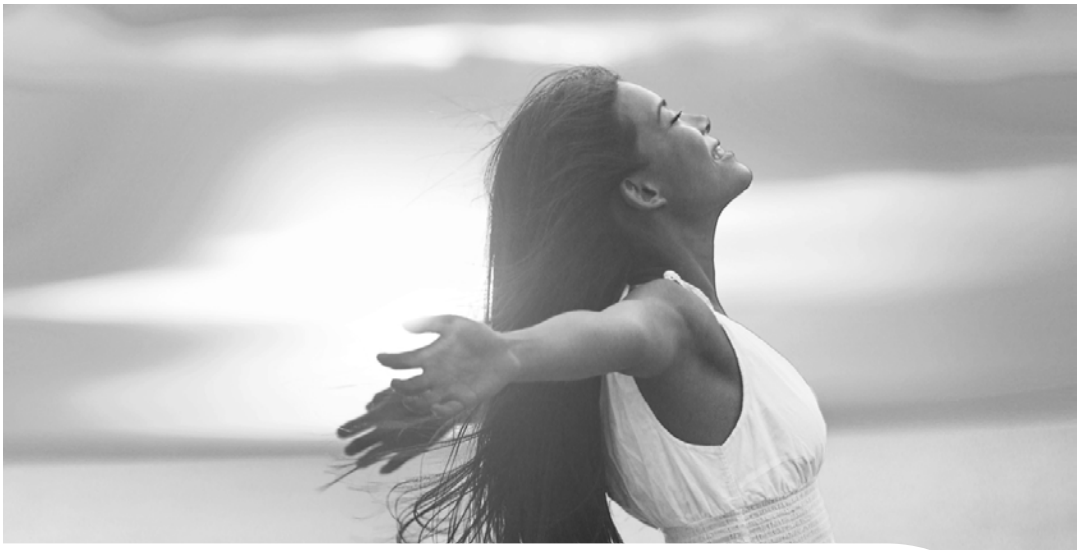

Our Product Disclosure Statement (PDS)

Your HIF overseas visitors health insurance in detail.

Visit online to get a quote and join.
Call **1300 13 40 60** or Int'l **+618 9227 4200**

hif.com.au/visitors

Australia's first certified Carbon Neutral health fund.

hif

What's inside?

So you're coming to Australia?

That's great! Whether you're here working, visiting relatives or you've decided to make Australia your home, we're sure you'll love it. And hopefully your time here will be accident-free. But just in case something happens, we've made organising health cover both easy and affordable for you and your family.

Who is visitors cover for?

We cover overseas workers and other visitors to Australia.

- Our Working Visa covers are suitable for visitors on working visas, aged 64 and under.
- Our Visitor Saver and Visitor Value cover is suitable for visitors on other visas aged 64 and under.

How does the health system work in Australia?

We have a health system that combines public and private health care services. Medicare is the public health care system, which provides limited cover for visitors from countries that have a reciprocal agreement, but only for emergency treatment, and only under certain conditions. In any case, with Medicare you aren't able to choose your doctor and you won't be covered for:

- Treatment in a private hospital
- Non-emergency visits to the doctor
- Extras services like dental and optical care or ambulance transport

Also, bear in mind that even if you are entitled to cover from Medicare, you may be put onto a hospital waiting list if your condition is not life threatening.

Important, please note: Unlike domestic health insurance, Overseas Working Visa policies are not required to meet the community rating principle created through the Private Health Insurance Act 2007. HIF reserves the right to decline or refuse an application for overseas visitors health cover at any time. For more information, please visit - hif.com.au/communityrating

Our Hospital and Medical cover options

At HIF, we like to make it as simple (and affordable) as possible to choose the right level of health cover for you and your situation. With that in mind, all of our hospital and medical products below can be combined with our Extras covers:

- **Basic Working Visa** ($500 Excess) – shared room in a public or private hospital
- **Essential Working Visa** (No Excess) – shared room in a public or private hospital
- **Intermediate Working Visa** (No Excess) – shared room in a private hospital. Private or shared room in a public hospital.
- **Comprehensive Working Visa** ($0 or $500/$1000 Excess) – private or shared room in a public or private hospital
- **Visitor Saver** ($250/$500 Excess) shared room in a public or private hospital
- **Visitor Value** ($250/$500 Excess) –shared room in a private hospital. Private or shared room in a public hospital.

What does our Private Hospital insurance cover?

Our Hospital insurance gives you access to the hospital system in Australia – your level of cover determines whether you're able to access public hospitals or both public and private hospitals. Before we go on, it's important that you understand the Medicare Benefits Schedule (MBS). The MBS is the schedule of fees set by the Australian Government for standard medical services. As an overseas visitor with HIF insurance, you'll be covered for at least 100% of the MBS fee if you are admitted (as an inpatient) in to a hospital or a day facility.

However, if your doctor charges more than the MBS fee you will need to pay these out-of-pocket expenses yourself.

What does our Medical insurance cover?

Our Medical insurance covers you for out-of-hospital services, such as consultations with general practitioners, doctors, specialist consultants and other services, including x-rays and blood tests and medical treatment in a hospital emergency or casualty department. Limits and exclusions apply to Visitor Saver, Visitor Value, Basic, Essentials and Intermediate Working Visa cover. For more details, please refer to the individual product information pages further on in this PDS.

