members changing their level of cover, waiting periods apply for increased benefits and limits of cover. During this period you will receive the same benefits and pay the same excess for hospital cover (and the co-payment applicable on some older covers) as your previous level of cover.

When you change your cover, we will explain to you which benefits you can claim immediately and any waiting periods that may apply (if any).

Waiting periods for pregnancy cover

When you change or increase your level of cover to include benefits for pregnancy and birth-related services, the 12 month waiting period applies to the actual delivery date of the baby – i.e. your hospital admission date – not the "expected" delivery date your medical practitioner provides you.

So if you're already pregnant but only joined or upgraded in the last 12 months, your benefits may be lower or you may not be entitled to any benefits.

Waiting periods for newborns and adopted or fostered children

Waiting periods do not apply for newborns provided you add them to your membership within 60 days from their date of birth and premiums are also paid from their date of birth.

Adopted or fostered children can also receive immediate cover (except for pre-existing conditions) provided you add them to your membership within 60 days of obtaining legal guardianship.

Please note: appropriate documentation must be provided to Health Partners to verify that the policyholder has full legal and financial responsibility for the child/children being added to a membership. Children adopted from overseas must be eligible for full Medicare benefits before health insurance benefits can be paid for hospital treatment.

Making changes or enquiries on a membership

The policyholder has the full and total authority to make changes to the membership, including adding or removing dependants/partner/ spouse, and claim enquiries about anyone on the policy (unless the dependant or partner/spouse has requested otherwise).

Delegation of Authority

Delegation of Authority can be granted by the policyholder and authorises another adult to discuss and manage aspects of the membership on their behalf, including matters relating to Health Partners Dental and Optical.

Delegation of Authority is provided to the partner/spouse of the policyholder automatically upon joining (this can be revoked by the policyholder at any time), however, the policyholder is free to elect anyone over the age of 18, even if they are not listed on the membership.

Delegation of Authority allows the nominated person to make changes to, or enquiries about, the membership regarding:

- Personal details (e.g. address, phone number)
- Level of cover
- Payment method
- Adding or removing a dependant
- Submitting claims on behalf of any member on the membership *(unless otherwise advised; excludes claims submitted via the MyHealth phone app)*
- General information regarding the membership, including dental and optical appointments.
- Access personal health information such as medical details or conditions regarding other members covered on that membership (unless otherwise advised)

This authorisation does not allow the nominated person to:

- Cancel the membership
- Change the status of the policyholder
- Nominate further delegated authorities
- Access or change passwords for the policyholder's Members Online account.

Nominating Delegation of Authority

For new memberships, Delegation of Authority is provided to the partner/spouse of the policyholder automatically on joining (but can be revoked at any time by the policyholder).

For existing memberships, a Delegation of Authority form can be filled out by the policyholder to nominate an adult not on the membership, or they can phone Member Care on 1300 113 113 to nominate their partner/spouse or another dependant already on the membership.

Removing Delegation of Authority

A person's Delegation of Authority can be removed by the policyholder at any time simply by contacting Health Partners.

Substitute decision-makers

Designated substitute decision-makers are able to make decisions on behalf of individuals who cannot do this for themselves.

Substitute decision makers may hold an Advance Care Directive (including the Power of Attorney designation), or an administration or guardianship order, from a relevant judicial body.

In terms of private health insurance memberships, the difference between someone with Delegation of Authority and someone with substitute decision-making orders is that the latter can also:

- Cancel the membership
- Change the status of the policyholder
- Operate the policyholder's Members Online account.

A policyholder can advise us of their appointed substitute decision-maker – or that person can contact Health Partners directly – by providing the appropriate documentation confirming their status.

Suspending your membership

Overseas travel

Health Partners offers suspension of membership for overseas travel. You are able to apply for a minimum of 21 days to a maximum of 2 years' suspension. Suspension applies for the period you are outside of Australia (or Australian waters for cruising purposes). During the time that a membership is suspended, health fund benefits and other membership entitlements are not available.

Criteria apply and you can find out all the terms and conditions on the downloadable Application to Suspend Membership form at healthpartners.com.au. If you are travelling for more than 2 years or have any questions, please contact us on 1300 113 113.

Membership must be financial, and the suspension form must be submitted prior to leaving for overseas. Travel proof will be required for all travellers to re-activate membership. The Medicare Levy Surcharge (refer to *Health Insurance Initiatives*) may apply for the period that your hospital cover is suspended.

Financial hardship

We understand that life circumstances change and these changes can impact on your financial situation. If you are experiencing financial difficulty we encourage you to call us to discuss your options, including suspending your membership in full for up to 12 months while you are experiencing hardship (conditions apply).

Benefits and limits

A *benefit* is the amount you receive back when you make a claim. If the service you require is included in your cover, Health Partners will help you cover some (or all) of the costs by paying the benefit specific to your cover.

Some item benefits are calculated at a set percentage based on your level of cover. For other items, a set benefit applies.

A *limit* is the total amount that you can claim back or the number of times you can claim a benefit, during the calendar year or a specified period. More information can be found in the *Extras Cover Information* section.

A *loyalty benefit and/or limit* may apply for some services on a range of covers. These benefits are based on the number of years of continuous membership on that level of cover with Health Partners and are not transferrable to or from another fund.

Some items that are subject to loyalty periods include, but are not limited to: hearing aids, sleep apnoea/CPAP apparatus, insulin pump replacements, and speech/sound processor replacements.

To determine how much you will get back for the service or treatment you require, or what limits apply to your level of cover, simply call our Member Care team to request a benefit quote on 1300 113 113.

Membership Information continued

Additionally:

- Benefits and limits are generally per person, per calendar year. However, there are some items, such as select ambulance and Wellness for Life items, that provide benefits and limits per *membership*, per year.
- Benefits are only payable on services and goods provided by Health Partners recognised or approved providers within Australia (refer to *Recognised Providers* section for more information). Health Partners benefits are not available overseas; medical and hospital costs incurred overseas are not covered.
- Except where otherwise permitted, benefits are only payable for services or treatments performed in person (telephone/internet/Skype consultations are not covered).
- Benefits are not payable on goods purchased over the internet or telephone unless the provider is specifically approved by Health Partners. Contact Health Partners prior to purchase to confirm product eligibility and provider recognition (exclusions apply).
- Benefits may only be claimed once per treatment, service or purchase of goods, and the benefit paid cannot be greater than the amount charged.
- Benefits are only payable once per provider and per service per day.
- Once waiting periods have been served, you are eligible for all benefits available on your chosen cover while premiums are up-to-date.
- Benefits must be claimed within 2 years from the date of service and count towards limits for the year in which the service was provided.
- The member co-payment for eligible pharmacy prescriptions is payable for each pharmacy item dispensed. Benefits for multiple pack dispensing can vary and multiple member co-payments may apply. Pharmacy benefits are only available at Health Partners Participating Pharmacies.
- Health Partners extras pharmacy cover provides benefits for some vaccinations. Approved private vaccination prescriptions can be claimed when purchased at Health Partners Participating Pharmacies. A limited range of vaccinations are also available at your GP, Travel Doctor – TMVC and SA Travel Bug Vaccination Centre, with benefits available when both supplied and administered by those providers.
- If transferring, benefits paid by your previous fund within the current calendar year or specified period will count towards your benefit limits with Health Partners for the same calendar year or period.
- If upgrading your cover, benefits already paid within the current calendar year or specified period will count towards your new benefit limits for the same calendar year or period.
- If downgrading your cover, benefits already paid within the current calendar year or specified period will count towards your new lower limits for the same calendar year or period, and in some cases may mean limits are already exceeded for that year and no further benefits will apply.
- Benefits are not paid on the GST portion of a claim or on freight/postage charges.

