Navy Health

IMPORTANT INFORMATION ABOUT YOUR POLICY

A Members Health Fund

Our not-for-profit status means our profits go towards minimising premiums and enhancing services.

Serving everyone connected to Defence.

Serving everyone connected to Defence.

Contents

MEMBERSHIP TYPES

Single membership

Cover is for one adult only.

Couple membership

Cover is for the member with a spouse/partner.

Family membership

Cover is for the member with a spouse/partner, plus;

- Any unmarried children until they turn 22 years of age or enter into a de facto relationship.
- Any unmarried children between the age of 22 and 31 years who are undertaking a course of study at a publicly funded or private sector tertiary institution which requires a full-time study workload in Australia.
- Any members with a Young Adult membership (see right).

You should advise Navy Health of any unborn children before the expected due date (if possible). To ensure no waiting periods will apply for newborn children, they must be added within two months of birth (and backdated to date of birth).

Please note: a dependant who is no longer eligible for cover under a parent's membership is able to take out membership in their own right. If the new cover is started the day after their 22nd birthday, with an equivalent level of cover, no additional waiting periods will apply.

Single parent family

Cover is for one adult and dependants.

Also applies to military families, where one adult is serving, as the serving person will not be listed or covered by the policy.

Dependants only

Cover is for dependants only. The adult listed as the member is not covered under the policy.

Young adult membership

Young adult membership is for non-student dependants over 22 years of age. They will remain covered under the existing family Hospital cover (at no extra charge) as long as they are covered on their own Extras cover.

Young adult membership applies until the dependant turns 27 years of age, marries or enters into a de facto relationship.

It's important to note that a non-student dependant must take up any Extras cover on the day after their 22nd birthday, with an equivalent level of cover, for no additional waiting periods to apply. Continuity of Hospital cover carried over from a parent's membership will be provided as long as the parent's membership is still current.

For more information please call **1300 306 289** or go to **navyhealth.com.au**.

MEMBERSHIP INFORMATION

When does membership commence?

Your membership commences from your chosen start date, once payment has been received.

How can I change my membership?

Any changes to the status of membership (i.e. level of cover, adding or deleting dependants) cannot be undertaken without Navy Health receiving written or verbal notification of the change.

Likewise, the change cannot be taken as being actioned without the member receiving written acknowledgement from Navy Health.

The easiest method of changing details is by calling our Member Services team on **1300 306 289** or emailing **query@navyhealth.com.au** and informing us of your change.

Cover changes

Transferring to a higher level of cover will result in the member and any persons covered having to serve new waiting periods. Whilst these waiting periods are in force, benefits will still be payable at the previous level of cover. New benefits are not payable for pre-existing ailments or conditions (regardless of whether or not they have been diagnosed) until a waiting period of 12 months has been served. This also applies to Pregnancy & Birth and Assisted Reproductive Services.

When are contributions payable?

Payment of contributions is always in advance. Direct debit payments can be made on a fortnightly, monthly, quarterly, six monthly or yearly basis.

Discounts

Members choosing to pay half-yearly will receive a 2% discount and annual payments will receive a 4% discount.

If you are an Active Reservist (SERCAT 3 and above) or hold a current Veteran Gold or White Card, you are eligible for a 10% discount on your policy premiums.*

A serving person's spouse/partner and/or underage dependants are eligible for a 10% discount on their policy premiums until the serving person discharges from the Australian Defence Force (ADF).*

When does membership cease?

A membership will cease on a date advised and paid to by the member or automatically when contribution payments are more than one month in arrears.

Cooling off period

Members can choose not to proceed with their Navy Health cover and request to have any premiums reimbursed. This reimbursement is on the condition that the member expresses their request to the fund within 30 days of their cover commencing, and that no claims have been lodged or are pending during the 30 day cooling off period.

Suspension of membership

Navy Health at its absolute discretion may allow, within a clearly defined limited set of circumstances, for a member to suspend their membership for an agreed period. Where the suspension has been approved in writing by Navy Health, members will be advised of the conditions relating to waiting periods and pre-existing condition rules which may be applied upon reinstatement of membership.

