PRODUCTS & BENEFITS GUIDE

APRIL 2019

If you're part of Australia's emergency services community, you'll understand how **tough**, how **demanding**, and how **fragile** life can be.

Because you're out there protecting our community, you'll appreciate that the **unexpected**, the **acute**, and the **dangerous** can lie just around the corner.

It can be a formidable challenge — **physically and emotionally** — for you and your family.

That's why people like you take health insurance so seriously — there really shouldn't be any compromises.

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The benefits

We believe we're the best health insurer for emergency services employees, volunteers and their families because:

- We're Australia's only private health insurer designed specifically for the emergency services community.
- We're a not-for-profit, private health insurer with straightforward products, ensuring our members receive the best health cover at the best possible price.
- We keep it simple and only offer the best. All you have to decide is if you want our *Gold Hospital* cover, *Rolling Extras* or a combination of both known as *Gold Combined*.
- We offer you 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.
- We're backed by the expertise and resources of Police Health - who have been providing health insurance to Australia's policing community since 1935 and now cover over 57,000 members nation-wide.

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, high quality and designed for life.

We understand health insurance can be confusing. So if you're new to private health insurance and you'd like to learn more, this brochure is the perfect place to start.

You can also visit our website at **eshealth.com.au**

Who is eligible to join?

Emergency Services Health Pty Ltd is a restricted access, private health insurer primarily for:

Fire Response & Recovery Sector

- Currently or previously employed/volunteering for a not-for-profit, commercial, or a national, state or territory government fire department/service or association/union.
- Currently or previously employed/volunteering for a registered training organisation and/or specialist emergency service equipment suppliers in the Fire Response & Recovery Sector.

Ambulance & Medical Response & Recovery Sector

- Currently or previously employed/volunteering for a not-for-profit, commercial, or a national, state or territory government ambulance department/service or association/union.
- Currently or previously employed/volunteering for a not-for-profit, commercial, or a national, state or territory government hospital service or association/union.
- Currently or previously employed/volunteering in a medical, nursing or allied health capacity and are registered with the Australian Health Practitioners Regulation Agency (AHPRA), or currently or previously employed by such a person or related organisation.
- Currently or previously employed/volunteering for a registered training organisation and/or specialist emergency service equipment supplier in the Ambulance & Medical Response & Recovery Sector.

Water Response & Recovery Sector

- Currently or previously employed/volunteering for a not-for profit, commercial, or a national, state or territory government life saving (or sea rescue) department/service or association/union.
- Currently or previously employed/volunteering for a registered training organisation and/or specialist emergency service equipment supplier in the Water Response & Recovery Sector.

State Emergency Response & Recovery Sector

- Currently or previously employed/volunteering for a not-for profit, commercial, or a national, state or territory government emergency services department/service or association/union.
- Currently or previously employed/volunteering for a registered training organisation and/or specialist emergency service equipment supplier in the State Emergency Response & Recovery Sector.

If you're not sure call us on 1300 703 703.

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.

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 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 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 early on in your life. You're rewarded with lower premiums for taking out cover and maintaining it.

This is how it works: if you wait until you're aged 31 and take out private hospital cover in the following financial year, 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.

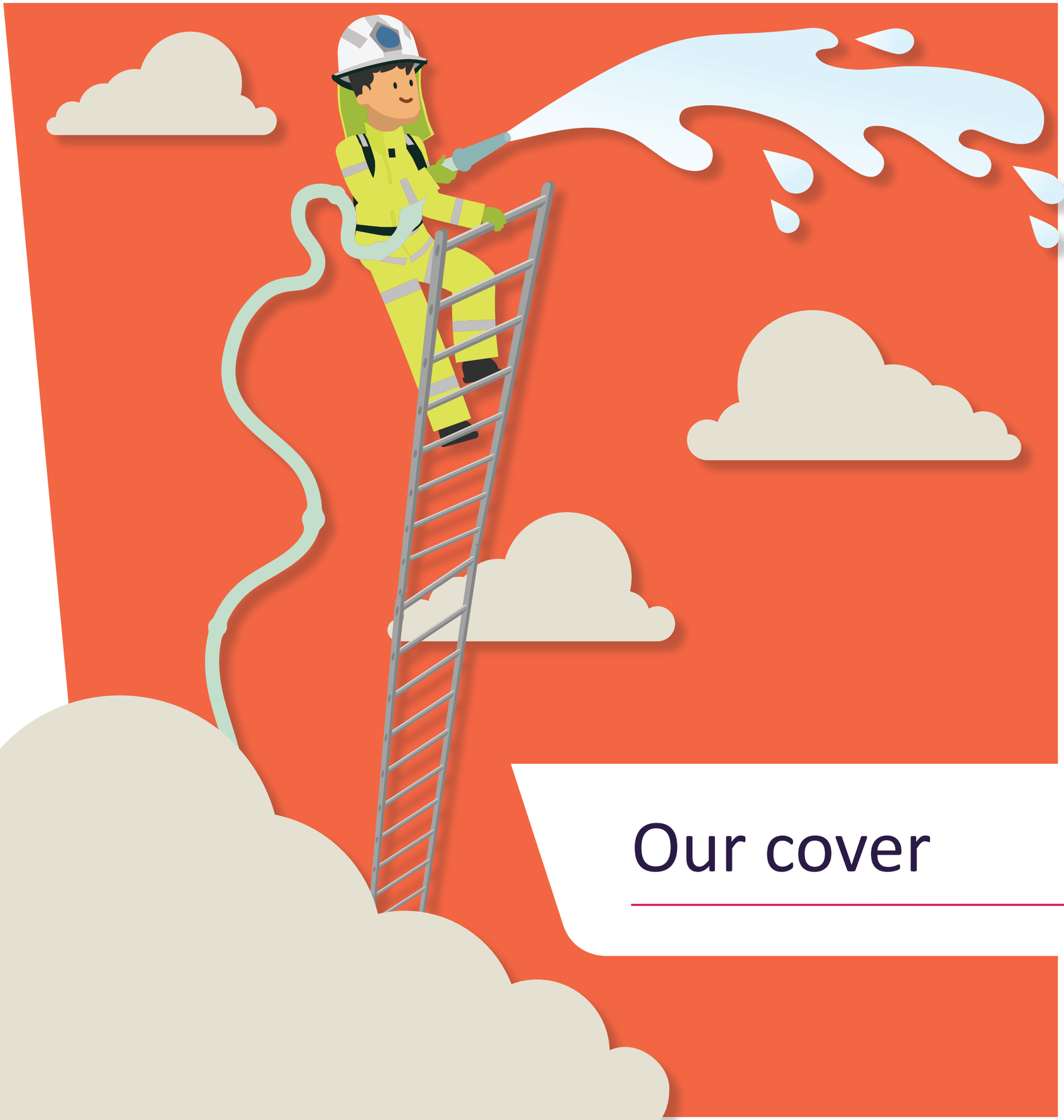
In other words, the earlier you take out private hospital cover, the better, as deferring your decision can be costly.

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).

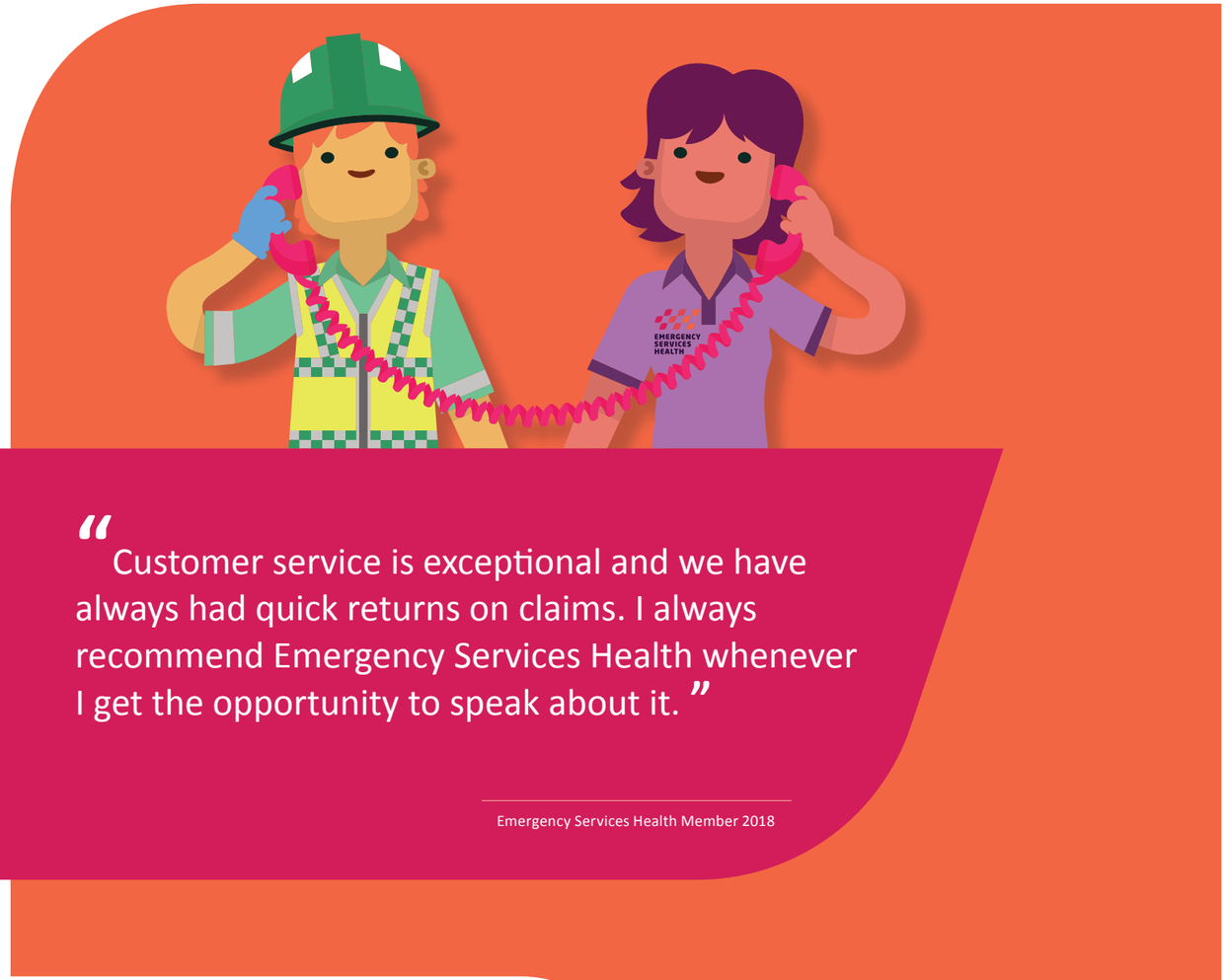
A 1% MLS applies to couples or families without hospital cover who have a combined annual income greater than $180,000*, and singles earning more than $90,000*. This increases aligned to the income tiers as shown in your State Premiums & Benefits Guide. Family thresholds are increased by $1,500 for the 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.

**Effective for 2018/19 income years.*



Our cover



"Customer service is exceptional and we have always had quick returns on claims. I always recommend Emergency Services Health whenever I get the opportunity to speak about it."

Emergency Services Health Member 2018

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

We often hear stories of those who get caught out by having inadequate cover when an unexpected health crisis takes hold. That's why Emergency Services Health provides only top level (comprehensive) cover.

By offering only top level cover you can be assured that you will be looked after when the need to use your cover arises. It's really quite simple, just great cover giving total peace of mind to you and your family.

What cover is right for me?

POLICY	WHO IS COVERED?	
Single Policy	Just yourself	
Single Parent Family Policy	Yourself and all your dependent children*	
Family Policy (includes couples)	Yourself, partner and dependent children* (if any)	or
Extended Family Policy and Extended Single Parent Family Policy	Yourself, partner, dependent children (if any) and non-student dependent children* aged 21-25	Yourself, your dependent children (if any) and non-student dependent children* aged 21-25

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: Single, Couple, Family, Single Parent Family
Rolling EXTRAS	Extras only product available for: Single, Couple, Family, Single Parent Family
Gold COMBINED	A combination of *Gold Hospital* and *Rolling Extras* available for: Single, Couple, Family, Single Parent Family, Extended Family, Extended Single Parent Family

** See page 28 for more information about dependents.*

Gold HOSPITAL

Australia's highest tier hospital cover

Exceptional value for money

Your choice of doctor and hospital*

Ultimate peace of mind for you and your family

- **No worries**
  No exclusions*
  No restrictions*
  No co-payments*
  No excess*
  ... so you have no worries!
- **Freedom to choose**
  We give you the freedom to choose who treats you and where, as long as the provider is recognised by us.*
- **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.

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

In the unlikely event that we cease to recognise a private hospital for full benefits, we'll advise members likely to be affected and publish the information on our website. You can also search for contracted hospitals on our website or call us for clarification on **1300 703 703** before your admission.

- **Theatre fees/labour ward**
  Covered for eligible treatments in recognised 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 recognised hospitals. Subject to the 35 day hospital rule explained on page 12.
- **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 page 9 for more details.

** Waiting periods and other conditions apply. Doctors, Hospitals and Service Providers must be recognised by us.*

Scope of cover

All the 38 Clinical Categories as listed below.

CLINICAL CATEGORIES COVERED BY EMERGENCY SERVICES HEALTH'S GOLD HOSPITAL	
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 10 and 11.

Additional treatment items included in our Gold Hospital cover

- **Ambulance***
  Covered for emergency transport, clinically required non-emergency transport, and treatment not requiring transport.
- **Aids and Applicances***
  Benefits towards continuous positive air pressure (CPAP) Machines and Non-surgically Implanted Prosthesis 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 year, per policy.
- **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***

** Waiting periods and other conditions apply. For more information about a specific benefit or type of treatment, please contact us on 1300 703 703*

ACCESS GAP COVER

Under Emergency Services Health 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 are one of the 25,000 doctors Australia wide who 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 call us or visit our website.

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 vitroFertilisation (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 (Prostheses) 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: surgery to remove wisdom teeth, and 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 managementof diabetes. For example: stabilisation of hypo-or hyper-glycaemia, contour problems due to insulin injections.
✓	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 tobreast cancer surgery, and gynecomastia.

	CLINICAL CATEGORY	HOSPITAL TREATMENT:
✓	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 glandtumour 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	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 months membership for obstetric 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, and goods and services under Non-surgically Implanted Prosthesis and Appliances and other aids and appliances.

If you're transferring to us from another health insurer you won't serve the same waiting periods twice on the same benefit 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 new born related health services, so if you're unsure whether you are on the right cover for your growing family, please give us a call on 1300 703 703 or visit our website.

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. (Some benefits may be payable for hospital treatment following this surgery. Please call us for more details.)
- 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 Federal Government's approved Prostheses List.
- Charges greater than the benefit defined in the Federal Government's approved Prostheses List.
- 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.

***** 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 call us on 1300 703 703.***

Frequently Asked Questions about our Gold Hospital Cover

Why don't you charge an excess, or co-payment?
Some insurers may charge an excess or a 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?
Other funds may apply exclusions or restrictions.

- 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 replacement.
- A restriction is when you agree to receive very limited benefits for certain treatments. For example you may be covered for joint replacement 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.

"Great value for money! Love it!"

Emergency Services Health Member 2017

Rolling EXTRAS

Extras cover that lets you rollover your unused Annual Maximum benefits from one calendar year to the next on an extensive list of services.*

- Visit the health provider of your choice, as long as they are recognised by us*
- Easy claiming on-the-spot with your Emergency Services Health card, or via our mobile app.
- Generous Annual Maximums, particularly in the areas of Psychology, Major Dental and Optical*
- New counselling benefits available*

Extra savings in optical

At OPSM and Laubman & Pank stores Emergency Services Health members holding Extras cover receive healthy discounts and assured benefits on your spectacles and contacts including:

- 20% off spectacle lenses and lens extras.
- 10% off non-prescription sunglasses.
- 20% off all contact lenses.
- Lower out-of-pocket costs with 100% benefits on prescription spectacle lenses and coatings and contact lenses (up to your Annual Maximum, and any eligible Rollover Maxiumum) and a set frame benefit of $110 applies.
- On the spot claiming with your Emergency Services Health card.

***Waiting periods and other conditions apply. Service providers must be recognised by us to qualify for benefits.**

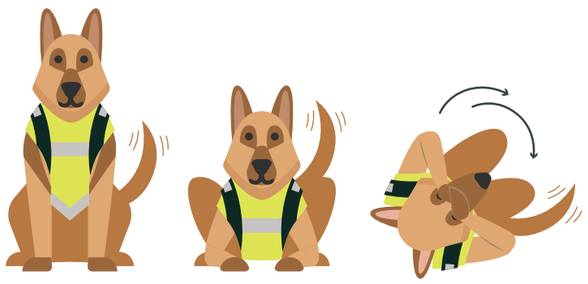
HOW OUR UNIQUE ROLLOVER BENEFIT WORKS...

Emergency Services Health and our sister fund Police Health are the ONLY private health insuers to offer a Rollover Benefit - allowing you to get more value from your cover.

Most benefits for extras services, like your major dental, chiropractic and optical have Annual Maximums, which are renewed each calendar year. The Rollover Benefit allows members to carry over any unused Annual Maximum benefit that is not claimed during the previous calendar year into the following year (Noting that claims are always paid from the current year's Annual Maximum before the Rollover Benefit is accessed).

New members are eligible for the Rollover Benefit after just 12 months (2 years for major dental).

The Rollover Benefit covers most extras services - for details please refer to the 'Rollover Maximum' column in the table opposite.



What is covered by Rolling Extras

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 State Premiums & Benefits Guide.

SERVICE TYPE	WAITING PERIODS	ANNUAL MAXIMUM PER PERSON	ROLLOVER MAXIMUM PER PERSON*
General Dental Includes check-ups, x-rays, simple extractions, fillings and root canal.	2 months	Unlimited	N/A
Major Dental Includes crowns, dentures, inlays and implants.	12 months	$1,500	$3,000^
Orthodontic Orthodontic benefits work slightly differently. Limits apply after completion of anniversary years. Visit the FAQs section on page 24 for more information. Lifetime limit $3,000.	12 months	1st year $0 2nd year $800 3rd year $800 4th year $1,500	N/A
Optical	2 months	$320	$640^
Physiotherapy	2 months	$850 combined	$1,700
Exercise Physiology	2 months	Sub-limit for exercise physiology $400 per person, up to $800 per family	N/A
Chiropractic	2 months	$700 combined	$1,400
Osteopathy	2 months		
Complementary Therapies Remedial Massage Therapy, Remedial Therapy, Myotherapy and Chinese Medicine.	2 months		N/A
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	2 months	$700	$1,400
Psychology	2 months	$850 combined	$1,700
Counselling**	2 months	Sub-limit for exercise counselling $400 per person, up to $800 per family	N/A
Ambulance	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 Doctor's referral may be required for some appliances.	12 months	Various limits apply. See the benefits breakdown insert.	N/A

Note: All the benefits shown here are payable only on services and at health providers recognised by Emergency Services Health.
**** Rollover Maximum available after 12 months membership with extras cover, except major dental which requires 2 years of membership.***
^2020 Rollover Benefit shown. In 2019, The Rollover Benefit is capped at $2,800 for Major Dental and $620 for Optical. For more information on how Rollover Benefits work, see page 14.
***** To qualify as recognised providers, counsellor's must be registered with the Australian Counseling Association Inc (ACA), be in private practice and meet a set of practice and educational criteria. For more information visit eshealth.com.au or call 1300 703 703.***

HAVE A QUESTION?

Our friendly, knowledgeable team are here to help.

Call 1300 703 703

Email enquiries@eshealth.com.au

"I can say this is the best there is. The price is just right for what you get!"

Emergency Services Health Member 2018

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 on the same benefit because we offer continuity of cover.

See page 20 for more information.

Benefit limits

Private Health insurers generally calculate an average charge for services and set their benefits based on those amounts. Emergency Services Health goes further and in the majority of cases recognises charges up to 10% higher than the calculated average. This means that when members make a claim for extras with Emergency Services Health, they tend to get more back - 80% in the majority of cases.

If the service charge is higher than the fee we recognise, 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. We've developed a benefit structure with fewer limits. Our limits on regular services such as dental are generous by comparison. 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 fee recognised 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, sports 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.

**** This provides a general description of what is not covered. Should you require information about a particular treatment or benefit please call us on 1300 703 703.***

For more information about how particular benefits work, give us a call on 1300 703 703 or visit our website eshealth.com.au

Gold**COMBINED**

Here for you and your family when you need us most

Our *Gold Hospital* and *Rolling Extras* combined at a reduced premium, providing even more value.

No wonder it's our most popular health cover.

Scope of cover

- All the benefits included in our **Gold Hospital** cover. *See pages 8-13 for details.*
- All the benefits included in our **Rolling Extras** cover. *See pages 14-17 for details.*
- Additional partial benefits for corrective laser eye surgery, not available when taking out either Gold Hospital or Rolling Extras only.*

**** Subject to a 3 year wait.***

Things you need to know

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 obstetric 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, and goods and services under Non-surgically Implanted Prosthesis and Appliances and other aids and appliances.

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, other appliances, 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 at the higher level of cover.

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 diagnostic imaging 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 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 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 pays the gap between the Medicare benefit and the Scheduled Fee.

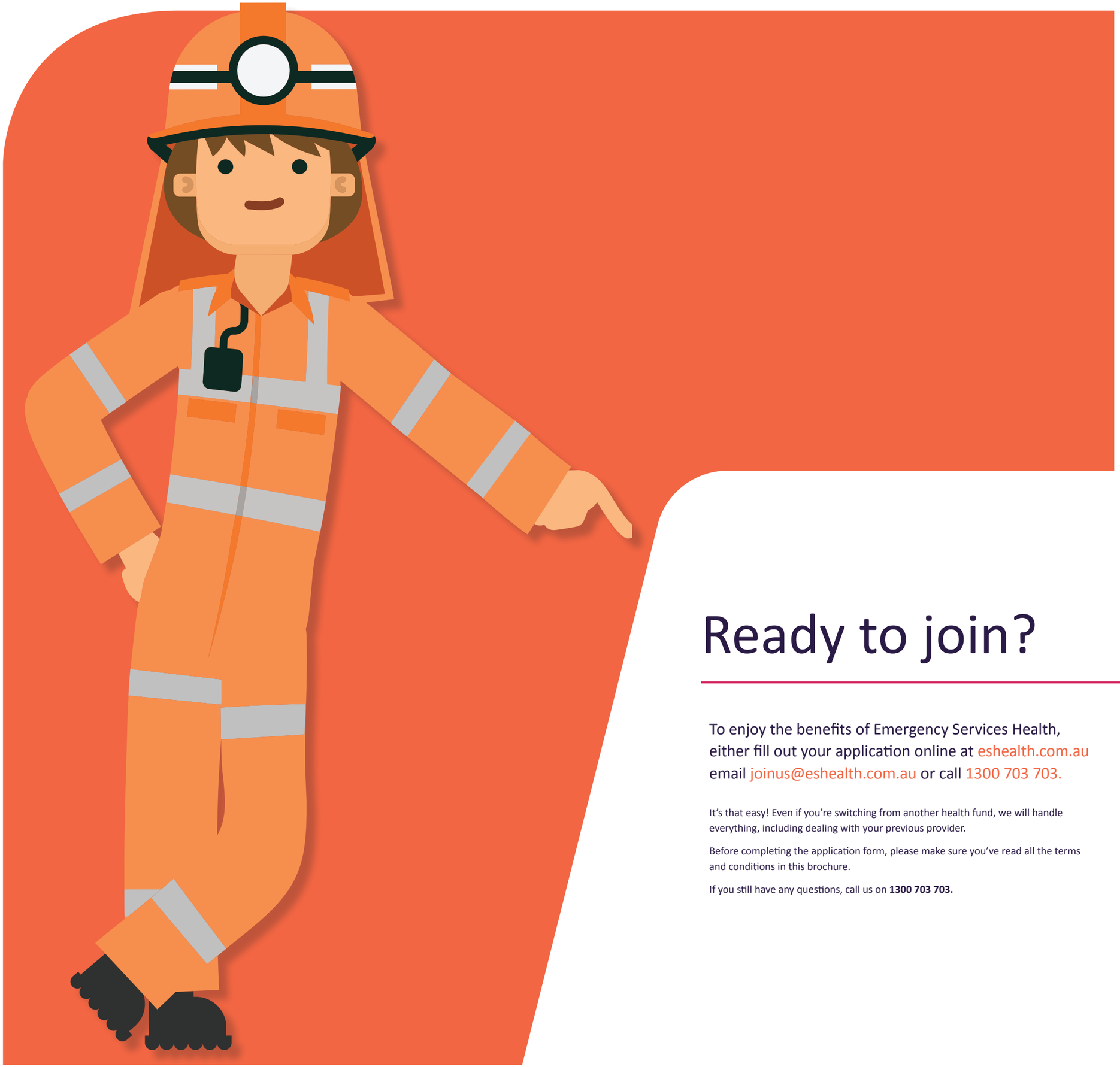
In the vast majority of cases where medical services are billed under our Access Gap Cover scheme, we can also cover the difference between the Scheduled Fee and actual fee charged. Where the fee exceeds that covered by Access Gap Cover, the service provider should advise you of any gaps that exist and 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 do not fall 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.

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



Ready to join?

To enjoy the benefits of Emergency Services Health, either fill out your application online at eshealth.com.au email joinus@eshealth.com.au or call 1300 703 703.

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

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, call us on **1300 703 703.**

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 provider's fee.
- We do not provide on the spot claiming for orthodontic, pharmacy, health appliances (including hearing aids), counselling, aromatherapy 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

Manual claims

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

- Download the free Emergency Services Health mobile claiming app from the iTunes 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 Emergency Services Health
Reply Paid 84966,
Halifax Street SA 5000

FAX 1300 151 152

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 directly 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.

How to receive your benefits faster!

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

FAQs

We know health insurance can be confusing, but 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

Important information

Privacy Notice

Like all health insurers, Emergency Services Health is required to collect personal information. We respect your privacy, treat this information confidentially and store it securely.

We collect and manage personal information in accordance with the Emergency Services Health Privacy Policy and the Australian Privacy Principles. You should read and be familiar with the Policy, and ensure that other persons that are covered by your health insurance policy also read and are aware of the Privacy Policy. This Privacy Notice contains a summary of some important issues, but the Policy has more detail.

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

- You apply for membership with Emergency Services Health to purchase a health insurance policy, and if accepted, you're the policy holder (Contributor) of the policy.
- You're a dependent (spouse, partner or child) under a health insurance policy and the policy holder (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 Emergency Services Health through one of its communication channels.

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

Once we've accepted you, and you're insured under a health insurance policy, we will collect personal information on a recurring basis for the duration of your health insurance policy. It's 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 by us is required, and, depending on the information, is also required under the Private Health Insurance Act 2007 and Private Health Insurance (Prudential Supervision) Act 2015.

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 won't 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 or in conjunction with Emergency Services Health, 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 can be found on our website **eshealth.com.au**

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's important that all persons (currently insured, or who become insured, or consider joining Emergency Services Health) 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, and where the policy holder (Contributor) has supplied an email address, remittance notices will be sent to that email address, unless an individual has requested their claims information be kept private in which case their claims information will not be shown on OMS or electronic remittance notices sent to the nominated email address.

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 Emergency Services Health's Privacy Policy can be obtained from our website **eshealth.com.au** or by contacting our office.

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.

Child dependents 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 additional waiting period provided they:

- Take out a policy with cover no greater than yours.
- Join from their 21st birthday (25th birthday for Family Plus Policy).

Or, if they have been covered as a student dependent, provided they:

- 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 25 years join from their 25th birthday.

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 the date you are paid up to with your premiums is not more than two months in arrears. You're responsible for ensuring that your premium payments are up-to-date.

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.

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 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.

Annual Maximum

The maximum benefit payable for services received during any calendar year for particular services or groups of services per person unless stated otherwise. The Annual Maximums start new on the 1st of January each year (orthodontics maximum is determined by length of membership based on anniversary 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.

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.

Contributor

A Contributor in Emergency Services Health 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 four different types of dependents: spouse/partner, child, student and non-student dependents. Our Fund Rules refer to the Contributor and dependents. Dependents may be a spouse/partner of the Contributor and any child dependents or student dependents of the Contributor and/or their spouse/partner.

A child dependent is a person who is a child of the Contributor or spouse/partner of the Contributor, does not have a partner and is either under 21 years of age, or is a student dependent or is a child non-student dependent.

A student dependent means under all policies, a person who is a child of the Contributor and/or their spouse/partner who is over 21 years of age but under 25 years of age, who is considered to be a full time student of a school, college, university or other tertiary institution recognised by Emergency Services Health.

A child non-student dependent is a person who is a child of the Contributor or the spouse/partner of the Contributor and is aged 21 years but under 25 years. Child non-student dependents can only be included in the Gold Combined product at the Extended Single Parent Family or Extended Family rates.

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. A child ceases to be eligible as a dependent if married or in a defacto relationship.

Eligibility

Emergency Services Health is a restricted access health insurer which means applicants need to meet certain qualifying criteria relating to emergency services to join Emergency Services Health.

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.

Extras / Ancillary Cover

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

Fund Rules

Rules that set out your rights and responsibilities as a member of Emergency Services Health, including establishing the rules for payment of our 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.

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 the Emergency Services Health insurance. It does not imply member voting rights as described in the constitution of Emergency Services Health Pty Ltd ABN 98 131 093 877.

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 of Emergency Services Health.

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 surgically implanted during your stay in hospital.

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.

Recognised fees

We have agreements with most hospitals and recognise their fees for rebate.

With extras services, generally each health insurer will calculate their own set of average fees based on the claims they have paid previously. At Emergency Services Health, most benefits start with our calculated average fee and are then increased by a further 10%. This ensures there are few surprises and that the majority of our members will receive a full 80% rebate on claims.

In determining your claimed benefit, Emergency Services Health will use the net amount payable of any account inclusive of discounts the provider might be offering at the time.

This may vary where, for the benefit of our members, Emergency Services Health has negotiated specific agreements with selected providers.

Restricted Membership Access

Emergency Services Health is a restricted membership private health insurer, meaning that people must meet certain criteria to be eligible to become a member, i.e. the general public cannot join.

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 are transitioning to a new format known as Private Health Information Statements (PHIS) under the Government's Private Health Insurance Reforms. Until this transition period ends on 30 March 2020, you may find these Information Statements in either SIS or PHIS format.

This is a Federal Government initiative and all health insurers are required to provide such statements by law. Emergency Services Health SIS 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	POST	Emergency Services Health Reply Paid 84966 Halifax Street SA 5000
FAX	1300 151 152		
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

Still not happy? Or do 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 complaints form, visit ombudsman.gov.au

Emergency Services Health's Complaints Policy is available at our website eshealth.com.au or by calling us.

CALL	**1300 362 072 - Select option 4 for Private Health Insurance.**
WEB	**ombudsman.gov.au/about/private-health-insurance**
POST	**Private Health Insurance Ombudsman** **Commonwealth Ombudsman, GPO Box 442, Canberra ACT 2601**

Notes

EMERGENCY SERVICES HEALTH

COVER LIKE NO OTHER

PHONE	1300 703 703
POST	Reply Paid 84966 Halifax Street SA 5000
EMAIL	enquiries@eshealth.com.au
FACEBOOK	facebook.com/EmergencyServicesHealth/
WEB	eshealth.com.au
CONTACT HOURS	Monday, Wednesday to Friday 8.30 am - 4.45 pm (SA Time) Tuesday 9.30 am - 4.45 pm (SA Time)

Emergency Services Health Pty Ltd ABN 98 131 093 877.
A registered, not-for-profit, restricted access private health insurer.
Products & Benefits Guide effective 01/04/2019

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