Lite Bronze Hospital Plus Cover Summary

Cost-effective cover for a range of treatments, plus accident cover

Features



Cover for your own private room[1]



Accident cover the day after you join



Unlimited urgent ambulance by road[2]



No excess for kids[3]

As an HBF member you'll:

- ✓ Be part of a not-for-profit health fund that's able to focus on giving more back to members.
- ✓ Be able to check your limits, view usage, update your details and get a benefit quote with myHBF, our member service portal.

How to contact us:



Call 133 423
For call centre opening hours, please visit hbf.com.au/contact-us



Go to hbf.com.au



Find a location near you
Please visit hbf.com.au/find-a-branch

[1] At a Member Plus hospital. Subject to availability.
[2] HBF will cover the cost for urgent ambulance transport by road only for circumstances classified as emergency or urgent. HBF does not cover air ambulance.
[3] No excess for kids applies to single parent or family hospital covers only. On child only policies, any applicable excess may still apply.

What am I covered for?

This is an overview of Lite Bronze Hospital Plus. Additional information you should know relating to this cover can be found in the Membership Guide available at hbf.com.au/membership-guide

Hospital treatments and services	Covered/Not covered
Rehabilitation	R✓
Hospital psychiatric services	R✓
Palliative care	R✓
Tonsils, adenoids and grommets	✓
Joint reconstructions	✓
Hernia and appendix	✓
Gynaecology	✓
Ear, nose and throat	✓
Bone, joint and muscle	✓
Kidney and bladder	✓
Male reproductive system	✓
Digestive system	✓
Gastrointestinal endoscopy	✓
Miscarriage and termination of pregnancy	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	✓
Skin	✓
Brain and nervous system	✓
Eye (not cataracts)	✓
Pain management	✓
Breast surgery (medically necessary)	✓
Diabetes management (excluding insulin pumps)	✓
Blood	✓
Dental surgery	✓
Lung and chest	✓
Sleep studies	✓
Back, neck and spine	×
Plastic and reconstructive surgery (medically necessary)	×
Pain management with device	×
Heart and vascular system	×
Podiatric surgery (provided by a registered surgical podiatrist)	×
Implantation of hearing devices	×
Insulin pumps	×
Cataracts	×
Joint replacements	×
Dialysis for chronic kidney failure	×
Pregnancy and birth	×
Assisted reproductive services	×
Weight loss surgery	×

R✓ Restricted hospital benefits only. Significant out-of-pocket costs may occur.
✓ Included service. This meets government requirements for a Bronze level of hospital cover.
✓ Included service. This is additional to the minimum government requirements for a Bronze level of hospital cover.
× Excluded service.

More information about your health cover

What is an included service?

When you have been admitted to hospital for treatment that is an included service on your cover, you'll be covered for private room accommodation and theatre fees (less any agreed excess) for all agreed services in a Member Plus hospital.

We may also pay a benefit towards your specialist fees and other in-hospital services, such as medically necessary investigative tests and/or examinations, if your treatment is covered by Medicare. These services must be required to support your treatment after you've been admitted to hospital.

If you choose to be treated as a private patient in a public or non-Member Plus hospital, we'll pay a benefit towards your accommodation and may pay a benefit towards theatre fees depending on the hospital (less any agreed excess). You may have private room accommodation, however these fees are not fully covered, so you are likely to incur out-of-pocket costs.

What is a restricted service?

When you have been admitted to hospital for treatment that is a restricted service on your cover, we'll pay a benefit which is limited to the minimum default benefit. This means we'll cover the same amount as the cost of receiving treatment at a public hospital, staying in a shared room. If you choose to receive treatment for a restricted service at a private hospital, you'll have to pay any differences, which means paying a large portion of your treatment costs out of your own pocket.

Accident Cover

What is Accident Cover?

Accident Cover provides temporary hospital coverage for up to 90 days following an Accident for services that are normally Restricted or Excluded if the hospital treatment is required for injuries that are sustained in the Accident.

How does claiming on it work?

To be eligible to claim benefits for an accident, it must meet HBF's definition of an accident set out as below.

An accident is an unforeseen event, occurring by chance and caused by an external force or object that results in an injury to the body requiring admission to hospital for medical treatment.

You must be seen by a medical practitioner within 7 days after the accident. If you require hospital treatment as a result of the accident, HBF covers you as an admitted patient for admissions within 90 days of the accident or initial medial presentation after the accident.

HBF will not pay a benefit for hospital treatment as a result of an accident when:

- The accident occurred prior to joining this cover or within the Accident cover waiting period.
- You did not seek any medical treatment within 7 days of the accident.
- The hospital treatment is more than 90 days after the accident/initial medical presentation.
- The hospital treatment was for the treatment of an illness, condition, alignment, sickness or injury that was either known or should reasonably have been known to you at any time.
- The accident occurred as a consequence of your employment of professional duties.
- The treatment is claimable through a third party insurer.

Urgent Ambulance

With Urgent Ambulance, you'll be fully covered for ambulance transport by road and on-site treatment, for circumstances classified as emergency or urgent provided by an approved HBF provider.