	Cover for Working Visa Holders				Cover for Non-Working Visa Holders	
	Basic Working Visa	**Essentials Working Visa**	**Intermediate Working Visa**	**Comprehensive Working Visa**	**Visitor Saver**	**Visitor Value**
Urgent ambulance cover	✓	✓	✓	✓	✓	✓
Private room, private hospital	×	×	×	✓	×	×
Shared room, private hospital	✓	✓	✓	✓	×	✓
Private room*, public hospital	×	×	✓	✓	×	✓
Shared room, public hospital	✓	✓	✓	✓	✓	✓
Theatre fees, prostheses, inpatient (PBS) pharmacy items etc	✓	✓	✓	✓	✓	✓
Access Gap Cover	×	×	×	✓	×	×
Outpatient services & emergency hospital department treatment (covered up to MBS fee)	×	×	✓ Up to $500 per person per calendar year	✓	×	✓ Up to $500 per person per calendar year
Excess	$500pp per-admission	×	×	$500/1000 (optional)	$250/500	$250/500
Cardiac (heart)	✓	✓	✓	✓	×	✓
Pregnancy and birth related services	✓	✓	✓	✓	×	✓
Assisted reproduction (IVF)	×	×	×	✓	×	×
Non-cosmetic eye surgery	✓	✓	✓	✓	×	✓
Joint replacement	✓	✓	✓	✓	×	✓
Bone marrow and organ transplants	×	×	×	✓	×	×
Repatriation#	$4,000 lifetime limit, once per person	$4,000 lifetime limit, once per person	$6,000 lifetime limit, once per person	$8,000 lifetime limit, once per person	×	×

Need a visa letter, pronto?

If you're applying for an Australian visa, you may need to provide the Department of Immigration and Border Protection (DIBP) with a Visa Compliance Letter from your health insurer to verify that you have met this requirement. If you choose to join HIF, your letter of visa compliance will be emailed to you instantly (PDF format) upon confirming your application.

For more details, please refer to the individual cover descriptions. * Where available. Please note: Visitor Saver cover is not a visa-compliant policy, so we can't issue a letter of visa compliance for this product. If you require non-working visa cover and you need a letter of compliance, please purchase our Visitor Value policy.

Exclusions and Conditions

Hospital Emergency Department Treatment

Under Australian legislation, services provided in the emergency department of a hospital are defined as 'outpatient medical' and not deemed to be a 'hospital treatment'. HIF will therefore only provide benefits for services provided in a Public or Private hospital Emergency Department, where a person is covered under HIF Intermediate Working Visa or Visitor Value ($500 limit per person, per year), or Comprehensive Working Visa (unlimited). Benefits for these services are not covered by Basic Working Visa or Essentials Working Visa policies.

Hospital and Medical cover waiting periods

Waiting periods (the time you need to wait before you can claim) are necessary for some services. All Australian health funds have waiting periods. Our waiting periods are:

- Psychiatric, rehabilitation or pallative care regardless of whether or not the condition is pre-existing - 2 months
- All obstetric related services - 12 months
- All treatment related to a pre-existing condition - 12 months

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

What's a pre-existing condition?

A pre-existing condition is any ailment, illness, or condition that you had signs or symptoms of during the six months before you joined our fund or upgraded to a higher level of cover or the same cover with a reduced or nil excess.

It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed. A condition can still be classed as pre-existing even if you haven't seen your doctor about it before joining or upgrading. If you knew you weren't well, or had signs of an ailment that a doctor would have detected (if you had seen one) during the six months prior to joining the Hospital cover then the ailment would be classed as pre-existing.

An example would be a person who had been treated for bone cancer, but the cancer had been in remission for one year. Six months after joining the fund the person requires hospitalisation because the cancer had reappeared. The fund medical advisor determined that the hospitalisation was for a pre-existing condition because the type of cancer was not considered cured until it had been in remission for five years.

For more information on the Pre-existing Conditions Rule, visit ombudsman.gov.au.

What's not covered

Please note we will not pay a benefit when:

- a claim for any form of compensation or damages can or will be made
- services where benefits are claimable from another source
- travelling to and from Australia
- services are provided outside Australia
- the services you're claiming for are not covered by Medicare for Australian residents
- services are not covered by Medicare (e.g. health screening insurance examinations and services that do not have a Medicare Benefits Schedule (MBS)
- services arranged prior to coming to Australia.

Things you need to know about our Hospital cover

When selecting Hospital cover, it's important to ensure that you understand how each level of cover will apply to you, as well as being aware of details such as limitations, restrictions or exclusions that might also apply to your chosen cover.

Access Gap Cover

Access Gap Cover is available on our Comprehensive Working Visa cover. Doctors can charge more than the Medicare Benefit Schedule (MBS) and if they do, their patients without gap cover insurance will incur an out of pocket expense for the difference between the fee charged and the MBS. The good news is that Access Gap cover is HIF's medical gap cover arrangement, designed to minimise or eliminate these pocket expenses for medical services whilst an in-patient in a registered overnight hospital or day facility. Australian doctors can nominate to opt in or out of the Access Gap arrangement, which may mean that if you choose an Access Gap Doctor you can have lower out-of-pocket costs. It is advisable to ask EACH doctor or specialist if they will treat you under the Access Gap cover if you hold a Comprehensive Hospital product. A list of registered participating doctors is available on our website, **hif.com.au/accessgap**

To find out more about specific payment amounts for upcoming procedures, please call us on **1300 13 40 60** or **+618 9227 4200** from overseas.