Reduced benefits

- Benefits will be reduced if you have already claimed, or plan to claim, through another insurer (eg. general insurance) or other source (eg. Medicare, injury compensation). In some cases, such as WorkCover, no Health Partners benefits will be paid. These rules apply whether the other insurance policy provides full or partial coverage, and also to any other source, third party compensation or damages claims.
- When making a claim for goods or services that are covered by an insurance policy other than Health Partners or any other agency (eg. Medicare), you must first claim through that insurer or source. This includes any government reimbursement programs where you are eligible to claim from both Medicare and Health Partners.
- If you are left with an out of pocket (excess/gap) amount after claiming through the other insurer or agency, you may receive a benefit from Health Partners on the out of pocket amount, according to your level of cover with Health Partners. Just submit the benefit statement from the other fund with your claim for us to assess (excludes Medicare claimable items).
- If a claim is made through another insurer or agency and the claim is paid in full, no further benefits apply.
- All benefits are subject to your policy's annual limits and Health Partners' Fund Rules. Benefits payable cannot exceed the fees and/or charges raised for any treatment and/or services rendered, being treatment and/or services covered after deduction of benefits paid from any other source.
- Additional information can also be found in section F7 of the Fund Rules *"Compensation Damages and Provisional Payment of Claims"* on our website.

Claiming

Claims must be supported by an itemised account(s) and/or Medicare Statement(s). We will not pay benefits on quotes.

Itemised accounts (or invoices) must show the following information:

- ABN
- The provider's name, provider number and address
- The patient's full name and address
- The date of service
- The description of the service, including any item numbers (and teeth numbers for dental claims where applicable)
- The amount charged
- The amount already paid (if applicable)

Please note membership premiums must have been paid up to the date of service for claims to be processed, and you cannot claim for services before they have been provided to you (e.g. if you choose to pre-pay a provider for a service, you cannot submit a claim until you have actually received the service).

Some claims may require additional supporting documentation from your medical practitioner at the time of submission for us to process them. Refer to the *Programs, Health Aids and Appliances explained* section for further information.

By submitting a claim for benefits, you authorise Health Partners to contact the provider to clarify or obtain further information about the claim.

Payment of claims

Member claims are deposited by direct credit directly into your preferred bank account (or a cheque is provided if required). Simply supply your bank account details on your membership application, on the Member Claim form or any time via a Benefit Payments form.

You only need to supply these details once – the next time you submit a claim (either via our app, online or a claim form), simply tick the "direct credit" box and we will transfer your benefit to that same account.

Direct credit claim payments allow benefits to be put into your account much quicker than waiting for a cheque to be posted and subsequently deposited into your bank account and then waiting for it to be cleared.

Once direct credit payments have been processed, a Remittance Statement will be sent to you outlining the benefits paid.

By default, claim payments will be paid to the policyholder (or to the provider if the account is unpaid); however, claims made by the partner/spouse or dependant for themselves over the age of 18 can be paid to them directly if advised at the time of claiming.

Please note benefits cannot be paid into a credit card account.

Claims security

All health funds are run according to the same strict solvency, capital adequacy and governance standards set out by the Australian Government, so you can feel secure when it comes time to claim.

Recognised providers

We will pay benefits when the service provider is recognised by Health Partners for benefit purposes. It is important to contact us if you would like to determine if your provider is recognised by us. Although uncommon, there are instances where a previously recognised provider may no longer be recognised (for example, if they have breached Health Partners Provider Terms and Conditions).

Providers must:

- Be recognised by Health Partners (and Medicare, when hospital benefits are being claimed);
- Have qualifications/credentials recognised in Australia to practice here; and
- For extras services/treatments, provide them in private practice in Australia.

Provider recognition is not to be taken as Health Partners' endorsement or recommendation of any particular service, treatment, practitioner or appliance.

Participating provider network

A participating provider is one that has an agreement with Health Partners. In addition to Health Partners own dental and optical centres, these include Barossa Dental, over 50 physiotherapists and over 50 pharmacies in South Australia. Members can expect to receive exclusive (and/or higher) benefits at these providers.

These providers are periodically reviewed and as such, may change from time to time. Visit 'Partner search' at healthpartners.com.au for a Health Partners Participating Provider near you.

Your choice of provider

Health Partners respects and encourages members' individual choices when it comes to selecting the type of treatment/practitioner for their health needs.

If you have a provider you already like, you don't have to change. If you use Health Partners Participating Providers, you receive additional benefits and limits. The choice is yours.

Claiming your way

When it comes to claiming, choose the option that suits you.

Health Partners MyHealth phone app

Simply download the free app to your smartphone, register your details, take a photo of your itemised account and submit. With no paperwork or hassle, most benefits are generally paid within 2 business days of your claim being submitted. Please note you'll need your dependant code which is the number in front of your name on the membership card.

Online

Policyholders can submit claims for anyone on the membership in three simple steps via Members Online at healthpartners.com.au.

On-the-spot

Your claim can be processed on-the-spot whenever you visit a provider that utilises electronic claiming (such as HICAPS or HealthPoint) or Health Partners professional. Simply present your membership card at the time of service and you will only have the balance to pay – or nothing at all, depending on your level of cover and available limit.

Not all claims are payable via electronic claiming (e.g. orthodontic claims).

Claim form

Claim forms are available on our website, at our centres and upon request. Once the form is completed (with itemised accounts attached), you can mail it freepost to:

Health Partners Claims Assessor
Reply Paid 1493, Adelaide SA 5001

If you prefer, submit your claims in person at any Health Partners centre. Please note that over-the-counter cash claiming is not available.

Direct billing with Access Gap Cover

If your doctor has chosen to participate in Access Gap, (refer to *Hospital Cover Information section*) they'll send your medical bill directly to us. We'll then send you a quarterly statement to let you know the benefits that have been paid on your behalf. If there is any amount outstanding, this will be payable by you.

Member Discounts

Health Partners members are offered the following discounts to help you save even more on everyday items. The discounts are unlimited which means you can save all year round.

Please note these discounts are for personal use only and available upon presentation of a valid membership card. Discounts are only available to current financial members.

20% pharmacy discount

With our state-wide pharmacy network you can access unique benefits and discounts at 50 pharmacies, at no extra cost. Members with extras cover are eligible to receive a 20% discount at Health Partners Participating Pharmacies for most non-prescription items, every day of the year!

That includes vitamins, beauty products, pain relief, gifts, quit smoking products, and much more.

The card must be presented at the Health Partners Participating Pharmacies at time of purchase to claim the discount. If you forget your card, your 20% discount on non-prescription items will be declined. Additionally, pharmacy discount is only redeemable 'on-the-spot' and is not redeemable retrospectively#.

30% sunglasses discount

All Health Partners members are eligible to receive a 30% discount at Health Partners Optical centres on the full range of non-prescription sunglasses, solutions and accessories.

20% oral health discount

All Health Partners members are eligible to receive a 20% discount at Health Partners Dental centres for all stocked oral health products.

Travel insurance

Whether you're travelling abroad or in Australia, as a Health Partners member you are eligible to receive a special member price on travel insurance purchased through us. Health Partners travel insurance is provided by Allianz Global Assistance.

Health Partners travel insurance offers a great range of options depending on your travel destination and needs.

You can purchase travel insurance at healthpartners.com.au or over the phone by calling Allianz Global Assistance on 1800 119 862 and quoting your membership number. You can also visit our Member Care centres and we can put you in contact with an Allianz Travel Insurance Specialist*.

Other discounts

For a listing of all other available discounts, such as gym memberships and various leisure activities, please refer to the 'Member Discounts' page at healthpartners.com.au.

#20% discount is applicable to the participating pharmacy's item price only (i.e. discount not available on price-matched items). It excludes agency lines (e.g. X-Lotto), Schedule 3 recordable items, and items already discounted by 40% or more.

**Before making decisions on your purchase, please read and consider the Travel Insurance Product Disclosure Statement (including Policy Wording) available online.*

Hospital Cover Information

Hospital cover helps pay for eligible Medicare recognised procedures when you are admitted to hospital. With all hospital cover options, you are eligible to receive benefits at your choice of participating hospital (private or public), Australia-wide.

What's covered

If the procedure or service you require is included in your cover, Health Partners will:

Pay for:

- ✓ Your accommodation in hospital (including registered day facilities).
- ✓ Your theatre, labour ward and intensive care fees.
- ✓ All PBS prescriptions relating to your admission, while you're in hospital.
- ✓ An extensive range of Government-recognised surgically implanted prostheses.
- ✓ Access to a range of Wellness for Life and support programs such as Home Health Partner.

