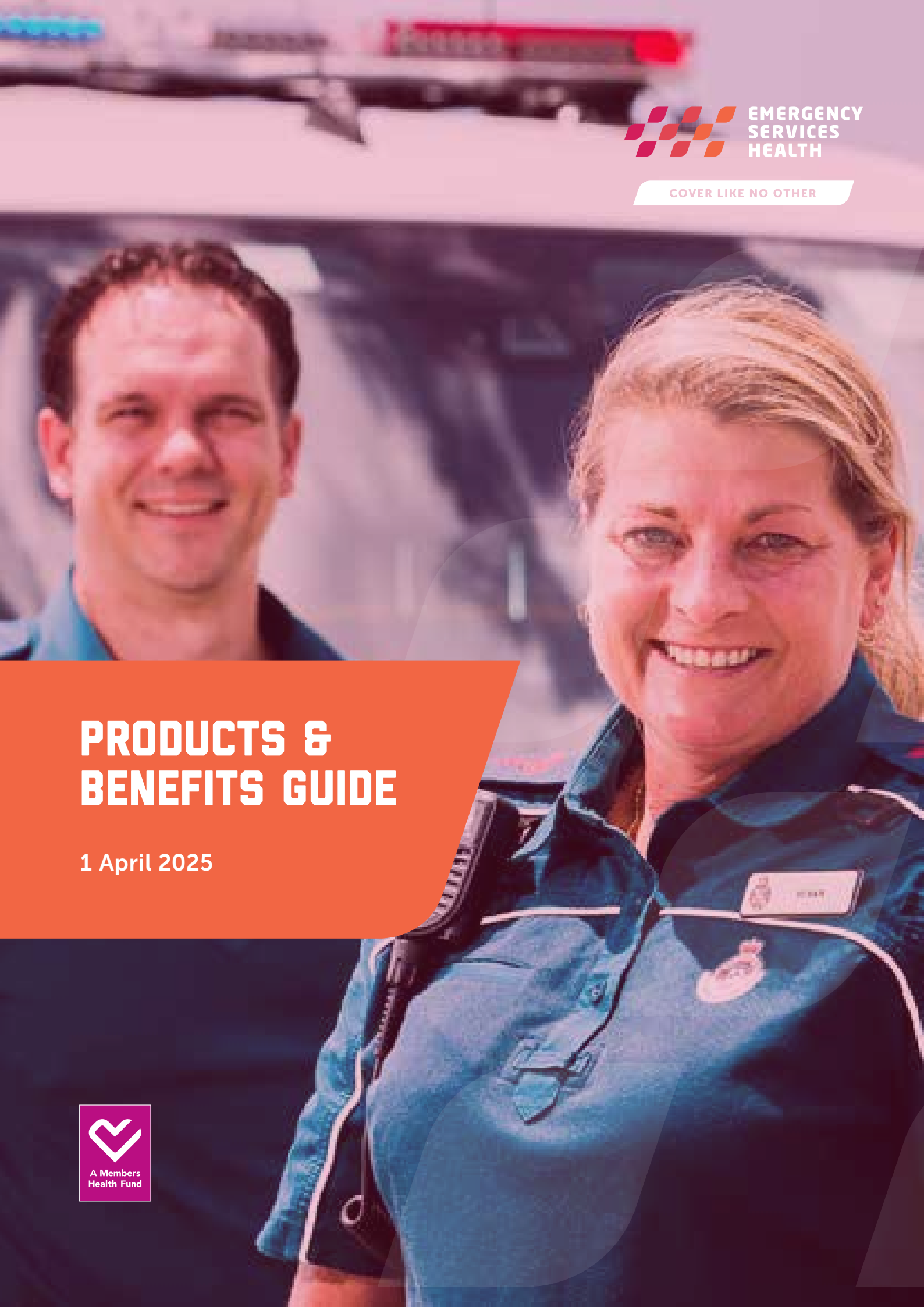


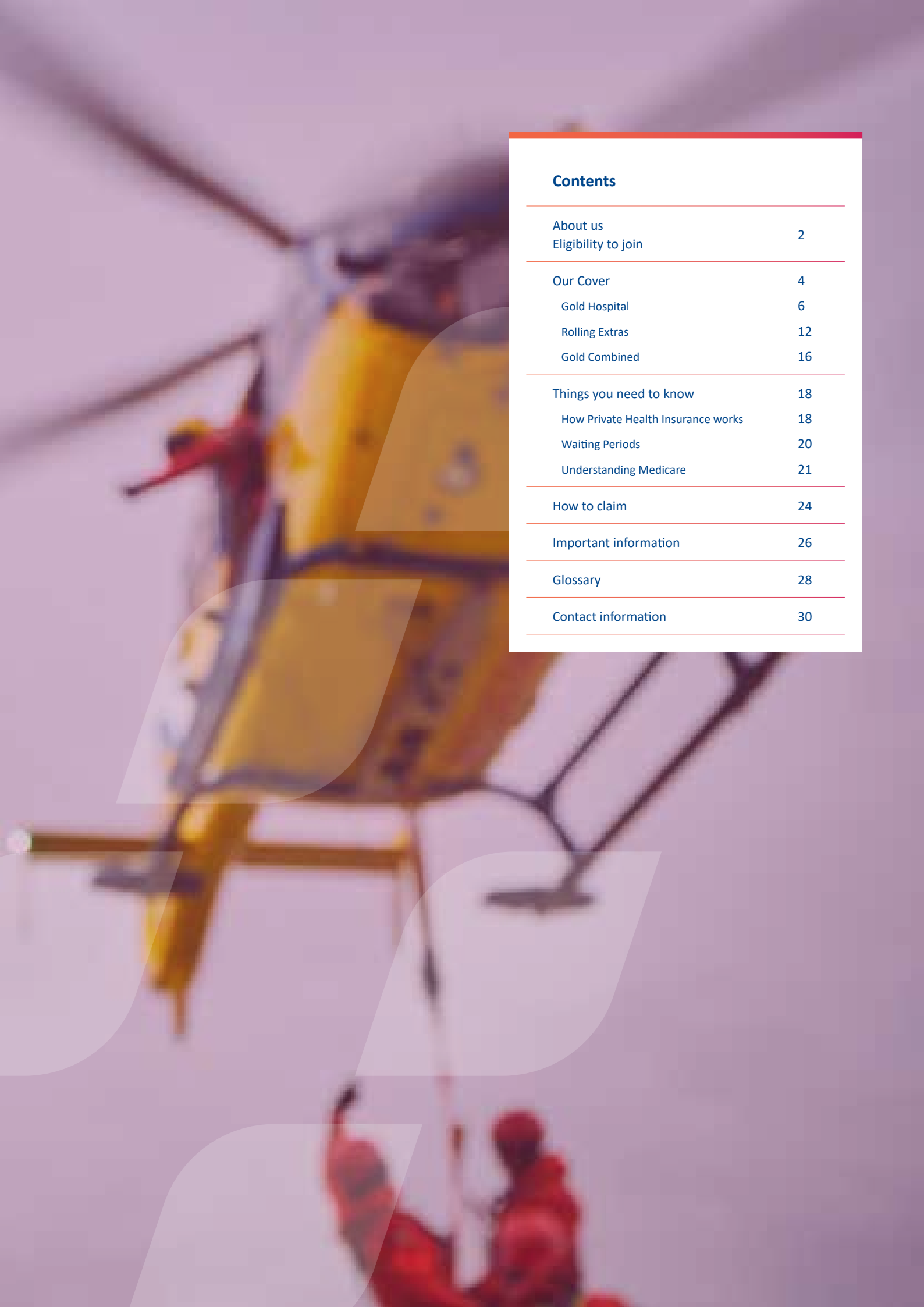
EMERGENCY SERVICES HEALTH

COVER LIKE NO OTHER

PRODUCTS & BENEFITS GUIDE

1 April 2025

A Members Health Fund

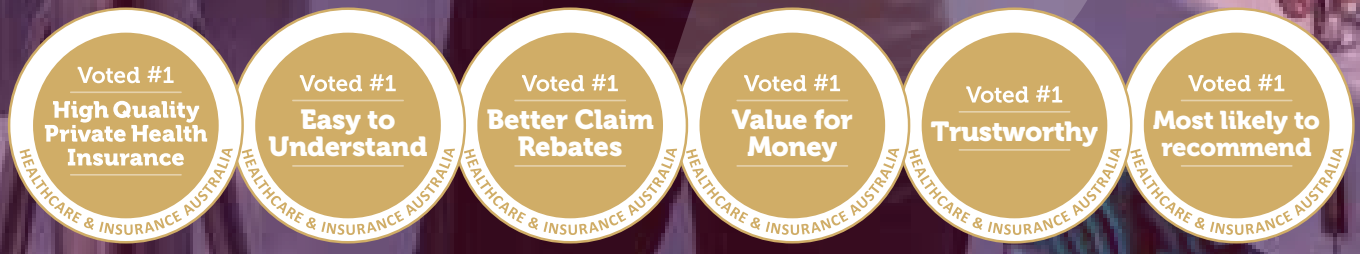


Contents

We're here to help.

