



Health cover made simple

Your guide to HIF
and health insurance

Health Cover Guide for Australian Citizens and Permanent Residents

The information in this Guide is correct as at 1 April 2025. 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](https://www.hif.com.au/guide)** and read in conjunction with HIF's product factsheets.

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



Contents

Why choose HIF?	3	Ambulance cover.....	15
About HIF Hospital cover	4	Making claims	16
Inclusions, restrictions and exclusions	4	How to make an Extras claim	16
Medical and hospital benefits, expenses and gap cover	6	HIF mobile app for members	16
Hospital accommodation costs, upgrades and co-payments	8	Hospital claims and AccessGap accounts ...	17
Dental and podiatry surgery	9	Frequently asked questions	18
Pregnancy and Birth Cover	9	HIF and you	20
About HIF Extras cover.....	11	Government legislation	22
What is Extras cover?	11	Glossary	24
Inclusions and exclusions	11	Useful links	27
Benefits and limits	12	Need some no-obligation advice?	27
Extras waiting periods	13		
Dental cover	13		
Orthodontic benefits	14		

Why choose HIF?

HIF is the Health Insurance Fund of Australia, and we've been providing great value health cover since 1954. As a not-for profit, here-for-you health fund, our members and their well-being are the sole reason we exist.

Why choose us? It's simple.

We're all about doing the right thing.
By our members. By our community.
By the environment.

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.

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 an HIF-contracted or public 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 in place 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 in place, you may have significant out-of-pocket expenses and you may be asked to pay up-front for your procedure.

Please note: *If you choose to have an excess on your hospital policy this amount is also payable upon admission to hospital, once per person per calendar year (to a maximum of twice per couple or family policy). For some covers, the excess does not apply for same-day admissions and/or dependant children under the age of 18. For more information, please read your product factsheet or visit www.hif.com.au/hospital.*

Where is your nearest 'agreement' private hospital?

We have hundreds of contracted hospitals in Australia. Visit hif.com.au/hospitalsearch or call us on **1300 134 060** to find your nearest hospital.

Which medical health providers are recognised by HIF?

Generally, we pay benefits for government-recognised health provider who provides hospital or hospital substitute (in your home) services that are included in the 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 134 060**.

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 Medicare Benefit Schedule (MBS).

Visit hif.com.au/hospital to check out our Hospital cover factsheets for a comprehensive rundown of inclusions, restrictions, 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 approved hospital means a facility which has obtained a Hospital declaration from the Government. It must obtain this in order to receive payments of health benefits from health insurers, following treatment of insured patients.

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 are restricted services?

Take a look at our product factsheets and you'll see some services or treatments referred to as 'restricted'. This means the benefits for that service or treatment are limited at the basic public hospital default rate (only) for accommodation – 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 Medical Devices and Human Tissue Products
- 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?

Where services, treatments and items are noted as excluded, it means no benefit is payable for services that are not included on your cover, therefore you are responsible for all costs beyond the Medicare benefit.

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

For more information on what's excluded on your cover, check out our product factsheets.

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, Medical Devices and Human Tissue Products 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
- 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)
- Any treatment or services by a provider who is not recognised by HIF
- Respite care.

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 Medicare Benefit Schedule (MBS) items you'll be billed for 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 134 060** and we can provide a benefit estimate over the phone.

Medical and hospital 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 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 for:

- Any claims submitted when membership is not paid up to date (i.e. in arrears or suspended) when the benefit is claimed
- Any claim for a service provided more than two years ago
- Any treatment, service or item listed as an exclusion on your policy
- The benefit amount doesn't exceed the excess payable on your policy
- Any treatment, service or item which is provided within a waiting period
- Any treatment, service or item which is subject to the Pre-existing Condition Rule
- Any treatment or service not yet received
- Any treatment or service not covered by Medicare

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-contracted private hospital
- Your health provider doesn't participate in AccessGap and their charge is higher than the 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 Medical Devices and Human Tissue Products item that's not covered under the Government's Approved Prescribed List of Medical Devices and Human Tissue Products
- 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 134 060**.

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 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, view our excess options or to read our product factsheets.

For some covers, the excess doesn't apply for same-day admissions and/or dependant children under the age of 18.

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 in an HIF-contracted hospital.

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. It's the only way we can protect our members from those who would otherwise join us only to make a big claim, then leave.

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

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

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.