Pay towards:

- ✓ Inpatient medical expenses (see *How to reduce your medical expenses*).
- ✓ A range of additional services depending on your level of cover.

Health Partners will also cover other allied health services provided during your admission, such as dental, physiotherapy and dietetics, in line with our agreement with the hospital and your level of extras cover.

For example

If your wisdom teeth need to be extracted surgically, we may cover your hospital admission-related fees but you must have an appropriate level of dental extras cover to receive benefits towards any dental item numbers that do not attract a Medicare Rebate.

You may have an out-of-pocket expense if the fees exceed the contracted allowances for these services.

What's not covered

There are some situations where your Health Partners hospital cover will not cover you:

- ✕ Non-Medicare recognised procedures (e.g. cosmetic surgery not medically necessary; experimental/trial treatments; some surgical procedures performed by a dentist; respite care; medical costs related to surgical podiatry, including the fees charged by the podiatric surgeon).
- ✕ Excluded services (refer to individual cover details).
- ✕ Treatment during a waiting period (including pre-existing conditions).
- ✕ Outpatient procedures (e.g. type 'C' procedures).
- ✕ Hospital treatment provided by a non-agreement hospital (including psychiatric and rehabilitation day programs).
- ✕ Treatments and services at unregistered day facilities.
- ✕ Hospital treatment provided by a medical practitioner not authorised by a hospital to provide that treatment.
- ✕ Treatment provided by a family member, relative or business partner.
- ✕ When you prefer to use your own allied health provider instead of the hospital's practitioner for services that form part of your in-hospital treatment (such as psychologists, physiotherapists or chiropractors).
- ✕ If you are in hospital for more than 35 days and have been classified as a 'nursing home type' patient (refer to *Limited benefits*).
- ✕ Hospital treatment provided outside of Australia.
- ✕ Emergency department fees.
- ✕ Where compensation, damages or benefits may be claimed through another source (e.g. general or other insurance, workers compensation).
- ✕ For some non-PBS or high cost drugs (contact us to confirm eligibility).
- ✕ Services received during any period when your membership is unfinancial (e.g. premiums are in arrears, membership has been suspended).

Refer also to the *Restricted Benefits* section.

Details on the services included with each cover can be found in the individual cover's details or on the Health Partners website. Call us on 1300 113 113 to check what you are covered for prior to your hospital admission.

Hospital Cover Information
continued

Participating hospitals

Participating private hospitals are hospitals which have an agreement with Health Partners. Agreements are in place to ensure that you receive quality benefits and services at most hospitals Australia-wide.

It is best to contact us when you are planning a hospital admission to check that the hospital of your choice is a participating hospital. In the rare event that the hospital (or day facility) is not recognised as a Health Partners participating hospital, you may have higher out-of-pocket expenses. It is the hospital's responsibility to advise their patients of applicable hospital charges.

Hospital excess and co-payments

An *excess* is an amount that you agree to pay towards the cost of hospital treatment, to reduce the cost of the policy. This is payable on admission to hospital up to the maximums shown in the following table, per rolling year (that is, you will never pay more than the yearly excess limit in a 12 month period).

Excesses are additional to any applicable out-of-pocket expenses (also known as 'gaps') incurred for in-hospital medical treatment.

Some Health Partners hospital cover include excesses, although these are waived for child dependants on Gold Value Hospital and Silver Hospital, and the Family Essentials package.

Refer to the table on the right for details of covers that include a hospital excess.

If you have an older Health Partners cover, you may also be required to pay a *co-payment* on admission to hospital. If this applies to you, further information about co-payments can be found on the website. Hospital co-payments do not apply to any of the covers outlined in this document.

Restricted benefits

A *restricted* benefit may be applicable to certain conditions, services or treatments which a policy covers only to a limited extent, and will pay reduced benefits on hospital admissions. It may not be sufficient to cover the cost of a private room in a public hospital or any room in a private hospital.

If you are admitted into a private hospital for treatment that is restricted on your policy, large out-of-pocket costs will apply. You will have to pay the full theatre fees and other costs as well as the difference for accommodation fees; in some cases theatre fees can exceed the cost of accommodation.

As a private patient in a public hospital, we will pay minimum shared room benefits but you will still have your choice of doctor. If these benefits are less than the public hospital charges, you will have out-of-pocket expenses to pay. If the services are eligible under Medicare, you can also still elect to receive treatment as a public patient. With both of these options, public hospital waiting lists will apply.

Some items, such as joint replacement procedures on Silver Hospital cover, are only covered for benefits when the treatment required is as a direct result of an accident that occurred after joining or transferring to that level of cover, and up to 24 months prior to the date of procedure admission.

Gold Value Hospital*	
Single or Sole Parent	$250/$500
Couple or Family	$250/$500 per person; $500/$1,000 per membership
Silver Hospital*	
Single or Sole Parent	$500
Couple or Family	$500 per person; $1,000 per membership
Bronze Hospital	
Single	$500
Couple, Family or Sole Parent	$500 per person; $1,000 per membership

Table above only includes covers that have an excess.
Where marked with an asterisk (*), the excess is waived for child dependants.

Limited benefits

Limited benefits apply for admissions where a Medicare rebate does not apply to the treatment procedures. Benefits paid are in accordance with the Commonwealth Government default payment schedule. This may result in large out-of-pocket expenses.

If included in your cover, the following limited benefits may also apply:

- Surgically implanted prostheses that are not listed in the Commonwealth Prostheses List are paid at 100% up to a maximum of $1,500.
- Surgical Podiatry Specialist benefits are paid at 85% up to the annual podiatry limit on eligible covers when the provider is a Fellow of the College of Podiatric Surgeons, and the surgery is performed at a hospital or registered day facility. Eligible covers include: Prime Living, Gold/Silver/Bronze Hospital (Gold/National Extras provide a benefit also, provided the procedure is not performed in a hospital, e.g. in-rooms).

  Benefit is only payable towards the Podiatric Surgeon's fee; hospital and day facility fees are the responsibility of the member because those procedures are not Medicare recognised.
- Nursing-home type patient benefits are limited as set by the Commonwealth Department of Health and Ageing.

How to reduce your medical expenses

The benefits you are entitled to for inpatient medical services are based on the Commonwealth Medicare Benefits Schedule. When you are admitted to hospital, Medicare pays 75% of the Medicare Schedule Fee and health insurance covers the remaining 25%. The gap is the amount charged above the Medicare Schedule Fee, which you pay.

Should you need hospital care, you can eliminate or reduce the gap with *Health Partners Access Gap Scheme*. When your doctor uses Health Partners Access Gap you will either:

- have no gap to pay, or
- know your exact gap before treatment.

Your doctor can bill Health Partners direct, to make claiming even simpler for you.

To determine if your doctor participates in Access Gap, contact us or visit the 'Doctor search' at healthpartners.com.au.

It is your doctor's choice to use Access Gap on a patient-by-patient basis. It is important to ask your doctor if they, or any other assisting doctor, will participate in Health Partners Access Gap Scheme. Ask if you will have a gap to pay and if so, how much it will be. This will encourage your doctor to participate in Access Gap.

Any excess (and co-payment associated with some older covers) applicable to your level of cover will still apply.

Informed financial consent

This is the provision of cost information (including out-of-pocket expenses) to you, by your treating doctor(s) or specialist(s) prior to your hospital admission.

As a private patient it is your responsibility to understand all the potential costs prior to being admitted to hospital.

Prior to any admission, please contact Health Partners to check your benefit eligibility. We can discuss with you the best ways to avoid or reduce potential out-of-pocket expenses.

How can patient status affect benefits?

Inpatient vs. outpatient

Inpatient care refers to a medical service that requires admission into a hospital, either for day surgery or overnight stays. You need to be formally admitted by a doctor into a hospital for a stay to be considered 'inpatient', so if you came through the emergency room and were asked to stay overnight for "medical observation", it does not make you an inpatient.

