Packaged Cover

Bronze Plus Simple Choice

Bronze Plus Simple Choice is a great value packaged cover option for singles, couples and families.

It includes commonly used inpatient hospital services like the surgical removal of tonsils, adenoids and appendix, as well as hernia repairs, joint reconstructions and more, plus Extras that provide 60% or more back on services such as General Dental, Major Dental, Optical, Physio, Chiro, Complementary Therapies, Psychology and more.

Bronze Plus Simple Choice – Hospital Cover

What's included, not included or restricted?

Ambulance services[1]	✓
Rehabilitation	R
Hospital psychiatric services	R
Palliative care	R
Brain and nervous system	✓
Eye (not cataracts)	✓
Ear, nose and throat	✓
Tonsils, adenoids and grommets	✓
Bone, joint and muscle	✓
Joint reconstructions	✓
Kidney and bladder	✓
Male reproductive system	✓
Digestive system	✓
Hernia and appendix	✓
Gastrointestinal endoscopy	✓
Gynaecology	✓
Miscarriage and termination of pregnancy	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	✓
Pain management	✓
Skin	✓
Breast surgery (medically necessary)	✓

Diabetes (excluding insulin pumps)	✓
Heart and vascular systems	✘
Lung and chest	✓
Blood	✓
Back, neck and spine	✓
Plastic and reconstructive surgery (medically necessary)	✘
Dental surgery[2]	✓
Podiatric surgery[3] (provided by a registered podiatric surgeon)	✓
Implantation of hearing devices	✓
Cataracts	✘
Joint replacements	✘
Dialysis for chronic kidney failure	✘
Pregnancy and birth	✘
Assisted reproductive services	✘
Weight loss surgery	✘
Insulin pumps	✘
Pain management with device	✘
Sleep studies	✓

Key ✓ = included R = restricted ✘ = not included

[1] *Please note: Not covered for*
- *Transportation from a hospital to your home, nursing home or other hospital.*
- *Transportation for ongoing medical treatment.*
- *Off road or air ambulance (e.g. plane, helicopter or boat).*

[2] *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.*

[3] *Limited benefits apply to Podiatric Surgery, and you may incur significant out of pocket expenses. Please refer to the Health Cover Guide for more information.*

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Information correct as at 1 April 2025.

Also included on this policy:

- Unlimited cover for both Emergency and Non-Emergency Ambulance ($50 co-payment per trip)
- Emergency treatment in hospital resulting from an accidental injury
- Your choice of treating doctor or specialist
- Private and shared room accommodation in an HIF-contracted hospital (subject to availability of a private room)
- Shared room accommodation in a public hospital, with the exception of public hospitals in New South Wales (NSW) where private and shared room coverage is available (subject to availability of a private room)
- AccessGap Cover for eligible inpatient medical services
- Benefits for surgically implanted Medical Devices and Human Tissue Products and other items on the Federal Government's Prescribed List of Medical Devices and Human Tissue Products
- Inpatient pharmacy drugs – charges vary between hospitals depending on the contract that's in place. Please check with the hospital or HIF.

What does restricted mean?

The term 'restricted' means that you can claim benefits for accommodation at the basic hospital default rate only for the services listed as restricted. However, full AccessGap coverage applies for inpatient medical procedures, and benefits will be paid towards Medical Devices and Human Tissue Products in accordance with the Federal Government's Prescribed List of Medical Devices and Human Tissue Products.

What about excluded benefits?

No benefits will be payable for services that are not included on your cover.

Other situations where you may not be covered by HIF include for cosmetic surgery, or when your membership isn't financial, or waiting periods are still being served.

For a comprehensive list, please read our Health Cover Guide. You can download a copy from **hif.com.au/guide**

Does a hospital excess apply?

For Bronze Plus Simple Choice, a standard excess applies:

Single memberships:

- $750 per calendar year.

Couple/family policies:

- $750 per person up to a policy maximum of $1,500 per calendar year.

You'll only need to pay the excess per-person per calendar year if admitted to hospital for same-day or overnight stays. No excess applies to dependants under the age of 18.

Hospital waiting periods

A waiting period refers to the period of time you have to wait (after purchasing or upgrading Hospital Cover) before you're entitled to receive benefits for services or items included on your chosen level of cover.

For Bronze Plus Simple Choice, the applicable waiting periods are:

- **Emergency Ambulance:** 1 day
- **Non-Emergency Ambulance**: 30 days
- **General hospitalisation:** 2 months
- **Psychiatric care, rehabilitation and palliative care:** 2 months
- **Pre-existing conditions:** 12 months

Please note: *In order to access higher benefits for specialist psychiatric care, members with at least two months tenure on a lower level of hospital cover are entitled to upgrade their cover without serving a two-month waiting period for psychiatric treatment. This waiting period upgrade is only available once in a lifetime (conditions apply, please contact us for more details).*

Information correct as at 1 April 2025.

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 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/specialist.

Make sure you read our Health Cover Guide

Our Health Cover Guide is your need-to-know resource for all things about health insurance.

The Health Cover Guide also outlines more information about your coverage as well as situations in which you might not be covered by HIF, so please read the guide carefully and retain a copy for your records.

Visit **hif.com.au/guide** to access a copy online.

Information correct as at 1 April 2025.

60% or more back
up to your annual limits.

Cover for General and Major Dental

Optical[3] – Annual limit of $200 per person and $400 per policy.

Service	Benefit	Annual limit	Waiting period
General Dental[1]			
Oral Examination (012) Dental x-ray (022) Scale and clean (114) Fluoride treatment (121) Surgical tooth extraction (322) Filling/tooth restoration (531)	60%	$600 per person $1,200 per policy	2 months
Major Dental			
Filling of one root canal (417) Full crown – non metallic (613) Full crown – veneered (615) Dentures – complete (719)[2]	60%	$600 per person $1,200 per policy	12 months
Optical			
Frames, prescription lenses and contact lenses[3]	100%	$200 per person $400 per policy	2 months

[1] *Limits apply to the number of times some items (such as bleaching) attract a benefit. You may also not be able to claim benefits for services performed with another item in the same course of treatment.*

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

[3] *Benefits are payable on prescription optical items.*

Information correct as at 1 April 2025.

Service	Benefit	Annual limit	Waiting period
Physiotherapy Individual consultation Group, hydrotherapy, antenatal	60%	Combined limit: $350 per person $700 per policy The annual combined limits includes the following sub-limits: Complementary Therapies sub-limit: $150 per person $300 per policy Healthy Lifestyle sub-limit: $150 per person $300 per policy Psychology sub-limit: $150 per person $300 per policy	2 months
Exercise Physiology Consultations			
Chiropractic Consultations X-ray			
Osteopathy Consultations			
Podiatry[4] Consultations			
Pharmacy[5] Non-PBS pharmaceuticals	60% (up to annual limit) of the balance after the PBS fee is deduct		
Flu vaccination *(Benefits payable from a registered pharmacy only)*	$20 (1 per person, per calendar year)		
Complementary Therapies[6] Services include acupuncture, myotherapy, remedial massage and traditional Chinese medicine	60%		
Healthy Lifestyle[7] Services include gym memberships, health assessments, weight management programs, quit smoking plans and skin cancer screenings			
Psychology Consultations			

[4] *Benefits are not payable on podiatry surgery or orthotics.*

[5] *Benefits are not payable on PBS (Pharmaceutical Benefit Scheme) prescriptions or over the counter items purchased with or without a prescription.*

[6] *Benefits are not payable on medicines.*

[7] *Benefits are payable for HIF approved programs delivered by registered providers only. Please contact us prior to commencing program to check eligibility.*

Information correct as at 1 April 2025.

How to make an Extras claim

With HIF, making an Extras claim is easy! In fact, the toughest bit is choosing from our host of convenient ways to make your claim:

1. Claim on the spot with most providers simply by swiping your HIF Member card through their HICAPS eClaiming terminal
2. Claim online through our 24/7 Member Centre
3. Claim on your mobile with our HIF Member App, available for Apple and Android devices
4. Claim by email – simply send copies of your signed claim form and receipts to **claims@hif.com.au**
5. Claim by posting your documents to: HIF, Whadjuk Country, GPO Box X2221, Perth WA 6847.

In any case, it's quick and easy and you'll have your benefit paid in no time. To find out more and download a claim form, visit **hif.com.au/claim**

Please note:

- *Benefits are payable by HIF only for services and programs delivered by registered providers that are approved by HIF.*
- *Benefits are paid by item number limits up to sub-limits/annual limits. Call us on **1300 134 060** prior to treatment to confirm your benefits payable.*

Understanding annual limits

Like most Extras health covers, there are annual limits (a limit on how much we will pay towards your claims) for most services. These annual limits reset to the full amount on January 1 each year.

Please note: *Benefits are payable up to your annual limit. Annual limits are per person per calendar year unless otherwise stated.*

What are waiting periods?

All health funds have to apply waiting periods. It's the only way we can protect our community of loyal Members from people who would otherwise join our fund to claim large amounts, then leave.

That said, we try to keep waiting periods to a minimum. That's why, if you switch to us from another health fund, we'll honour any waiting periods already served with your previous insurer on an equivalent level of cover.

Got a question?

Visit our handy online knowledge base for 24/7 access to a wealth of information.

Visit **hif.com.au/help** to get started or call us on **1300 134 060**

Information correct as at 1 April 2025.