The pre-existing condition waiting period does not apply to psychiatric care, rehabilitation and palliative care (a two-month waiting period applies to these services).

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.

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 and if the procedure is provided by a registered podiatric surgeon, you can claim benefits for:

- Limited hospital accommodation; and
- The cost of Medical Devices and Human Tissue Products as listed in the Prescribed List of Medical Devices and Human Tissue Products set out in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, as in force at that time.

Please note: No benefits are paid for anaesthetist costs. For the podiatric surgeon fees and theatre costs you could incur significant out of pocket expenses. Please call us on **1300 134 060** prior to surgery to confirm your benefits payable.

Pregnancy and Birth Cover

Do we provide pregnancy and birth cover?

Yes, we do – pregnancy and birth cover 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 pregnancy and birth 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 pregnancy and birth cover if you're planning to have a baby – it'll give you more peace of mind as you plan this exciting journey.

With HIF pregnancy and birth cover you can:

- Choose your hospital, obstetrician and other specialists
- Enjoy private-room accommodation during your stay in hospital. (*Please refer to the product factsheet for accommodation benefits on pregnancy and birth*)
- Claim for labour ward fees
- Your partner may be able to stay with you in hospital as a boarder at no extra cost.

Please note: Private room and boarder accommodation is subject to Hospital availability.

What is the waiting period for Pregnancy and birth cover?

The waiting period for all pregnancy and birth services is 12 months. That means you'll need to have held pregnancy and birth cover for 12 months prior to your delivery 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 child dependants may be covered up to at least 21 years of age or up to 31 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 you hold a single or couple 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 134 060** for over-the-phone credit card payments.
- 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, Whadjuk Country, 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 general healthcare services, which are not related to hospital treatment. 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.

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 134 060** 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 and when will benefits not be paid?

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, service or item provided outside Australia
- Any treatment, service or item 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)
- Any treatment or service by a provider who is not recognised by HIF, or services which are not in the HIF-approved range of treatments (e.g. trainee providers)
- Any treatment or service deemed by HIF to be inappropriate or not medically necessary for the patient's condition (based on expert clinical advice)
- Any 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
- Any treatment, service or item that is provided within a waiting period or prior to joining HIF
- Any policy which is not financial (i.e. in arrears or suspended) when the benefit is claimed
- Any claim is for a service provided more than two years ago
- Any treatment, service or item not listed as an inclusion on your policy
- Any claim where you've exceeded the maximum claimable limit or sublimit for a service (i.e. the maximum you're allowed to claim in a calendar year for a given service, treatment or item).

Benefits and limits

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

We pride ourselves on affordable premiums and great member 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:

Benefits won't be paid on included services if:

- The treatment, service or item fee is greater than the maximum benefit payable by HIF
- 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 same service, treatment, item and the combined benefit exceeds the annual limit or sublimit for the 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.

Please read our product factsheets (available at hif.com.au/extras) for detailed info about 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 (most limits are renewed at the start of every year).

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

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.

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



Extras waiting periods

Why do we have waiting periods?

Waiting periods exist so we can protect our members from people who would otherwise become members to claim for expensive treatment, only to leave once their treatment is complete. If waiting periods didn't exist, customers could take out private health insurance or upgrade to a higher level of cover only when they knew or suspected that they might need cover and then immediately make a claim. This would lead to much higher premiums for all existing contributors to health insurance.

Waiting periods apply to new policies, or when you upgrade your policy to include more services or higher benefits or annual limits. Read our product factsheets for more info about specific waiting periods.

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

If you join or switch 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 re-serve any waiting periods.

But please note:

- If you switch from another Australian health fund to a higher level of Extras cover with HIF (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 benefits for your future claims in the same calendar year (or regarding the Lifetime Limit for orthodontics).

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 benefit in advance, giving you total peace of mind.

To request a dental estimate, call **1300 134 060**, email hello@hif.com.au or visit hif.com.au/dentalestimate

How are your dental benefits calculated?

We'll pay a set maximum benefit or percentage back for each service, treatment or item depending on your level of cover.[^]

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

[^]*Benefits may be limited where potential benefits exceed dental service sublimits or annual limits.*

Dental Surgery

Dental surgery is classified as Hospital treatment for surgery to the teeth and gums.

Please note: *If you undergo surgery by a recognised dentist in a hospital, you may be able to claim benefits for theatre, accommodation and anaesthetist costs. Benefits towards your dentist's fees will only be paid if you also hold a suitable Extras product and have served all relevant waiting periods in addition to your Hospital cover.*

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 orthodontics treatment?