You're an *outpatient* if you receive treatment via the emergency department or treatment rooms, outpatient clinics, specialist consultations, plus lab tests, scans, or any other hospital services that do not require you to be admitted as an inpatient (including type 'C' procedures). In most instances you will not be covered by private health insurance but these services may be claimable in part or in full through Medicare if you have an eligible Medicare card.

Public vs. private inpatient

Public patient

- You have the right to choose to be treated as a public patient even if you are privately insured; Medicare will cover the cost to all eligible people.
- Medicare will also cover the cost of all related medical services including specialist, X-rays, and pathology tests.
- You will be treated by a doctor appointed by the hospital; you cannot choose your own.
- You may not have a choice when or where you are admitted to hospital (excluding emergencies) and some waiting lists can be extensive.
- If you elect to be a public patient in a public hospital, Health Partners will pay for services such as television hire and telephone calls.

Private patient

- You have the choice to be treated as a private patient in either a public or a private hospital.
- You can choose your own doctor, as a private patient in a private hospital that your doctor attends.
- You may have more choice as to when you are admitted to hospital, though public hospital waiting lists may still apply.
- You are covered for all services on your level of hospital cover except those listed as a restriction or exclusion.
- If you choose to be a private patient in a public hospital you are waiving your right to be fully covered under your Medicare eligibility:
  - Medicare will cover you for 75% of the Medicare Benefits Schedule (MBS) fee for associated medical costs and Health Partners the remaining 25%.
  - Any remaining hospital and medical costs will be charged to you. These can include hospital associated costs, prostheses costs, pharmaceuticals and associated doctor fees, though in a lot of cases a doctor may simply bulk bill their fees or use the Health Partners Access Gap Scheme to reduce your out-of-pocket costs.

Further information is available on the *Going to Hospital* and *Having a Baby* flyers available from our website.

Hospital Cover Information
continued

Post-admission benefits

Pharmaceutical prescriptions

You will be covered for PBS Government subsidised prescriptions prescribed by the discharging hospital.

Plus, on eligible covers, you may also be covered for all Health Partners approved non-PBS pharmaceutical prescriptions prescribed by the discharging hospital, up to your annual limit.

Aids for recovery

If recovery aids are included on your cover, Health Partners will pay a benefit towards a device that is either hired or purchased up to six months following related hospital admission to assist with your recovery. This may include items such as splints/braces, bed rail, shower chair/rail, crutches, walking frame, wheelchair, plus some compression garments, as recommended by your medical provider.

Benefits for some aids may also be available through eligible extras covers if not related to a recent inpatient admission.
Please contact Health Partners for more information.

Psychiatric lifetime limit upgrade

Where a member has completed the general two month hospital waiting period for psychiatric treatment, a member may upgrade from a hospital cover that offers restricted psychiatric treatment benefits to one which offers full private hospital cover, without serving the additional upgrade waiting period for that treatment.

This upgrade exemption is only available once per person, per insured lifetime and does not include wavering the right to any excess or co-payment that may apply. When transferring between insurers, this waiver will be recognised on a clearance certificate. All other applicable waiting periods for the new cover will apply.

Home nursing benefits

If home nursing is included on your cover, Health Partners will pay benefits towards complex wound management, IV medication management and palliative care, up to daily and yearly limits applicable to each eligible cover, when services are provided by a Registered Nurse and a benefit is not payable under a suitable *Home Health Partner* hospital substitute program (refer to page 42).

Approval is given subject to level of cover and benefit limit remaining on date of approval, and where that treatment is for an illness or injury which would otherwise require admission and treatment of the kind provided in an approved hospital.

Private patients' hospital charter

The charter is a guide on your rights and responsibilities as a private patient in a private, public or day hospital facility.

The guide is issued by the Minister of Health and Ageing and is available from Health Partners.

Going to hospital?

No-one likes to go to hospital but if you have to go, it's good to know as much as you can about your treatment and any costs that might be involved. Here are some things to consider when you learn you have a hospital admission coming up:

Hospital

- ☑ Am I fully covered for my hospital admission? If not, what level of hospital cover is required for my procedure?
- ☑ Do I have any restrictions or exclusions on my level of cover?
- ☑ Have I served all the required waiting periods on my level of cover?
- ☑ Do I have an excess (or co-payment) on my policy that I need to pay?
- ☑ Am I covered for rehabilitation if I need it?
- ☑ If I have the procedure in a public hospital, will I be covered for my TV, phone?
- ☑ Is my choice of hospital covered under my policy?
- ☑ Am I covered for any aids that can assist in my recovery?
- ☑ Am I covered for any prescribed medication upon discharge from hospital?

Specialist

- ☑ Can I have this procedure in a public hospital as a public patient?
- ☑ Does my specialist participate in the Health Partners Access Gap Scheme?
- ☑ Will any associated medical providers (e.g. Anaesthetist, Assistant Surgeon, Pathology Provider, Radiology Provider) also participate in the Access Gap Scheme?
- ☑ What will my out-of-pocket amount be for my medical expenses and when do I have to pay them?
- ☑ Will I have any out-of-pocket expenses related to my prosthesis (e.g. knee, hip replacement)?
- ☑ What paperwork will I need to complete before or after my hospital stay if I am a private patient?
- ☑ Will I require rehabilitation after my procedure and if so, will I be able to have the rehabilitation at home?
- ☑ Will I need further physiotherapy, hydrotherapy, home nursing or other allied services to assist with my care when I leave the hospital?
  → if yes, please contact Health Partners

Extras Cover Information

With extras cover, you can claim for a range of services that generally aren't covered by Medicare and that aren't covered by hospital cover. The level of extras cover you choose will determine whether you are covered for a particular service.

Details on the services included with each cover can be found in individual cover details or on the Health Partners website.

Benefits

A benefit is the amount you receive back when you make a claim. Benefits and limits generally are per person, per calendar year but can be per membership, per year.

Benefit quote

Not all benefits are listed for all extras services.

To check if a specific service or item is covered, please contact Health Partners for a benefit quote. This will help you determine how much you will get back when you claim for a particular service. In order to provide a quote, we will ask for the provider name, the provider number, the item number(s) you wish to claim and the fees charged by your provider (and in the case of dental, the teeth numbers may also be required). Your service provider will be able to confirm the item numbers and fees for you.

Set benefits

A *set benefit* is the set amount that you will be able to claim for a particular item number. For some services, like dental, you will be required to contact us for a benefit quote if you would like to know in advance the amount you will get back.

Set gap

A *set gap* is the amount you will pay out of your pocket for specific items when using Health Partners Participating Pharmacies and Physiotherapists. This way you know upfront what your expenses will be.

Refer to individual cover details or the Health Partners website for more information about benefits and gaps.

When benefits are not payable for covered services

There are instances where extras benefits are not payable, such as but not limited to: when a provider is not recognised by us; when the treatment/service is provided by a family member/relative or business partner; for services received or items purchased overseas, including items sourced on the internet; when you've reached your limits; when waiting periods have not been served; when your health cover payments are not up-to-date; fees for completing claim forms and/or reports required for claims' supporting documentation; where compensation, damages or benefits may be claimed by another source (e.g. general or other insurance, workers compensation, Medicare - refer to example below); for services that had not been provided at time of the claim; or when your level of cover at the time of treatment is not eligible for a benefit.

Refer to the *Benefits and Limits* and *Claiming* sections for additional information.

Medicare example - when benefits are not payable

Medicare rebates are available for psychological treatment by registered psychologists under the Australian Government's *Better Access to Mental Health Care* initiative. This scheme allows up to 10 sessions in a calendar year with a registered psychologist for a variety of different disorders.

If psychology is included in your extras cover, you cannot claim a benefit to top up the Medicare rebate for these services. You can only use one or the other so you'll need to decide if you will use Medicare or extras cover to pay for psychological services you receive.

You may find more information at psychology.org.au or by contacting your GP.

There are other extras modalities that may also attract a medicare benefit for applicable members eg physiotherapy. Members cannot access both a Medicare benefit and Health Partners.

Participating providers

As stated in the *Membership Information* section, if you already have a provider you like, you don't have to change. If you use the Health Partners network or participating providers, you receive additional benefits and limits. The choice is yours.