If you are uncertain about your eligibility or you have any questions, whether they relate to our cover, your current policy or health insurance in general, please get in touch. We understand private health insurance can be confusing.

ABOUT US AND ELIGIBILITY TO JOIN



As a not-for-profit our members' distinct needs are our priority – and that devotion makes our members really happy. Named the 'Number 1 Health Fund for Member Satisfaction, Better Claim Rebates and Customer Services in the 2023 Healthcare & Insurance Australia research survey undertaken by Ipsos Australia.

We believe we're the best private health insurer for emergency services workers, volunteers and their families

We've been looking after the health and wellbeing of the police community for over 90 years — and now our top-level cover is available to other emergency services (including front line allied health) workers, volunteers, their families and close relations!

Our products are designed specifically for the first responder community and include a variety of everyday services that keep you healthy both in body and mind.

Our members are our priority, and it's this dedication that makes them happy – with a Member Satisfaction Rating of 96% in 2024.*

We give you the freedom to choose your preferred hospital, doctor and any other service provider, such as your physiotherapist and dentist, as long as the provider is recognised by us.

Whether it's a chronic illness, short-term fix or sporting injury, our cover has your back, allowing you to skip public hospital waiting lists — reducing time off from the job.

We keep it simple by only offering top level cover. All you have to decide is if you want Hospital, Extras or both.

Covering over 100,000 members Australia-wide, we're the health cover of choice for the emergency services community and their families.

* Members Health Fund Alliance (MHFA) Member Satisfaction Research, 2024 IPSOS.

Looking out for each other extends beyond the job and our members really are our biggest advocates. So ask around, chat to your colleagues or read online reviews from others in the front-line community — they'll assure you that Emergency Services Health is cover like no other.

PLEASE NOTE: To understand the terms "membership" and "member" as used in this brochure see page 29. Please read the information contained in this brochure carefully and retain it for future reference. The information in this brochure is subject to change without notice. Additional information on the operation of a health insurance policy can be obtained by visiting our website or by contacting us.

Who is eligible?

Emergency Services Health is for those who are or were employed/volunteered in the:

1. **Fire Response & Recovery Sector**

   Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Fire Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the Fire and Response & Recovery Sector.

2. **Ambulance & Medical Response & Recovery Sector**

   Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Ambulance Department/Service or Association/Union or (b) for a Not-for-profit, Commercial, or a National, State or Territory Government Recognised Hospital Service or Association/Union or (c) in a medical, nursing or allied health capacity and is registered with the Australian Health Practitioners Regulation Agency (AHPRA), or currently or previously employed by such a person or related organisation or (d) for a registered training organisation and/or specialist emergency service equipment supplier in the Ambulance & Medical Response & Recovery Sector.

3. **Water Response & Recovery Sector**

   Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Life Saving or Sea Rescue Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the Water Response & Recovery Sector.

4. **State Emergency Response & Recovery Sector**

   Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Emergency Services Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the State Emergency Response & Recovery Sector.

Eligibility also extends to close relations of the above, such as:

- Dependent Child
- Partner/Spouse
- Former Partner/Spouse
- Sibling
- Sibling's Partner/Spouse
- Sibling's Dependent Child
- Parent
- Adult Child
- Adult Child's Partner/Spouse
- Adult Child's Dependent Child
- Grandchild
- Grandchild's Partner/Spouse
- Grandchild's Dependent Child

OUR COVER

What cover is right for me?

Policy	Who is Covered?
Single Policy	Just yourself 
Single Parent Policy	Yourself and your dependent children (aged less than 21) and/or dependent students (aged 21-31 inclusive)* 
Family Policy (includes couples)	Yourself, partner and your dependent children (aged less than 21) and/or dependent students (aged 21-31 inclusive)*  Yourself and your partner 
Extended Family Policy and Extended Single Parent Family Policy	Yourself, partner and at least one child who is a dependent non-student (aged 21-24 inclusive) and if any younger dependent children (aged less than 21) and/or dependent students (aged 21-31 inclusive)*  Yourself and at least one child who is a dependent non-student (aged 21-24 inclusive) and if any younger dependent children (aged less than 21) and/or dependent students (aged 21-31 inclusive)* 
Continued Care Family	Yourself, partner and at least one child who is registered with us as a dependent person with a disability, and if any younger dependent children (aged less than 21), dependent non-students (aged 21-24 inclusive) and dependent students (aged 21-31 inclusive)* 
Single Parent Continued Care Family	Yourself and at least one child who is registered with us as a dependent person with a disability, and if any younger dependent children (aged less than 21), dependent non-students (aged 21-24 inclusive) and dependent students (aged 21-31 inclusive)* 

Our products

To take the confusion out of health insurance, Emergency Services Health have just top level products to choose from:

Gold Hospital

Hospital only product available for:

Rolling Extras

Extras only product available for:

Gold Combined

A combination of Gold Hospital and Rolling Extras available for:

Note: A single membership can be created for a child provided the membership has a person over 18 years old authorised to operate the membership. *See page 29 for a definition of the term 'dependent'.

Emergency Services Health

GOLD HOSPITAL

When it comes to your health you can't predict what you're going to need cover for, the same way a paramedic or fire fighter can't predict each triple-zero call.

Which is why our Gold Hospital has no excess or exclusions, giving you ultimate peace-of-mind when the unforeseen happens.[1]

Emergency Services Health specialises in Gold cover. Australia's highest tier hospital cover – to be classified as Gold the policy must provide cover for all 38 mandated clinical categories.

Freedom to choose – we give you the freedom to choose your doctor and hospital, as long as the provider is recognised by us.[1]

100% national Ambulance cover – for eligible services which includes clinically required emergency and non-emergency transport and treatment not requiring transport.[2]

More than just the standard clinical categories – our Gold cover goes above and beyond – covering much more than the 38 mandated clinical categories. Read on to discover what sets our cover apart.

Home Nursing and Hospital at home – get in touch to find out more.[1]

[1] Waiting Periods and other conditions apply. Doctors, Hospitals and Service Providers must be recognised by us. [2] Excludes ambulance services covered by a third party arrangement such as a State/Territory government ambulance scheme or ambulance subscription. Service providers must be recognised by Emergency Services Health.

Emergency Services Health's Gold Hospital covers you in any recognised hospital or day-surgery of your choice (public or private) anywhere in Australia.

We also have contracts with around 500 private hospitals around the country, which you can search for on our website. Choosing a Contracted Hospital will ensure you avoid any unnecessary out-of-pocket costs. in the event that a hospital goes out of contract we'll advise members likely to be affected and publish information on our website.

- **Theatre fees/labour ward**
  Covered for eligible treatments in Contracted Hospitals.
- **Hospital accommodation**
  Covered for intensive/coronary care accommodation, same day hospitalisation and day surgery accommodation, in either a private or shared room (subject to availability) for eligible treatments in Contracted Hospitals. Subject to the 35 day hospital rule (explained on page 10).
- **Drugs supplied**
  Covered when related to the reason for admission in hospital and covered under the agreement we have with the hospital. Some high cost drugs are excluded. Public hospitals generally supply medication without charge.
- **Doctor's fees for hospital treatment**
  At a minimum, we will cover the difference between the Medicare rebate and the Medicare Benefits Schedule (MBS) Fee. If your doctor chooses to use the Access Gap Cover schedule of fees, we can cover up to 100% of the doctor's agreed fee. See below for more details.

ACCESS GAP COVER

Under Emergency Services Health's Access Gap Cover you may never have to pay a doctor's bill. Before you're admitted to hospital check with your doctor if they have an arrangement with us under the Access Gap Cover scheme. When doctors bill under this arrangement we can pay higher benefits to eliminate, or at least reduce, your out of pocket costs. Your doctor can forward all accounts to us and we pay them on your behalf.

While all doctors can be involved in the scheme, it is up to individual doctors to participate on a case-by-case basis. For a list of providers eligible to participate and who have agreed for their details to be published, please contact us or visit our website.

Scope of cover

All 38 Clinical Categories as listed below.

Clinical categories covered by Emergency Services Health's Gold Hospital
Benefits only payable when admitted as a hospital in-patient
Sleep studies
Pain management with device
Insulin pumps
Weight loss surgery
Assisted reproductive services
Pregnancy and birth
Dialysis for chronic kidney failure
Joint replacements
Cataracts
Implantation of hearing devices
Podiatric surgery (by a registered podiatric surgeon) Does not include fees by the podiatric surgeon or related fees from the anaesthetist
Dental surgery
Plastic and reconstructive surgery (medically necessary)
Back, neck and spine
Blood
Lung and chest
Heart and vascular system
Diabetes management (excluding insulin pumps)
Breast surgery (medically necessary)
Skin
Pain management
Chemotherapy, radiotherapy & immunotherapy for cancer
Miscarriage and termination of pregnancy
Gynaecology
Gastrointestinal endoscopy
Hernia and appendix
Digestive system
Male reproductive system
Kidney and bladder
Joint reconstructions
Bone, joint and muscle
Tonsils, adenoids and grommets
Ear, nose and throat
Eye (not cataracts)
Brain and nervous system
Palliative care
Hospital psychiatric services
Rehabilitation

For a detailed explanation about what's covered under each clinical category, please see page 8 and 9.