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. For HIF Premium, Super, Special Options covers, we pay a set benefit per orthodontic item as an immediate benefit (claimable when your braces are fitted), subject to your annual or lifetime orthodontic limits.

For other HIF covers, we will pay a benefit per orthodontic item. In these instances, we'll pay benefits up to your annual limit on your initial claim.

If your orthodontic treatment continues across multiple calendar years and you maintain orthodontic cover under your Extras policy, we may pay benefits up to your annual limits each calendar year, until you reach your lifetime limit.

Contact us to prior to your treatment to understand how benefits will be paid and which limits are applicable to your level of cover.

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 Essential, Advanced or Top 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 eligible Extras cover on the date your braces are fitted, we'll be unable to provide a benefit for any instalment payment plan or invoice.

For HIF Premium, Super, Special Options covers, we pay a set benefit per orthodontic item as an immediate benefit (claimable when your braces are fitted), subject to your annual or lifetime orthodontic limits.

Already have Extras cover and considering orthodontic treatment?

Then please contact us on **1300 134 060** 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.

Ambulance cover

Are ambulance services included on Hospital cover?

Yes! All of our Hospital policies pay benefits for emergency ambulance callouts and transportation. Visit [hif.com.au/hospital](https://www.hif.com.au/hospital) for more information.

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.

Do you get ambulance cover with Extras?

Yes! All of our Extras policies pay benefits for emergency ambulance callouts and transportation. Visit [hif.com.au/extras](https://www.hif.com.au/extras) for more information.

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.

At HIF, on all levels of Hospital and on selected levels of Extras Cover, if your ambulance service is classified as 'non-emergency' by the attending ambulance service personnel, all you have to contribute is a \$50 co-payment per trip.

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
- Benefits are not payable for inter-hospital transport except in cases of emergency or new illness where approved on a case by case basis by HIF at its absolute discretion.
- 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. If you have HIF Extras cover, HIF will pay for the ambulance bill; however depending on your level of cover a co-payment of \$50 per trip may apply, if your ambulance service is classified as 'non-emergency' by the attending ambulance service personnel. Visit [hif.com.au/extras](https://www.hif.com.au/extras) for more info.

WA, SA, Victoria and the NT

In all other locations and circumstances, you can claim on your Hospital/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).

What is Emergency ambulance transport?

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.

Making claims

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.

By email. For paid Extras accounts, simply email a scan of your completed HIF claim form* and associated receipts to claims@hif.com.au.

By post. Complete a claim form* and post it to: HIF, Whadjuk Country, GPO Box X2221, Perth WA 6847.

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

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 and Extras limits, order replacement membership cards, contact HIF plus 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.

Things to note

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, items or treatments rendered outside Australia are not payable by HIF.

Full terms and conditions at hif.com.au/legal-stuff/hif-app-terms-and-conditions

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 request a reply paid to envelope and send to: HIF, Whadjuk Country, 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, Whadjuk Country,
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.

Please note: If you attend an emergency department of a private hospital and you are not admitted into the hospital, you may need to pay a fee that will be determined by the hospital. You will be informed of this by the hospital staff at the time of admission.

Frequently asked questions

How long can children remain on family policies?

With HIF, your dependants may be covered up until the age of 21, or up to 31 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 inpatient 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'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 over the income amount set by the Government.

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 an Australian 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.

Visit hif.com.au/mls to calculate your MLS eligibility.

What is Lifetime Health Cover (LHC) loading?

The Australian Government introduced Lifetime Health Cover loading to encourage Australians to take out private hospital cover at a younger age and encourage them to maintain it.

To find out more about LHC loading visit [hif.com.au/lhc](https://www.hif.com.au/lhc)

Does HIF cover same-sex couples?

Absolutely. We support choice 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 134 060.

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 Australian Government Rebate on Private Health Insurance means tested?

Yes, the Australian 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.

The Australian Government Rebate applies to Hospital and/or Extras cover. For more information on the Australian Government Rebate, please visit [hif.com.au/rebate](https://www.hif.com.au/rebate)



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 is to maintain and enhance regulatory compliance and service standards across the private health insurance industry. 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 privatehealthcareaustralia.org.au



For further information call HIF on **1300 134 060**.

Our Commitment

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.