Visit 'Partner search' at healthpartners.com.au for a Health Partners Participating Provider near you.

Limits

For most extras, there are limits to the amounts that you can claim back or the number of times you can claim a benefit, during the calendar year or the specified period. Depending on your level of cover, Health Partners offers some unlimited benefits and discounts – for example in dental and optical at Health Partners' centres – allowing you to save more. Refer to individual cover details for more information. Most of our limits are 'per person' unless otherwise stated.

Combined limits

Some limits are combined which means that one set limit is available across two or more services, giving you more flexibility. For example, Gold and National Extras include a combined limit for chiropractic and exercise physiology which means that any benefits paid for either of these services will count towards the one combined annual limit.

Sub-limit

A sub-limit is part of (rather than in addition to) an overall limit. It indicates the total amount claimable for that particular service/item within an overall limit.

Lifetime limits

Some extras have lifetime limits which indicate the total amount you can claim in your lifetime across all health funds (for example, orthodontics). Once you reach the limit, no further benefits will apply in future.

Orthodontic benefits

If included in your cover, a treatment plan may need to be provided from the orthodontist or dentist providing the treatment (e.g. item 881: complete course of orthodontic treatment), which also includes the estimated length of treatment, prior to benefits being paid.

Orthotic benefits

If orthotics are included in your cover, benefits are available for custom-made orthoses only when the service/treatment is provided by a Health Partners approved orthotist, podiatrist, or medical practitioner.

Royal District Nursing Service

A benefit is provided only on Gold and National Extras, when provided by a registered nurse who satisfies the recognition criteria, for an illness, injury or condition which does not require admission to a hospital and is not hospital-substitute treatment.

Programs, Health Aids and Appliances explained

Select hospital and extras covers give you access to various programs that may assist with improving your overall health and wellbeing.

Wellness For Life

Wellness for Life* programs are designed to support members who are looking to improve the way they manage their condition(s) and overall health.

Wellness for Life can help you to manage coronary artery disease, bone health and type 2 diabetes, and can also include benefits for weight management and quit smoking programs, home sleep studies, plus gym and fitness programs, amongst others, on a range of Health Partners covers.

Members suffering from chronic disease, complex health or mental health issues who are determined by Health Partners as requiring ongoing support will be entitled to register for Health Coaching. This service provides telephone-based information and support for self-management of these health conditions.

Personal Health Assessment

An online assessment to help you identify areas in your health where you are doing well or may need improvement. The resulting report can also alert you to potential health or lifestyle risks plus help you set targets to help you get to a healthy point in your life.

Home Health Partner

Health Partners provides all members who have hospital or package cover with various options to assist with care and recovery in the home - at no extra cost.

Hospital in the Home

Hospital in the Home# is a personalised service designed to make the transition from hospital to home easier for you.

If it is appropriate, you may be able to leave hospital early after an operation and continue receiving the care and support you need to help you on the road to recovery, in the comfort of your own home. By working with the hospital staff and your doctor, services including specialised nursing care and home help can be arranged.

Hospital in the Home may even assist you to avoid a hospitalisation altogether.

Rehabilitation at Home

Rehabilitation at Home^ provides an alternative to hospital-based rehabilitation.

Instead of staying in hospital for rehabilitation, you get a tailored therapy program that can be provided in the comfort and privacy of your own home.

Your program, delivered by an experienced rehabilitation team, provides a short term therapy solution to help regain your independence and improve your quality of life.

Pregnancy and Newborn Support

Newborn Support Program

Pregnancy can mean the beginning of a new stage in your life – a stage which can bring joy, excitement and usually some challenges and adjustments. At Health Partners, we want to support you during this time of change, which is why we've developed a program just for you.

Our Newborn Support Program provides you with ongoing support from the time you learn of your pregnancy through to the first 8 weeks of your baby's life.

The program includes:

- 3 gap-free lactation consultations (with a doctor's referral)
- Post-natal advice on a range of topics
- Baby development and what to expect
- First aid for babies
- General parenting support

And when you enrol, you'll get:

- Access to an experienced midwife
- Access to a Medicare recognised lactation consultant
- A first aid kit and first aid e-course
- A gift bag with essentials for you and your baby
- The choice of electronic, face-to-face and over-the-phone support

Eligible members can enrol in the program via Members Online at healthpartners.com.au, or by completing an enrolment form (available on our website or by calling us on 1300 113 113).

Program and benefit availability varies according to level of cover so simply check the cover comparison tables or individual cover details to see which programs are included with each. Membership payments must remain up to date throughout each program to continue receiving benefits.

**For approved conditions or when medically necessary, at recognised providers, subject to eligibility requirements. A letter from your medical practitioner may be required.*
#All cases are individually reviewed by the hospital prior to your discharge to the care of your GP, with a care plan developed appropriate to your clinical needs.
^Referral to the program is made by the staff of the hospital (this may be your doctor/specialist or discharge coordinator). Program not available in all areas.

Wellness for Life benefits

Certain criteria might need to be met before we pay a benefit towards these items, such as proof of program or screening completion or that the item or service is for an approved medical condition and medically necessary, which may require confirmation from a recognised provider. If included in your cover, some examples may include:

Bone density test

A benefit is payable towards a Dual Energy X-ray Absorptiometry (DEXA) scan when performed by a Medicare-recognised radiologist with a Location Specific Provider Number (LSPN), where the member is not eligible for a Medicare rebate.

Bowel cancer screening

A benefit is payable towards the cost of a testing kit purchased at a participating pharmacy or the Cancer Council. You will be required to include supporting documentation with your claim, confirming that your test is finalised. This may include a copy of the test results or a letter from the company providing the screening service.

Diabetes/Asthma Australia membership

A benefit may be payable towards the cost of your membership in your state (or territory) of residence, when supported by a letter from your medical practitioner confirming your diagnosis.

Diabetes education

Benefits may be payable for consultations with a recognised diabetes educator (credentialed by the Australian Diabetes Educators Association) for members diagnosed with type 2 diabetes, when referred by a medical practitioner or specialist. The consultation must be in person and the member must not be an admitted patient of a hospital at the time of consultation.

Gym and fitness

Benefits are payable only when the gym or fitness program is confirmed by your doctor or recognised provider to specifically assist treatment for a medically diagnosed condition. You will be required to submit a Health Partners Gym/Fitness Therapy Approval form signed by that doctor or recognised referring provider to assess your eligibility. No benefits are payable if used for general fitness.

Home sleep studies

A benefit is payable towards sleep studies performed in the member's home when supported by satisfactory evidence from a medical practitioner recommending the service, and when performed by a Health Partners recognised provider.

Mole check body scans

A benefit is payable towards a full or part body scan where a Medicare rebate is not applicable, when performed by a qualified Dermatologist, GP with qualifications in Primary Care Dermatology or Skin Cancer Medicine, or a Registered Nurse or Melanographer who undertakes the examination but results are diagnosed by the Specialist GP or Dermatologist.

Post-natal lactation consults

A benefit is payable towards consultations provided by a registered, qualified specialist mid-wife who is an International Board Certified Lactation Consultant (IBCLC) where a Medicare rebate is not applicable.

Quit smoking

Benefits are payable towards the cost of Nicotine Replacement Therapy when purchased at Health Partners Participating Pharmacies. You will be required to include a completion certificate or confirmation of a government-approved Quit Smoking program with your claim.

Weight management

A set benefit is payable upon confirmation of joining an approved/recognised weight management program (e.g. to help with your first month of membership). This amount is payable once per year up to the lifetime limit. Upon reaching your weight loss goal, some high-level covers may allow you to claim an additional completion benefit up to the lifetime limit.

You will be required to include a completion certificate with your claim.

Refer to individual cover details to see which wellness benefits each cover provides. Please note benefits are not payable on any applicable freight charges, and are only applied after any applicable discounts, government payments or subsidies.