The most common urgent ambulance service is a call-out that requires a trip to a hospital emergency department.

Emergency or urgent treatment by paramedics at the scene, such as resuscitation, are also considered an urgent ambulance service and will therefore be eligible for benefit under your cover.

Each state runs a little differently when it comes to Ambulance cover, so here's what you need to know when you get your bill:

- If you live in VIC, SA, WA or NT and receive a bill for emergency or urgent ambulance transport or on-site treatment, send it to us for processing.
- If you live in NSW or ACT, you need to return your bill to your respective state/territory ambulance levy scheme with your HBF member information.
- If you live in TAS or QLD and are a permanent resident, you are covered under your state-based scheme for ambulance services within your state.
- If you hold a concession card, you may have subsidised ambulance services depending on the state you live in.

HBF won't pay a benefit for:

- Situations where the service is not classified as emergency or urgent and you are not transported to, and received by, an emergency department, including transport to medical appointments.
- Any transport not by road, including air ambulance services.
- Situations where the benefit or cost is subsidised by a state scheme or is payable by a third party, including inter-hospital transfers.
- Any transport between public hospitals.

Are there any exclusions on benefits?

There are some common situations where HBF won't pay a benefit for any hospital treatment fees including accommodation, medical or theatre fees:

- If you receive treatment that is excluded on your cover or is not eligible for a Medicare benefit
- If you receive an outpatient treatment including treatment in a private emergency department
- If you receive treatment which is deemed to be cosmetic and not medically necessary
- Your premium payments are not up-to-date at the time of treatment
- Your claim is not lodged within two years of the date of service
- If you have not yet received your treatment at the time you claim
- Your treatment is provided outside of Australia
- Your claim is covered by worker's compensation, third party or other legal right

See the **Membership Guide** for further exclusions.

When can I claim?

If you're new to private health insurance or if you've upgraded to a higher level of cover, you'll have to serve a waiting period before you can claim.

Waiting periods for Lite Bronze Hospital Plus are listed below:

Service	Waiting periods
Accident cover	**1 day**
Urgent ambulance (by road)	**7 days**
All other in-hospital treatments	**2 months**
Pre-existing ailments or conditions[4]	**12 months**

Where you have continuous hospital cover, we'll honour any waiting periods you served on your previous health cover, so you won't have to re-serve them. If you are part-way through a waiting period, you will just have to serve the remainder before you can claim.

If there are new services on this cover, that were not on your previous cover, you will have to serve the relevant waiting periods for those services before you can claim any benefits.

If there are higher benefits on this cover compared to your previous cover, you will have to serve the relevant waiting periods before you can claim the increased benefits.

If you're moving from a cover with an excess to a cover with a lower or no excess, you'll need to pay the higher excess if you're admitted to hospital during the waiting periods applicable to that service. This includes pre-existing conditions.

What is a pre-existing condition and how does it work?

This is an illness or condition which, in the opinion of an independent medical practitioner (appointed by HBF), was known to exist, or where signs or symptoms were evident during the six-month period before you became an HBF member, including on the day you joined. This also applies if you transferred to a level of cover with higher benefits or reduce your excess level.

If you proceed with a hospital admission without confirming what benefits you're eligible for and your condition is determined to be pre-existing, you will be required to pay all outstanding hospital and medical charges not covered by Medicare.

Will I have any out-of-pockets?

Receiving treatment that is listed as an exclusion from your cover and does not meet the accident cover definition, will result in significant out-of-pocket expenses.

If you receive treatment from the result of an accident, you could still face some out of pockets.

Below are some common out-of-pocket costs and how to manage them. To reduce or avoid out-of-pockets, simply contact us before you go to hospital, and we'll help you understand ways to save.

Excess

An excess is a sum of money you pay upfront before you receive hospital treatment. Generally, the higher your excess, the lower your premium. The excess is paid once per member per calendar year (to a maximum of twice per couple or family policy) no matter how many times you may be hospitalised. The excess applies for day and overnight admissions. You won't be required to pay an excess for any dependent children on your single parent or family policy.

Lite Bronze Hospital Plus has a $500 & $750 excess option available.

How to manage out-of-pockets: Some HBF products have a lower excess option to reduce the amount you pay upfront when you go to hospital, but keep in mind a lower excess generally means a higher premium.

Hospital Gaps

HBF has agreements with a large network of private hospitals, which we call Member Plus hospitals, to cover the cost of accommodation and theatre fees for all agreed services at that hospital. Although you may have a hospital treatment included on your cover, an agreed service is specific to the hospital you attend.

If the hospital you attend does not have an agreement with HBF, or if the service you require is a 'non-agreed' service (not covered as part of your hospital's agreement with HBF), HBF will pay a lower benefit which means you will have an out-of-pocket cost. No benefit will be payable for accommodation or theatre fees if the treatment category is excluded on your level of cover.

How to manage out-of-pockets: Stay at a Member Plus hospital and contact us prior to your treatment to check it is an agreed service at that hospital.