Additional treatment items included in our Gold Hospital cover[1]

- **Ambulance**
  Covered for emergency transport, clinically required non-emergency transport, and treatment not requiring transport.

- **Aids and Appliances**
  Benefits towards continuous positive air pressure (CPAP) Machines and Non-surgical Items and Appliances such as (but not limited to): Insulin Pumps, Prosthetic Eye (Non-implant), External Breast Prothesis, Pressure Garments, Ankle or Knee Brace, Custom Footwear.

- **Travel and accommodation**
  Up to $500 per calendar year per policy[1].

- **Hospital at home**
  Emergency Services Health has agreements with some hospitals to deliver out-of-hospital care to patients for services such as wound management, intravenous therapy and post-natal care.

- **Home Nursing**

- **Antenatal education**

- **Lactation nursing consultants[2]**

- **Nourish Baby program – Pregnancy Support**
  Nourish Baby brings you education on pregnancy, childbirth, and early parenting from qualified obstetric, midwifery, and child health professionals through a range of online courses.

- **Robotic assisted surgery**
  In most cases robotic assisted systems used in surgery (like the da Vinci Surgical Robot) is covered under our contract with the hospital. Before booking your surgery please call us to confirm so you can make an informed decision before being treated.

- **Chronic Disease Management Programs**
  - Cancer Support Program
  - Healthy Weight for Life Programs for; Osteoarthritis Management, Heart Health and Type 2 Diabetes
  - Kieser Osteoarthritis and Spinal Program

[1]Waiting Periods and other conditions apply. For more information about a specific benefit or type of treatment, please contact us. [2] Claimable for services within 3 months of childbirth.

Clinical Categories covered by Gold Hospital

Clinical category	Hospital treatment:
Sleep Studies	For the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.
Pain management with device	For the implantation, replacement or other surgical management of a device required for the treatment of pain. For example: treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device (for example an infusion pump or neurostimulator).
Insulin pumps	For the provision and replacement of insulin pumps for treatment of diabetes.
Weight loss surgery	For surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.
Assisted reproductive services	For fertility treatments or procedures. For example: retrieval of eggs or sperm, In Vitro Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT).
Pregnancy and birth	For investigation and treatment of conditions associated with pregnancy and child birth. Treatment for the baby is covered under the clinical category relevant to their condition.
Dialysis for chronic kidney failure	For dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.
Joint replacements	For surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint, spinal disc replacement.
Cataracts	For surgery to remove a cataract and replace with an artificial lens.
Implantation of hearing devices	To correct hearing loss, including implantation of a prosthetic hearing device.
Podiatric surgery (by a registered podiatric surgeon)	For the investigation and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, but limited to cover for: accommodation; and the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Medical Devices and Human Tissue Product) Rules, as in force from time to time. Does not include fees by the podiatric surgeon or related fees from the anaesthetist.
Dental surgery	For surgery to the teeth and gums. For example: dental implant surgery.
Plastic and reconstructive surgery (medically necessary)	Which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma.
Back, neck and spine	For the investigation and treatment of the back, neck and spinal column, including spinal fusion. For example: sciatica, prolapsed or herniated disc, and spine curvature disorders such as scoliosis, kyphosis and lordosis.
Blood	For the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants.
Lung and chest	For the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest.
Heart and vascular system	For the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls.
Diabetes management (excluding insulin pumps)	For the investigation and management of diabetes. For example: stabilisation of hypo-or hyper-glycaemia, contour problems due to insulin injections.

Clinical category	Hospital treatment:
Breast surgery (medically necessary)	For the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy. For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia.
Skin	For the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin-related condition is also included. For example: melanoma, minor wound repair and abscesses.
Pain management	For pain management that does not require the insertion or surgical management of a device. For example: treatment of nerve pain and chest pain due to cancer by injection of a nerve block.
Chemotherapy, radiotherapy and immunotherapy for cancer	For chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours.
Miscarriage and termination of pregnancy	For the investigation and treatment of a miscarriage or for termination of pregnancy.
Gynaecology	For the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer.
Gastrointestinal endoscopy	For the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP).
Hernia and appendix	For the investigation and treatment of a hernia or appendicitis.
Digestive system	For the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids.
Male reproductive system	For the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer.
Kidney and bladder	For the investigation and treatment of the kidney, adrenal gland and bladder. For example: kidney stones, adrenal gland tumour and incontinence.
Joint reconstructions	Hospital treatment for surgery for joint reconstructions. For example: torn tendons, rotator cuff tears and damaged ligaments.
Bone, joint and muscle	For the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and bone cancer.
Tonsils, adenoids and grommets	For the investigation of the tonsils, adenoids and insertion or removal of grommets.
Ear, nose and throat	For the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer.
Eye (not cataracts)	For the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye.
Brain and nervous system	For the investigation and treatment of the brain, brain-related conditions, spinal cord and peripheral nervous system. For example: stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease.
Palliative care	For care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.
Hospital psychiatric services	For the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.
Rehabilitation	For physical rehabilitation for a patient related to surgery or illness. For example: inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.

What you need to know about our Gold Hospital Cover

Hospital 35-day rule

Hospital benefits are payable 365 days a year. However, if your hospital stay exceeds 35 consecutive days you must obtain and send us an Acute Care Certificate to continue receiving comprehensive benefits. Benefits will be reduced and out of pocket expenses apply where an Acute Care Certificate is not obtained. The hospital is aware of this and will usually arrange a certificate on your behalf.

Waiting Periods

A Waiting Period is the period of time you need to be covered before you're eligible to claim on certain procedures or services, and may apply to new or upgraded policies.

- 2 months membership for all benefits, excluding accidents.
- 12 month membership for pregnancy and birth (obstetrics) treatment.
- 12 months membership for pre-existing conditions, excluding psychiatric care, rehabilitation or palliative care.
- 12 months membership for continuous positive air pressure (CPAP) machines, goods and services under Non-surgical Items and Appliances, travel and accommodation (general treatment) and home nursing.

If you're transferring to us from another health insurer you won't serve the same Waiting Periods twice because we offer continuity of cover.
See page 20 for more information.

THINKING ABOUT HAVING A BABY?

Then it's a good time for you to review your health insurance and make sure you understand what your policy does and doesn't cover. Waiting Periods of up to 12 months can apply for pregnancy, birth and newborn related health services, so if you're unsure whether you are on the right cover for your growing family, please contact us.

To request a copy of our Pregnancy Guide, which outlines how Emergency Services Health supports your pregnancy, please get in touch.

What is not covered (non-exhaustive list*)

- Services incurred before Waiting Periods have been served.
- Outpatient services, unless there is an agreement between Emergency Services Health and the hospital.
- Treatment for which Medicare does not pay a benefit, including cosmetic surgery.
- Services that are provided outside of the Commonwealth of Australia.
- Services where an entitlement exists or may exist under any compensation, sports club or third party insurance.
- A claim for a service that is submitted more than two years after the date of service.
- Pharmaceuticals not related to the reason for hospitalisation or not covered under the agreement with the hospital or provided on discharge.
- Exceptional high cost drugs where no or limited benefits are paid.
- Prostheses items that are not included on the Government's Prescribed List of Medical Devices and Human Tissue Products.
- Charges greater than the benefit defined in the Government's Prescribed List of Medical Devices and Human Tissue Products.
- Personal and take-home items, e.g. newspapers, toiletries, television, hairdressing, manicure, etc.
- Treatment provided to a person in a private hospital emergency department.
- Aged care and accommodation in an aged care facility.
- If you're in hospital for more than 35 consecutive days and not classified as an acute care patient, your benefits will significantly reduce.
- Benefits for ambulance services covered by a third party arrangement such as a State/Territory transportation scheme.
- Fees from a podiatric surgeon (benefits may be payable under our Extras cover) or related anaesthetic fees.
- Use of robotic assisted systems not covered under the hospital contract.

*** This provides a general description of what is not covered. These are not "excluded or restricted" hospital treatments or services. Should you require information about a particular treatment or benefit please contact us.**

Frequently Asked Questions about our Gold Hospital Cover

Why don't you charge an excess, or co-payment?

An excess is the amount you agree to pay towards the cost of hospital treatment. For example if you have an excess of $500, when you're admitted to hospital you'll have to pay the first $500 of the hospital costs on top of anything else not covered by your policy.

A co-payment is the agreed amount you'll pay per day in hospital.

At Emergency Services Health our hospital cover has no excesses or co-payments (other than where Waiting Periods apply for transfers), because we know that this can become a barrier to treatment when other unexpected and uncontrollable out of pocket costs hit at the same time – such as gap payments for doctors and anaesthesiologists who charge over the MBS fee, and legally uninsurable out-patient consults with specialists.

These unexpected costs often hit patients at the same time that they're dealing with a loss of income, so removing any excess or co-payments from the equation helps protect our members from the unforeseen – as we believe good insurance should.

What does no exclusions and restrictions mean?

An exclusion is when you agree not to be covered at all for certain treatments. For example you may have hospital cover but it excludes joint replacements.

A restriction is when you agree to receive very limited benefits for certain treatments. For example you may be covered for joint replacements only at a public hospital, and if the joint replacement is undertaken in a private hospital, only basic accommodation benefits and no procedure benefits are paid – which may leave you with substantial out-of-pocket costs.

At Emergency Services Health our Hospital cover has no exclusions and no restrictions (other than where Waiting Periods apply for transfers before benefits or higher benefits, as applicable, are payable), because we don't think our members should have to predict what health needs they or their family will have in the future. You wouldn't insure just half of your house or car, so why insure just part of your health?

It's important to note that all health insurers are governed by the Private Health Insurance Act 2007. This legislation sets out what health insurers can and cannot pay benefits towards. Within the hospital as an inpatient, health insurers can only pay benefits towards treatment and procedures where Medicare pays a benefit. That means for some services, like elective cosmetic surgery, health insurers cannot pay a benefit towards this treatment, and this is not classed as a restriction or an exclusion on a policy.

Interested in a quote or benefit comparison?

Get in contact with our friendly team. We're here to help.
Call **1300 703 703** or email **joinus@eshealth.com.au.**

Emergency Services Health

ROLLING EXTRAS

With our Rolling Extras cover, you can carry over unclaimed Annual Limits from one calendar year to the next on most Extras services.[1]

Further benefits of Rolling Extras include:[2]

Generous Annual Maximums – particularly in the areas of Psychology, Major Dental, Physiotherapy and Optical.

Plus, we pay 80% back up to the Item Limit on most Extras services at the provider of your choice – so you're able to stick with your family dentist or local physio.

No Annual Maximum on General Dental – services include check-ups, x-rays, extractions, fillings and endodontic and periodontic treatment.[3]

100% national Ambulance cover – for eligible services which includes clinically required emergency and non-emergency transport and treatment not requiring transport.[4]

Individual, couple and group Counselling benefits – providing access to specialised support no matter what the job, or everyday life throws at you.

Additional discounts on Optical

While members can access our benefits at any provider of their choice, we have arrangements with a number of leading optical providers to give extra discounts to members:

- OPSM
- Laubman & Pank
- Specsavers
- Bailey Nelson

Visit the Optical Benefits Guide on our website for an up-to-date list of discounts:
eshealth.com.au/optical-benefits-guide

HOW OUR UNIQUE ROLLOVER BENEFIT WORKS

Most Extras services, such as Major Dental, Chiropractic, and Optical, have an Annual Limit, which resets each calendar year. Our Rollover Benefit allows you to carry over any unused portion of your Annual Limit into the following year.[1]

For example, if you didn't use your Optical benefit last year, your $350 limit rolls over into this year, allowing you to claim up to $700 on Optical.

Claims are always deducted from the current year's limit first before accessing any rolled-over benefits.

New members become eligible for the Rollover Benefit after 12 months (or 2 years for Major Dental). For details, refer to the 'Rollover Maximum' column in the table on the next page.

[1] Rollover Benefit is available on the majority of extras services and is subject to Waiting Periods, Annual Maximums and other conditions. Rollover Maximum is available after 12 months of membership on Rolling Extras, except for Major Dental, which requires 2 years. [2] Subject to Waiting Periods, Annual Maximums and other conditions. Provider must be recognised by Emergency Services Health. [3] Service Limits apply. [4] Excludes ambulance services covered by a third party arrangement such as a State/Territory government ambulance scheme or ambulance subscription. Service providers must be recognised by Emergency Services Health.

Scope of cover and benefits

All funds have limits to their benefits and we keep ours as simple as possible. Apart from the Waiting Periods, Annual Maximums and Rollover Maximums outlined below, services may be subject to service limits, sub-limits and the operation of the Fund Rules. For examples of benefits paid and service limits please refer to your relevant State Premiums & Benefits Guide.

Service Type	Waiting Periods[1]	Annual Maximum per person	Rollover Maximum per person[2]
General Dental Includes check-ups, x-rays, extractions, fillings and treatments for endodontic and periodontic issues. Some service limits apply: ■ Oral exams/consults/specialist visits (2 per calendar year) ■ Scale and clean (2 per calendar year) ■ Tooth bleaching internal (2 per calendar year) ■ Mouth guard (1 per calendar year)	2 months	Unlimited[3]	N/A
Major Dental Includes crowns, dentures, inlays and implants.	12 months	$1,500	$3,000
Orthodontic **Lifetime limit $3,000.**	12 months	$1,500	N/A
Optical	2 months	$350	$700
Physiotherapy	2 months	$850 combined	$1,700 combined
Exercise Physiology			
Chiropractic	2 months	$700 combined	$1,400 combined
Acupuncture			
Osteopathy			
Complementary Therapies Remedial Massage Therapy, Remedial Therapy, Myotherapy & Chinese Medicine.			
Speech Therapy	2 months	$850	$1,700
Occupational Therapy	2 months	$600	$1,200
Eye Therapy	2 months	$600	$1,200
Dietary	2 months	$600	$1,200
Podiatry Includes custom made orthotics.	2 months	$700	$1,400
Psychology	2 months	$850 combined	$1,700 combined
Counselling[4]			
Ambulance[5]	2 months	Unlimited	N/A
Pharmaceutical Available at any recognised pharmacy.	2 months	$600	$1,200
School Accident	2 months	$500	N/A
Health Appliances Includes blood glucose monitors, blood pressure monitors, hearing aids, TENS machines, blood coagulation monitors (INR) and nebulisers. Doctor's referral may be required for some appliances.	12 months	Various limits apply	N/A

Note: All the benefits shown here are payable only on services and at health providers recognised by our Fund. [1] Waiting periods do not apply to benefits for treatments in relation to accidents. [2] Rollover Maximum is available after 12 months of membership on Rolling Extras, except for Major Dental, which requires 2 years. [3] Some service limits apply. [4] To qualify as recognised providers, counsellor's must be registered with the Australian Counselling Association Inc (ACA) or Psychotherapy and Counselling Federation of Australia (PACFA), be in private practice and meet a set of practice and educational criteria. [5] Excludes ambulance services covered by a third-party arrangement such as a State/Territory government ambulance scheme or ambulance subscription.

"CUSTOMER SERVICE IS EXCEPTIONAL AND WE HAVE ALWAYS HAD A QUICK RETURN ON CLAIMS.

I ALWAYS RECOMMEND EMERGENCY SERVICES HEALTH WHENEVER I GET AN OPPORTUNITY TO SPEAK ABOUT IT."

Emergency Services Health Member

What you need to know about our Rolling Extras cover

Waiting Periods for extras

- 2 months membership for all benefits, excluding accidents.
- 12 months membership for Major Dental (such as crowns, bridges, inlays, indirect fillings and dentures), orthodontic, hearing aids, nebulisers, blood glucose and blood pressure monitors, blood coagulation monitor and for pre-existing conditions.
- 12 months membership for Rollover Benefit and access to Rollover Maximum (2 years for Major Dental).

If you're transferring to us from another health insurer you won't serve the same Waiting Periods twice because we offer continuity of cover.
See page 20 for more information.

Benefit limits

If the service charge is higher than the Item Limit, the percentage amount you receive will reduce accordingly.

Our 80% benefit applies to the net amount payable on an account, inclusive of any discounts the provider might be offering; this may vary where, for the benefit of our members, Emergency Services Health has negotiated specific agreements with selected providers. To see examples of benefits paid please see your relevant State Premiums & Benefits Guide.

Limit on services

Like all insurers, we have limits on how often services are used and the way some services are combined for the purpose of paying of benefits. We've developed a benefit structure with fewer limits. Our limits on regular services such as dental are generous by comparison, but we do utilise the principles outlined in the Australian Schedule of Dental Services Guidelines.

For extras services such as physiotherapy, chiropractic or podiatry, we limit claims to one consultation per person per day per service type.

What is not covered (Non-exhaustive list*)

- Claims for a service that has exceeded the Annual Maximum and Rollover Maximum.
- A second and subsequent consult with the same professional on the same day.
- Where the service charge exceeds the Item Limit by Emergency Services Health, the benefit you receive may be less than 80% of your cost.
- Where the service provider is a partner, child or parent of the person being treated. Business partners within the practice are also excluded.
- Services incurred before a Waiting Period has been served.
- Services where a Medicare benefit is payable.
- Services that are provided outside of the Commonwealth of Australia.
- Services where an entitlement exists or may exist under any compensation, sport club or third party insurance.
- A claim for a service that is submitted more than two years after the date of service.
- Services provided by practitioners not registered or recognised by the fund.
- Benefits for ambulance services covered by a third party arrangement such as a State/Territory transportation scheme.
- Limit on services (see adjacent paragraph).

*** This provides a general description of what is not covered. Please contact us should you require information about a particular treatment or benefit.**

For more information about how particular benefits work, get in touch.