Programs, Health Aids and Apparatus explained continued

Health Aids

As with our wellness programs, certain criteria might need to be met before we pay a benefit towards these items, such as proof the item is for an approved medical condition and medically necessary, which may require confirmation from a recognised provider. Some examples include (but are not limited to):

Aids for recovery (post-admission)

A benefit may be payable for the purchase or hire of recovery aids up to 6 months following hospital admission, when an invoice is provided by a recognised agency or pharmacy and the item has been recommended by a registered medical practitioner or physiotherapist. Items could include braces, splints, moon boots, crutches, wheelchair and bed pulleys.

Compression garments

A benefit may be payable for the purchase of compression garments when an invoice is provided by a recognised agency or pharmacy and the item has been recommended by a registered medical practitioner, physiotherapist or occupational therapist in relation to the management of a specific medical condition. Items could include pregnancy shorts, lymphoedema garments, surgical and pressure stockings.

Hip safety kit

A benefit may be payable for the purchase of a hip safety kit for members with diagnosed osteoporosis, who have been assessed as at risk of hip fracture by a registered medical practitioner, when an invoice is provided by a recognised agency or pharmacy.

Non-surgically implanted prostheses

If included in your hospital or package cover, benefits may be payable for wigs, prosthetic bras or erectile dysfunction prostheses following surgery, artificial eyes and limbs, up to annual limits.

Refer to individual cover details to see if health aid benefits are included with your chosen level of cover. Please note benefits are not payable on the GST portion or any applicable freight charges, and are only applied after any applicable discounts, government payments or subsidies.

Health Appliances

A health appliance is an item prescribed by a medical or health practitioner such as your doctor, physiotherapist or other specialist to help treat a particular medical condition or to compensate for reduced functionality. Like health aids, if included on your level of cover, some additional information will be required with each claim you make:

Asthmatic spray appliances

Supporting documentation from your medical practitioner recommending the appliance will be required.

Blood glucose monitoring machines

Supporting documentation from your medical practitioner recommending the appliance will be required.

Blood pressure machines

Supporting documentation from your medical practitioner recommending the appliance will be required.

Circulation booster (e.g. TENS machine)

Supporting documentation from your medical practitioner recommending the appliance may be required.

Hearing aids

Supporting documentation from your Medical Specialist may be required.

Insulin pump replacements

Benefits may be payable for a replacement Insulin Pump once a current pump's warranty has expired and supporting documentation and relevant form is provided by an accredited Diabetes Educator or Endocrinologist (in-patient procedures only).

Low vision optical magnification aids

Supporting documentation from your GP or Optometrist/Ophthalmologist may be required. Item must be purchased from a registered Optical store, the Royal Society for the Blind of SA (RSB), or medical practitioner. General daily living aids not covered.

Sleep apnoea/CPAP apparatus

Supporting documentation from your GP or an accredited Sleep and Respiratory Physician recommending the appliance will be required.

Speech/sound processor replacements (e.g. Cochlear Implants)

Benefits may be payable for a non-surgically implanted replacement speech/sound processor once a current processor's warranty has expired and supporting documentation and relevant form is provided by an Audiologist or Medical Specialist.

Refer to individual cover details to see if appliance benefits are included with your chosen level of cover. Please note benefits are not payable on any applicable freight charges, and are only applied after any applicable discounts, government payments or subsidies. Benefits are also not payable on hire charges.

Ambulance Cover Information

As ambulance services are not covered by Medicare, it's reassuring to know that it's available within Australia on all Health Partners covers.

It incorporates Australia-wide coverage by road or air, provided by an approved ambulance provider, for services required on medical grounds up to $20,000 per person, per year.

There are two types of ambulance services — non-emergency ambulance and emergency ambulance.

Non-emergency ambulance

If this is included in your cover, you will be covered for the cost of any service required on medical grounds (excluding clinic-car type transport) regardless of whether the service is classed as emergency or non-emergency.

Additionally, you will be covered for treatment where no transport is required.

Emergency ambulance

Emergency ambulance cover is provided on all our other policies, giving you peace of mind.

You will be covered for the cost of service required on medical grounds (excluding clinic-car type transport) that is deemed or classed as 'emergency' only (emergency classification determined by approved ambulance provider).

Limits apply: Please refer to individual cover details for more information.

Please note: When combining your own standalone hospital and extras covers where each provides separate ambulance cover, both are applicable. The limit per service remains at $20,000 per person.

Holding private health insurance does not restrict you from purchasing a separate ambulance subscription in your state of residence, if required.

Norfolk Island residents please note:

The Australian Government pays for emergency transport to the mainland for medical reasons, similar to arrangements in other remote island communities such as Christmas Island. Therefore Health Partners ambulance cover is not applicable on the island.

Health Insurance Initiatives from the Australian Government

The Rebate

The Australian Government Rebate on Private Health Insurance was introduced as a financial incentive to help Australians afford private health cover. The rebate depends on your age, is income-tested and applies to all Health Partners products.

The rebate is indexed by the lesser of CPI of the percentage change in your premium each year, using a Government calculated formula.

Claiming the rebate

You may claim the rebate as a reduction in your premiums by nominating a rebate tier. Alternatively, you can claim the rebate via your tax return.

Please note that if you have a Lifetime Health Cover (LHC) loading, the rebate is not claimable on the LHC component of your private health cover premiums.

Nominating a tier

Use the table to the right to determine your Rebate Tier. Nominate a tier when you join, or at any time by contacting Health Partners or via Members Online at healthpartners.com.au

If you are unsure of which rebate tier is applicable to you, please contact your tax agent. Health Partners are unable to give advice on which tier you should select.

The income thresholds are subject to change as determined by the Federal Government.

For more information please visit:

- healthpartners.com.au/governmentrebates
- privatehealth.gov.au
- ato.gov.au

The information below relates to the 2018-2019 financial year.

Income thresholds

Base Tier	Singles Families	$90,000 or less $180,000 or less
Rebate Tier 1	Singles Families	$90,001 to $105,000 $180,001 to $210,000
Rebate Tier 2	Singles Families	$105,001 to $140,000 $210,001 to $280,000
Rebate Tier 3	Singles Families	$140,001 or more $280,001 or more

Rebate percentage

Private health insurance rebate effective from 1 April 2018 to 31 March 2019

Base Tier	Aged under 65 Aged 65-69 Aged 70 or over	25.415% 29.651% 33.887%
Rebate Tier 1	Aged under 65 Aged 65-69 Aged 70 or over	16.943% 21.180% 25.415%
Rebate Tier 2	Aged under 65 Aged 65-69 Aged 70 or over	8.471% 12.707% 16.943%
Rebate Tier 3	Aged under 65 Aged 65-69 Aged 70 or over	0% 0% 0%

Note: Single parents and couples (including de facto couples) are subject to the family tiers. For families with children, the income thresholds are increased by $1,500 for each child after the first. Rebate levels are adjusted annually on 1 April based on the Government's Rebate Adjustment factor.

Lifetime Health Cover

Lifetime Health Cover (LHC) is a Government initiative designed to encourage you to take out private hospital cover earlier in life, and to maintain your cover.

People who take out (and keep) hospital insurance before their 'base day' pay lower premiums throughout their lifetime than people who join later. Generally, your base day is the later of 1 July 2000 or the 1 July following your 31st birthday.

For every year you are aged over 30 and do not have private hospital cover, you will pay an additional 2% loading on top of your 'base' hospital premium (or your share of a couple or family premium), when you do join.

For example, if you join at 35 you pay 10% more, and if you join at 50 you'll pay 40% more.

LHC only applies to hospital policies – there are no age penalties for general treatment (extras) policies. Loading is removed after 10 years of continuous hospital cover.

So to avoid the LHC loading, you must take out hospital cover before 1 July following your 31st birthday.

Certified age

In most cases, your certified age is the age on the 1st of July before the day on which you first took out private hospital cover. This is used to calculate your LHC loading. The minimum certified age is 30.

If you know your certified age, use the table on the right to determine the loading that may apply to you. For couples and families, look up the loading for each partner, add the loadings together and divide by two.