Healthcare providers

HIF covers Extras, medical and hospital providers throughout Australia. To confirm if a provider is approved by HIF, email us at **hello@hif.com.au** or call us on **1300 13 40 60** or **+618 9227 4200** from overseas.

Benefits will not be paid for any services provided outside Australia, or for services purchased or provided within Australia from a non-Australian provider.

Medicare Benefits Schedule (MBS)

The Medicare Benefits Schedule (MBS) is the schedule of fees set by the Australian Government for standard medical services. As an overseas visitor you will be entitled to claim at least 100% of the MBS on all HIF hospital products for inpatient services.

Excluded services

Where services are noted as 'excluded' in your Hospital cover, this means that you are not covered and you must pay all costs.

Hospital Admission

If you are admitted to hospital and a private room is the only option available, a co-payment per night may apply. This charge will be the difference between your chosen hospital's shared room and private room rate. To confirm the applicable co-payment (if any), please contact your hospital prior to admission.

Workers Compensation and Dual Insurance

Benefits cannot be claimed and are not payable by HIF where you have or can claim benefits or compensation (in full or in part) for treatment, goods or services from a third party including Workers Compensation or Public Liability sources, your employer or any other Insurance policy.

Transferring and upgrading your cover

New Members who transfer Hospitalcover from another Australian health fund to an equivalent level of HIF Hospital cover will not have any waiting periods applied, providing these were served with the previous fund.

- New members who transfer Hospital cover from another Australian health fund to a higher level of Hospital cover, or equivalent level of cover with a reduced or nil excess, will have qualifying periods applied for the higher level of cover and/or benefits. During these periods benefits will be payable at the equivalent level of cover to that of your previous fund.
- Existing HIF Members who upgrade to a higher level of Hospital and/or Extras cover, or choose to reduce or remove their hospital excess, must serve the applicable waiting periods for the higher level of cover and/or benefits before being eligible to claim. During the waiting periods, benefits will be paid based on the original level of cover held.
- We may recognise cover from an IInternational fund if you can provide enough information for us to compare the products with our products. You will need to provide start and end date of cover, all members covered, recent claims.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Want more information about the Australian Health System?

Visit the Overseas Visitors Cover category in our online knowledge base for more information on Medicare eligibility, visa compliance letters, and why purchasing HIF Visitors Health Cover is a smart idea.
hif.com.au/help

Basic Working Visa (Hospital only cover)

This is our entry level cover for visitors to Australia on Working Visas and aged 64 and under. As the name suggests, it covers all the basics and also has a $500 excess applied to reduce the cost, making it the most affordable choice if you just want Hospital cover. However, it doesn't cover outpatient services such as visits to a general practitioner (GP) for things like the flu or a virus.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

And if you are admitted as an inpatient into a hospital or day facility:

- **Hospital accommodation.** You're covered for a shared room in a private hospital.

Yes, it's visa-compliant!
Our Basic Working Visa Cover is the minimum cover required to meet the Department of Home Affairs visa requirements. All of our other Working Visa covers are DIBP-compliant too.

- **Inpatient medical (doctors) bills.** You're covered for all charges up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology (e.g. x-rays) and pathology (e.g. blood tests).
- **In-hospital pharmacy drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the Pharmaceutical Benefits Schedule (PBS) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care.

Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.

- **Surgically implanted prostheses.** You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

Please note: A medical annual limit of $1,000,000.00 applies per person on this policy.

What isn't covered with Basic?

Hospital Emergency Department Treatment
Under Australian legislation, services provided in the emergency department of a hospital are defined as "outpatient medical" and not deemed to be a "hospital treatment".

HIF will therefore only pay benefits for services provided in a hospital Emergency Department, where a person is covered under HIF Intermediate Working Visa ($500 limit per person, per year) or Comprehensive Working Visa covers or Visitor Value ($500 limit per person).

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.
- for outpatient services and emergency hospital department treatment.

Services that are not covered at all (known as exclusions) include:

- artificial reproductive techniques and investigations or treatment relating to infertility (IVF)
- bone marrow and organ transplants
- Any inpatient hospital service not normally covered by Medicare for Australian residents, including most cosmetic and podiatric surgery.
- outpatient medical services, including visits to doctors and specialists, radiology and pathology, except public hospital emergency department fees that lead to an admission in hospital
- services and treatments that are covered by compensation and damages provision
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy
- minimum policy term is two months.

What about repatriation?

You are covered for repatriation – up to $4,000 per person, payable once in a lifetime. See page 49 for more information about repatriation.

Waiting periods for new and upgrading members

- Psychiatric, rehabilitation and palliative care – 2 months
- Pregnancy and birth related services – 12 months
- All other covered treatment in relation to a pre-existing condition – 12 months.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you are admitted (as an inpatient) into a hospital or day facility?

A $500 excess applies per-person per-admission, then you are covered for all inpatient medical (doctor) bills up to the Medicare Benefit Schedule fee. What's more, no co-payments are required for a shared room in a public hospital. We recommend you contact us before going to into hospital to find out if you will incur an out-of-pocket expense.

Essentials Working Visa (Hospital only cover)

As the name suggests, this policy covers all the essentials, making it the smart choice if you just want Hospital cover. However, it doesn't cover outpatient services such as x-rays, pathology or visits to a general practitioner (GP) for things like the flu or a virus.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

And if you are admitted as an inpatient into a hospital or day facility:

- **Hospital accommodation.** You're covered for a shared room as a private patient in a private hospital.
- **Inpatient medical (doctors) bills.** You're covered for all charges up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology (e.g. x-rays) and pathology (e.g. blood tests).
- **Pharmaceutical drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the Pharmaceutical Benefits Schedule (PBS) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care.
  Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.
- **Surgically implanted prostheses.** You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

What isn't covered with Essentials?

Hospital Emergency Department Treatment
Under Australian legislation, services provided in the emergency department of a hospital are defined as "outpatient medical" and not deemed to be a "hospital treatment".

HIF will therefore only provide benefits for services provided in a hospital Emergency Department, where a person is covered under HIF Intermediate Working Visa ($500 limit per person, per year) or Comprehensive Working Visa covers or Visitor Value ($500 limit per person).

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.f

Services that are not covered at all (known as exclusions) include:

- bone marrow and organ transplants
- artificial reproductive techniques and investigations or treatment relating to infertility (IVF)
- any service not normally covered by Medicare for Australian residents, including cosmetic and podiatric surgery
- outpatient medical services, including visits by doctors and specialists, radiology and pathology, except public hospital emergency department fees that lead to an admission in hospital
- services and treatments that are covered by compensation and damages provision
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy
- minimum policy term is two months.

What about repatriation?

You are covered for repatriation – up to $4,000 per person, payable once in a lifetime. See page 47 for more information about repatriation.

Waiting periods for new and upgrading members

- Psychiatric, rehabilitation and palliative care – 2 months
- All obstetric (pregnancy) related conditions – 12 months
- All other covered treatment in relation to a pre-existing condition – 12 months

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you are admitted (as an inpatient) into a hospital or day facility?

There's no excess, and you are covered for all inpatient medical (doctor) bills up to the Medicare Benefit Schedule (MBS) fee. What's more, no co-payments are required for a shared room in a public hospital.

We recommend you contact us before going to into hospital to find out if you will incur an out of pocket expense.

Intermediate Working Visa (Hospital and Medical cover)

A step up from Essentials Working Visa, our mid-range Intermediate option for working visitors aged 64 and under covers you for a shared room in a private or public hospital. Plus, you're covered for some out-of-hospital medical expenses, such as x-rays and visits to a GP. You can also choose your doctor.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

And if you are admitted as an inpatient into a hospital or day facility:

- **Hospital accommodation.** You're covered for a shared room in a private hospital or shared or private room as a public patient in a public hospital.
-

  Inpatient medical (doctors) bills. You're covered for all charges up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology (eg. xrays) and pathology (eg. bloodtests).

- **Theatre fees and labour ward charges.**
- **Pharmaceutical drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the PBS (Pharmaceutical Benefits Schedule) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care. Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.
- **Surgically implanted prostheses.** You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

What services are covered if you are not admitted to hospital?

Hospital Emergency Department Treatment
Under Australian legislation, services provided in the emergency department of a hospital are defined as "outpatient medical" and not deemed to be a "hospital treatment".

All outpatient medical (doctor) bills are covered, as are public hospital emergency department fees that lead to an admission to hospital. So that's full cover up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology and pathology (up to $500 per person, per calendar year).

What isn't covered with Intermediate Working Visa?

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.

Services that are not covered at all (known as exclusions) include:

- bone marrow and organ transplants
- artificial reproductive techniques and investigations or treatment relating to infertility (IVF)
- any service not normally covered by Medicare for Australian residents, including cosmetic and podiatric surgery
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy
- minimum policy term is two months.

What about repatriation?

You are covered for repatriation – up to $6,000 per person, payable once in a lifetime. See page 49 for more information about repatriation.

Waiting periods for new and upgrading members

- Psychiatric, rehabilitation and palliative care – 2 months
- All obstetric (pregnancy) related conditions – 12 months
- All other covered treatment in relation to a pre-existing condition – 12 months.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you are admitted into a hospital or day facility?

There's no excess, and you are covered for all inpatient medical (doctor) bills up to the Medicare Benefit Schedule fee. What's more, no co-payments are required for shared rooms in HIF contracted hospitals. However, you may be required to make an additional co-payment for each day that you stay in a private room or non HIF contracted hospital. Some doctors may charge above the MBS, we recommend you contact us before going to into hospital to find out if you will incur an out-of-pocket expense.

Comprehensive Working Visa
(Hospital and Medical cover, with optional excess)

'Comprehensive' is the word. This option for working visitors aged 64 and under provides complete peace of mind, with full cover for a private room in a private hospital and out-of-hospital medical expenses for a host of services. Choose your doctor. Visit a GP. And with the excess option, you get it all at a reduced premium.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

  And if you are admitted as an inpatient into a hospital or day facility:

- **Hospital accommodation.** You're covered for a shared or private room in a private hospital or as a public patient in a public hospital.
- **Inpatient medical (doctors) bills.** You have full Access Gap cover for medical procedures. (See page 8)
- **Theatre fees and labour ward charges.**
- **Pharmaceutical drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the Pharmaceutical Benefits Schedule (PBS) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care. If you want to be covered for out-of-hospital pharmaceutical drugs you can take out one of our extras products which will pay a benefit towards your prescription if it is listed on the PBS. Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.
- **Surgically implanted prostheses.** You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

What services are covered if you are not admitted to hospital?

