hif
Your health's best friend

Health cover made simple

Your guide to HIF and health insurance

PRODUCT DISCLOSURE STATEMENT FOR AUSTRALIAN CITIZENS AND PERMANENT RESIDENTS

Contents

*The information in this Guide is correct as at 01 April 2021. Minor changes may occur after that date. HIF Members are encouraged to regularly download the latest copy of this Guide from **hif.com.au/guide**, or contact us and we will send one to you.*

Health Insurance Fund of Australia Ltd (HIF) ACN 128 302 161 An Australian public company limited by guarantee.
A registered private health insurer.

This Guide should be ready carefully and in conjunction with HIF's product factsheets.

Why choose HIF?

HIF is the Health Insurance Fund of Australia, and we've provided great value health cover to Australians since 1954.

As a not-for profit health fund, our Members and their wellbeing are the whole reason we exist.

Today, we're a multi-award winning health fund and our priority is to ensure you get the best deal and the biggest benefits.

Simple as that!

Less confusion. More choice.

Health insurance can be confusing. We get it. But that's why we're here, to make it easy to understand, so you get the most from your cover.

More specific information

We created this Guide to answer any general questions you might have about our Hospital and Extras cover. It's been designed to be read in conjunction with our product factsheets, which outline our policies and include details about specific benefits, inclusions, waiting periods and more.

Got a question?

Visit our handy online knowledge base for 24/7 access to a wealth of information. Visit **hif.com.au/help** to get started or call us on **1300 13 40 60**

Unless otherwise stated, the information in this Guide refers to all HIF domestic health insurance products and applies to Australian citizens and permanent residents. This Guide should be read in conjunction with the policy documentation (product factsheet) specific to your cover.

About HIF Hospital cover

Let's start at the beginning: What is Hospital cover?

Our Hospital cover is private health insurance that covers you for overnight or same-day treatment as a private patient in hospital.

Hospital cover includes benefits for services provided by:

- Any HIF-contracted medical or hospital provider
- Non-agreement medical or hospital providers
- Public hospitals.

You're also covered for a range of treatments and services provided in your home (hospital substitute services) by a recognised health service provider.

What are 'agreement' or 'contracted' private hospitals?

We have agreements with most private hospitals across Australia. This means there is an agreed schedule of fees, including inpatient accommodation, theatre and special care/intensive care fees. These fees are charged by the hospital and paid by us on your behalf, so on most occasions, you'll never see a bill.

So, wherever we have an agreement in place, you're less likely to have out of pocket expenses. However, if you're admitted to a private hospital where we don't have an agreement, you may have significant out-of-pocket expenses.

Where is your nearest 'agreement' private hospital?

We have over 530 contracted hospitals in Australia. Visit **hif.com.au/hospitalsearch** or call us on **1300 13 40 60** to find your nearest hospital.

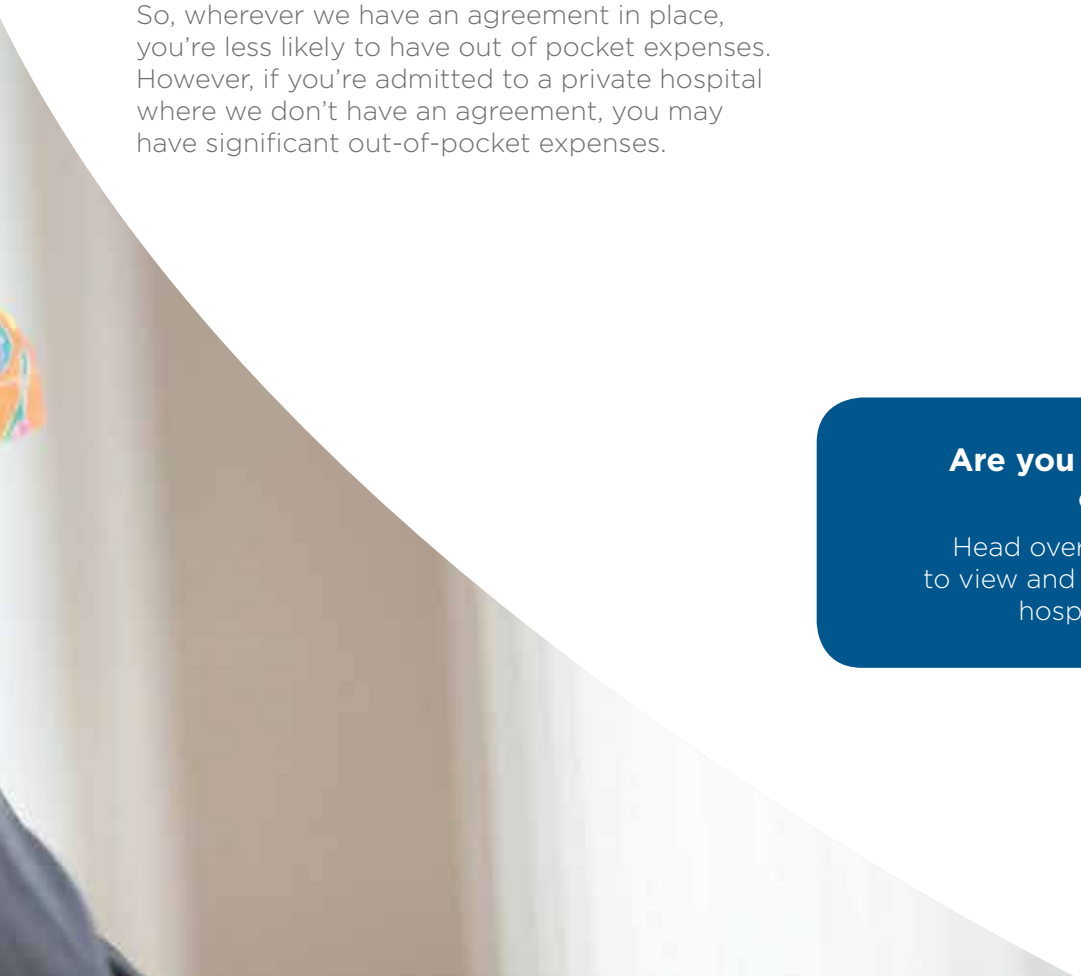
Which medical health providers are recognised by HIF?

Generally, we pay benefits for any government-recognised health provider who provides hospital or hospital substitute (in your home) services that are included in the Commonwealth Medicare Benefit Schedule (MBS).

What are hospital substitute services?

Hospital substitute services are hospital services that are delivered in the comfort of your own home, including chemotherapy, rehabilitation, complex wound management (home nursing) and chronic health disease management.

If you're not sure about the status of a provider or hospital substitute service, please call us on **1300 13 40 60**.



Are you an international visitor or temporary resident?

Head over to **hif.com.au/visitor-cover** to view and compare our visa-compliant hospital & medical cover options.

Inclusions, restrictions and exclusions

What hospital or hospital substitute services are included?

For all the inpatient services included in your policy (inclusions), you're covered for hospital accommodation and the delivery of medical treatments and services that are itemised in the Commonwealth Medicare Benefit Schedule (MBS).

Visit **hif.com.au/hospital** to check out our Hospital cover factsheets for a comprehensive rundown of inclusions, exclusions, excesses and waiting periods – they differ from cover to cover.

What is the difference between an inpatient and outpatient?

An inpatient refers to a person who has been admitted to an approved hospital or day facility, allocated a bed and then discharged following treatment.

An outpatient refers to a person who has received medical treatment in a doctor's surgery or hospital emergency department, but hasn't been admitted to hospital as an inpatient.