The agreed suspension period is not subject to change without written notification to and written confirmation from Navy Health.

ADF personnel can suspend their cover when they are posted overseas. Members who move into continuous full time service (CFTS) can also suspend their cover for the duration of the CFTS.

For more information please go to **navyhealth.com.au**.

* Veteran White and Gold Cardholders and Active Reservists (SERCAT 3-5) must be covered by the membership for the discount to apply. Active Reservists and serving ADF members must pay via direct debit on selected payment frequencies. Only one discount can be applied to a membership. Proof of eligibility must be provided for discount to apply. Discounts will only be applied up to a maximum of 10% across the policy. Please visit **www.navyhealth.com.au/defence-discounts/**for full terms and conditions.

AUSTRALIAN GOVERNMENT PRIVATE HEALTH INSURANCE REBATE

Most Australians with private health insurance currently receive a rebate from the Australian Government to help cover the cost of their premiums

The rebate you are eligible for depends on your age*, is income-tested and applies to all Navy Health health insurance covers. The rebate isn't applicable to the Lifetime Health Cover loading portion of membership payments.

Below are the thresholds set by the Australian Government as of 1 July 2025.

The rebate is indexed each year by the difference between the Consumer Price Index (CPI) and the industry average increase in premiums using a Government calculated formula.

Claiming the rebate

If you are eligible for the rebate, there are two ways you can claim:

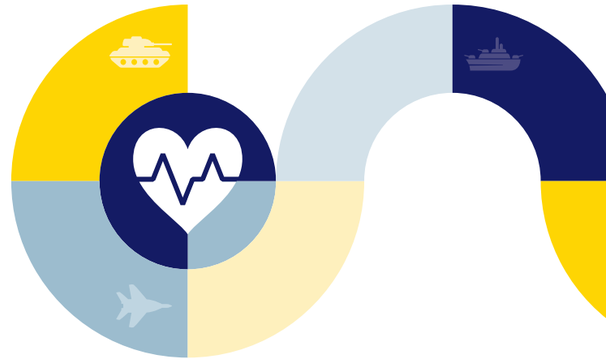
- Through a reduced premium; or
- Through your tax return with the Australian Tax Office (ATO).

If you choose to receive your rebate through your insurer, you will be asked to nominate the tier you expect to fall into in order to avoid a tax liability.

You can nominate your tier by contacting Navy Health.

More information regarding the Australian Government Rebate is available at **navyhealth.com.au/knowledge-base-articles/private-health-insurance-rebate** or by phoning **1300 306 289**.

If you aren't sure which rebate tier you should choose, please contact your tax agent, financial advisor or the ATO at **www.ato.gov.au/privatehealthinsurance**.



Federal Government Rebate*					
	Income for rebate purposes		Under 65 years	65-69 years	70+ years
Base Tier	Single	$101,000 or less	24.288%	28.337%	32.385%
	Couple/family	$202,000 or less			
Tier 1	Single	$101,001-$118,000	16.192%	20.240%	24.288%
	Couple/family	$202,001-$236,000			
Tier 2	Single	$118,001-$158,000	8.095%	12.143%	16.192%
	Couple/family	$236,001-$316,000			
Tier 3	Single	$158,001 or more	0%	0%	0%
	Couple/family	$316,001 or more			

* Single parents and couples (including de facto couples) are subject to family tiers. For families with children, the income thresholds are increased by $1,500 for each child after the first. Your entitlement is based on the eldest person covered on your policy.

LIFETIME HEALTH COVER LOADING

Lifetime Health Cover (LHC) is an Australian Government initiative that started on 1 July 2000. It was designed to encourage people to take out Hospital insurance earlier in life and to maintain their cover.

If you take out Hospital Cover after 1 July following your 31st birthday, you could face a 2% loading penalty on your private health insurance premiums for each year over the age of 30 you have not held Hospital Cover, up to a maximum of 70%.