Exceptions

You may be eligible for an exemption to the LHC loading if:

- You were born on or before 1 July 1934
- You have been living overseas since 1 July following your 31st birthday or since 1 July 2000
- You have migrated to Australia and became eligible for Medicare benefits in the last 12 months
- You hold or have held a Gold Card
- You are an active member of the Australian Defence Force.

Certified age	Lifetime Health Cover loading
30	0%
31	2%
32	4%
33	6%
34	8%
35	10%
36	12%
37	14%
38	16%
39	18%
40	20%
41	22%
42	24%
43	26%
44	28%
45	30%
46	32%
47	34%

Certified age	Lifetime Health Cover loading
48	36%
49	38%
50	40%
51	42%
52	44%
53	46%
54	48%
55	50%
56	52%
57	54%
58	56%
59	58%
60	60%
61	62%
62	64%
63	66%
64	68%
65	70% (max)

Please note that the Australian Government Rebate (previous page) does not apply to the LHC component of your private health cover.

Health Insurance Initiatives from the Australian Government continued

Permitted days

Permitted days are the number of days you are able to drop your hospital cover without affecting your loading. You can drop your hospital cover for a cumulative period of 1,094 days (i.e. 3 years less 1 day). Once you have used these permitted days without hospital cover, a 2% loading will apply for each year or part year you are without hospital cover.

You can drop your cover without using permitted days and without affecting your loading when:

- You have suspended your membership
- You are overseas for at least 12 months. You can return to Australia for visits of up to 90 days at a time and still be considered as being overseas.

Please be aware that if you do drop your hospital cover, you may need to re-serve hospital waiting periods upon re-joining.

Removal of LHC loading after 10 years

Your LHC loading can be removed after you have completed 10 years of continuous cover with one or more health funds.

Please note that although you can break up your 10 years of continuous cover with any of the above permitted periods without hospital cover, the breaks in cover do not count towards the 10 years.

You should also note that if you use up your full 1,094 permitted days, the continuity of your 10-year period of cover is broken. If you re-join hospital cover after exceeding the 1,094 days, you will have to pay an increased loading and you will have to restart your 10 years of continuous cover from the date of re-joining.

More information

For more information, please visit privatehealth.gov.au.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a maximum 1.5% surcharge imposed on people who earn above a certain income and who do not have applicable private hospital cover. The level of surcharge depends on your level of income for MLS purposes and is payable in addition to the standard Medicare Levy. It may apply for any period during which you suspend your hospital cover; for example, if you suspend your cover for overseas travel.

Use the table to determine if the MLS may apply for you. The information below relates to the 2018–19 financial year.

Income thresholds

Base Tier	Singles Families	$90,000 or less $180,000 or less
Rebate Tier 1	Singles Families	$90,001 to $105,000 $180,001 to $210,000
Rebate Tier 2	Singles Families	$105,001 to $140,000 $210,001 to $280,000
Rebate Tier 3	Singles Families	$140,001 or more $280,001 or more

The family income threshold is increased by $1,500 for each child after the first.

Medicare Levy Surcharge

Base Tier	Rate	0.0%
Rebate Tier 1	Rate	1.0%
Rebate Tier 2	Rate	1.25%
Rebate Tier 3	Rate	1.5%

More information

For more information, including when the levy applies, levy percentages and surcharge thresholds, please visit ato.gov.au or call the Australian Taxation Office on 13 28 61.

Privacy Policy

Health Partners is committed to providing quality and affordable health care services and insurance in a way which meets your needs. We appreciate and highly value our relationship with you. As an important part of this relationship, we are committed to protecting your privacy. In accordance with privacy legislation, we comply with the Australian Privacy Principles (APPs) in the *Privacy Act 1988* (Cth) in relation to our handling of your personal information.

The following is a summary of our Privacy Policy. If you would like to know more about how your privacy is protected, you may view a full copy of Health Partners Privacy Policy at our website healthpartners.com.au or contact us on 1300 113 113.

Your personal information

The type of personal information we hold about you depends on the nature of your relationship with us and the extent to which you have utilised our services. Such information includes your name, address, age, dependants, contact details (including telephone and mobile numbers, and email addresses). Certain financial information may also be collected from time to time, including bank account and credit card details, Medicare numbers and details about your premium payments and claims history.

We may also hold information concerning your employer if you have elected to pay premiums via a payroll deduction scheme.

Sensitive information about you (including health information) may also be collected from time to time. All sensitive information will be collected in accordance with Health Partners Privacy Policy or as otherwise prescribed by the APPs.

If your personal information is not provided

If you do not provide us with all of the information we request, we may be unable to provide you with the products or services you require.

How we use your personal information

The primary purpose of the collection of your personal information is to enable us to provide health benefits and services to you and to fulfil our legal obligations as a registered private health insurer.

To ensure that we can effectively provide you with the quality of health benefits and other services that you expect, we will use your personal information for:

- Claims processing and administration
- Product development, marketing and research purposes to improve and extend our range of services to you
- Information technology requirements and systems maintenance
- Investigating and resolving complaints about the provision of services by us (or organisations associated with us)
- Direct marketing initiatives in accordance with the APPs
- Compliance with any legislative and regulatory provisions
- Any secondary purpose to which you consent.

You may contact us at any time to indicate you do not wish to receive direct marketing material from us.

When we disclose your personal information

We may disclose your personal information to our agents, contractors or service providers who act or provide their professional services on our behalf. The identity of these agents, contractors and service providers may change from time to time. In general, the types of persons and organisations your information may be disclosed to include:

- Federal and State health authorities, and government agencies including Medicare Australia
- The Private Health Insurance Administration Council
- Health service providers including hospitals, doctors, specialists and other medical and related professionals
- Other service providers providing services associated with your health and wellbeing
- Our outsourced contracted service providers, including:
  - payment systems operators
  - mail houses
  - recruitment organisations
  - research providers
- Your employer (if part of a payroll deduction scheme)
- Other parties to whom we are permitted, authorised or required by law or the APPs to disclose your personal information.

Any law that requires the particular information to be collected

Health Partners is required under Commonwealth and State health legislation to collect, store and disclose certain personal information about individuals from time to time. The *Private Health Insurance Act 2007* (Cth), for instance, requires us to collect certain sensitive information as a condition of registration as a registered private health insurer.

You can access your personal information

You may request access to the personal or sensitive information that we hold about you at any time (although under the APPs some requests may be denied in certain circumstances).

All requests should be made in writing to us, or by contacting our Member Care team on 1300 113 113. We may also charge an administrative fee for this service (the amount of which will be advised at the time of your request).

Your responsibilities

It is a condition of membership that you ensure that every person on your membership is aware of the Health Partners Privacy Policy.

In case of a complaint

Health Partners strives to provide you with quality products and services. However, we recognise that despite our best intentions, members may have concerns or complaints regarding their interactions with us.

To ensure that all feedback and concerns are heard and addressed fairly and satisfactorily, we have a formalised **Dispute Resolution Process**.

If you are not satisfied with, or have concerns about our products, service, decision on claims, or service from a Health Partners Participating Provider, please take the following steps:

Step 1

Contact us

We are committed to discussing and addressing your concerns promptly. Please contact us by:

Phone
1300 113 113

Mail
Health Partners
Reply Paid 1493
Adelaide SA 5001

Email
ask@healthpartners.com.au

In person
With a Member Care Consultant, Senior Member Care Consultant or Manager at the centre that handled your matter.

To assist us in helping you, gather all documentation, including your membership details, and consider the questions and information that may assist us in resolving the issue. Once you have explained your concern, we will work toward resolving the matter to your satisfaction.

Step 2

Escalation

If, once you have contacted us and despite our best efforts, you are not satisfied with the outcome, the matter can be referred to the Health Partners' Dispute Resolution Officer, by:

Phone
1300 113 113

Mail
Manager Customer Relations
Health Partners
Reply Paid 1493
Adelaide SA 5001

Email
complaints@healthpartners.com.au

If, after this, you are still not satisfied with the outcome, we will refer the matter to the Health Partners Chief Executive Officer.

Procedures are in accordance with International Quality Standard ISO 10002–2014 (Quality Management – Customer Satisfaction).