What is HIF Second Opinion?

HIF Second Opinion is a complementary service for HIF members who have top Hospital or Extras cover.

It gives you and your family instant access to the global Best Doctors' network, which has changed and saved thousands of lives around the world. From providing peace of mind, through radically improving treatment, outcomes and even saving lives, this unique service gives you remote access to some of the medical profession's leading minds – 50,000 medical experts spanning 40 specialties and 430 subspecialties.

You can use HIF Second Opinion to tap into specialist medical advice on any medical or health concern - from allergies and minor injuries to life threatening conditions such as cancer - whether you want a complete case review, or just some information, answers or peace of mind.

What are restricted services?

Take a look at our product factsheets and you'll see some services or treatments are referred to as 'restricted'. This means the benefits for that service or treatment are limited at the basic public hospital benefit rate – it's just a way to keep the cost of that particular cover down.

Restricted benefits include:

- The cost of a shared room in a public hospital
- A benefit towards the cost of surgically implanted prosthesis
- AccessGap cover for inpatient medical services.

No other benefits are payable for restricted services, so there could be significant out-of-pocket expenses for you.

What are excluded services or 'exclusions'?

Some HIF policies exclude benefits for certain services, which means the policy can be offered at a lower price.

For more information on excluded services, check out our product factsheets where services are noted as excluded, it means you're not covered at all for that service or treatment, so you are responsible for all costs beyond the Medicare benefit.

What should you do if the treatment you need is restricted or excluded on your policy?

Always check with us, your doctor or hospital prior to admission to ensure your planned treatment is covered (an 'inclusion') on your policy and that all applicable waiting periods have been served.

If the treatment or service you are planning is not covered and you do not want to be liable for the personal expense that will apply, you can ask your doctor to treat you as a public patient in a public hospital (if they practice in this capacity).

What's not included in any of our Hospital covers?

The following services are not covered under any of our Hospital policies:

- Any treatment, service, pharmaceutical item or device, or circumstances of provision which is:
  - Not approved for payment by Medicare or the Therapeutic Goods Administration (TGA)
  - Does not meet the requirements or standards legislated under the *Private Health Insurance Act (2007)*, including in-hospital services such as high cost drugs, experimental drugs, procedures, prostheses and technologies
- Any treatment or service provided as an outpatient (i.e. when you're not admitted as an inpatient) or where you're not being treated by an approved hospital substitute service
- Any ambulance or transport service (unless you live in New South Wales or the ACT – see the next section for more details).
- Charges raised by your dentist for dental surgery in hospital. If you wish to claim a benefit towards the dentist's fees you'll need to hold Extras Cover
- Any treatment or service provided outside Australia
- Any treatment or service for a patient who's not eligible for Medicare benefits – for example, cosmetic surgery
- Any treatment or service where a patient has the right to claim costs from a third party (e.g. another private health insurer, Workers' Compensation or motor vehicle insurance)
- Treatment or services by a provider who is not recognised by HIF
- Respite care.

Are ambulance services included on Hospital cover?

Ambulance cover is not included in any of our Hospital policies; however, under New South Wales and Australian Capital Territory legislation, we're obliged to contribute toward the cost of operating state or territory-provided emergency ambulance services on behalf of anyone with HIF Hospital cover who is a permanent state or territory resident. Residents of New South Wales or the ACT with HIF Hospital cover simply submit their emergency ambulance invoice (from their resident state or territory emergency ambulance service) to us and we'll finalise the invoice with the relevant service provider.

Please note, ambulance benefits may not be claimable if the service was not provided by your local state-controlled ambulance service, or if the service was not deemed by the ambulance attendant to be an emergency (i.e. medically necessary).

For more info, please see page 15 or visit **hif.com.au/ambulance**

What about Workers' compensation and dual insurance?

You're not entitled to benefits under your policy if you can claim benefits or compensation (in full or in part) from a third party, including Workers' Compensation or public liability sources, your employer or any other insurance policy.

Can I get a medical benefit estimate before having treatment?

Absolutely! In fact, it's something we strongly recommend that you do.

To request a benefit estimate in advance, please ask your doctor or specialist for a detailed medical estimate (this will include a list of the items you'll be billed for including fees for each item and your doctor's provider number), then complete our online estimate request form at **hif.com.au/medical-estimate**

Alternatively, you're welcome to call us on **1300 13 40 60** and we can provide a benefit estimate over the phone.

Benefits, expenses and gap cover

What is the 'medical gap'?

The medical gap refers to the out-of-pocket expenses that apply if your medical provider's fee is higher than the Commonwealth Medicare Benefit Schedule (MBS) fee for the services provided.

If your provider's fee is the same or less than the MBS fee, you'll be covered by Medicare and HIF. However, different providers can charge different prices for the same procedure, and if your provider's fee is higher than the MBS fee, you're likely to have an out-of-pocket (gap) expense.

If you're planning a procedure, ask your medical provider and any associated health provider (e.g. anaesthetist or assistant surgeon) if they will participate in our AccessGap scheme (see below) to help minimise or eliminate your out-of-pocket expenses.

If they don't confirm your out-of-pocket expenses, contact us with your provider's details, item numbers and charges and we'll provide you with a benefit estimate.

What is HIF AccessGap Cover?

AccessGap Cover (our medical gap cover) is designed to minimise or eliminate any out-of-pocket expenses for inpatient medical services. Medical providers can opt in or out of the AccessGap scheme, so it's important to check whether your provider will participate.

When will benefits for included services not be paid?

Benefits won't be paid if:

- Your policy is not financial (i.e. in arrears or suspended) when the benefit is claimed
- The claim is for a service provided more than two years ago
- The treatment, service or item is listed as an exclusion on your policy
- The initial benefit amount doesn't exceed the excess payable on your policy
- The treatment, service or item is provided within a waiting period
- The treatment, service or item is subject to the Pre-existing Condition Rule.

When could benefits be less than the provider's fee?

You're likely to have an out-of-pocket (gap) expense when:

- The treatment, service or item is listed as a restriction on your policy
- You're admitted to a non-agreement private hospital
- Your health provider doesn't participate in AccessGap and their charge is higher than the Commonwealth Medicare Benefit Schedule (MBS) fee
- Your health provider participates in AccessGap but charges above the fully covered gap schedule fee
- Your policy requires you to pay an initial excess amount
- You're required or elect to pay a co-payment for a private room (if you're not covered for private room accommodation)
- You were charged for services in a hospital that are not part of the treatment and care for your admitted condition (e.g. access to a TV, internet access, vehicle parking)
- You require a prostheses item that's not covered under the Government's Approved Prosthesis List
- You have take-home equipment, appliances or items from your hospital stay (e.g. pressure stockings, pharmaceuticals and pharmacy items).

Find an AccessGap doctor or specialist

Want to find a medical provider who's part of our AccessGap scheme? Go to **hif.com.au/accessgap** or call us on **1300 13 40 60**.

What is an excess?

An excess is the amount selected on a hospital insurance policy which the Member agrees to pay for a hospital admission before a benefit will be payable from HIF. For more information on the applicable excess that applies to your policy please refer to the relevant product factsheet.

Do I have to pay an excess?

It depends on the cover you choose. If you opt for cover with an excess, which reduces your premiums, you'll have to pay an excess per-person per calendar year (to a maximum of twice per couple or family policy) if admitted to hospital.

Members can choose from a range of optional excesses to reduce their premiums.

Visit **hif.com.au/hospital** to compare covers and view our excess options.