Other things to know about LHC:

- The maximum LHC loading you can have is 70% at 65 years old;
- People who were born on or before 1 July 1934 are exempt from the loading;
- LHC loadings stay on your cover for 10 years. Once you have paid for 10 continuous years of Hospital cover the loading is removed (some conditions apply); and
- If you are a member of the Australian Defence Forces (ADF) your medical services are provided by the ADF, so you are considered to have Hospital cover. If you joined the ADF prior to 1 July 2000, your entry age for LHC purposes upon discharge will be 30. If you joined the ADF on or after 1 July 2000, your entry age for LHC purposes is that at which you joined the ADF, unless you previously had private health insurance.

Lifetime Health Cover on discharge

Health care costs of serving members are met by the Commonwealth until the date of discharge. This is regarded as the equivalent of private health insurance and as such, no Lifetime Health Cover penalty applies to members of the ADF when they separate, providing they take out Hospital cover immediately following discharge.

ADF personnel and Veteran Gold Card Holders

If you hold a Veterans' Gold Card you are considered to have Hospital cover. If you have held a Gold Card at any time since 1 July 2000, and the card was subsequently withdrawn by the DVA, you may claim the period you held the card as a period with private health insurance.

To accommodate small breaks in your cover the Government allows a number of permitted days without Hospital cover. For a full explanation of how this works and other LHC conditions go to **privatehealth.gov.au**.

MEDICARE LEVY SURCHARGE

The MLS aims to encourage individuals to take out private Hospital cover and where possible, to use the private system to reduce the demand on the public system.

The Medicare Levy Surcharge (MLS) is levied on Australian taxpayers who do not have private Hospital cover and earn above a certain income.

The MLS covers you and your dependants. Your dependants include your spouse/partner, any of your children who are 21 years of age or under, students who are under 31 years of age, or dependents under 27 with a young adult membership.

The MLS is calculated at the rate of 1% to 1.5% of your income. It is in addition to the Medicare Levy of 2%, which is paid by most Australian taxpayers.

Single parents and couples (including de facto couples) are subjected to family tiers. For families with children, the thresholds are increased by $1500 for each child after the first.

You may also be subject to the MLS, if your taxable income is over the threshold and you have a dependent who is not currently covered by an approved health cover.

As an ADF serving member, you would have been exempt from paying the levy if you were single or only paid 1% if you had a family. Although as an ADF member you may not require health insurance, if your combined family income is above $180,000, your family will need to take out private Hospital cover to avoid MLS.

If you or your family receive a high income, it may be beneficial to consider private health insurance to avoid the MLS.

For more information regarding the MLS please go to **navyhealth.com.au/knowledge-base-articles/medicare-levy** or the Australian Taxation Office website at **ato.gov.au**.

Income for Rebate Purposes			
			MLS
Base Tier No change to rebate or MLS	Single	$101,000 or less	0.0%
	Couple/family	$202,000 or less	
Tier 1	Single	$101,001-$118,000	1.0%
	Couple/family	$202,001-$236,000	
Tier 2	Single	$118,001-$158,000	1.25%
	Couple/family	$236,001-$316,000	
Tier 3	Single	$158,001 or more	1.5%
	Couple/family	$316,001 or more	

Medicare Levy Surcharge information correct as of 1 July 2025.

BENEFIT CONDITIONS

Benefit year

For general treatment (Extras) the Navy Health benefit year is 1 July to 30 June. For Hospital products with an excess, the benefit period is a rolling 12 month period. (i.e. the excess is payable once per adult, in full, up to the family maximum, in any rolling 12 month period).

When are benefits not payable?

Benefits are not payable, but is not limited to, when:

- Claims are over two years from the date of service;
- Claims for the same service exceed two treatments on the same day;
- The provider is not recognised in a private practice;
- The provider is not recognised by Australian Health Practitioner Regulation Agency (AHPRA);
- For Natural Therapies, the provider is not recognised by the Australian Regional Health Group (ARHG), or Exercise and Sports Science Australia (ESSA);
- If the service forms any part of a payment from Workers' Compensation, Third Party or any other liability provision, Navy Health reserves the right to seek full reimbursement on any benefits paid in these circumstances;
- The inpatient medical procedure does not have an assigned Australian Government Medicare Benefits Schedule item number;
- The claim is within a specified waiting or replacement period or annual/sub limits have been reached;
- The membership is in a period of suspension or payment arrears;
- The services are considered to be cosmetic surgery (not deemed medically necessary);
- The Extras service provided has an assigned Medicare item number;
- When treatment is provided during an emergency department visit; and
- Treatment has been already subsidised by any Government department.