Emergency Services Health

GOLD COMBINED

Gold Combined brings together our Gold Hospital and Rolling Extras at a reduced premium and also includes partial benefits for laser eye surgery – providing even more value.[1]

No wonder it's our most popular health cover.

Scope of cover

- All the benefits included in our Gold Hospital cover. See pages 6-11 for details.
- All the benefits included in our Rolling Extras cover. See pages 12-15 for details.
- Additional partial benefits for corrective laser eye surgery, not available when taking out either Gold Hospital or Rolling Extras only.[2]

Unlock more after ten years of continuous cover

- If you hold a Gold Combined policy continuously for ten years, Emergency Services Health are proud to be able to increase the Laser Eye Surgery Lifetime limit from $1,600 to $2,400[2] per person (based on individuals ten years of continuous memberships of cover). It's our way of thanking you for your loyalty to the Emergency Services Health family.

[1] Subject to Waiting Periods. [2] Subject to a 3 year wait. $800 per service and $1,600 lifetime limit. Then $1,200 per service and $2,400 lifetime limit after 10 years continuous membership.

"EXCELLENT CUSTOMER SERVICE AND GREAT BENEFITS. THEY OPERATE FOR THEIR MEMBERS INSTEAD OF SHAREHOLDERS. IT'S EASY TO GET THROUGH ON THE PHONE IF NEEDED AND YOU SPEAK TO SOMEONE WHO IS BASED IN THIS COUNTRY. THEY ALSO HAVE AN EASY TO USE APP."

Emergency Services Health Member

The nature of health insurance is that you never know what health service you might need or when you might need it.

As a first responder, you're often the bearer of bad news. It's your job to handle the initial reaction of a parent or family member after they learn of a fatal accident involving their loved one. Many will express their emotion through tears, others will withdraw into silence, but the common theme is shock — *they never thought it would happen to them.*

Ask any cancer sufferer, rehabilitation patient or the person holding the unconscious hand of their loved one, they'd tell you something similar.

The lesson here is that you never know what lays around the corner. We often hear stories of those who get caught out by having inadequate cover when an unexpected health crisis takes hold. By only offering top level cover you can be assured that you will be looked after when the need to use your cover arises.

THINGS YOU NEED TO KNOW

How health insurance works in Australia

The Australian Government provides certain incentives to encourage all Australians to take out private health insurance.

The Australian Government Rebate on Private Health Insurance (Rebate) is an incentive whereby you're offered a Rebate on your private health insurance to help cover the cost of premiums. The level of Rebate on private health insurance is based on your household income and the age of the oldest person covered by the policy.

If you're eligible for a Rebate you can choose to receive it either as a reduced premium or in a lump sum at tax time. Most people choose to take advantage of the lower premiums. See your relevant State Premiums & Benefits Guide to help you work out which Rebate Tier may be applicable to you.

For more information on how to claim at tax time, visit ato.gov.au.

Lifetime Health Cover (LHC) Loading is a legislated requirement that encourages you to take out private hospital cover earlier in life and encourages you to maintain it.

If you purchase hospital cover earlier in life, and keep it, you will avoid paying an extra amount called 'LHC loading'.

This is how it works: if you wait until you're aged 31 and take out private hospital cover in the following financial year, your premiums will be 2% more expensive. This increases by 2% for each subsequent year you delay taking out private hospital cover. This additional percentage is called the LHC Loading.

For example, if you wait until you're 40, you end up paying 20% more on your private hospital cover. Similarly, if you wait until you're aged 50, you end up paying 40% more.

The LHC Loading is capped at 70% at age 65, and removed after 10 continuous years of appropriate private hospital cover.

In other words, the earlier you take out private hospital cover, the better, as deferring your decision can be costly.

Medicare Levy Surcharge (MLS) is a levy you should be aware of. Most Australian taxpayers are charged a 2% Medicare Levy. However, those who do not have appropriate private hospital cover may have to pay an additional levy called the Medicare Levy Surcharge (MLS).

The MLS aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public Medicare system.

The MLS applies to couples or families without hospital cover who have a combined annual income greater than $202,000*, and singles earning more than $101,000*. This increase is aligned to the income tiers as shown in your relevant State Premiums & Benefits Guide. Family thresholds are increased by $1,500 for the second and subsequent dependent child.

Both partners must have hospital cover; otherwise both have to pay the levy. If you have dependent children they also need to be covered by a policy or you may have to pay the levy, even if you're separated. If you're unsure how this might affect you, we recommend you seek further advice from your tax advisor or the Australian Taxation Office. For details on what income is included in the assessment please contact the ATO or refer to their website.

***Income thresholds for the 2025-26 financial year (from 1 July 2025 up to and including 30 June 2026)**

Have a question?

Our friendly, knowledgeable team are here to help with all your questions and enquiries.

Call **1300 703 703** or email **enquiries@eshealth.com.au.**

Waiting Periods

A Waiting Period is the period of time you need to be covered before you're eligible to claim on certain procedures or services. Waiting Periods may apply to new or upgraded policies.

If you're transferring from another health insurer, we offer continuity of cover which means you won't serve the same Waiting Periods twice. However, if you're transferring to us from a lower level of cover, you'll only be able to claim up to the level you were already covered for until you have served the Waiting Period.

Example: Sue decides to switch her hospital cover to Emergency Services Health. Sue has a $500 excess that currently applies to claims under her previous policy. As she has served all Waiting Periods with her current fund she only has to serve Waiting Periods for the level of extra cover provided by Emergency Services Health – in Sue's case the $500 excess. She receives immediate cover on all other aspects of her Emergency Services Health hospital policy. Sue must serve the 2 month general and 12 month obstetrics and pre-existing condition Waiting Periods (as relevant) before the $500 excess does not apply at Emergency Services Health.

But rest assured, there are no Waiting Periods applied for claims resulting from an accident occurring after joining.

Waiting Periods for Hospital:

- 2 months membership for all benefits, excluding accidents.
- 12 months membership for pregnancy and birth related (obstetrics) treatment.
- 12 months membership for pre-existing conditions, excluding psychiatric care, rehabilitation or palliative care.
- 12 months membership for continuous positive air pressure (CPAP) machines, goods and services under Non-surgical Items and Appliances, travel and accommodation (general treatment) and home nursing.

Waiting Periods for Extras:

- 2 months membership for all benefits, excluding accidents.
- 12 months membership for Major Dental (such as crowns, bridges, inlays, indirect fillings and dentures), orthodontic, hearing aids, nebulisers, blood glucose and blood pressure monitors, blood coagulation monitor and for pre-existing conditions.
- 12 months membership for Rollover Benefit and access to Rollover Maximum (2 years for Major Dental).

Waiting Periods for Combined cover in addition to the above:

- 3 years membership for corrective laser eye surgery.

Pre-existing conditions

A pre-existing condition is one where signs or symptoms of your ailment, illness or condition, in the opinion of a medical practitioner appointed by us (not your own doctor), existed at any time during the six months preceding the day on which you purchased your health insurance or upgraded to a higher level of hospital cover.

The medical practitioner we appoint must consider any information regarding signs and symptoms provided by your own treating doctor and specialist.

If you're new to health insurance, you may need to have held membership for 12 months before cover will be provided for treatment relating to pre-existing conditions.

If you're transferring your existing health insurance, the 12 month wait on pre-existing conditions may apply to any increased level of cover you take with us. For example, if you have an excess, excluded or restricted treatment under your previous policy, you need to serve 12 months membership with us before your treatment is covered.

Psychiatric care, rehabilitation and palliative care are not subject to the 12 month wait on pre-existing conditions.

Understanding Medicare

Understanding who pays for what, whether it's your private health insurer, Medicare or a combination of both can be confusing. The table below outlines various situations and who pays for what.

How Doctors can bill (includes surgeons, assistant surgeons, anaesthetists, pathology and radiology)	Medicare	Health fund required benefit	Emergency Services Health Access Gap Cover	Patient out-of-pocket
Out of hospital services				
If doctor bulk bills you	85% Scheduled Fee	Benefits not allowed	N/A	No
If doctor bills you the Scheduled Fee	85% Scheduled Fee	Benefits not allowed	N/A	Yes
If doctor bills you above the Scheduled Fee	85% Scheduled Fee	Benefits not allowed	N/A	Yes
For services when you're in hospital*				
If doctor bulk bills you	75% Scheduled Fee	N/A	N/A	No
If doctor bills you the Scheduled Fee	75% Scheduled Fee	25% Scheduled Fee	N/A	No
If doctor bills you above the Scheduled Fee but not under Access Gap Cover	75% Scheduled Fee	25% Scheduled Fee	Nil	Yes
If doctor bills you under Access Gap Cover to agreed level	75% Scheduled Fee	25% Scheduled Fee	Fully covered	No
If doctor bills you under Access Gap Cover but above agreed level	75% Scheduled Fee	25% Scheduled Fee	Partially covered	Yes but reduced

Excludes the Private Hospital Emergency Department ER Fees and medical services provided while in the Emergency Department with these medical services treated as out of hospital services.

What is Medicare?

Medicare is a publically funded universal health care scheme operated by the Australian Government.

