

Intermediate Visitors Cover - Hospital and Medical



This cover is designed for visitors to Australia who are not entitled to cover under the Australian Medicare Scheme. The policy includes hospital charges and medical services provided in and out of the hospital. This cover is compliant for Temporary Business (Long Stay) (Subclass 457) visa purposes. The details for this cover were last updated 14th October 2011.

<p>WHAT'S COVERED IF I HAVE TO GO TO HOSPITAL?</p>	<ul style="list-style-type: none"> ✓ Ambulance - 100% of the charge, that is not otherwise covered by third party arrangements, for transport by ambulance provided by, or under an arrangement with, a government approved ambulance service when medically necessary for admission to hospital, emergency treatment on site, or inter-hospital transfer for emergency treatment. ✓ Hospital treatment, including shared room in a Private Hospital. ✓ Hospital Treatment, including shared or private room accommodation as a public patient in a Public Hospital. ✓ Doctors' bills in hospital up to the Medicare Benefits Schedule Fee. ✓ Theatre fee and Labour ward charges. ✓ Pharmaceutical Drugs – All Pharmaceutical Benefits Schedule (PBS) listed drugs that are prescribed according to the PBS approved indications, that are administered during and form part of an admitted episode of care – a benefit equal to the PBS listed price in excess of the patient contribution. ✓ Artificial appliances and prostheses, non-approved medical treatments and consumables. ✓ Surgically Implanted Prostheses –No gap prostheses and gap permitted prostheses as listed in the Private Health Insurance (Prostheses) Rules 2007: Benefit at least equal to 100% of the minimum benefit amount listed. Benefits may be restricted for non-hospital contract medical treatments or consumables
<p>WHAT MEDICAL SERVICES ARE NOT COVERED AT ALL? (Exclusions)</p>	<ul style="list-style-type: none"> ✗ En-route to and from Australia. ✗ Services provided outside of Australia. ✗ Services arranged prior to coming to Australia. ✗ For cosmetic reasons ✗ For bone marrow and organ transplant ✗ For artificial reproductive techniques, investigation or treatment relating to infertility ✗ For any service for which Australian residents would not be covered under the national Medicare scheme. ✗ Services and treatment which are covered by compensation and damages provisions of any kind.
<p>WHAT MEDICAL SERVICES ARE COVERED IN HOSPITAL?</p>	<p>✓ Full cover of the charge up to the Medicare Benefits Schedule amount.</p>
<p>WHAT MEDICAL SERVICES ARE COVERED OUT-OF-HOSPITAL?</p>	<p>✓ Full Cover of the charge up to the Medicare Benefit Scheduled Fee. Limited to \$500 per person covered under the policy per calendar year.</p>
<p>HOW LONG ARE THE WAITING PERIODS FOR NEW AND UPGRADING MEMBERS?</p>	<p>2 Months - Psychiatric, rehabilitation and palliative care 12 Months - All obstetric related services. 12 Months - All other covered treatment in relation to a pre-existing ailment or condition.</p>
<p>WILL I HAVE TO PAY ANYTHING IF I GO TO HOSPITAL?</p>	<p>Excess: No excess payments are applicable. Extra cost per day (co-payments): No co-payments.</p>
<p>WHAT OTHER FEATURES DOES THIS POLICY HAVE?</p>	<p>Repatriation - For you and any other person covered under the policy who has to be repatriated to their home country because they are terminally ill or suffer from a substantial life-altering illness or injury, HIF will pay a contribution towards the cost of your return travel with one other family member and one other person qualified to give you medical supervision, provided that a benefit, up to a maximum Limit, is only payable after your treating medical practitioner and HIF agree that you are terminally ill or suffer from a substantially life-altering illness or injury. In the event of death your mortal remains and those of any other person covered by your policy</p>

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	may be repatriated to their home country if legally permissible. Maximum Limit: Once per person covered under the policy per lifetime: \$6,000 maximum.
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Pre-Existing Ailment Rule

The Pre-Existing Ailment Rule is an industry standard rule designed to ensure that long-term members are not financially disadvantaged by new members who join a table and seek to claim for conditions of which signs or symptoms would have been in place at the time the cover was commenced.

The Rule states: The Fund may not be required to pay benefits for a period of 12-months if the pre-existing ailment rule is applicable. A pre-existing ailment is an ailment or condition of which the signs or symptoms were in evidence at any time during the six months prior to when the member joins the Fund or upgrades to a higher level of cover.

If the Fund considers that the pre-existing ailment rule may be applicable, benefits will not be paid until the fund has been satisfied, through the production of suitable medical evidence, that the condition or signs or symptoms relating to the condition were not in place at the time the cover was commenced. HIF will appoint a medical adviser to determine, from the information provided by the patient and the treating/referring practitioner, if the claim will be revoked.

Excluded Services

Where services are noted, as 'Excluded' in your hospital cover, are not covered by a benefit and all associated costs must be paid by the member.

General Information

Contracted Private Hospitals

If you wish to find a Contracted Hospital with HIF you can do so in the following three ways:

- Refer to our website – www.hif.com.au
- Email HIF directly at info@hif.com.au
- Contact a HIF Customer Service Representative on 1300 13 40 60.

Medical Providers

Further information regarding medical coverage can be obtained from our AccessGap Cover leaflet which can be obtained in the following ways:.

- Refer to our website – www.hif.com.au
- Email HIF directly at info@hif.com.au
- Contact a HIF Customer Service Representative on 1300 13 40 60.

Privacy Policy

HIF recognises the importance of keeping the personal information that you entrust to us private and confidential. HIF's 'Privacy Policy' has been compiled to outline how your personal information is handled and the steps taken by HIF to ensure your privacy. If you would like to find out more about HIF's 'Privacy Policy' you can:

- Refer to our website – www.hif.com.au
- Email HIF directly at info@hif.com.au
- Contact a HIF Customer Service Representative on 1300 13 40 60 to request a copy of our Privacy Policy brochure.

Providing Feedback or Making a Complaint

HIF is committed to providing our members with access to the highest possible level of service and we value the feedback that our members provide. As part of HIF's commitment to continuous improvement if you have a concern regarding your HIF membership, our products, benefits or our service we would be happy to hear from you.

If you have a complaint or concerns, you can:

- Discuss this with one of our Customer Service Representatives on **1300 13 40 60**. HIF's internal complaint handling process ensures where our people are unable to assist you with your concerns or complaint they will escalate your issue to a senior manager.
- Access the Internal Complaint Handling process by addressing your complaint in writing to:

Operations Manager

Health Insurance Fund of Australia Ltd

GPO Box X2221

PERTH WA 6847

Or

Email your complaint to info@hif.com.au

If after discussing your concerns with us, and you believe the outcome or decision is not appropriate and you wish to take the matter further you can:

Contact the Private Health Insurance Ombudsman:

- Via the website www.phio.org.au or
- By ringing toll free on 1800 640 695, or
- Write to Suite 2, Level 22, 580 George Street, Sydney NSW 2000.