All outpatient medical (doctor) bills are covered, which means full cover up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology and pathology.

What isn't covered with Comprehensive Working Visa?

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.

Services that are not covered at all (known as exclusions) include:

- any service not normally covered by Medicare for Australian residents, including cosmetic and podiatric surgery
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy

What about repatriation?

You are covered for repatriation – up to $8,000 per person, payable once in a lifetime. See page 49 for more information about repatriation.

Optional excess

You can reduce your premium by selecting an optional excess of $500 for a single policy or $1,000 for a family policy.

NB: The minimum policy term is two months.

Waiting periods for new and upgrading members

- Psychiatric, rehabilitation and palliative care – 2 months
- All obstetric (pregnancy) related conditions – 12 months
- All other covered treatment in relation to a pre-existing condition – 12 months.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you are admitted into a hospital or day facility?

Yes, if you select the optional excess, you will have to pay an excess of $500 per person, per overnight admission, up to a maximum of $1,000 per family policy per calendar year. That said, you are covered for all inpatient medical (doctor) bills up to the Access Gap fee (see page 8) and the excess doesn't apply to same-day surgery. What's more, you aren't required to make any co-payments for any room in an HIF contracted hospital. Some doctors may charge above the Medicare Benefit Schedule (MBS), we recommend you contact us before going to into hospital to find out if you will incur an out of pocket expense.

Visitor Saver (Hospital cover only)

Designed for young holiday makers and visitors on non-working visas, this product covers the basics in a shared room in a public hospital. This cover is not compliant for visa purposes.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences. And if you are admitted as an inpatient into a hospital or day facility:
- **Hospital accommodation.** You're covered for a shared room as a public patient in a public hospital.
- **Inpatient medical (doctors) bills.** You're covered for all charges up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology and pathology.
- **Pharmaceutical drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the Pharmaceutical Benefits Schedule (PBS) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care.
  Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.
- **Surgically implanted prostheses.** You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

What isn't covered with Visitor Saver?

Hospital Emergency Department Treatment
Under Australian legislation, services provided in the emergency department of a hospital are defined as "outpatient medical" and not deemed to be a "hospital treatment".

HIF will therefore only provide benefits for services provided in a hospital Emergency Department, where a person is covered under HIF Intermediate Working Visa ($500 limit per person, per year) or Comprehensive Working Visa covers or Visitor Value ($500 per person).

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.

Services that are not covered at all (known as exclusions) include:

- bone marrow and organ transplants
- artificial reproductive techniques and investigations or treatment relating to infertility (IVF)
- any service not normally covered by Medicare for Australian residents, including cosmetic and podiatric surgery
- outpatient medical services, including visits by doctors and specialists, radiology and pathology, except public hospital emergency department fees that lead to an admission in hospital
- services and treatments that are covered by compensation and damages provision
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy
- cardiac-related conditions, medical treatment and surgical procedures, including arrhythmias, artery bypass grafts, coronary angioplasty, congenital defects, heart disease, heart transplants, pacemakers, defibrillators and stent insertion.
- eye surgery (any procedure on the surface or within the structures of the eye)
- gastric banding and obesity services
- joint replacement
- obstetrics or any maternity related services
- palliative care services
- psychiatric
- rehabilitation
- renal dialysis
- repatriation

Waiting periods for new and upgrading members

- All covered treatment in relation to a pre-existing condition – 12 months.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you are admitted into a hospital or day facility?

Yes, you will have to pay an excess of $250 per person per admission up to a maximum of $500 per family policy per calendar year. That said, no co-payments are required for a shared room in a public hospital.

We recommend you contact us before going into hospital to find out if you will incur an out-of-pocket expense.

NB: The minimum policy term is two months.

Visitor Value (Hospital and Medical cover)

A step up from Visitor Saver cover, our mid-range value option for visitors on non-working visas aged 64 and under. It covers you for a shared room in a private or public hospital. Plus you're covered for some out-of-hospital medical expenses, such as x-rays and visits to a GP. You can also choose your doctor. This cover is compliant for visa purposes.

What's covered if you have to go to hospital and you are admitted (as an inpatient) into a hospital or day facility?

- **Ambulance.** You're covered 100% for unlimited urgent transport by road ambulance with a government approved ambulance service. That includes emergency admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment, where the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.
  And if you are admitted as an inpatient into a hospital or day facility:
- **Hospital accommodation.** You're covered for a shared room in a private hospital or shared or private room as a public patient in a public hospital.
- **Inpatient medical (doctors) bills.** You're covered for all charges up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology (eg. xrays) and pathology (eg. bloodtests).
- **Theatre fees and labour ward charges.**
- **Pharmaceutical drugs.** You're required to pay an amount equal to the Australian government patient contribution but you will receive a benefit for the rest of the cost, based on the PBS (Pharmaceutical Benefits Schedule) listed price. This is paid for all PBS listed drugs that are prescribed according to the PBS's approved indications and administered during, and as part of, an admitted episode of care.

  Benefits may not apply or may be restricted for non - Therapeutic Goods Administration approved, experimental or high cost drugs.