What is the Medicare Benefits Schedule?

The Medicare Benefits Schedule is a list of medical services and procedures provided by doctors and specialists and includes radiology and pathology services. It contains the fees recognised by the Australian Government (known as the scheduled fee) and the amount of benefit Medicare will pay you when you receive those services. It is important to note that doctors are free to set fees and charge for their services as they see fit.

Services not recognised by Medicare

There are certain services that are not recognised by Medicare, including some types of cosmetic surgery and sterilisation reversal. If you're intending to undergo this kind of surgery, please check with us first.

What is Medicare bulk billing?

Bulk billing is when your health professional accepts the Medicare benefit as full payment for a service.

How much does Medicare cover for out-of-hospital services?

Certain out-of-hospital medical services are paid by Medicare and are therefore not covered by private health insurance.

These include visits to or by your doctor plus medical services (including pathology and radiology) when provided to you as an outpatient or in a hospital emergency department (as the patient is not admitted). A hospital visit by a paediatrician to a newborn also falls into this category if the baby has not been admitted to the hospital as a patient in their own right.

In all these cases, claims should be lodged with Medicare for payment.

Medicare pays 85% of its Scheduled Fee for medical services provided to people who have not been admitted to hospital.

- **How much does Medicare pay for in-hospital medical services?**

Medicare pays 75% of the Scheduled Fee for medical services provided to people who have been admitted (in-patient).

- **Who pays the difference?**

For medical services provided to you as a hospital in-patient, Emergency Services Health pay the gap between the Medicare benefit and the Scheduled Fee.

In the vast majority of cases where medical services are billed under our Access Gap Cover scheme, we can also cover the difference between the Scheduled Fee and actual fee charged. Where the fee exceeds that covered by Access Gap Cover, the service provider should advise you of any gaps that exist and what you will need to pay.

- **What about out-of-pocket costs?**

We strive to minimise treatment costs to members. While we have succeeded in covering most situations, there are some occasions when members will incur a charge from the service provider:

- Charges greater than the Scheduled Fee that are not billed within the Access Gap Cover.
- Charges greater than those recognised for Access Gap Cover.
- Non in-patient medical services, including those medical services provided while treated in the emergency department of a hospital.
- Visits by a paediatrician to a newborn who has not been admitted to hospital as a patient in their own right
- Treatment at a non-Contracted Hospital. You can search for contracted hospitals on our website.

For more information on what Medicare covers visit **medicareaustralia.gov.au.**

WE WERE QUITE SURPRISED TO FIND EMERGENCY SERVICES HEALTH OFFERED A REALLY COMPREHENSIVE PACKAGE TAILORED JUST FOR US. THE PRICE IS RIGHT FOR WHAT YOU GET TOO.

Emergency Services Health Member

BEST HEALTH FUND AWARD FROM ME. PROFESSIONAL, FRIENDLY SERVICE EVERY TIME! EXCELLENT VALUE AND GREAT PERCENTAGE PAID ON CLAIMS. EASY TO SUBMIT CLAIMS ELECTRONICALLY WHEN NECESSARY AND BENEFITS PAID INTO ACCOUNT QUICKLY. SO PLEASED WE WERE ABLE TO JOIN ESH.

Emergency Services Health Member

HOW TO CLAIM

Making a claim

On-the-spot claims

- The majority of Extras claims, such as dental and optical, can be claimed on the spot. Most service providers use eftpos-style electronic claiming facilities. Simply swipe your Emergency Services Health membership card. You'll only have to pay the difference between our benefit and the providers fee.
- We do not provide on the spot claiming for pharmacy, health appliances and eye therapy.

Refer to the list of providers using the HICAPS network for on the spot claims available on our website at eshealth.com.au.

We only pay benefits for services by Recognised Health Providers. If you wish to ensure that your provider is covered please speak to us prior to treatment.

Manual claims

For extras and medical receipts and accounts, you can either:

- Download the free Emergency Services Health mobile claiming app from the App Store or Google Play. No paper claim form is required, just take a photo of the receipt or account and send through your claim!

OR

- Download the claim form from our website and send the completed form to us along with receipts and accounts by one of the following options:

Email **myclaim@eshealth.com.au** – please include your membership number in the subject line.

Post **PO Box Reply Paid 6111**
Halifax Street, Adelaide SA 5000

Payments covering medical gap or extras services will be made payable to you if you've already paid the account.

If you've not paid the account, we'll send you a cheque made out to the health service provider. You will need to forward this cheque, together with your part of the payment, to the provider.

Hospital claims

Hospital accounts and medical accounts under Access Gap Cover are usually sent direct to us by the hospital or medical provider and we pay them on your behalf. If you receive a hospital account from your stay in hospital please send it to us.

If you receive a medical account from your stay in hospital please send to Medicare first then forward on the Medicare statement you receive back to us.

Remember, you can search for Contracted Hospitals on our website or contact us for clarification before your admission.

How to receive your benefits faster!

Claim as soon as possible. Provide us with your bank account details so your benefit is paid directly into your account. Claims for services older than two years will not be accepted.

Important information

Privacy Notice

In this Privacy Notice, reference to "we", "us" or "our" is reference to Police Health Limited (ABN 86 135 221 519), the registered not for profit, restricted access private health insurer, including the brands Police Health and Emergency Services Health. Reference to "you" or "your" is reference to a customer or a person insured under a private health insurance policy.

Like all health insurers, we are required to collect personal information.

We respect your privacy and treat this information confidentially and store it securely.

Personal information is collected and managed by us in accordance with our Privacy Policy (available at the respective websites policehealth.com.au or eshealth.com.au) and the Australian Privacy Principles. You should read and be familiar with the Privacy Policy, and ensure that other persons that are covered by your health insurance policy also read and are aware of the Privacy Policy. This Notice contains a summary of some important issues, but the Privacy Policy has more detail.

We will collect personal information from you, a responsible person, or a third party, either directly or indirectly, when:

- You apply for membership with us to purchase a health insurance policy, and if accepted, you are the policy holder (Contributor) of the policy.
- You are a dependent (spouse or child) of a Contributor and the Contributor holds or has applied to purchase a health insurance policy which covers you.
- A claim for benefit is made on your health insurance or when dealing with us through one of our communication channels.

Personal information collected includes names, addresses, ages, bank account details, telephone numbers, email addresses and sensitive (health) information.

You should be aware that once you have been accepted by us and you are insured under a health insurance policy, we will collect personal information on a recurring basis for the duration of your health insurance policy. It is necessary for us to collect your personal information when you or a responsible person on your behalf interact with us, especially when making a claim for health treatment either by post, facsimile, through electronic channels or through a third party such as a hospital, medical practitioner or other service provider who may claim directly from us on your behalf.

Collection and disclosure of your personal information is required by us, and is permitted under the Private Health Insurance Act 2007 and the Australian Privacy Principles. We collect personal information for the purposes described in the Privacy Policy and, in particular to manage the health insurance and health-related services we provide.

If we do not receive the necessary information or the information is not accurate or complete, then we will not be able to provide you with our services, including:

- Processing your application for a health insurance policy and insuring you or other people on the health insurance policy.
- Providing services associated with billing and claiming of benefits.
- Effectively dealing with your enquiries, issues or complaints.
- Providing you with other benefits and services in relation to your health insurance cover.

Personal information may also be used in advising you of direct marketing offers such as products or services provided by us, or in conjunction with other organisations, which we consider may be of interest to our members.

We may need to disclose personal information to other people insured under the same health insurance policy, government agencies, other health insurers, organisations or individuals with whom we contract for services, health service providers, financial institutions and your employer. We are not likely to disclose personal information to overseas recipients.

The Privacy Policy contains further information on how you may:

- Have reasonable access to and seek correction of your personal information;
- Complain to us about a breach of the Australian Privacy Principles and how we will deal with such a complaint.

Our contact details may be found on our forms, brochures and websites.

The policy holder (Contributor) or another insured person must only provide personal information relating to other people on the policy if authorised to do so.

It is important that all persons (currently insured, or who become insured, or considering joining us) are aware of and understand this Notice and our Privacy Policy. It is the responsibility of the policy holder (Contributor) to ensure that every other person covered under the policy is aware of this Notice and the Privacy Policy. Other people on the policy should be made aware that the policy holder (Contributor) receives and can view through our On-line Member Services (OMS) all information relating to their claims for benefits and hence the policy holder (Contributor) has access to their health information, unless an individual has requested their claims information be kept private in which case claims information will not be shown on OMS.

If any insured person aged 18 years or older wishes to ensure that their personal information is not disclosed to other people on the policy, they should purchase their own health insurance policy.

A copy of our Privacy Policy can be obtained from the respective websites policehealth.com.au or eshealth.com.au or by contacting our office. The Australian Privacy Principles, and information about privacy, are available from the website of the Office of the Australian Information Commissioner at www.oiac.gov.au.

Conditions of membership

This brochure does not contain all Emergency Services Health's conditions of membership.

A full copy of the Fund Rules is available at our head office in Adelaide, or send a request for a copy in writing to our office.

Compliance Policy

Our commitment to compliance is articulated in our Compliance Policy, which can be viewed at **eshealth.com.au**

Cooling-off period

If for any reason you're not satisfied, we provide new members or existing members who change their level of cover with a cooling-off period. We will refund in full without penalty any premiums paid for a new policy or increased premiums paid relating to a cover change, provided the request to cancel the new policy or cover change is received in writing within 30 days of commencement. The cooling-off period does not apply if there have been any benefits paid relating to the new policy or cover change.

Children ceasing to be covered

Once your children reach an age where they are no longer protected by your cover, they can sign up to their own Emergency Services Health policy without any Waiting Period provided they:

- Take out a policy with cover no greater than yours; and
- Join from their 21st birthday (25th birthday for Gold Combined Extended Family or Single Parent Extended Family).

Or, if your children have been covered as a dependent students, provided they:

- Take out a policy with cover no greater than yours; and
- Join from March 1 following a completed study year, or
- Join from the date they left full-time study, or
- If still a student at the age of 31 years, join from their 32nd birthday.

Or, if your children have been covered as a dependent persons with a disability, but they are no longer participating in the NDIS:

- Take out a policy no greater than yours; and
- Join from the date they ceased to participate in the NDIS.

In all these circumstances, your children have two months in which to join with their premiums being calculated from the date they ceased to be an eligible dependent.

State of residence

Premiums must be paid according to the state or territory of residence. Members who relocate to another state must notify us within one month of such a move. They will be required to pay the premiums that apply in their new state or territory of residence.

Membership arrears

Benefits are not payable if your premium payments are in arrears. If the level or amount of arrears exceeds two months, your cover will lapse and may be cancelled by Emergency Services Health. You can bring your membership up-to-date provided that the level or amount has not been in arrears for more than two months. You're responsible for ensuring that your premium payments are up-to-date.

Code of Conduct

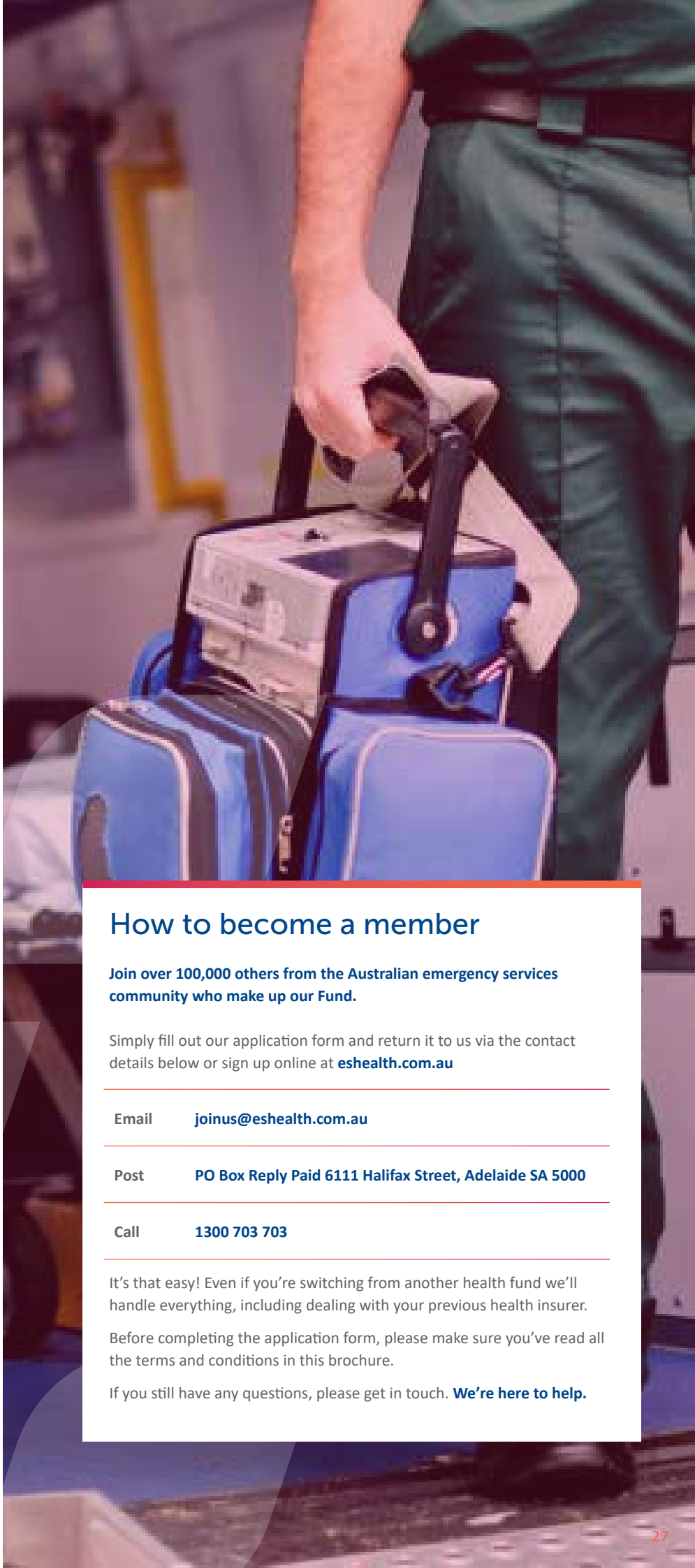
Emergency Services Health is a signatory of the Private Health Insurance Code of Conduct. This self-regulated code ensures our service is of the highest standard. It promotes regulatory compliance and consumer service standards through improved staff training, policy documentation, privacy and dispute resolution. Copies of the code can be viewed at **eshealth.com.au**

WorkCover, compensation or damages.

We recognise that there will be times when you'll be eligible for compensation or damages from WorkCover or other insurance claims, including compulsory third party, public liability or an accident. Your medical and hospital expenses may be postponed until the third party pays. Emergency Services Health can help you if this is not the case.

If this occurs, let us know as soon as you can. We have information and experience that we can share with you to help you make informed decisions about your situation. In addition we may agree to pay your benefits subject to conditions. Under these circumstances you'll be required to reimburse us for any fund benefits you receive for services subsequently covered by the other insurance provider.

Any compensation you receive for future medical expenses should be consistent with the medical reports relating to your claim for compensation. We may not reimburse costs relating to your illness or injury if you accept an offer of compensation which is not reasonably consistent with the anticipated future treatment costs. You should notify us of any claim for compensation relating to illness or accident.



How to become a member

Join over 100,000 others from the Australian emergency services community who make up our Fund.

Simply fill out our application form and return it to us via the contact details below or sign up online at **eshealth.com.au**

Email	**joinus@eshealth.com.au**
Post	**PO Box Reply Paid 6111 Halifax Street, Adelaide SA 5000**
Call	**1300 703 703**

It's that easy! Even if you're switching from another health fund we'll handle everything, including dealing with your previous health insurer.

Before completing the application form, please make sure you've read all the terms and conditions in this brochure.

If you still have any questions, please get in touch. **We're here to help.**

We know health insurance can be confusing, so we're here to help.

We publish, and regularly update, a variety of help guides and FAQ resources on our website, which you can view at your convenience by visiting **eshealth.com.au.**

For help with more specific questions, please give us a call on **1300 703 703** or email **enquiries@eshealth.com.au.**

Glossary

Access Gap Cover

Emergency Services Health's scheme to eliminate or reduce out-of-pocket expenses for medical services (doctors, radiology, and pathology) during hospital stays. We participate in this scheme through our affiliation with Australian Health Service Alliance.

Accident and Emergency Facility Fee

A facility fee charged to patients by private hospitals for the treatment in an accident and emergency department. It is not covered by Medicare or private health insurance.

Ancillary Cover/Extras

Generally refers to non-hospital and non-medical health services such as dental, optical, or physiotherapy. Also sometimes referred to as General Treatment.

Annual Maximum

The maximum benefit payable for services received during any calendar year for particular services or groups of services. The Annual Maximums start new on the 1st of January each year.

Accommodation-Hospital

Accommodation included in your hospital cover generally includes all in-hospital services such as meals, bed and nursing care. Accommodation does not include take home or personal items, e.g. toiletries, television, hairdressing, manicure etc.

Benefit

The amount payable by Emergency Services Health to you, or on your behalf to a service provider in respect of a claim made relating to the provision of health services, treatment, care, or goods by a recognised provider.

Benefit Limits

The maximum amount payable for specific services or groups of services within a set timeframe, typically annually.

Calendar Year

From January 1 to December 31.

Claim

A request submitted by a member to Emergency Services Health for the payment of benefits for hospital treatment, in-patient medical treatment or extras treatment. All claims must be made within two years of receiving treatment.

Code of Conduct

A set of rules outlining responsibilities, best practices and ethical codes for a health insurance organisation to conduct itself.

Contributor

A Contributor in the Fund Rules refers to the person who is registered as the Contributor of the policy, in which the policy holds their name as the authorising contact, recipient for all written and/or electronic communications and is responsible for premiums of the policy.

Co-payment

A co-payment is an amount that a member agrees to pay towards the cost of each day spent in hospital. Emergency Services Health does not have co-payments on its hospital coverage. However, if you transfer to Emergency Services Health and your previous cover had a co-payment component, you'll be required to serve Waiting Periods in relation to the co-payment and you may be required to pay the co-payment if you receive hospital treatment during the Waiting Periods.

Dependent

Emergency Services Health's literature refers to a number of different types of dependents.

Our Fund Rules refer to the Contributor and dependents. Dependents are any spouse/partner and any child of the Contributor eligible to be covered under your policy.

The Fund Rules collectively refers to your children eligible

to be covered under your policy as "dependent persons" and are made up of the following types:

- Dependent child;
- Non-classified dependent person;
- Dependent student;
- Dependent non-student; and
- Dependent person with a disability.

A dependent child is where your child is aged under 18 and a non-classified dependent person is when your child is aged 18 and over but under 21. Together, we refer to these two types of dependent persons as younger dependent children (that is, where the child is aged less than 21 years).

A dependent student is a child of the Contributor who is 21 years and over, but under 32 years of age, who is considered to be a full time student of a school, college, or university recognised by our Fund.

A dependent non-student is a child of the Contributor who is 21 years and over but under 25 years of age, and not eligible to be a student dependent.

A dependent person with a disability is a child of the Contributor and the child is participating in the National Disability Insurance Scheme (NDIS) and hence holds an active NDIS plan. The child may be any age 18 years and over, but would only be registered as a dependent person with a disability if they do not meet any of the other dependent person types.

In all cases a child is taken to include a natural child, adopted child, foster child or a child who is a legal ward of the Contributor or their spouse/partner.

Other than for a dependent person with a disability, a child ceases to be eligible as a dependent on a policy if they are married or in a defacto relationship.

Eligibility
Police Health Limited is a restricted access private health insurer and applicants to Emergency Services Health need to meet certain qualifying criteria, described on page 3. This means that the general public cannot join.

Excesses
An excess is an amount that a member agrees to pay upfront before a health insurance benefit is paid towards hospital accommodation as set out under a health insurance policy, similar to a motor insurance policy. Emergency Services Health does not have excesses on any of its hospital products. However, during Waiting Periods you may be required to pay an excess if you were subject to one under your previous policy.

Fund Rules
Rules that set out your rights and responsibilities under your health insurance policy with Emergency Services Health, including establishing the rules for payment of benefits. All persons covered by a health insurance policy with Emergency Services Health are subject to the Fund Rules, which are subject to change.

Gap
This most commonly refers to the difference between the Medicare Benefits Schedule Fee for a medical service and the amount covered by Medicare. It can also refer to the uninsured difference between the fee charged for a service and the benefit paid by Emergency Services Health (and Medicare if applicable), in effect your out-of-pocket cost.

In-patient
A person who has been admitted to a hospital. This does not include a person being treated in the out-patient or accident & emergency sections of a hospital.

Item Limits
A limit that is set per item, determining the maximum benefit payable for that item. These limits are periodically reviewed and may be adjusted over time. If the service charge exceeds the Item Limit, the reimbursement percentage may be reduced.

Lifetime Health Cover (LHC)
A Government initiative that rewards people who take out private hospital cover early in life by guaranteeing lower premiums than what would apply if joining later in life.

Lifetime Limit
The maximum cumulative total benefit limits payable in the lifetime of the member on a particular service. Where lifetime limits apply, any benefits paid by your previous private health insurer are treated as part of this Lifetime Limit.

Medicare Benefits Schedule (MBS)
A list of medical services and fees recognised by the Australian Government.

Member
The use of the words "membership" and "member" in this brochure relates to the policy holder (Contributor) and all dependents under the policy of Emergency Services Health insurance. It does not imply you are a member of Police Health Limited ABN 86 135 221 519.

Member of the Company
Someone who has member voting rights as described in the constitution of Police Health Limited ABN 86 135 221 519.

Membership Arrears
When a member is not up-to-date with policy payments, the membership will be in arrears and no benefits will be paid to or on behalf of the member. The policy may be cancelled by Emergency Services Health if in arrears greater than two months.

Not-for-profit
Emergency Services Health operates on a not-for-profit basis. This means we do not pay dividends to shareholders, and any surpluses are retained to benefit members.

Out-of-pocket Expenses
The portion of charges you incur that is not covered by Medicare or health fund benefits.

Out-patient
A person receiving treatment at a hospital but not admitted to hospital.

Palliative Care
Specialised health care to support and comfort people with life-limiting illnesses.

Pharmaceutical Benefits Scheme (PBS)
An Australian Government subsidy scheme that lowers the cost of prescription medicine. Health funds are not permitted to pay benefits towards medicines that receive a government subsidy except when they are supplied while an in-patient of a hospital.

Policy/Product
This refers to a health insurance policy with Emergency Services Health and the treatment you're insured for in exchange for a set premium. The policy is governed by the Fund Rules.

Policy Holder
Emergency Services Health's reference to a policy holder refers to the contributor of the policy (not everyone covered under the policy).

Pre-existing Condition
Where signs or symptoms of an ailment, illness or condition (in the opinion of a medical practitioner appointed by us) existed at any time during the six months before you purchased your policy or upgraded to a higher level of cover.

Premium
The amount you pay for your Hospital, Extras or Combined cover policy. You must pay the premium that applies to your policy in the state in which you live. This means that if you move states, different premiums will apply.

Prostheses
Prostheses include screws and plates, intraocular lenses, replacement joints, cardiac stents, defibrillators and other devices that are listed on the Government's Prescribed list of Medical Devices and Human Tissue Products.

Provider
An individual or institution that provides preventive, curative, palliative or rehabilitative health care services to individuals, families or communities

Recognised Health Providers
Recognised health providers are those who are in private practice in Australia and recognised by us. We only pay benefits for services by these providers. If you wish to ensure that your provider is covered please speak to us prior to treatment.

Rollover Maximum
The Rollover Maximum means the total of an Annual Maximum in a particular calendar year and any Rollover Benefit from the previous calendar year (where both are available) available to a person for benefit purposes in any given calendar year, with the Annual Maximum used first, followed by the Rollover Benefit.

Service Limits
Restrictions on how often a particular service can be used within a given period, such as limits on the number of consultations per year.

State of Residence
The state or territory where the Contributor of the policy lives.

Information Statements (SIS or PHIS)
Information Statements are available on all private health insurance products in Australia. These statements are designed to assist you in reviewing and comparing different health insurance policies. Prior to April 2019, these statements have been known as Standard Information Statements (SIS), but transitioned to a new format known as Private Health Information Statements (PHIS) under the Government's Private Health Insurance Reforms.

This is a Federal Government initiative and all health insurers are required to provide such statements by law. Emergency Services Health's Information Statements (PHIS) are available on request or can be found on our website **eshealth.com.au**.

For further information on Information Statements and other detailed information on private health insurance in Australia visit the Federal Government website **privatehealth.gov.au**.

Suspension of Private Health Cover
Under certain circumstances, such as travelling overseas, members may suspend the payment of their premiums for an agreed period of time (conditions apply).

Waiting Periods
A 'Waiting Period' in the context of private health insurance means the period of time from the commencement of cover or increase in cover, to when the benefit or new benefit can be claimed by the member under their chosen cover (excludes accidents).

We value your feedback.

We're constantly trying to improve the quality of our products, processes and services. Your feedback is an important part of this process.

If you're happy with the service and benefits we provide we'd love to hear about it, but more importantly we'd love you to tell your colleagues – it's our members word of mouth that helps us grow. If for some reason you're not satisfied please also let us know and we'll endeavour to resolve the problem.

Call	**1300 703 703**
Email	**enquiries@eshealth.com.au**
Post	**PO Box Reply Paid 6111 Halifax Street, Adelaide SA 5000**
Facebook	**facebook.com/EmergencyServicesHealth/**
Email	For all enquiries looking for a response, please email: **enquiries@eshealth.com.au**

Our Customer Service Officers can address a wide range of issues on the spot. If necessary, their supervisor will be on hand to discuss your concerns and, if you're still not happy, your complaint will be escalated to the senior manager responsible.

Private Health Insurance Ombudsman

If you require independent advice about your policy or health insurance, the Private Health Insurance Ombudsman (PHIO) provides an independent service to help consumers with health insurance problems and enquiries. For further information or an online complaint form, visit ombudsman.gov.au. Emergency Services Health's Complaints Policy is available at our website **eshealth.com.au** or by calling us **1300 703 703**.

Ombudsman contact details

Call	1300 362 072
Complaints	www.ombudsman.gov.au
General	www.privatehealth.gov.au
Post	Private Health Insurance Ombudsman, Commonwealth Ombudsman GPO Box 442, Canberra ACT 2601

Notes

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"EMERGENCY SERVICES HEALTH HAS JUST TURNED OUT TO BE PERFECT AND I CERTAINLY RECOMMEND ESH TO ANYONE, AND I HOPE OTHER PEOPLE JOIN BECAUSE IT'S SUCH GOOD VALUE."

Emergency Services Health Member

EMERGENCY SERVICES HEALTH

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