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 134 060**
- 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 complaints in an equitable manner, with the best interests of all members in mind
 - Escalate complaints (if necessary) and resolve them swiftly, within two business days
 - Use feedback to improve our products and services by passing it on to our Product team
 - Invite you to further escalate complaints (that could not be resolved to your satisfaction) to our formal Member Action Review Committee who will formally review all of your concerns and our actions within one month of lodging your complaint and will direct a representative to advise you of the outcome of the hearing within three days of the Committee hearing
 - If you're not satisfied with the outcome of our internal dispute resolution process, you can seek an independent review by the Private Health Insurance Ombudsman, Health Care Compliant Commission or Fair Trading Body in your State and/or the Australian Competition Consumer Commission. You can also contact the Ombudsman on **1300 362 072** or write to them at: GPO Box 442, Canberra, ACT 2601 or Privacy Commissioner.

Your cooling-off period

We offer a 30-day cooling-off period for new HIF health insurance policies. If you decide during this time that the policy isn't right for you, you can cancel your policy and receive a full refund of any premiums you have paid within 30 days of your policy starting, as long as you haven't yet 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.

Please note: Member's privacy will be handled in accordance with the Privacy Act, Australian Privacy Principles and HIF's Privacy Policy. For a complete HIF Privacy Policy Statement, please contact us on **1300 134 060** or download a copy at **hif.com.au/privacy**.

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 Australian Government Rebate on Private Health Insurance

The Australian 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, visit hif.com.au/rebate

The Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a 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

Lifetime Health Cover loading

The Government introduced Lifetime Health Cover (LHC) loading to encourage Australians to take out private hospital cover at a younger age.

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

- Are aged under 31 years old
- Had continuous private hospital cover since 1 July 2000
- Were born on or before 1 July 1934
- Are an Australian citizen or resident who is overseas at the time of the deadline and take out Hospital Cover within 12 months of your return. (In order to review your LHC correctly, we will require a copy of your International Movements Record which you can obtain from Department of Home Affairs)
- Are a new migrant aged 31 or over but take out hospital cover within 12 months of being eligible for Medicare
- Are a member of the Australian Defence Forces
- Are a Department of Veteran Affairs Gold Card Holder.

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.

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



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 for a condition or illness 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 134 060. 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.

Australian Government Rebate on Private Health Insurance

The private health insurance rebate is an amount the government contributes towards the cost of your private health insurance premiums. The rebate is income tested which means if you have a higher income, your rebate entitlement may be reduced, or you may not be entitled to any rebate at all.

Basic Benefit (public default rate)

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 children/student 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.

Dependant

A person dependant upon the primary member. This includes:

- 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 31 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

An excluded service means no benefit is payable for services that are not included on your cover, therefore you are responsible for all costs beyond the Medicare benefit.

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 which are generally not covered by Medicare. Extras cover is also known as Ancillary or General Treatment cover.

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.

Medical Devices and Human Tissue Products

Medical Devices are any product or equipment intended for a medical use. It can be an instrument, apparatus, appliance, software, implant, reagent, material, or other article. It can

be used alone or in combination, as defined by the manufacturer.

Human Tissue Products are human cells or tissues intended for implantation, transplantation, infusion, or transfer into a human recipient. They are used for non-surgical, minimally invasive treatments that use the body's own ability to heal, repair and regrow tissue.

Effective 1 July 2023 the Department of Health changed the name from *Prostheses to Medical Devices and Human Tissue Products*.

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.

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 emergency 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.

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.

The pre-existing condition waiting period does not apply to psychiatric care, rehabilitation and palliative care (a two-month waiting period applies to these services).

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."

Policyholder or 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. The person who is responsible for the insurance policy. Also known as the 'primary member'.

Waiting 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.

Restricted service

Hospital services which are only covered for payments at the public default rate.

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.



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

We understand the importance of protecting your health at home and away. That's why we also offer great-value travel insurance for HIF members.

Visit [hif.com.au](https://www.hif.com.au) to find out more and get a quote.

Useful links

- 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
- 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 134 060

hello@hif.com.au

**Whadjuk Country,
GPO Box X2221
Perth WA 6847**

*The information in this Guide is correct as at 1 April 2024. 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** and read in conjunction with HIF's product factsheets.*

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

Freedom to choose.

Call, email or visit us online.

 [hif.com.au](https://www.hif.com.au)

 1300 134 060

 hello@hif.com.au

 Whadjuk Country GPO Box X2221 Perth WA 6847

Find us on:

