Health cover made simple

Your guide to HIF and overseas workers and visitors health insurance

A Health Cover Guide for Overseas Workers and Visitors to Australia.

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** or contact us and we will send one to you. This Guide should be read carefully and 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.

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** and **Non-Working** overseas visitor covers are suitable for visitors aged less than 65 years of age.

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. 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.

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 HIF-contracted private hospital.
- **Essential Working Visa** (No Excess) – shared room in a public or HIF-contracted private hospital.
- **Intermediate Working Visa** (No Excess) – private or shared room in a public or HIF-contracted private hospital.
- **Comprehensive Working Visa** (Excess options – $0 or $500 per person up to a policy maximum of $1000 per calendar year) – private or shared room in a public or HIF-contracted private hospital.
- **Visitor Saver** (Excess – $250 per person up to a policy maximum of $500 per calendar year) – shared room in a public or HIF-contracted private hospital.
- **Visitor Value** (Excess – $250 per person up to a policy maximum of $500 per calendar year) – shared room in an HIF-contracted private hospital. Private or shared room in a public hospital.

	Cover for Working Visa Holders				Cover for Non-Working Visa Holders	
Service	Basic Working Visa	Essential Working Visa	Intermediate Working Visa	Comprehensive Working Visa	Visitor Saver[1]	Visitor Value[2]
Emergency ambulance cover	✓	✓	✓	✓	✓	✓
Non-Emergency ambulance cover^	✓	✓	✓	✓	✓	✓
Private room, private hospital*	✗	✗	✓	✓	✗	✗
Shared room, private hospital	✓	✓	✓	✓	✓	✓
Private room*, public hospital	✗	✗	✓	✓	✗	✓
Shared room, public hospital	✓	✓	✓	✓	✓	✓
Access Gap Cover	✗	✗	✗	✓	✗	✗
Outpatient services & emergency hospital department treatment (covered up to MBS fee)	✗	✗	✓	✓	✓	✓ Up to $500 per person per calendar year
Excess	$500 per person per admission	✗	✗	Nil Excess option **or** $500/$1000	$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	✗	✗

For more details, please refer to the individual cover descriptions.

[1] *Visitor Saver cover is not a visa-compliant policy, so we can't issue a letter of visa compliance for this product.*
[2] *Visitor Value is currently not being offered for new joins.*
^ *We will not cover off road or air ambulance (e.g. plane, helicopter or boat).*
* *Where available.*

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?

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*** *or* ***+618 9227 4200*** *from overseas, prior to surgery to confirm your benefits payable.*

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 certain Overseas policies. For more details, please refer to the individual product factsheets on **hif.com.au/visitors.**

Need a visa letter, pronto?

If you're applying for an Australian visa, you may need to provide the Department of Home Affairs 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.

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 Visitor Value ($500 limit per person, per year), or Intermediate Working Visa, Comprehensive Working Visa and Visitor Saver (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. Our waiting periods are:

- Emergency Ambulance – 1 day
- Non-Emergency Ambulance – 30 days
- Rehabilitation regardless of whether or not the condition is pre-existing – 2 months
- All pregnancy and birth related services – 12 months
- All treatment related to a pre-existing condition – 12 months
- All other treatments – no waiting period.

What's a pre-existing condition?

The Pre-existing Condition Rule is a 12-month waiting period for hospital treatment relating to a pre-existing condition – it's a rule that applies whether the ailment, illness or condition was known to the member or not.

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

The pre-existing condition waiting period applies to new members and existing members upgrading their cover. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition, not on a diagnosis (i.e. it's not necessary for the member or their doctor to know what their condition is or for it to be diagnosed). In forming an opinion about whether or not an illness is a pre-existing condition, an HIF-appointed medical practitioner will take into account information provided by the member's treating doctor.

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)

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 134 060** 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 134 060** 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.

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 Scheme (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 Medical Devices and Human Tissue Products

You get a benefit at least equal to 100% of the minimum benefit amount listed for No Gap and Gap Permitted Medical Devices and Human Tissue Products, as listed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules 2007. Benefits may not apply for non-approved medical treatments or consumables.

Transferring and upgrading your cover

New members who transfer Hospital cover 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 waiting 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 International 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

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

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.

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.

Ambulance cover

Do you get ambulance cover with Overseas Hospital Cover?

You're covered 100% for unlimited emergency and non-emergency 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. We will not cover off road or air ambulance (e.g. plane, helicopter or boat).

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.

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 claim form and your hospital and medical accounts, we can arrange payment of your 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 the HIF 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 the claim form before sending a copy to us
- Send your claim form and any accounts directly to us.

What about inpatient pathology and radiology accounts?

Send your inpatient pathology and radiology accounts directly to us along with the completed and signed HIF claim form.

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.*

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.

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.

For HIF Premium, Super, Special Options' covers, benefits towards orthodontic treatment (including payment plans) are not payable by HIF if the treatment or service has commenced prior to joining HIF.

For other eligible Extras cover, if you're already on a treatment plan and intend to take out HIF Extras cover, it's important to note we only cover (bundled fees for the fitting and management of braces) if you have an eligible level of Extras cover on the date your braces are fitted and served the 12-month waiting period. If you don't have eligible Extras cover on the date your braces are fitted, we'll be unable to provide a benefit for any installment payment plan or invoice.

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.

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.

Frequently asked questions

How long can my child stay on my policy?

Providing your child or children are dependant 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 31 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.

If you reside in Australia, you are considered an Australian resident for tax purposes. The surcharge is levied on Australian taxpayers who earn above a certain income and don't have private domestic Hospital cover.

For more info visit **hif.com.au/mls** or for specific advice regarding your individual situation, please visit ato.gov.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.

For more information on countries with a reciprocal health care agreement with Australia, please visit **servicesaustralia.gov.au/reciprocal-health-care-agreements**

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.

What happens when I get permanent residency?

When you get permanent residency, you will receive a Medicare Eligibility letter. If you're over the age of 31, this 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 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 enter Australia.

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

We are obliged to update the Department of Home Affairs if requested by them, if your policy is currently active or 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 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.**

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.

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

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

Can HIF refuse an application?

HIF reserves the right to decline or refuse an application for overseas visitors health cover at any time.

What is a pre-existing condition?

The Pre-existing Condition Rule is a 12-month waiting period for hospital treatment relating to a pre-existing condition – it's a rule that applies whether the ailment, illness or condition was known to the member or not.

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

The pre-existing condition waiting period applies to new members and existing members upgrading their cover. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition, not on a diagnosis (i.e. it's not necessary for the member or their doctor to know what their condition is or for it to be diagnosed). In forming an opinion about whether or not an illness is a pre-existing condition, an HIF-appointed medical practitioner will take into account information provided by the member's treating doctor.

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

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 child dependants.

Dental Item Code

A dental item code is a three digit number for dental items or clinical procedures considered to be part of current dental practice by the Australian Dental Association.

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.

Not withstanding 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.
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.

Freedom to choose.

Call, email or visit us online.

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