EMERGENCY SERVICES HEALTH

COVER LIKE NO OTHER

WAITING PERIODS FOR PRIVATE HEALTH INSURANCE

APRIL 2022

A guide about how and why waiting periods operate, including the rules on pre-existing conditions.

A Members Health Fund

Waiting Periods

At Emergency Services Health, we make your private health insurance choices as simple as possible to ensure maximum value. We don't cut corners, we don't overload you with options, or opt-ins or opt-outs. Our products are simple, top quality & designed for life.

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. Like all private health funds, Emergency Services Health has waiting periods for new members, including people transferring from another insurer when taking out a higher level of cover. Waiting periods also apply to current members upgrading their cover.

Waiting periods are designed to protect the interest of our members. Without them it would be easy for people to join only at the times when they need cover and to receive benefits. This would lead to higher premiums for all fund members.

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 until you have served the waiting period.

At Emergency Services Health the waiting periods are:

Hospital benefits

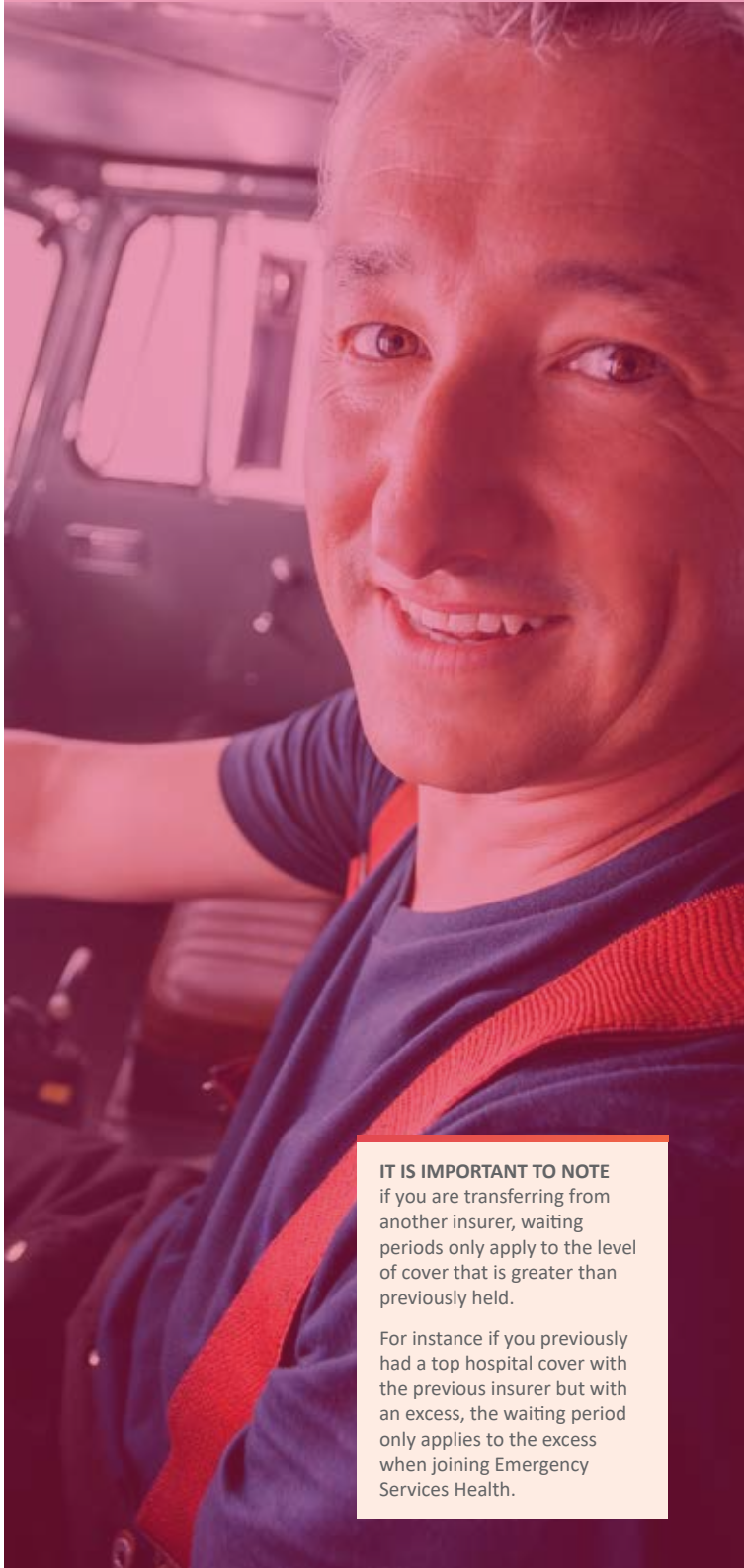
- 2 months membership for all benefits, except for accidents
- 12 months membership for obstetric treatment
- 12 months membership for pre-existing conditions, except for psychiatric care, rehabilitation or palliative care (in which case the waiting period is 2 months).
- 12 months travel and accommodation (general treatment) and home nursing.
- 12 months membership for aids & appliances.

Extras benefits

- 2 months membership for all benefits, except for accidents
- 12 months membership for major dental (like crowns and dentures) and orthodontics, goods and services under Non-surgically Implanted Prosthesis and appliances, hearing aids, nebulisers, blood glucose monitors, TENS machines (appliances), INR self-monitoring devices (blood coagulation monitors), blood pressure monitors, continuous positive air pressure machines and other appliances, travel and accommodation (for general treatment), and pre-existing conditions.
- 12 month membership for Rollover Benefit (2 years membership for Major Dental Rollover Benefit).

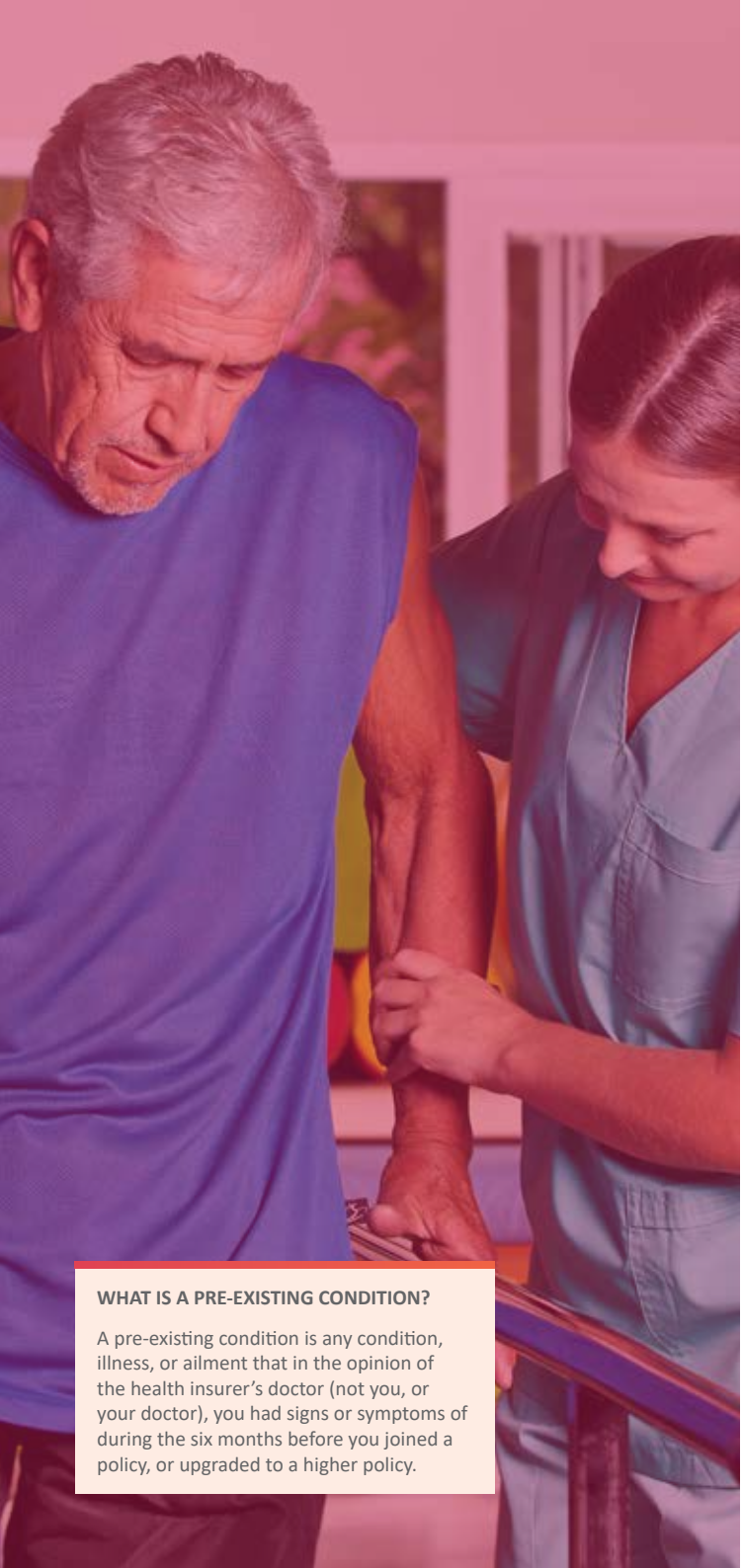
Additional Combined Cover

- 3 years membership for corrective laser eye surgery.



IT IS IMPORTANT TO NOTE
if you are transferring from another insurer, waiting periods only apply to the level of cover that is greater than previously held.

For instance if you previously had a top hospital cover with the previous insurer but with an excess, the waiting period only applies to the excess when joining Emergency Services Health.



WHAT IS A PRE-EXISTING CONDITION?

A pre-existing condition is any condition, illness, or ailment that in the opinion of the health insurer's doctor (not you, or your doctor), you had signs or symptoms of during the six months before you joined a policy, or upgraded to a higher policy.

Pre-existing Conditions

It is not necessarily that you or your doctor knew what your condition was or that the condition had been diagnosed. A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher policy. Risk factors, including family history of a condition, are not signs or symptoms of a pre-existing condition.

What happens if I need to go to hospital during the pre-existing condition waiting period?

If you need to be admitted to hospital during your waiting period, you should contact Emergency Services Health to check if you will be entitled to hospital benefits.

Your condition will be assessed by a medical practitioner appointed by us (not your own doctor), to determine whether signs or symptoms of your ailment, illness or condition, 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 will consider any information regarding signs and symptoms provided by your own treating doctor and specialist.

If you need to go to hospital urgently, Emergency Services Health might not have enough time before you are admitted to decide whether your condition is pre-existing. This means that you may not know, before you are admitted, whether you will receive any health insurance benefits. If you proceed with your admission before we have advised you whether you are entitled to benefits, you may become responsible for all costs associated with the admission.

If you are concerned that you may be liable for your own private hospital treatment and want to look at other options, it is a good idea to check with your doctor for advice. Your doctor is in the best position to advise you if delaying treatment is medically advisable or whether you can opt to use the public system instead.

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, or excluded or restricted treatment under your previous policy, you need to serve 12 months membership with us before your treatment is covered.

When transferring to Emergency Services Health hospital cover, if your previous policy offered lower or restricted benefits for in-patient psychiatric care, to access higher benefits you usually have to complete a two month waiting period. However, you may be eligible to access the psychiatric care waiting period exemption and upgrade without having to serve this waiting period. This exemption applies only once per lifetime (with Emergency Services Health or another private health insurer) and can only be accessed if you have already completed an initial two months of continuous membership on any level of hospital cover.

Planning a family

If you're thinking of starting a family, now's a great time to review your health insurance to make sure you're happy with, and understand, your cover. We only offer top level Hospital cover, which includes pregnancy and birth-related services.

However, many less expensive hospital policies do not cover obstetrics, or pay restricted benefits that only cover you for obstetrics as a private patient in a public hospital.

A 12 month waiting period applies to all private health insurance benefits for Obstetrics treatment (pregnancy and childbirth). This is an industry standard enforced by most health insurers including Emergency Services Health so you need to think ahead to make sure you're adequately covered.

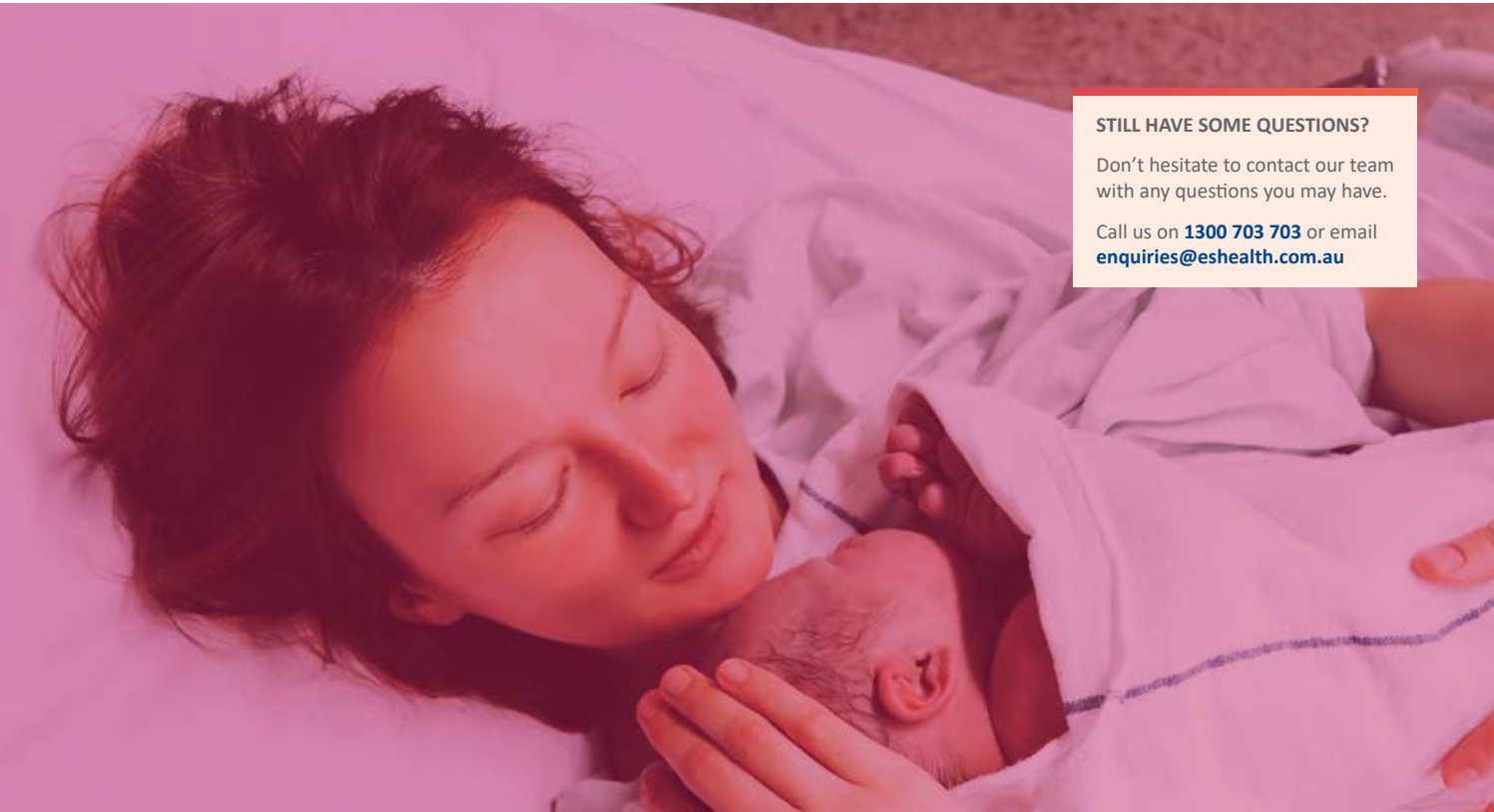
You will receive advice on an 'expected delivery' date from your doctor; but if your baby arrives earlier than anticipated and you have not served the 12 month waiting period, health insurers are not required to pay a benefit. If you're considering switching insurers and have already served relevant waiting periods on your current policy, we provide continuity of cover.

To make sure your newborn is covered by your health insurance policy you'll need to officially register your new born baby on your health insurance policy with Emergency Services Health. If you're already on a Family policy (including Couples) or Single Parent Family policy with us, you need to add your baby within six month of birth and, assuming no other changes to the policy, this won't change your premiums. However, if you've been on a Single policy, you'll need to upgrade to either a Family or Single Parent family policy within two months of your baby's birth and back pay the difference in Premiums from the date of your baby's birth.

Your baby will assume the same level of cover as the policy Contributor from birth, meaning that if the contributor has served all waiting periods, then so has your baby. By serving your 12 month hospital waiting periods before giving birth, your newborn will be covered if they need to be admitted into hospital in their own right. This normally only happens if there are complications. For straightforward, low risk births only the mother will be admitted as an inpatient in the hospital.

Expecting twins or more?

In the case of a multiple birth, only one baby will be put under your admission (assuming there are no complications), and the other babies will be admitted to hospital as an inpatient with an account billed in their name, not the mother's.



STILL HAVE SOME QUESTIONS?

Don't hesitate to contact our team with any questions you may have.

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

Call	**1300 703 703**
Post	**Reply Paid 6111 Halifax St Adelaide SA 5000**
Email	**enquiries@eshealth.com.au**
Facebook	**facebook.com/EmergencyServicesHealth/**
Web	**eshealth.com.au**
Office Hours	**Monday, Wednesday - Friday** **8.45am - 4.45pm (SA Time)** **Tuesday** **9.30am - 4.45pm (SA Time)**

Emergency Services Health brought to you by Police Health Limited
ABN 86 135 221 519

EFFECTIVE FROM 1 APRIL 2022