  Surgically implanted prostheses. You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted prostheses, as listed in the Private Health Insurance (Prostheses) Rules 2007. Benefits may be restricted for non-approved medical treatments or consumables.

What services are covered if you are not admitted to hospital?

Hospital Emergency Department Treatment
Under Australian legislation, services provided in the emergency department of a hospital are defined as "outpatient medical" and not deemed to be a "hospital treatment".

All outpatient medical (doctor) bills are covered, as are public hospital emergency department fees that lead to an admission to hospital. So that's full cover up to the Medicare Benefit Schedule fee (MBS). This includes consultations with doctors and specialists, radiology and pathology (up to $500 per person, per calendar year).

What isn't covered with Visitor Value?

You are not covered:

- en route to and from Australia
- for services provided outside Australia
- for services arranged prior to coming to Australia.

Services that are not covered at all (known as exclusions) include:

- bone marrow and organ transplants
- artificial reproductive techniques and investigations or treatment relating to infertility (IVF)
- any service not normally covered by Medicare for Australian residents, including cosmetic and podiatric surgery
- services where benefits are claimable from another source including workers compensation, public liability sources, your employer or any other insurance policy
- repatriation

NB: The minimum policy term is two months.

Waiting periods for new and upgrading members

- Psychiatric, rehabilitation and palliative care – 2 months
- All obstetric (pregnancy) related conditions – 12 months
- All other covered treatment in relation to a pre-existing condition – 12 months.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

Do you have to pay anything if you go to hospital (and are admitted as an inpatient)?

Yes, you will have to pay an excess of $250 per person per admission up to a maximum of $500 per family policy per calendar year. That said, no co-payments are required for a shared room in a public hospital, although you may be required to make an additional co-payment for each day that you stay in a private room or a non HIF contracted hospital. You are covered for all inpatient medical (doctor) bills up to the Medicare Benefit Schedule (MBS) fee.

We recommend you contact us before going into hospital to find out if you will incur an out-of-pocket expense.

Things you should know about our Extras Cover

Why choose HIF Extras?

Here at HIF, we pride ourselves on enabling member choice.

So, unlike some health fund insurers who pay lower benefits if you don't go to their "preferred providers", with HIF you're free to visit any extras provider in Australia.

Our only requirement is that members must visit healthcare providers who are legally qualified to practise in Australia (and approved by HIF).

So as long as your preferred doctor, dental provider, optical provider, physiotherapist, chiroprator or other type of healthcare provider is approved by HIF, you're free to use **whichever one you want.**

Head over to **hif.com.au/extras** to view and compare our Extras cover options.

Our Member Loyalty Program

HIF rewards members who retain their Extras cover each year by providing increasing benefits or annual limits.

Our dental limits increase every year from commencement until the maximum limit is available in your sixth year of membership. Benefits or limits for services like optical, physiotherapy, occupational and speech therapy increase after 5 years and benefits or limits increase for complementary therapies, chiropractic, osteopathic and pharmacy after 3 years.

Where a policy is upgraded to a higher level of Extras cover, annual limits and benefits will automatically move to the next highest loyalty benefit on the new level of cover and progress each year until all maximum benefits and limits are reached.

Annual limits

HIF Extras covers have an annual limit for most services, which means there is a limit on how much HIF will pay toward your claims. Most limits are for the calendar year (January to December) and each January your benefit limits will be refreshed, allowing you to claim benefits again for extras services provided in the new year.

Claiming timeframe limitation

Claims must be made within two years of the service being provided.

Approved consultations

Unless stated, to be eligible for HIF benefits all services must be provided by a HIF approved health provider at that provider's registered practice address in a face-to-face setting, or as otherwise approved by HIF.

Workers Compensation and Dual Insurance

Benefits cannot be claimed and are not payable by HIF where you have or can claim benefits or compensation (in full or in part) for treatment, goods or services from a third party including Workers Compensation or Public Liability sources, your employer or any other Insurance policy.

Ways to claim

Electronic Claiming

Providers with electronic claiming technology (HICAPS or iSOFT) can settle your account with you on the spot. Simply swipe your HIF membership card and pay any difference.

HIF Member App

Members who own an Apple or Android mobile device can now submit paid extras accounts by using their mobile's in-built camera to photograph receipts and invoices. To find out more, visit **hif.com.au** or download HIF Member App now from the Apple App Store or the Android Market.

Fast-Track e-Claiming (email/fax)

For paid extras accounts of $1000 or less, try our quick and easy Fast-Track option. Simply scan your completed HIF claim form and associated receipts and invoices, and email a copy to claims@hif.com.au or fax a copy to **(08) 9328 1685** or **+618 9328 1685** from overseas. To find out more, visit **hif.com.au**

Hospital and AccessGap Accounts

If you need to go into hospital, please contact us prior to admission.

A number of doctors around Australia can choose to participate in HIF's AccessGap scheme, which means that they may charge above the Medicare Benefit Schedule and subject to condition, HIF will pay or cover a proportion of that additional amount on your behalf.

Your doctor may send the accounts to HIF direct. If not, you can send the unpaid account to us for processing the HIF and Medicare benefits payable. We will then send the payment direct to your doctor or hospital on your behalf. Please call us before you go into hospital so we can assist you with your claims.

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** or mailed to you on request.

For more information on the different ways to make a claim, check out **hif.com.au/claim**

Important information about your dental cover

Benefits are only paid on accounts rendered by a registered dentist or dental prosthetist. The dentist or dental prosthetist must be in private practice. Dental prosthetists are allowed to perform a limited range of services for benefit purposes.

There are some items within item code ranges for which HIF does not pay a benefit, or if they are performed with another item in the same course of treatment. Limits apply to the number of times some items, such as bleaching, attract a benefit.

Benefits for replacement dentures and partial dentures are not paid within three years of previous supply.

Orthodontic limits are lifetime limits per person. Benefits are not payable in excess of the annual limit shown and include benefits paid under another health insurance policy. The applicable benefit is payable on the date the service is rendered e.g. the date braces are fitted.

Benefits towards orthodontic treatment (including payment plans) are not payable by HIF if the treatment or service has commenced prior to joining HIF.

We welcome all customers transferring from other insurers, however if you're engaged in an instalment payment plan with another health provider it is critical (to avoid potential out of pocket expenses) that you clarify the specifics of your arrangement with HIF prior to transferring cover.

If you are unsure of your entitlements, please contact us before commencing a course of treatment with full details of the necessary dental items as provided by your dental provider and we will provide you with a benefit estimate.

Annual limits are refreshed on 1 January each year, so if you're planning a course of treatment it may be financially advantageous to stagger services over two calendar years.

Feedback, disputes and privacy

Compliments and complaints

Your feedback is valuable to us, so don't be afraid to get in touch. You may wish to comment on your personal experiences with HIF, or you may wish to lodge a compliment (or complaint) about the service you've received from our team.

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.

To submit feedback, simply visit **hif.com.au/contact** and complete the online feedback form. Alternatively, you can email **hello@hif.com.au** or call us on **1300 13 40 60** or **+618 9227 4200** (overseas number).

Our dispute resolution process

We are committed to providing our members with access to the highest level of service and we value the feedback that our members provide. If you have a concern regarding your HIF membership, our products, benefits or our service, we would be happy to hear from you, please call us on **1300 13 40 60** or **+618 9227 4200** (overseas number) or email **hello@hif.com.au**

We will gladly discuss the matter with you or escalate the matter to a senior manager if required. Should you be unhappy with the outcome, please rest assured that we have an internal dispute resolution process in place. To escalate your complaint to this level, please put the issue in writing and send it to: Member Action Review Committee HIF, GPO Box X2221, PERTH, WA 6847

Your privacy

The personal information you provide to us will be primarily used by HIF to deliver health insurance products and services as requested by you. The information supplied by you will remain confidential. This information may be disclosed to third parties and authorised government agencies in order 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 **+618 9227 4200** (overseas number) or download a copy at **hif.com.au/legal-stuff**

Frequently asked questions

How long can my child stay on my policy?

Providing your child or children are dependent and living with you, they can be included on your policy until they turn 21. If they are studying in an approved Australian education institution, they can remain on your policy until they are 25 years of age.

What is Medicare Levy Surcharge (MLS)?

The Medicare Levy Surcharge (MLS) is a Federal Government initiative designed to encourage individuals to take out private Hospital cover and use private hospitals, thereby reducing demand on the public system.

The surcharge is levied on Australian taxpayers who earn above a certain income and don't have private Hospital cover.

For more info visit **hif.com.au**

What if you're from a 'reciprocal country'?

If you are from a country that has a reciprocal health care agreement with Australia, you are entitled to receive emergency treatment in a public hospital anywhere in Australia. The key word here is 'emergency'.

Reciprocal health care agreements aren't designed to replace private travel and health insurance. If you rely on a reciprocal agreement, you may have to wait a while before you're treated, even for emergency treatment.

Taking out private health insurance means you won't have to go on a public waiting list. What's more, you'll be able to choose your own doctor and hospital.

The countries with reciprocal health care agreements are: New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway. However, please note that students from Norway, Finland, Malta and the Republic of Ireland aren't covered by agreements with those countries.

Frequently asked questions (Cont)

What are waiting periods?

A waiting period is the standard period of time that must be served as an HIF member before you're eligible to claim a benefit.

Important, please note: Waiting periods are effective from your arrival into Australia. For example, if your policy start date is January 1, however you do not arrive into Australia until March 1, your 12-month pre-existing waiting period will end on March 2 the following year.

What happens when I get permanent residency?

When you get permanent residency, you will receive a Medicare Eligibility letter. The letter will give you one year to purchase domestic private health insurance cover before you are charged Lifetime Health Cover loading (LHC). When you become eligible for Medicare, you are also entitled to the Federal Government Rebate.

What is the Lifetime Health Cover loading (LHC)?

The federal Government introduced the Lifetime Health Cover loading to encourage permanent residents of Australia 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 – so the earlier you take out health cover, the cheaper your premiums.

How is the 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 (increasing each year until it reaches 70%). For example, a single 37 year old would pay 14% LHC loading – so it really pays to take out private Hospital cover sooner rather than later.

For couples and families, however, the loading is initially calculated based on your respective dates of birth and then halved. For example, If you find that you will incur a loading, you will be required to pay this on top of the base premium that you're initially quoted for your Hospital cover. If you decide to join HIF, your loading will automatically be applied to the quoted amount once you provide your date of birth.

What happens to my visa if I don't take out Hospital cover?

If you don't take out Hospital cover and it is a requirement of your visa, your visa will be refused and you won't be able to come to Australia.

What if I cancel my cover before my visa runs out?

We are obliged to notify Department of Home Affairs if your policy is cancelled.

Can I swap health funds if I received a visa compliance letter from another fund?

Yes, you can. Your health insurance cover is completely portable and we will even recognise your full length of membership with your previous fund, which means you don't have to re-serve waiting periods you've already served with another health insurance provider.

What is 'out-patient medical'?

'Out-patient medical' refers to any treatment you receive in a doctor's rooms or a hospital emergency/casualty department. For example, a visit to your general practitioner, doctor or specialist, or services such as x-rays or blood tests.

How do I claim if I go to a doctor?

If you consult a doctor or specialist you will need to pay the charge to the receptionist at the time of your visit. You'll receive a receipt outlining the costs, which you can mail to us with a claim form – you can download a claim form from **hif.com.au/claim.**

How long do I need to be covered for?

Refer to the individual policy.

If my visa is not approved, can I get a refund?

Yes, you are entitled to a refund, although a $50 admin fee will be charged.

What do I need to bring when I arrive in Australia?

If you currently have health insurance in your country of residence, you will need to bring your policy details, including:

- The start and end dates of your policy
- Details of policy coverage and, if possible, a policy document or brochure that outlines exactly what is covered
- Who is covered on the policy
- Any claims that have been made in the last 12 months

Your health fund should be able to give you all of this information.

What is a pre-existing condition?

In accordance with HIF's Fund Rules and The National Health Act, a pre-existing ailment is an ailment, illness or condition of which the signs or symptoms, in the opinion of a medical practitioner appointed by HIF, existed during the six months preceding the day on which the member commenced cover with HIF for:

1. Benefits in accordance with the applicable benefits arrangement; or
2. If applicable, benefits in accordance with a previous benefits arrangement.

In forming an opinion referred to above, the medical practitioner appointed by the organisation must have regard to any information relating to the ailment, illness or condition that was given to him or her by the medical practitioner who treated the ailment, illness or condition.

This rule applies whether the ailment, illness or condition was known to the member or not.

What is repatriation?

If you're covered by our Working Visa covers and you have to be repatriated to your home country because you are terminally ill or suffer from a substantial life-altering illness or injury, we will pay a contribution towards the cost of your return travel with another family member and a professional who's qualified to provide medical supervision.

The benefit is only payable after we and the treating medical practitioner agree that repatriation is necessary due to a terminal illness or a substantially life-altering illness or injury.

In the event of death, the deceased person's mortal remains, and those of any other person covered by the policy, may be repatriated to their home country, if legally permissible.

Glossary

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

Admission
The period of time during which a person is admitted as an inpatient for a condition or illness 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 benefits payable to a member in a calendar year, commencing 1st January and ending 31st 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.

Benefit
The payment due to the primary member for services received by an approved provider.

Dependant
A person dependent upon the primary member. This includes:

- Domestic partners, your own 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, nor the child of a dependant child).
- Student dependants – children, stepchildren, legally adopted children and children to whom the primary 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 primary member agrees to pay before a benefit will be payable.

Excluded service
Services that are not covered by a benefit, so all costs will be paid by you.

Extras Cover
At HIF, we call ancillary cover 'Extras' – it's our name for all those day-to-day health care services, such as dental, optical and physio, plus a whole host more, including emergency ambulance 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 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.

Medicare Benefit Schedule (MBS)
The schedule of benefits produced by the Department of Health and Aged Care, listing eligible services, fees and benefits for Medical Services, including inpatient services.

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 benefit applies).

Out-of-pocket
The amount remaining to be paid by the member after the HIF benefits have been paid.

Outpatient
An outpatient is someone who has received medical treatment in a doctor's surgery or casualty department and has not been admitted into hospital.

Policy holder
A holder of an insurance policy who is referable to HIF. A holder of a HIF insurance policy is referred to as the 'primary member'.

Practitioners in private practice
A practitioner who does not:

a) 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 under the extras table

b) 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
A pre-existing condition is defined as an ailment, illness, or condition that you had signs or symptoms of during the six months before you joined our fund or upgraded to a higher level of cover or the same cover with a reduced or nil excess. It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed. A condition can still be classed as pre-existing even if you haven't seen your doctor about it before joining or upgrading. If you knew you weren't well, or had signs of an ailment that a doctor would have detected (if you had seen one) during the six months prior to joining the Hospital cover then the ailment would be classed as pre-existing.

Primary member
The first named member, 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/ agents authority is required.

Qualifying periods
Any period occurring immediately after joining the fund or joining a higher benefiting table, during which either some or all fund benefit is not payable.

Recognised educational institution
An Australian educational institution such as a school, college or university, recognised by the Commonwealth, State or Territory Governments.

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

Follow us on

At HIF we're all about choice.

Call, email or contact us online.

- **hif.com.au/visitors**
- **1300 13 40 60 or Int'l +618 9227 4200**
- **hello@hif.com.au**
- **GPO Box X2221 Perth WA 6847**

Australia's first certified Carbon Neutral health fund.

The information in this brochure is correct as at 01 April 2021. Minor changes may occur after that date. If major changes occur, a separate insertion will be included in the brochure or the brochure will be reprinted. HIF members are encouraged to regularly download the latest copy of this brochure from **hif.com.au**, 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.