Overseas benefits

Navy Health will not pay benefits on any services, treatments or products received outside of Australia or when purchased from a provider without an Australian Business Number (ABN).

HOSPITAL BENEFITS AND CLAIMING

Navy Health aims to close the gap on out-of-pocket, in-hospital expenses.

A gap payment is the difference between the fee charged by the hospital or doctor and the benefit paid by Navy Health and Medicare.

When treated as a private patient in a hospital, members may face extra costs when the treating doctor charges more than the Medicare Benefits Schedule (MBS) allows for the service provided.

Gap medical

The 'gap' is defined as the monetary variation between the MBS fee and the doctor's fee.

If the member receives treatment as a private patient in a hospital from a doctor who chooses not to participate in the Access Gap Scheme, Gap Medical benefits will apply (see below).

Under Gap Medical benefits, Medicare will cover 75% of the MBS fee for the service that has been provided. The insurer will pay the remaining 25% of the MBS fee.

If the doctor charges more than the MBS fee, the member will be responsible for any 'gap' payment.

Access Gap

Navy Health's Access Gap scheme aims to minimise the difference between the Medicare fee and what your Specialist charges. Specialists can choose to take part in Access Gap on a case-by-case basis; if they take part you'll either have no gap or be told exactly what your out-of-pocket costs will be. Even if your Specialist elects not to take part, you are legally entitled to know any out-of-pocket cost before your procedure — ask your Specialist.

MBS Fee		Gap
Medicare 75%	Fund 25%	Patient 100%

Private and day hospital — contracted facilities and services

Prior to admission, please check with Navy Health as to whether or not your treatment or service is contracted. Contracted services relate to hospital fees such as accommodation and theatre.

Navy Health has been able to negotiate 100% benefits on most treatments and services at over 500 private hospitals and day facilities. Product excesses still apply.

Medical devices and human tissue product items are payable at 100% of the minimum Government recommended fee. There is at least one medical device and human tissue product item available for every surgery with no out-of-pocket expense to the patient. Drugs prescribed for discharge and drugs not directly associated with the reason for admission are excluded from contracts and are the patient's responsibility.

In addition, if a patient chooses to stay in an executive suite, the patient will be required to pay the difference between the private room benefit and the executive suite charge.

There are two ways the Access Gap scheme can work for you; Known Gap Scheme or No Gap Scheme.

MBS Fee		Access Gap Fee	Gap
Medicare 75%	Fund 25%	Fund 100%	Patient 100%

Known Gap Scheme

If your chosen Specialist bills with a Known Gap through Access Gap, your out-of-pocket expenses relating to your in-hospital treatment will be capped. You won't be charged any additional amounts other than what you've agreed to in your Informed Financial Consent before your in-hospital treatment.

No Gap Scheme

If your chosen Specialist chooses to bill you with no gap, you will not have any out-of-pocket expenses for their in-hospital treatment.

The maximum an individual specialist can charge under the Access Gap scheme is $500 per admission to hospital, or $800 for obstetrics (as a private patient). Specialists can no longer charge fees not associated with the Medicare item number.

Navy Health's agreements are negotiated by the Australian Health Service Alliance (AHSA).

Please refer to **navyhealth.com.au/knowledge-base-articles/cover-the-gap** for further information.

Medical devices and human tissue product appliances

A medical device and human tissue product is an artificial substitute or replacement body part attached or applied to the body to replace a missing part.

If you are having surgery to implant or apply a medical device and/or human tissue product, your private health insurer must pay a benefit for it if:

- You have the correct cover for the treatment and the product is on the Australian Government Prostheses List;
- The insurer will pay the recommended minimum benefit as shown on the Prostheses List; and
- The Prostheses List will have at least one no gap medical device and human tissue product or device item for every in-hospital procedure covered on the MBS.

No benefit is payable where the hospital charges for a medical device and human tissue product not listed on the Prostheses List.

HOSPITAL BENEFITS AND CLAIMING CONTINUED

Podiatry surgery

Benefits are available only when Podiatric Surgery is performed in a contracted hospital by an Australian Government Accredited Podiatrist.

For further information call Member Services on **1300 306 289**.

Pharmacy

Any drugs administered in-hospital that are not on the pharmaceutical benefits scheme (PBS) may incur out-of-pocket expenses to be paid by you. Please ensure the hospital provides you with informed financial consent.

Exclusions

Where excluded services are listed on your policy, no benefits will be paid.

Restricted cover

For services that are listed as restricted on your policy, you can only be treated as a private patient in a public hospital. If you are treated at a private hospital, you will be significantly out of pocket.

Full ambulance cover

All Navy Health Hospital and Extras policies provide full ambulance cover within Australia, provided that the service is from a State/Territory registered ambulance service and deemed medically necessary.

Transport services by Patient Transport vehicles are not ambulance services and are not covered.

Hospital claiming

Generally hospitals will invoice Navy Health directly.

If you do receive an invoice for your hospital stay please contact Navy Health on **1300 306 289**.

To search for agreement hospitals and specialists in your area, please go to **https://navyhealth.com.au/find-a-provider/**.

EXTRAS BENEFITS AND CLAIMING

You can make claims for most Extras services at your provider at the time of service.

Preferred optical providers

If a member uses one of Navy Health's preferred optical providers, they can receive an additional benefit (subject to the annual maximum). To view the list of preferred optical providers go to **https://navyhealth.com.au/optical-provider/**.

The preferred optical provider list is subject to change without notice.

Natural therapies and recognised providers

Natural therapies include Acupuncture, Chinese Herbal Medicine, Myotherapy, Remedial Massage and Exercise Physiology.

Benefits are not payable on any medications, herbal or dietary preparations, or organised weight reduction programs.

Medically Prescribed Appliances (MPA)

MPA claims must be accompanied by a referral from a registered practitioner. The following are examples of items that can be claimed under the MPA category: Nebulisers, Humidifiers, Blood Glucose Monitors, Heart Rate/Blood Pressure Monitors, Support Aids/Mobility Aids, Compression Garments, Non-cosmetic medical device and TENS Machine/Circulation Boosters.

The MPA category covers the purchase, hire and repairs to appliances that are covered under the category up to the annual limit.

CPAP devices

CPAP devices can be purchased once in any rolling three year period. The rolling three year replacement period starts from the first date of purchase.

Pharmacy

Your Extras policy will cover pharmacy items that meet the following criteria:

- Already covered under the Pharmaceutical benefits scheme (PBS);
- Are fully approved by the Therapeutic goods administration (TGA);
- Are not experimental drugs or are part of a drug trial;
- Prescribed by an Australian registered medical practitioner, including dentists and nurses;
- Supplied by a registered Australian Pharmacist and are schedule four or eight medicines only; and
- Are not weight loss drugs or contraceptives (unless prescribed by a registered Australian Medical Practitioner for medical purposes), herbal medicines, over the counter pharmacy or non-prescription drugs.

Electronic claiming

All you need is your Navy Health membership card to use the electronic claiming system. After a consultation, your card can be swiped through the electronic claiming facility by the service provider. They will enter the claim details and process the transaction on your behalf.

Once the transaction has been authorised by Navy Health electronically you simply pay the balance amount (this is the difference between the fee charged for the treatment and the benefit amount paid by Navy Health).

Navy Health Member Portal claiming

You can claim your Extras services (excluding Orthodontic, MPAs and Pharmacy) immediately via the Navy Health Member Portal.

To register and for more information go to **https://members.navyhealth.com.au/**.

Mobile app

The Navy Health mobile app enables you to access your information, submit claims in a matter of seconds, check your benefits and limits on the go, and much more. Download the app from the **App Store** or **Google Play**.