Read our product factsheets for more information about your excess options. You can find them at **hif.com.au/hospital**

Hospital accommodation costs, upgrades and co-payments

Depending on the cover you choose, you're either fully covered for a shared room or a private room.

If your policy provides full cover for a shared room, you can still choose to upgrade to a private room – you'll just be charged a co-payment by the hospital (i.e. the additional cost won't be covered by your insurance).

Important

If you're admitted to hospital and a shared room isn't available, you may be given a private room instead. In those instances (if you don't have private room cover), the hospital has the right to charge you a daily co-payment for the duration of your stay.

Hospital waiting periods and the Pre-existing Condition Rule

A waiting period is the time you have to wait before you can claim for a service, treatment or item. All health funds have to apply waiting periods to their Hospital cover – it's the only way we can protect our Members from those who would otherwise join HIF only to make a big claim, then leave.

However, we always try to keep waiting periods to an absolute minimum.

That's why, if you switch to us from another health fund, we'll take your previous membership into account so you don't have to re-serve any waiting periods already served on an equivalent or higher level of cover.

How do waiting periods work?

Waiting periods apply when you first join HIF or if you're already a Member and upgrade your cover.

If you join us or upgrade to a higher level of Hospital cover, or take out an equivalent level of cover with a reduced or nil excess, waiting periods will apply to the higher level of cover and benefits. Your previous excess will also apply until you have served your waiting period for pre-existing conditions.

The Pre-existing Condition Rule

All health insurers apply a 12-month waiting period for hospital treatment relating to a pre-existing condition – it's a rule that applies whether the ailment, illness or condition was known to the Member or not.

A pre-existing condition is defined as, 'Any ailment, illness, or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of six months ending on the day on which the person became insured under the policy.'

The pre-existing condition waiting period applies to new Members and existing Members upgrading their cover. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition, not on a diagnosis (i.e. it's not necessary for the Member or their doctor to know what their condition is or for it to be diagnosed).

In forming an opinion about whether or not an illness is a pre-existing condition, an HIF-appointed medical practitioner will take into account information provided by the Member's treating doctor.

Dental and podiatry surgery

Is inpatient dental surgery covered?

It depends on your level of Hospital cover; but, assuming your policy includes dental surgery and you undergo surgery by a recognised dentist in a hospital, you can claim benefits for theatre, accommodation and anaesthetist costs in a public or private hospital.

If your dentist is not a recognised medical surgeon, benefits towards your dentist's costs will only be paid under a suitable Extras policy (check out our Extras factsheets at **hif.com.au/extras** for details). This means, if you only have Hospital cover, you won't be able to claim a benefit towards your dentist's fees.

Is inpatient podiatry surgery covered?

Again, it depends on the cover you choose – check out our Hospital cover factsheets or visit **hif.com.au/hospital** to compare options.

If your cover includes podiatry surgery, you can claim limited benefits for hospital accommodation and theatre expenses only, but not anaesthetist costs. A limited benefit for your podiatrist's fees is only available on selected covers subject to annual limits and recognised service items.

Maternity cover

Do we provide maternity cover?

Yes, we do – maternity services are included on our Gold level of Hospital cover. You'll find more information about inclusions and benefits in our product factsheets available from **hif.com.au/hospital**

What do you get with maternity cover?

Whether it's your first or your fifth child, a new addition to the family is always a magical time. But it can also be stressful, which is why it makes sense to take out maternity cover if you're planning to have a baby – it'll give you more choices and peace of mind as you plan your maternity journey.

With HIF maternity cover you can:

- Choose your hospital, obstetrician and other specialists
- Choose a natural birth or an elective caesarean (not always an option in the public system)
- Enjoy private-room accommodation during your stay in hospital. Please refer to the product factsheet for accommodation benefits on childbirth.
- Claim for all of your labour ward fees
- Invite your partner (or a parent, sibling or friend) to stay with you in hospital as a boarder at no extra cost.

What is the waiting period for maternity cover?

If you're taking out maternity cover for the first time, the waiting period for all obstetric-related services is 12 months. That means you'll need to have held maternity cover for 12 months prior to your due date.

Will your baby be covered on your Hospital policy?

Yes, your baby will be covered on your family policy. In fact, there's no limit to the number of children that can be included on your family policy, and all children are covered up to at least 21 years of age.

If you hold a single membership, you have two months from your baby's date of birth to add them to your policy. If you add them after two months they'll have to serve waiting periods.

If you hold a family membership, you have four years from your baby's date of birth to add them to your policy. If you add them after four years they'll have to serve waiting periods.

Read the 'Frequently Asked Questions' and 'Glossary' sections in this Guide for more information about dependants.

Ways to pay

We're all about choice and making life easy. Choose the cover that suits you. Choose your hospital, your doctor, your specialist, your dental provider. And choose the most convenient way to pay your premiums and make a claim.

Direct debit. Flexible. Automatic. Convenient. No wonder it's our most popular payment option.

Manually. We send you an account when your premium is due and you can pay however you like:

By phone. Call **1300 13 40 60** for over-the-phone credit card payments (we accept Mastercard, Visa, Diners Club and AMEX).

Via BPAY. Simply use your bank's phone or internet banking system.

Via our website. Simply visit **hif.com.au/members** and log in to the secure Members' Area.

Post Billpay. Just hop on the phone or the internet.

In person. At any Australia Post branch.

By mail. Post your cheque or money order and the lower half of your invoice to: HIF, GPO Box X2221, Perth WA 6847.

Pay upfront and save

When you pay for six months' cover in advance you get a 2% discount. Pay a whole year in advance and you'll save 4% on your premiums.

About HIF Extras cover

What is Extras cover?

Extras health insurance covers you for everyday healthcare services. The services must be provided by a recognised provider (or allied health service professional) – dentists, optometrists, physios and many more – but you're free to choose any provider you like with HIF.

Extras cover also includes other popular services like remedial massage, health management plans, weight loss and gym memberships... the list goes on.

Which Extras providers are recognised by HIF?

We recognise and accept most providers. In fact, any allied health service professionals who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) – which regulates health practitioners and health service delivery standards – are automatically recognised.

For disciplines that aren't regulated by AHPRA, we'll assess and approve them on a case-by-case basis, based on formal qualifications.

If you're not sure if your chosen provider is recognised, call us on **1300 13 40 60** to check.

We know how important it is that you're comfortable with your provider. That's why at HIF, we let you choose your own.

Inclusions and exclusions

What services are included with Extras cover?

We're all about choice, which is why we offer a range of Extras options, giving you the flexibility to choose the ideal cover for your budget and lifestyle.

Check out our product factsheets to find out what services are included (inclusions) and excluded (exclusions) with each level of cover, or compare online at **hif.com.au/extras**.

What isn't covered on included services?

You'll find a detailed description of inclusions and exclusions for each of our Extras covers in our product factsheets, but in general terms our Extras insurance doesn't cover:

- Any general treatment or service that does not meet the requirements or standards legislated under the *Private Health Insurance Act (2007)*
- Any treatment or service provided outside Australia
- Any treatment or service where a patient has the right to claim costs from a third party (e.g. another private health insurer, Workers' Compensation or motor vehicle insurance)
- Treatment or services by a provider who is not recognised by HIF, or services which are not in the HIF-approved range of treatments
- Any treatment or service deemed by HIF to be inappropriate or not medically necessary for the patient's condition (based on expert clinical advice)
- Services that have already been claimed from another insurer or where another insurer or third party has a liability to cover that service
- Any treatment, service or item which is claimable from Medicare.

On-the-spot claiming

You can claim on the spot with most Extras providers. Find out more at **hif.com.au/claim**

Benefits and limits

Does Extras insurance cover the entire cost of a service or treatment?