Step 3

External Review

If you feel that your issue is still unresolved or that the complaint was not dealt with fairly, we encourage you to seek an external review. Depending on the nature of your complaint, we would suggest that you contact the following departments for free and independent advice:

Membership and Fund related disputes

Private Health Insurance Ombudsman (PHIO)

Phone

1300 362 072
(select option 4 for Private Health Insurance during business hours)

1800 640 695
(free call from anywhere in Australia, excluding mobile phone calls)

Fax

(02) 6276 0123

Email

phio.info@ombudsman.gov.au

Post

Private Health Insurance Ombudsman
Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Internet

ombudsman.gov.au

Optical and Dental related general service disputes

(ie if you are raising your dispute for: an explanation; an apology; a refund or compensation; access to your health records; a change in policy at the place of health service)

Health and Community Services Complaints Commissioner (HCSCC)

Phone
(08) 8226 8666

1800 232 007
(Toll free from Country SA landline)

Available Mon-Fri 9.00am to 5.00pm

Fax

(08) 8226 8620

Email

info@hcscc.sa.gov.au

Post

HCSCC
PO Box 199
Rundle Mall SA 5000

Internet

hcscc.sa.gov.au

Optical and Dental related disputes regarding practitioners and their conduct

(ie if you believe a practitioner is placing the public at risk; they are preforming their duties in an unsafe way; or you are concerned about a practitioners ability to make safe judgments because of their health)

Australian Health Practitioner Regulation Agency (AHPRA)

Phone
1300 419 495

Available Mon-Fri 9.00am to 5.00pm

Online Enquiry

ahpra.gov.au/About-AHPRA/
Contact-Us/Make-an-Enquiry

Post

AHPRA
GPO Box 9958
Adelaide SA 5001

In Person

Level 11
80 Grenfell Street
Adelaide SA 5000

Internet

ahpra.gov.au

Procedures are in accordance with International Quality Standard ISO 10002-2014 (Quality Management — Customer Satisfaction).

Member Care Charter

At Health Partners, we're committed to providing you with the best possible service. Take a look at what you can expect from us.

We're not only friendly, we're attentive as well

When you visit Health Partners, you'll be greeted with a smile by someone who's not only polite, but will identify themselves and listen carefully to what you're saying. Friendly service also means ensuring you have up-to-date information, having things explained clearly and simply and providing you with a contact name – in case you have any further questions.

Responsive action is a great responsibility

If you call Health Partners, you'll be greeted by a real person – not a machine. We'll aim to personally answer 80% of calls within 30 seconds. We'll also respond to your correspondence within two working days and process your claims within five working days (faster, if you choose the direct credit benefit payment option). Every enquiry is important and we'll explain to you how we make a decision, how long it will take and contact you directly by phone or in writing once it's made.

Honesty and integrity – it could almost be our motto

When you deal with Health Partners, we undertake to apply our policies fairly and with a healthy dose of respect. We'll inform you of your rights, respect your privacy, act respectfully to all cultures and importantly, not discriminate against you in any way. You can be confident your information will be recorded accurately and stored properly and safely. We'll also explain how you can seek a review if you're unhappy with a decision we've made.

Improving our service is something we'll always do

By measuring member satisfaction each year and responding to your feedback, we're ensuring our service to you is always given the highest priority. We'll make sure you're kept informed of any new or updated products or services and provide our staff with the necessary skills and training required.

You'll always get the best out of us

Health Partners will review our Member Care Charter annually, make any necessary or appropriate changes and make sure you're kept up-to-date each year. We also believe it's important to operate at all times within the Private Health Insurance Code of Conduct.

We expect the same in return

We'll always strive to give you the very best service – and there are little things you can do to help. Things like treating our staff with the same courtesy, honesty and respect as we show you; respecting our property; letting us know if you're having difficulty meeting your payment obligations; managing your dental and optical appointments responsibly and advising us if you can't attend; ensuring the information you provide *us* is accurate and up-to-date; and making sure you read correspondence we send you as it may contain important information that affects your benefit entitlements and/or premiums, which we are legally required to provide.

Health Partners values and welcomes your feedback; please let us be the first to know if you're unhappy with any aspect of our service.

Procedures are in accordance with International Quality Standard ISO 10002-2014 (Quality Management – Customer Satisfaction).

Where to find us

Health Partners Administration

(registered office)

Adelaide

Level 3, 101 Pirie Street
Adelaide SA 5000

Phone 1300 113 113
Fax (08) 8113 2259
Web healthpartners.com.au

Health Partners Member Care

Phone 1300 113 113
Fax (08) 8113 2259
Email ask@healthpartners.com.au*
WebChat* via healthpartners.com.au

Adelaide

101 Pirie Street
Adelaide SA 5000

Opening hours
Mon to Thu 8.30am – 5.30pm
Fri 9.00am – 5.30pm
Sat 9.00am – 1.00pm

Modbury

Level 1, 27 Smart Road
Modbury SA 5092

Opening hours
Mon to Fri 8.30am – 5.30pm
Sat 9.00am – 1.00pm

Morphett Vale

118-120 Main South Road
Morphett Vale SA 5162

Opening hours
Mon to Fri 8.30am – 5.30pm
Sat 9.00am – 1.00pm

Phone services available (all locations)
Mon to Fri 8.00am – 8.00pm
Sat 9.00am – 1.00pm

Health Partners Optical

Adelaide

101 Pirie Street
Adelaide SA 5000

Phone 1300 115 115

Modbury

27 Smart Road
Modbury SA 5092

Phone 1300 127 127

Goodwood

92 King William Road
Goodwood SA 5034

Phone 1300 116 116

Morphett Vale

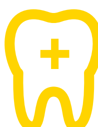
118-120 Main South Road
Morphett Vale SA 5162

Phone 1300 191 191

Opening hours (all locations)
Mon to Wed 8.30am – 5.30pm
Thu 8.30am – 8.30pm
Fri 9.00am – 5.30pm
Sat 9.00am – 1.00pm

Phone services available
Mon to Fri 8.30am – 5.30pm
Thu 8.30am – 8.30pm

Health Partners Dental



Adelaide

Level 1, 101 Pirie Street
Adelaide SA 5000

Phone 1300 114 114

Opening hours
Mon to Thu 8.00am – 6.30pm
Fri 8.00am – 5.00pm

Morphett Vale

118-120 Main South Road
Morphett Vale SA 5162

Phone 1300 114 114

Opening hours
Mon & Wed 8.00am – 5.30pm
Tue & Thu 8.00am – 7.30pm
Fri 8.00am - 5.00pm
Sat 9.00am – 1.00pm (fortnightly)

Modbury

Level 1, 27 Smart Road
Modbury SA 5092

Phone 1300 114 114

Opening hours
Mon & Wed 8.00am – 5.30pm
Tue & Thu 8.00am – 7.30pm
Fri 8.00am – 5.00pm

Barossa Dental

37 Barossa Valley Way
Nuriootpa SA 5355

Phone 08 8562 1444

Opening hours
Mon to Wed 8.30am – 5.00pm
Thurs 8.30am – 8.00pm
Fri 8.30am - 5.00pm
Sat 8.30am - 1.00pm

**If you are a current Health Partners member, please ensure you include your full name plus member number and date of birth so we can correctly identify you as per our Privacy Policy.*

Health Partners puts the security of your information at a high priority, however e-mail transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses, despite our best efforts to protect your data. Emails you send us could be intercepted before they reach us, leaving sensitive information at risk of being disclosed to unwanted entities. Therefore, you should always check your computer for threats with appropriate anti-virus/malware software to minimise your risk.

Health Partners will take receiving an email or webchat request from you as authorisation to allow us to reply to you in the same format. Health Partners accepts no liability for any damage caused by a transmitted email or webchat message sent by us, whether due to virus or other issue.

Alternatively, you can contact us via phone or in person with your enquiry.

Call 1300 113 113 (SA) **or 1800 182 322** (interstate and SA country)

Visit healthpartners.com.au

Email us ask@healthpartners.com.au

Health Partners is a registered private health insurer since 1937.
All information in this brochure is effective 1 August 2018.
Health Partners Ltd ABN 43 128 282 904