Making claims by post and email

A completed Navy Health claim form must accompany all claims submitted manually. A copy of receipts forwarded for benefits will be held electronically by Navy Health on your behalf.

Original receipts will not be returned to the member. Claim forms can be downloaded from **https://navyhealth.com.au/forms-brochures/**.

Benefit payment

Benefit payments not processed at time of service can be direct deposited into a nominated bank account (within Australia and excluding credit cards).

GENERAL INFORMATION

To find out if you are eligible and how to join Navy Health go to https://navyhealth.com.au/fund-eligibility/

Waiting periods

Waiting periods for the selected level of cover are detailed in the preceding product fact sheet and need to be read carefully.

If you transfer to a higher level of cover, new waiting periods will be applied. However, benefits at the previous level will still be available whilst the new waiting periods are being served.

If you transfer to a Hospital product with a lower excess, the previous higher excess will apply for the first 2 months or 12 months if the condition is deemed to be pre-existing.

Transferring from another fund

Waiting periods are not applicable if you had an equivalent level of cover and completed all waiting periods with the previous fund.

Waiting periods will apply to those aspects of the Navy Health cover not covered previously by your past fund, and for those items specifically nominated within the products as requiring extended waiting periods. Whilst the 2, 6 and 12 month waiting periods are being served, benefits are payable at the previous level of cover, including any excesses applicable to your previous level of cover.

Pre-existing conditions*

A pre-existing condition is where signs or symptoms of an ailment, illness or condition, in the opinion of a medical practitioner appointed by Navy Health existed at any time during the six months preceding the day on which you joined the insurer or transferred to a higher benefit cover. This is irrespective of whether your medical practitioner, you and/or your dependants were aware of the condition or ailment.

The pre-existing condition rule also applies when resuming a suspended membership and symptoms or signs developed during the suspension period.

The pre-existing condition waiting period provides protection for existing members against people joining or upgrading cover only when they require treatment. This assists health funds in keeping premiums as low as possible. Claims and benefits within the first 12 months of joining the insurer or increasing to a higher level of cover are subject to the pre-existing condition rule.

Veteran Gold Cardholders

Members who are, or become Veteran Gold Cardholders have the option of retaining or cancelling their cover with Navy Health.

Where a member chooses to cancel their coverage, they must advise Navy Health directly. The cover will be cancelled from the date Navy Health receives notification, not from the date of issue of the card. The person holding the Veteran Gold Card may re-apply for membership to Navy Health without waiting periods or penalties (excluding pre-existing conditions), as they are deemed to have continuity of cover.

Any person who has previously held a Veteran Gold Card is entitled to join Navy Health from the date their Veteran Gold Card is no longer valid without serving any waiting periods. Proof of previous Veteran Gold Card status that shows the activation and cancellation dates is required.

Where a member chooses to retain their coverage, benefits will be paid on costs incurred after the Department of Veterans' Affairs (DVA) payment in line with the level of cover held, however the benefit must not exceed the total charge or the Navy Health benefits and annual limits and you may still incur an out-of-pocket expense.

Where a member with a Veteran Gold Card has Premium Gold Hospital coverage, Navy Health will pay the supplement (top up) benefit for a private room in a private hospital, as DVA already cover the cost of a shared ward.

Feedback and complaint handling policy

If for any reason you are not satisfied with the service you receive from Navy Health or feel that it has failed to meet your expectations, we would appreciate your feedback. We are committed to resolving your complaints in a fair and efficient manner and view your feedback as a vital opportunity to improve.

Navy Health provides an accessible, impartial, free-of-charge complaints handling procedure for members.

This procedure can be viewed at **https://navyhealth.com.au/contact/** or by phoning **1300 306 289**.

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman (PHIO) was set up by the Australian Government to deal with complaints where the member has not been able to resolve an issue with their insurer.

Whilst we actively encourage all members to discuss any such matters with our office in the first instance, the PHIO will gladly mediate if required.