Medical Gaps

If your doctor/s (e.g. your surgeon, specialist or anaesthetist) charges more than the Medicare Benefits Schedule fee, you will pay the difference (known as 'the gap') out of your own pocket. HBF may cover all, some or none of this gap, depending on the agreement the doctor has chosen to participate in. Doctors outside of WA can choose to participate in agreements with HBF on a case by case basis. No benefit will be payable for doctors fees if the treatment category is excluded on your level of cover.

How to manage out-of-pockets: Speak to your doctor/s prior to your procedure to check what arrangement they have with HBF and what, if any, gap you'll have to pay. You can contact us for more information and a list of doctors HBF has agreements with, within WA.

Private Patient in Public Hospital

When you are admitted as a private patient in a public hospital, HBF will pay a benefit towards your treatment. There may be an out-of-pocket cost for your hospital admission related to your hospital excess, or if you stay in a private room.

How to manage out-of-pockets: If you choose to use your private hospital insurance in a public hospital, contact us before your treatment and we'll guide you through any out-of-pocket costs.

[4] Pre-existing waiting periods do not apply for Hospital psychiatric services, Rehabilitation or Palliative care.

Medicare Eligibility

Most Australian citizens and permanent residents are eligible for Medicare; however, if you aren't eligible for Medicare, you'll experience large out-of-pocket hospital and medical expenses even if you have hospital cover with HBF.

How to manage out-of-pockets: You may wish to consider HBF's range of overseas visitor cover, which provides benefits for services Medicare would normally cover.

In-hospital Pharmacy

When you're admitted into hospital for an approved procedure, it's likely you'll be given medication. In a number of Member Plus hospitals, in-hospital non-PBS pharmacy items are specified in the hospitals' Participating Hospital Provider Agreement. These items may be included in the hospital charges, which means you may have limited or no out-of-pocket costs to pay.

Where the non-PBS pharmacy items are not specified as included within the Member Plus hospital's agreement, we will pay benefits up to $1400. A member co-payment of $100, per hospital episode may be payable depending on the hospital agreement. There's no limit on the number of times you can claim per year, however re-admissions within seven days may be considered continuous and therefore only one limit and co-payment applies. If the hospital does not have an agreement with HBF, no benefit is payable on non-PBS pharmacy items.

Medical Devices and Human Tissue Products

Medical devices and human tissue products, such as pacemakers and artificial joints, are items that may be provided during hospital treatment. HBF will only pay a benefit towards items that are listed on the federal government-prescribed list. If your doctor uses an item that isn't listed on the prescribed list, HBF will not pay a benefit and you'll have an out-of-pocket expense.

How to manage out-of-pockets: We suggest you discuss the choice of medical device or product and the associated costs with your doctor prior to receiving any treatment.

Dental surgery

Where your Dental surgery treatment is not covered by Medicare, HBF won't pay a benefit for the oral surgeon's fees under your hospital cover, however you'll still be covered for the accommodation and theatre fees.

How to manage out-of-pockets: You may be able to receive a benefit for these treatments if you hold an eligible Extras cover and waiting periods have been served. Contact us before your treatment to understand what out-of-pocket costs will apply and any benefits you may be able to receive with one of our Extras covers.

Cancer Treatment

If you need to go to hospital for cancer treatment, you may need chemotherapy, radiotherapy or immunotherapy and surgical removal of the cancer with an operation.

Surgical procedures related to cancer will be covered if the relevant body system is an included service on your cover. You'll also be covered for Chemotherapy, radiotherapy and immunotherapy for cancer if this is an included service on your cover.

You may have an out-of-pocket cost if either the affected body system or Chemotherapy, radiotherapy and immunotherapy for cancer isn't included on your cover. For example, if you're covered for Chemotherapy, radiotherapy and immunotherapy for cancer but aren't covered for Heart and vascular system, you'll be covered for chemotherapy treatment for a heart tumour however you'll have an out-of-pocket cost for the surgical removal of the tumour.

How to manage out-of-pockets: You can contact us for more information about any out-of-pockets you may have for cancer treatment.

Skin Treatment

The Skin Hospital treatment category provides cover for the investigation and treatment of skin, skin-related conditions and nails, including the removal of foreign bodies, minor wound repair and surgical treatment for melanoma. The Skin category also includes plastic surgery that is medically necessary relating to the treatment of a skin-related condition. However, the removal of excess skin due to any form of weight loss is not included under this treatment category, this treatment falls under Weight loss surgery which is excluded on this level of cover.

How to manage out-of-pockets: If you would like to be covered for excess skin removal after weight loss, you may wish to consider HBF's Gold Hospital cover, which includes cover for Weight loss surgery.

Before receiving any treatment, you may contact us for a health benefit quote so you know what you are covered for and the benefits you'll receive.

HBF reserves the right to make changes to its products, benefits and terms and conditions from time to time. HBF will notify the policyholder a reasonable time in advance of any changes that might be detrimental to the member's interests.

HBF Health Limited **ABN** 11 126 884 786 **Telephone** 133 423 **Postal address** GPO Box C101 Perth WA 6839 **Online** hbf.com.au

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