We pride ourselves on our low premiums and big benefits; however, depending on your level of cover and the type of service, there may be a gap between the cost of the service and the benefit you receive. This is what's called an out-of-pocket expense, and it happens when:

- The treatment, service or item fee is greater than the maximum benefit payable by HIF
- You've already claimed your annual limit or sublimit (i.e. the maximum you're allowed to claim in a calendar year for a given service, treatment or item)
- Your provider performs more than one consultation or treatment less than two hours after an identical service on the same day
- You've switched to HIF from another health fund, and your old fund has already paid your annual limit on the service/treatment/item in the current calendar year
- You've switched to HIF from another health fund, claiming a benefit from both us and them for the service/treatment/item, and the combined benefit exceeds the annual limit or sublimit for the service, treatment or item.

Read our product factsheets for more info about Extras benefits and annual limits.

What is an annual limit?

The annual limit for a service is simply the maximum amount we can pay toward your claims in a calendar year (your limits are renewed at the start of every year).

Extras item limits and replacement periods

Benefits for some items – such as dentures, orthotics and hearing aids – are either limited in number or subject to item replacement periods.

For more details on this, visit **hif.com.au/extras**

Do our Extras benefits and limits increase over time?

Yes, if you take out Saver, Special, Super or Premium Extras cover, we'll reward your loyalty for some services by increasing your benefits and annual limits.

Your dental limits will increase every year until the maximum available limit is reached in your sixth year of membership. Benefits and limits for services like optical, physio, occupational and speech therapy increase after five years, and benefits and limits increase for remedial massage, chiro, osteo and pharmacy services after three years.

When will benefits not be paid?

Benefits won't be paid on included services if:

- Your policy is not financial (i.e. in arrears or suspended) when the benefit is claimed
- The claim is for a service provided more than two years ago
- The provider of the treatment or service is not recognised (e.g. trainee providers)
- The treatment, service or item is not listed as an inclusion on your policy
- You have already exceeded the maximum claimable limit or sublimit for a service
- The treatment, service or item is accessed within a waiting period or prior to joining HIF.

Please read our product factsheets (available at **hif.com.au/extras**) for detailed info about benefits and annual limits.

What about Workers' Compensation and dual insurance claims?

We're unable to pay benefits if you can claim benefits or compensation (in full or in part) from a third party, including Workers' Compensation or public liability sources, your employer or any other insurance policy.

You have plenty of time to claim – all claims must be made within two years of the date the service was provided.

Extras waiting periods

Why do we have waiting periods?

All health funds apply waiting periods to their health insurance; it's the only way we can protect our Members from people who would otherwise become Members to claim for an expensive treatment, only to leave once their treatment is complete.

Waiting periods apply to new policies, or when you upgrade your policy to include more services or higher benefits or annual limits. However, we always try to keep waiting periods to an absolute minimum (see 'What happens if you switch to HIF or upgrade your cover?').

Read our product factsheets for more info about specific waiting periods.

What happens if you switch to HIF or upgrade your cover?

If you upgrade your HIF Extras cover, or you join from another health fund and you take out an equivalent level of cover with us, we'll take your previous membership into account so you don't have to re-serve any waiting periods you've already served.

For example, if you've already served the optical waiting period with your previous insurer, and you switch to an equivalent or lower level of cover with us, you won't have to reserve it. But please note:

- If you switch from another Australian health fund to a higher level of Extras cover with HIF (or an equivalent level of HIF cover that provides additional or higher benefits), waiting periods will be applied before you are entitled to claim for the higher level of cover or benefits. During these periods, benefits will be payable at the equivalent benefit level of your previous cover.
- If you upgrade your existing HIF Extras cover to a higher level, waiting periods will be applied for the higher level of cover or benefits. During these periods, benefits will be payable at the lower level of cover.
- If you switch from another fund, any benefits paid by your previous insurer will be considered when determining rebates for your future claims in the same calendar year (or regarding the Lifetime Limit for orthodontics).

Ambulance cover

Do you get ambulance cover with Extras?

Yes! All of our Extras policies pay benefits for emergency ambulance call-outs and transportation. Visit **hif.com.au/ambulance** for more information.

Why is ambulance cover important?

Contrary to popular belief, Medicare doesn't cover the cost of emergency ambulance services, so it makes sense to have emergency ambulance cover, especially when you consider urgent ambulance transport can cost over $900.

What ambulance services are covered?

We recognise all emergency road ambulance transport services provided by the state/territory ambulance service. Benefits are only paid on charges raised for approved emergency ambulance services that transport you to the emergency ward of a hospital.

Where your transport is deemed to be 'non-emergency' by the attending ambulance service personnel, you will be required to pay a $50 co-payment.

What ambulance services are not covered?

Benefits are not payable for transportation:

- From a hospital to your home, nursing home or other hospital
- For ongoing medical treatment.

Private ambulance, off-road, sea and air emergency ambulance service providers are not recognised and any services provided are not eligible for benefits from HIF.

Do state governments subsidise emergency ambulance services?

Some do, and some pensioners and low-income earners may be entitled to free ambulance assistance. If you're eligible for a government subsidy, we will still pay a benefit (less your entitlement).

How do ambulance services and ambulance cover differ from state to state?

Here's a quick guide to the states and territories:

Queensland and Tasmania

Residents are covered for unlimited emergency services provided by their respective state governments. Interstate ambulance service charges for these residents may not apply if reciprocal agreements are in place with the other states where the ambulance service was required.

NSW and the ACT

Residents who hold HIF Hospital cover are covered for unlimited emergency ambulance services provided in their home state by their state government or territory ambulance service. Interstate emergency services may also be covered if there's a reciprocal state agreement.

WA, SA, Victoria and the NT

In all other locations and circumstances, you can claim on your Extras insurance for emergency ambulance services, subject to the service being provided by the recognised St John or state government-controlled ambulance organisation (the service being deemed as medically necessary by the attending ambulance officer).

Emergency ambulance transport is when...

...an approved transport ambulance service provider classifies your case as requiring urgent attention, or where you're admitted to the emergency department of a hospital.

Dental cover

Before you start a course of treatment

Please contact us with full details of your proposed dental service before starting any course of dental treatment. That way, we can estimate your rebate in advance, giving you total peace of mind.

To request a dental estimate, call **1300 13 40 60,** email **hello@hif.com.au** or visit **hif.com.au/dentalestimate**

How are your dental benefits calculated?

We'll pay a set maximum benefit for each service, treatment or item.^

For more information, visit **hif.com.au/dental**, or read our product factsheets for details.

^Benefits may be limited where potential rebates exceed dental service sublimits or annual limits.

Contact us on **1300 13 40 60 for details of these services.*

Brush up on your dental care

Check out the free online dental information on our Healthy Lifestyle Blog. All articles are written by a professional dentist who answers questions from our Members.

Visit **hif.com.au/blog**.

Orthodontic benefits

Having braces fitted?

Braces are fitted and managed according to a personal treatment plan prepared by your orthodontist. This incorporates the initial fitting of the braces, scheduled ongoing visits for adjustments, and eventual removal of the braces as your teeth are gradually repositioned to the preferred alignment.

Your orthodontist will charge a 'bundled' fee for this treatment plan to cover all services that are likely to be provided over the course of the treatment.

How do you claim for your orthodontist's 'bundled' fee?

While the total cost of your braces treatment plan is one bundled price, orthodontists may allow you to pay off your treatment plan in instalments.

Some private health insurers pay benefits upon receipt of each instalment invoice, but we pay the full applicable orthodontic rebate as an immediate benefit (claimable when your braces are fitted), subject to your annual or lifetime orthodontic limits. This arrangement is usually preferred by orthodontists as they receive the full health insurer rebate immediately.

Already on an orthodontic treatment plan and planning to switch to HIF?

If you're already on a treatment plan and intend to take out HIF Extras cover, it's important to note we only cover (bundled) fees for the fitting and management of braces if you have an eligible level of Extras cover on the date your braces are fitted and served the 12 month waiting period.

If you don't have Extras cover on the date your braces are fitted, we'll be unable to provide a benefit for any instalment payment plan or invoice.

Already have Extras cover and considering orthodontic treatment?

Then please contact us on **1300 13 40 60** or email **hello@hif.com.au** with the details of your proposed dental or orthodontic treatment (your dentist or orthodontist can provide the item numbers) and we'll let you know how much you can claim.

Got a question?

Visit our handy online knowledge base for 24/7 access to a wealth of information. Visit **hif.com.au/help** to get started.

Call us on **1300 13 40 60**

How to make an Extras claim

HIF Members can choose from the following options to lodge an Extras claim:

- **On the spot.** Healthcare providers with electronic claiming technology (HICAPS or iSOFT) can settle your account with you on the spot. All you need to do is swipe your HIF membership card and pay the difference (if any).
- **Online.** Our online Member Centre gives you access to a range of services to help manage your policy including lodging an Extras claim online. Even better, you'll instantly see the estimated benefit payable! Before you get started, you'll just need to ensure that your provider's fees are paid in full before uploading receipts. Go to **hif.com.au/members** to claim online.
- **On your mobile.** Submit Extras claims anytime, anywhere, with our easy-to-use mobile App. It's fast, free and reduces paper waste. Read more about our Member App overleaf.
- **By email or fax.** For paid Extras accounts, simply email a scan of your completed HIF claim form* and associated receipts to **claims@hif.com.au**. Alternatively, you can fax everything to **(08) 9328 1685**.
- **By post.** Complete a claim form* and post it to: HIF, GPO Box X2221, Perth WA 6847.

Claim forms can be downloaded from **hif.com.au/claimform or mailed to you on request.*

Your easy checklist for claiming by mobile, email or fax

- Is this an Extras claim?
- Is the invoice paid?
- Is the image of the invoice clear and in focus?
- Is the eftpos receipt removed?
- Does HIF have my direct credit details (so they can pay my benefit directly to my account)?

HIF mobile app for Members

Our handy mobile app enables Members to manage their policy at a time that suits them. Available to download free of charge from the Apple and Android stores, the app lets you update your contact details, view your policy information, lodge an Extras claim, view your claims history, order replacement membership cards, contact HIF and more.

Make Extras claims on the go

While swiping your membership card is still the quickest way to make Extras claims, there may be times when electronic claiming isn't an option.

When that happens, the HIF Member App is there to take the pain out of the manual process, ensuring you're reimbursed asap.

All you have to do is:

- **Tap.** Review and confirm your personal info and claim details.
- **Snap.** Use your phone or tablet to photograph your invoices, then the HIF Member App will cleverly bundle them up with your claim details.
- **Submit.** Hit the submit button to send your claim to us.

Mobile claims terms of use

Our handy App puts the power to claim in the palm of your hand. When lodging a claim please bear in mind that:

- The HIF Member App can only be used for Extras claims, not hospital or medical claims
- Incomplete or illegible photographs of invoices and other accounts will be rejected until an acceptable replacement is provided
- Provider invoices must be paid in full prior to lodging a mobile claim
- The date of service (on your invoice) must be no more than two (2) years prior to the date you lodge a claim
- You must retain all original invoices/receipts for two years from the date you lodge the claim
- HIF reserves the right to randomly select claims for auditing purposes
- Benefits for services or treatments rendered outside Australia are not payable by HIF.

Available on the iPhone App Store

GET IT ON Google play

Hospital claims and AccessGap accounts

When you're admitted to hospital as a private patient you'll be asked to pay the excess (if applicable). With your excess paid, all hospital accounts will be forwarded directly to us on your behalf. The same goes for your doctor's accounts (this includes surgeons, specialists, anaesthetists and assistant surgeons).

Once we receive your HIF and Medicare claim forms and your hospital and medical accounts, we can arrange payment of your HIF and Medicare benefits, settling your accounts directly with your doctor or hospital. If any out of pocket expenses apply, you'll receive a bill from your provider.

Received a hospital or doctor's account in post?

No problem. We'll take care of it – simply post it free of charge to HIF, Reply Paid GPO Box X2221, Perth, WA 6847.

How to claim

If you're claiming for hospital or medical treatment, you'll need to complete two forms:

- Our claim form
- Hospital inpatient claim form.

Both forms can be downloaded from **hif.com.au/claim** – you can type directly into our claim form, then save or print a copy.

Please send your claims to HIF, Reply Paid GPO Box X2221, Perth, WA 6847.

Don't forget

To ensure your claim is processed as quickly as possible, please remember to:

- Complete both an HIF claim form and a Medicare claim form, including:
  - The Member's name
  - The patient's name
  - The healthcare provider's name
  - An itemised account (original copy)
  - The receipt (if paid)
- Sign each new claim form before sending a copy to us
- Send your claim forms and any accounts you receive to us, not Medicare (claims sent to Medicare first are not eligible for any AccessGap payments).

What about inpatient pathology and radiology accounts?

Inpatient pathology and radiology accounts can either be submitted to us or Medicare first. Claim forms for both HIF and Medicare are required when submitting these accounts.

About to be admitted to hospital?

Please call us prior to admission so we can help you with your claims and provide a medical estimate.

Please note:

- We'll retain all documents relating to a claim.
- All claims must be lodged within two years of the date of service.
- Claims for services older than two years will not be processed.

Frequently asked questions

How long can children remain on family policies?

With HIF, your dependants are covered up until the age of 21, or up to 25 years of age for those who are (a) registered as full-time students at a recognised educational institution; and (b) not living in a defacto relationship.

If I have private hospital insurance can I still be admitted to public hospital as a public patient?

Yes. Every public hospital is required to ask if you wish to be treated as a public or private patient. It's your choice if you use your insurance or not.

When you're admitted to a public hospital, it's usually at a time when you're scared, in pain or stressed – particularly if it's an emergency. And, it can be really confusing too. When you're asked for your private health insurance details it's natural to just do what you're asked and hand them over. Unfortunately though, this is leading to premium increases for everyone.

So next time you're admitted to a public hospital, think about whether you really need or want to use your private health insurance and together we can all work to reduce premium increases.

Which bills should I claim from HIF, and which ones should I claim from Medicare?

If you don't have Hospital cover, then you claim directly from Medicare for medical services, including doctors, specialists, eye examinations, X-rays and pathology.

However, if you have HIF Hospital cover, you send all your hospital and medical claims and accounts to us, so we can arrange payment of your HIF and Medicare benefits.

Similarly, if you have HIF Extras cover, we'll process all your bills for Extras services, such as dental, physiotherapy or optical treatments.

Check out our Hospital and Extras product factsheets for more information about what we cover, and learn more about how to make a claim in the 'Hospital claims and AccessGap accounts' and 'Extras claims' sections in this Guide.

What is the Medicare Levy Surcharge (MLS)?

The Medicare Levy Surcharge (MLS) is levied on Australian taxpayers who earn above a certain income and don't have private hospital cover. The MLS is a Federal Government initiative designed to encourage individuals to take out private hospital cover and, where possible, to use the private hospital system to reduce demand on the public system.

You'll find more information in the 'Government legislation' section on page 27, or visit **hif.com.au/mls** to calculate your MLS eligibility.

What's the difference between the Medicare Levy and Medicare Levy Surcharge?

Medicare Levy: this is a compulsory tax that's automatically deducted from your annual taxable income if you earn $21,980 or more per year.

Medicare Levy Surcharge (MLS): this is an additional tax which you'll pay if you earn over $90,000 a year (or $180,000 as a couple) and don't have private hospital insurance, or visit **hif.com.au/mls** to try our MLS calculator.

What is Lifetime Health Cover (LHC) loading?

The Federal Government introduced Lifetime Health Cover loading to encourage Australians to take out private hospital cover at a younger age. Basically, it recognises the length of time you've had private health insurance and rewards that loyalty by offering lower premiums.

Find out more about LHC loading in the 'Government legislation' on page 27, or visit **hif.com.au/lhc** to check your eligibility.

Does HIF cover same-sex couples?

Absolutely. We support choice in every aspect of life and our policies cover all types of couples and families. We were also the first private health fund to add our brand's support to the Australian Marriage Equality campaign back in 2014.

If you'd like to chat to one of our consultants about joining HIF, or you'd like to add your partner to your existing policy, please email **hello@hif.com.au** or call **1300 13 40 60**.

What isn't covered by private hospital insurance?

Private hospital insurance doesn't cover you for outpatient services. These services include visits to your GP and consultations with specialists, as well as X-rays and blood tests (unless they're taken once you're admitted to hospital).

Is the Federal Government Rebate on private health insurance means tested?

Yes, the Federal Government Rebate on private health insurance is means tested, as is the Medicare Levy Surcharge (MLS).

There are four taxable annual household income tiers for singles, couples and families. The rebate you receive for holding private health insurance and the size of the MLS you pay are determined by your age and annual income.

Here's an example: If you're a single person under the age of 65 and you're earning less than $90,000 a year, you'll receive a 24.608% rebate on the cost of your health insurance. Your applicable rebate will be automatically factored into your quoted premium at the time of joining HIF.

The Federal Government Rebate applies to Hospital and/or Extras cover.

Got a question?

Visit our handy online knowledge base for 24/7 access to a wealth of information. Visit **hif.com.au/help** to get started.

Call us on **1300 13 40 60**

Private Health Insurance salary thresholds and rebate tiers (1 April 2021 – 31 March 2022)

Policy type	Base tier	Tier 1	Tier 2	Tier 3
Single	$90,000 or less	$90,001 - $105,000	$105,001 - $140,000	$140,001 or more
Couple/family	$180,000 or less	$180,001 – $210,000	$210,001 – $280,000	$280,001 or more
Age	**Applicable private health insurance rebate**			
Under 65	24.608%	16.405%	8.202%	0%
65-69	28.710%	20.507%	12.303%	0%
Over 70	32.812%	24.608%	16.405%	0%

Note: The thresholds increase annually, based on growth in Average Weekly Ordinary Time Earnings. Single parents and couples (including de facto couples) are subject to the family tiers. For families with children, the thresholds are increased by $1,500 for each child after the first.

Want more answers?

Visit **hif.com.au/help**, call us on **1300 13 40 60** or email us at **hello@hif.com.au**

General policyholder terms and conditions

About Australian private health insurance

All Australian private health insurers, and residents and non-residents who pay tax in Australia, have potential responsibilities, obligations and entitlements under Australian health insurance laws.

These laws include directions about services that can or must be covered, entitlement to the private health insurance rebate and obligations to pay the Medicare Levy Surcharge (MLS) and the Lifetime Health Cover (LHC) loading.

The legislation or rules that affect your premiums, cover and membership obligations include:

- *The Private Health Insurance Act 2007 (the PHI Act)*
- *Fairer Private Health Insurance Incentives Act 2012*
- *Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Act 2012*
- *Fairer Private Health Insurance Incentives (Medicare Levy Surcharge – Fringe Benefits) Act 2012*

Under the PHI Act, we are required to document our operating guidelines, known as Fund Rules or Business Rules. All private health funds have to do this. These rules detail our obligations as a private health insurer, as well as the obligations of our Members. As such, when you become an HIF Member, you agree to be bound by these rules. Visit **hif.com.au/legal-stuff**

If you would like a copy of our Fund Rules, Annual Reports, or more information about our not-for-profit business, please email **hello@hif.com.au**, call us on **1300 13 40 60** or visit **hif.com.au/legal-stuff**

HIF and you

Our promise to you

We're a not-for-profit private health insurer. This means we don't have shareholders, so any income we earn (after paying our Members' benefits and covering our operating expenses) is used to pay bigger and better benefits in future.

We aim to continually improve the value of our products and services and make it easier for you to deal with us. We'll keep you informed, treat you with respect and protect your privacy by fully complying with Australian legislation and industry best practice.

Our Code of Conduct

The Private Health Insurance Code of Conduct is a self-regulatory code with the primary goal of enhancing Member service and understanding of private health insurance. We support and apply these industry standards in four fundamental ways:

1. Our employees are trained in private health insurance.
2. The information we provide to you is communicated in a way that is easy to understand and allows you to make an informed decision.
3. We openly communicate our procedures for resolving any concerns you may have about your HIF membership and private health cover.
4. We ensure that any information you provide to us is maintained in accordance with our privacy policy.

To download a full copy of the Code of Conduct, please visit **hif.com.au/legal-stuff**

Our values

We will respect you and your circumstances, with the intention of optimising the benefits you receive from your policy and ensuring equity and value for all Members, by following our core values of:

- Care
- Agility
- Innovation

Compliments and complaints

We're always looking for ways to continually improve our service, products and benefits, so your feedback is valuable to us, whether you'd like to lodge a compliment or a complaint.

Whatever your feedback relates to, we address each and every compliment/complaint and will always respond accordingly. Your input is a vital part of ensuring our organisation meets or ideally exceeds your expectations at all times.

If you have a compliment, complaint or concern, you can:

- Complete the online feedback form at **hif.com.au/contact-us**
- Discuss it with one of our Member service representatives on **1300 13 40 60**
- Email your feedback to **hello@hif.com.au**.

Whether your feedback is positive or negative, we promise to:

- Treat you with respect and deal with your concerns promptly
- Resolve any complaints at the first point of contact, wherever possible
- Escalate complaints (if necessary) and resolve them swiftly, within two business days
- Invite you to further escalate complaints (that could not be resolved to your satisfaction) to our formal Ex-gratia Committee (you should address your complaint in writing to Executive Manager – Member Experience, Health Insurance Fund of Australia, GPO Box X2221, Perth WA, 6847)
- Openly share our complaints with you, including external resolutions options, like involving the Private Health Insurance Ombudsman (you can contact the Ombudsman on 1300 362 072 or write to: GPO Box 442, Canberra ACT 2601, or Privacy Commissioner)
- Resolve complaints in an equitable manner, with the best interests of all Members in mind
- Use feedback to improve our products and services by passing it on to our Product Development Committee.

Your cooling-off period

When you've applied for membership, you have 2 months to read your policy. If you decide during this time that you do not wish to take up the cover, you may cancel the policy and we will give you a full refund, provided you have not made a claim.

Your privacy

The personal information you provide will be primarily used to deliver the health insurance products and services you have requested. The information you supply will remain confidential.

This information may be disclosed to third parties and authorised government agencies to facilitate the delivery of services associated with your health insurance. Failure to provide personal information may result in the failure to process or deliver the service requested.

For a complete HIF Privacy Policy brochure, please contact us on **1300 13 40 60** or download a copy at **hif.com.au/legal-stuff**.

Your obligations to HIF

As an adult insured under an HIF policy, you agree it is your responsibility to:

- Read and seek clarification if you're unsure of the policy terms and conditions relating to you or your dependants, benefit eligibility conditions (including waiting periods), the services you are covered for and the circumstances under which they may not be covered or only partially covered
- Claim benefits for services to which you are lawfully and contractually entitled and provide information relevant to your claim or policy which is accurate and truthful
- Pay your policy contributions within the timeframe and manner agreed, including honouring your Direct Debit Service Agreement, where applicable
- Seek informed financial consent from your health practitioner prior to being admitted to hospital for treatment, and where you're unsure of coverage, benefits or gaps, contacting HIF in advance of any procedure.

Government legislation

The Federal Government Rebate

The Federal Government Rebate on private health insurance is means tested, with four annual income tiers for singles, couples and families. The rebate you receive for holding private health insurance is dictated by your age and annual income.

For more information on the rebate, read the 'Frequently asked questions' section on page 22.

The Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a Federal Government initiative, designed to encourage individuals to take out private hospital cover and, where possible, use the private hospital system to reduce the demand on the public system.

The MLS is levied on Australian taxpayers who do not have private hospital cover and who earn above a certain income. The income thresholds increase incrementally, as does the MLS itself, depending on your annual household Adjusted Taxable Income (ATI).

For a full rundown of how the MLS works, along with the current ATI thresholds, visit **hif.com.au/mls**

Did you know...

If you're likely to incur the MLS, it could be more cost effective to take out HIF Hospital cover – a number of our covers could actually be cheaper than the additional tax you'll have to pay.

Lifetime Health Cover loading

The Federal Government introduced Lifetime Health Cover (LHC) loading to encourage Australians to take out private hospital cover at a younger age. Basically, it penalises those who do not take out private health insurance earlier in life.

Not everyone is subject to LHC loading. You won't incur the loading if you:

- Take hospital cover before 1 July following your 31st birthday; or
- Had Hospital cover on 1 July 2000 and have maintained it since then; or
- Were born on or before 1 July 1934; or
- Immigrated to Australia after your 31st birthday and took out Hospital cover within 12 months of becoming eligible for full Medicare benefits.

How is LHC loading applied?

For every year over the age of 30 that you don't have private hospital cover, a 2% loading is applied to the cost of your insurance (the loading increases each year until it reaches 70%).

For example, a single 37-year-old person would pay 14% LHC loading – so it really pays to take out private Hospital cover sooner rather than later.

It's slightly different for couples. The loading is initially calculated based on your respective dates of birth and then halved. For example, a couple aged 33 and 36 years would generate a combined loading of 18% initially (6% + 12%), so the final loading that is applied to their joint policy would be 9%.

If you find that you'll incur a loading, you'll be required to pay this on top of the base premium initially quoted for your HIF Hospital cover. If you decide to join HIF, your loading will automatically be applied to the quoted amount once you provide your date(s) of birth.

What if you're already over 31?

If you're over 31, it still makes sense to take out Hospital cover. Remember, the sooner you join, the smaller your loading. And once you've held continuous private Hospital cover for 10 years, your loading will be removed (as per the *Private Health Insurance Act 2007*).

For more info, visit **hif.com.au/lhc**

Got a question?

Visit our handy online knowledge base for 24/7 access to a wealth of information. Visit **hif.com.au/help** to get started.

Call us on **1300 13 40 60**

Glossary

AccessGap Cover

AccessGap Cover is our medical gap cover arrangement, designed to minimise or eliminate your out-of-pocket expenses for medical services when you're an inpatient in a registered hospital or day facility.

Accident

An accident is an unforeseen event, occurring by chance and caused by an external force or object which results in an injury to the body.

Admission

The period of time during which a person is admitted as an inpatient into an approved hospital/day facility for the purpose of receiving hospital treatment until the time they are discharged from the hospital/day facility.

Annual limit

The maximum limit of Extras benefits payable to a Member in a calendar year, commencing 1 January and ending 31 December.

Approved service provider

A provider or service that's approved by HIF. If you're unsure about the status of a Hospital, Medical or Extras provider, contact us on **1300 13 40 60**. Unless stated, Extras services are not approved unless the health provider and HIF Member (patient) are both physically present in the health provider's registered practice at the time of a consultation.

Basic benefit

When the benefit payable is equivalent to the benefits available if the service was provided in a shared room in a public hospital.

Benefit

The payment due to the Member for services received by an approved provider.

Couples

A couples membership includes one adult Member and partner only. It does not include child dependants.

Dental Item Code

A dental item code is a three digit number for dental items or clinical procedures considered to be part of current dental practice by the Australian Dental Association. For example, the 014 code is used for a general dental consultation.

Dependant

A person dependent upon the primary Member. This includes:

- Domestic partners, children, stepchildren, legally adopted children to whom the primary Member is the legal guardian (they must be under the age of 21, unmarried and not in a de facto relationship)
- Student dependants – children, stepchildren, legally adopted children and children to whom the Member is the legal guardian, where the dependant is under the age of 25 years, unmarried, not in a de facto relationship and enrolled in a full-time course of study at a recognised educational institution.

Excess

The amount selected on a Hospital cover which the Member agrees to pay before a benefit will be payable.

Excluded service

Services that aren't covered by a benefit, meaning all costs will be paid by you.

Extras services

At HIF, we call ancillary cover 'Extras' – it's our name for all those day-to-day healthcare services, such as dental, optical and physiotherapy, plus a whole host more, including emergency ambulance cover. Extras cover is also known as Ancillary or Auxiliary cover.

Federal Government Rebate

The proportion of private health cover premiums that the Government contributes for permanent Australian residents.

HICAPS/iSOFT

Providers with HICAPS or iSOFT technology can electronically claim your Extras benefit directly from HIF.

Inpatient

A person who has been admitted into an approved hospital or day facility, allocated a bed and then discharged following treatment.

Lifetime Health Cover Certified Age of Entry

The age that each Member of a health fund is assigned when they first purchase Hospital cover from a registered health fund. The Certified Age of Entry is based on a person's actual age when purchasing Hospital cover for the first time.

Medicare Benefit Schedule (MBS)

The schedule of benefits produced by the Department of Health, listing eligible services, fees and benefits for medical services, including inpatient services.

As an admitted patient (or inpatient), Medicare will pay a benefit of 75% of the Medicare Benefit Schedule (MBS) fee.

Non-contracted hospital

A private hospital not contracted by the Australian Health Services Alliance or HIF to provide services to HIF Members. Out-of-pocket costs cannot be guaranteed in these hospitals (basic default benefits apply).

Out-of-pocket (Gap expense)

The amount remaining to be paid by the Member after the HIF and/or Medicare benefits have been paid.

Outpatient

An outpatient is someone who has received medical treatment in a GP's surgery or casualty department and has not been admitted to hospital. Benefits for outpatient services are only payable by Medicare.

Partner

A person who lives with a fund Member in a marital or de facto relationship and who is covered under the same fund membership, notwithstanding the primary fund Member and partner may live apart temporarily.

Policy holder

The person who is responsible for the insurance policy. Also known as the 'primary Member'.

Practitioners in private practice

A practitioner who does not:

- Use any publicly funded hospital, clinic, health centre or other such facility, including a facility provided by a municipal authority for, or in connection with, the provision of an Extras service for which a benefit is claimed on Extras cover.
- Receive publicly funded assistance or support, whether by way of remuneration, subsidy or otherwise, in connection with the provision of the Extras service, except where the Extras service is provided at the clinics of strategic alliance partners, joint ventures or HIF's clinics.

Pre-existing condition

Under the *Private Health Insurance Act 2007*, a health insurer may impose a 12-month waiting period on benefits for hospital treatment for pre-existing conditions.

A pre-existing condition is defined as, "Any ailment, illness, or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of six months ending on the day on which the person became insured under the policy."

The pre-existing condition waiting period applies to new Members and Members upgrading their policy to any higher level benefits under a new policy. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition, not on a diagnosis (i.e. it is not necessary for the Member or their doctor to know what their condition is or for it to be diagnosed).

In forming an opinion about whether or not an illness is a pre-existing condition, the HIF-appointed medical practitioner who makes the decision must take into account information provided by the Member's treating doctor. This rule applies whether the ailment, illness or condition was known to the Member or not.

Primary Member

The first named Member on a policy, irrespective of who pays contributions to HIF for the provision of health cover. The primary Member also holds the legal responsibility to ensure the membership is kept financial at all times, and holds the right to add or remove dependants from the membership. In the instance that the primary Member wishes to provide authority for another person to act on their behalf, a spousal/agent authority form is required.

Qualifying periods

Any period occurring immediately after joining the fund or joining a higher level of cover, during which either some or all fund benefit is not payable.

Recognised educational institution

An Australian, government-recognised educational institution such as a school, college or university.

Glossary continued

Restricted service
Hospital services which are only covered for payments at the basic benefit level.

Transfer certificate
The document transferred between registered health funds, detailing the Member's fund history (including 'certified age at entry'), confirmation of the financial status of the Member and claims history.

Waiting periods
The standard period which applies before a Member becomes eligible for benefit.

For more glossary terms, visit **hif.com.au/help**

Useful links

Health Cover Guide – **hif.com.au/guide**
Hospital cover factsheets – **hif.com.au/hospital**
Extras cover factsheets – **hif.com.au/extras**
Medicare Levy Surcharge calculator – **hif.com.au/mls**
Lifetime Health Cover loading calculator – **hif.com.au/lhc**
Get a health insurance quote – **hif.com.au/health**
Get a pet insurance quote – **hif.com.au/pet**
Get a travel insurance quote – **hif.com.au/travel**
HIF knowledge base – **hif.com.au/help**
Online Member Centre – **hif.com.au/members**
Contact HIF – **hif.com.au/contact-us**

Need some no-obligation advice?

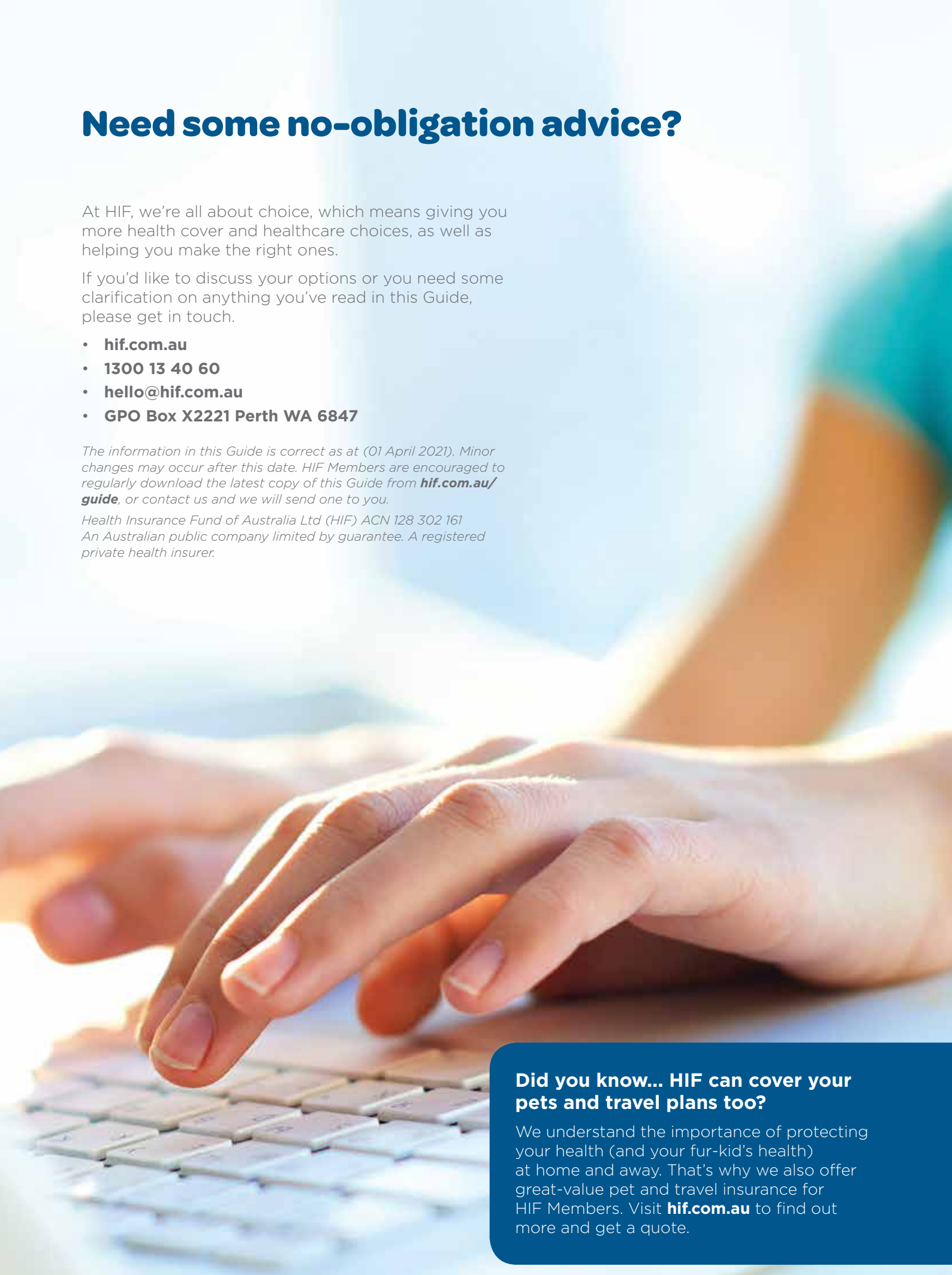
At HIF, we're all about choice, which means giving you more health cover and healthcare choices, as well as helping you make the right ones.

If you'd like to discuss your options or you need some clarification on anything you've read in this Guide, please get in touch.

- **hif.com.au**
- **1300 13 40 60**
- **hello@hif.com.au**
- **GPO Box X2221 Perth WA 6847**

*The information in this Guide is correct as at (01 April 2021). Minor changes may occur after this date. HIF Members are encouraged to regularly download the latest copy of this Guide from **hif.com.au/guide**, or contact us and we will send one to you.*

Health Insurance Fund of Australia Ltd (HIF) ACN 128 302 161
An Australian public company limited by guarantee. A registered private health insurer.



Did you know... HIF can cover your pets and travel plans too?

We understand the importance of protecting your health (and your fur-kid's health) at home and away. That's why we also offer great-value pet and travel insurance for HIF Members. Visit **hif.com.au** to find out more and get a quote.

At HIF we're all about choice.

Call, email or visit us online.

hif.com.au

1300 13 40 60

hello@hif.com.au

GPO Box X2221 Perth WA 6847

Find us on:

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