The PHIO can be contacted on **1300 362 072**, by email **phio.info@ombudsman.gov.au** or you can write to: **Commonwealth Ombudsman, GPO Box 442, Canberra ACT 2601**.

Navy Health rules and constitution

New memberships must be in accordance with the rules and constitution of Navy Health Ltd.

Benefits are also paid in accordance with these rules.

Members can request a copy of the fund rules. All members are bound by the rules of Navy Health Ltd.

TERMS AND CONDITIONS

Navy Health is committed to protecting your privacy. By taking out cover with us, you agree to our collection, use, and disclosure of your personal information in accordance with our Privacy Policy (available at **http://www.navyhealth.com.au/policies/privacy-policy/**).

We collect only the information necessary to provide and manage your health cover, process claims, and verify eligibility, in line with the *Private Health Insurance Act 2007 (Cth)* and *Privacy Act 1988*. This may include data from healthcare providers, employers, or brokers if you are part of a corporate health plan.

Your information may be shared with related entities, regulatory bodies, and third parties acting on our behalf.

If we transfer your information outside of Australia, we will take reasonable steps to ensure the overseas recipient does not breach the Australian Privacy Principles in relation to your personal information.

As a policy holder, you must ensure all insured members understands our Privacy Policy. You may at any time, access or update your information with us, or opt out of marketing communications at any time.

If you or any insured individual does not consent to the way we handle personal information or fails to provide the necessary information, we may be unable to provide our products and services.

Direct debit service agreement

This agreement ("Direct Debit Service Agreement") outlines the terms and conditions of the direct debit arrangements between the person signing the direct debit request ("you") and Navy Health ("us").

You agree to be bound by these terms and conditions upon your execution of the Direct Debit Request.

Direct debit arrangements

(a) We will, in accordance with the terms of the direct debit request and any other existing agreement, periodically debit the nominated account for the agreed amount(s).

(b) The debits will occur according to the frequency you have nominated i.e. fortnightly, monthly or as agreed. The amount debited will vary according to the amount falling due.

(c) If any drawing falls due on a non-business day, it will be debited from the nominated account on the prior business day.

Your rights

(a) You can change your direct debit arrangements by calling us on **1300 306 289** at least five (5) business days prior to the next direct debit. Changes include altering arrangements, stopping an individual debit or cancelling a direct debit request completely.

(b) We will give you at least 14 days notice by telephone or writing (including e-mail) of any change to the terms of the direct debit arrangements, unless otherwise agreed.

(c) If you believe we have drawn on your account incorrectly, please contact us on **1300 306 289** so the matter can be resolved. We will make every attempt to resolve the dispute within five (5) business days.

Your obligations

(a) You must ensure that:

(i) Before completing the direct debit request, you check the account details of your nominated account are accurate (check against a recent statement from your financial institution);

(ii) Your nominated account can accept direct debits (your financial institution can confirm this);

(iii) Your nominated account has sufficient clear funds on the drawing date to allow payment to be made in accordance with the direct debit request and any other existing agreement between you and us.

(b) You must advise us immediately if your nominated account is not current.

(c) If any drawing is returned or dishonoured by your financial institution, we may, at our discretion, reprocess the transaction following receipt of the notification of return or dishonour, or request an alternative form of payment from you. We may also charge any dishonour fees back to you.

Code of conduct

Navy Health abides by the Private Health Insurance Code of Conduct.

By subscribing to the code, Navy Health ensures that members receive clear information and transparency in their dealings with Navy Health.

The code ensures Navy Health will:

- Continue to improve standards of practice and service;
- Provide information to members in clear and plain language;
- Ensure the policy documentation is full and complete;
- Ensure that Navy Health staff are appropriately trained to provide clear explanations;
- Provide members with access to an internal dispute resolution procedure and advise members of their rights to take an issue to the Private Health Insurance Ombudsman.

A copy of the code may be provided on request or can be viewed at **navyhealth.com.au/code-of-conduct**.

Private Health Insurance Code of Conduct™

CONTACT US

If you have any questions don't hesitate to contact us at:

query@navyhealth.com.au

1300 306 289 | query@navyheath.com.au

Navy Health