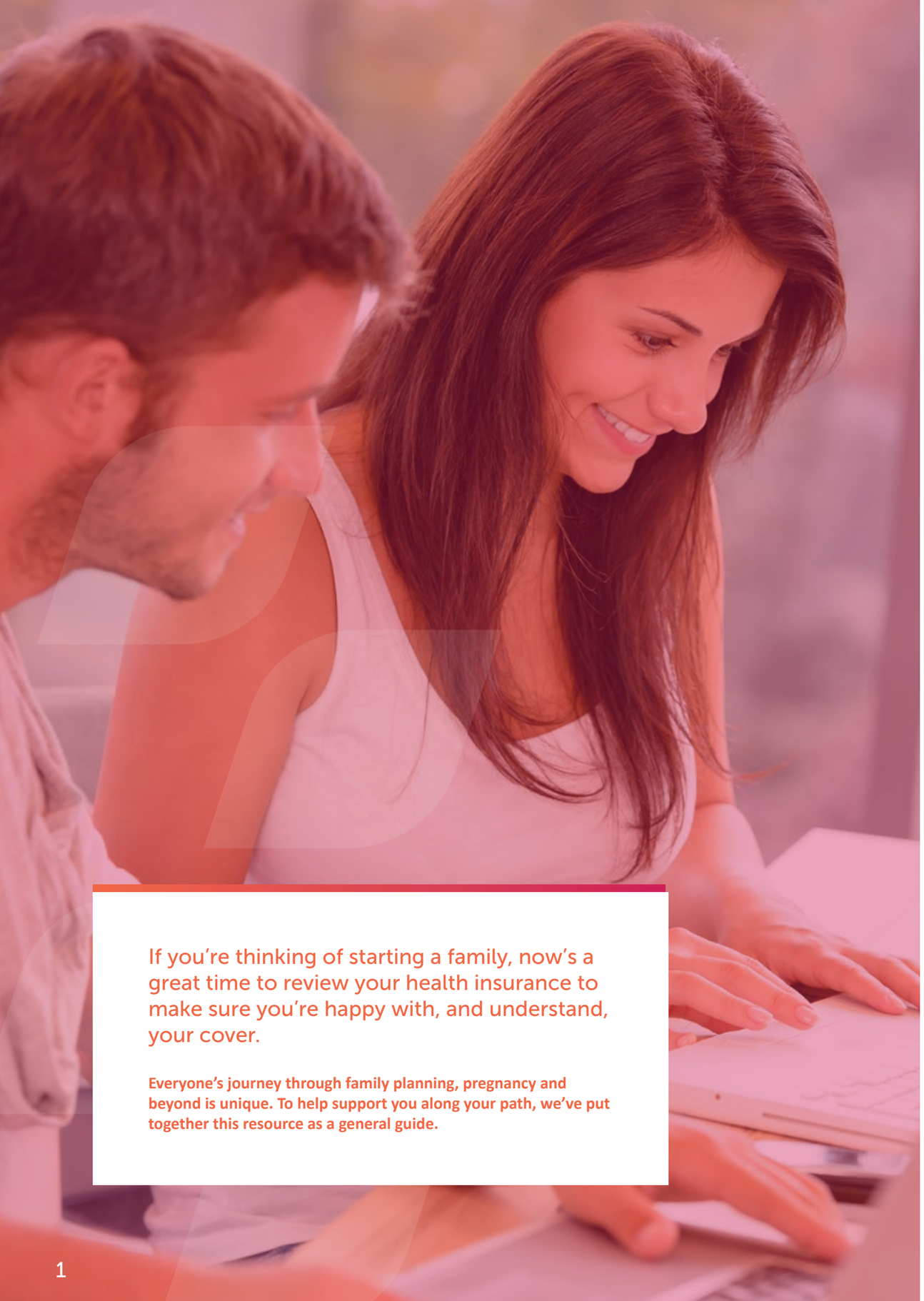
EMERGENCY SERVICES HEALTH

COVER LIKE NO OTHER

PREGNANCY AND PRIVATE HEALTH INSURANCE

A Members Health Fund



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.

Everyone's journey through family planning, pregnancy and beyond is unique. To help support you along your path, we've put together this resource as a general guide.

Health Insurance Checklist

Not all private health insurance is created equal, so it's important to know the details of what you're covered for and who is covered under a policy, without making assumptions.

Here are some health insurance questions you may like to explore as you embark on your journey into parenthood;

- What exactly does my health insurance policy cover in terms of pregnancy and childbirth?
- How generous are the benefits?
- Can I choose my preferred medical provider and hospital?
- Will I have served my 12 month waiting period by the time I'm due to give birth?
- What's covered under Hospital and what's covered under Extras? Do I need my policy to include both?
- Will my policy cover my new born baby from birth?
- Am I covered if there are any complications?
- Is Ambulance cover included?
- Do I understand what proportion of medical services is covered by Medicare and what is covered by my health insurer?

Emergency Services Health's recommended cover

We're often asked which health insurance policy we recommend for those planning a new addition to their family.

Our answer is simple because our products are simple – we only offer top level cover, with no opt-ins or opt-outs, so all you have to choose is whether you want Hospital, Extras or both.

We recommend our Gold Combined cover, which includes both Gold Hospital and Rolling Extras. Choosing our combined cover means you can claim benefits on both Hospital and Extras services you utilise throughout your journey. At a minimum we recommend you take out Hospital cover if you'd like to have your baby in the private system.

Making 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 there are no other changes to the policy, this won't change your premium.

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.

Please note, 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.

GOLD COMBINED

What's covered?

Please note the following information is intended as quick reference guide for pregnancy and birth related services. Please read our Products & Benefits Guide for more information.

Gold Hospital Benefits

- ✓ **Labour Ward/Theatre Fees**
  100% covered*
- ✓ **Accommodation**
  Full cover* for either private or shared room accommodation (subject to availability)
- ✓ **Your Choice of Hospital**
  We don’t restrict you to any particular hospital.
- ✓ **Your Choice of Doctor**
  We give you freedom to choose your own medical professional, as long as they are recognised by us.
- ✓ **Doctor's Fees While in Hospital** (Including Obstetricians, Anaesthetists, Radiologists and Pathologists) 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 our Access Gap Cover and charge the schedule of fees of that scheme, we can cover up to 100% of the doctor’s agreed fee. Before you select your obstetrician you should ask for a breakdown of their costs so that you can provide informed financial consent.
- ✓ **Ambulance**
  100% covered for emergency transport, clinically required non-emergency transport, and treatment not requiring transport.#
- ✓ **Hospital at Home**
  Emergency Services Health has agreements with some hospitals to deliver out-of-hospital care to patients for services such as post-natal care. This can be received in the home or in a hotel setting.
- ✓ **No Excess#**
- ✓ **No Co-Payment#**
- ✓ **No Benefit Limitation Period#**
- ✓ **No Exclusions#**
- ✓ **Antenatal Classes – Midwives Recognised#**
- ✓ **Lactation Nursing#**

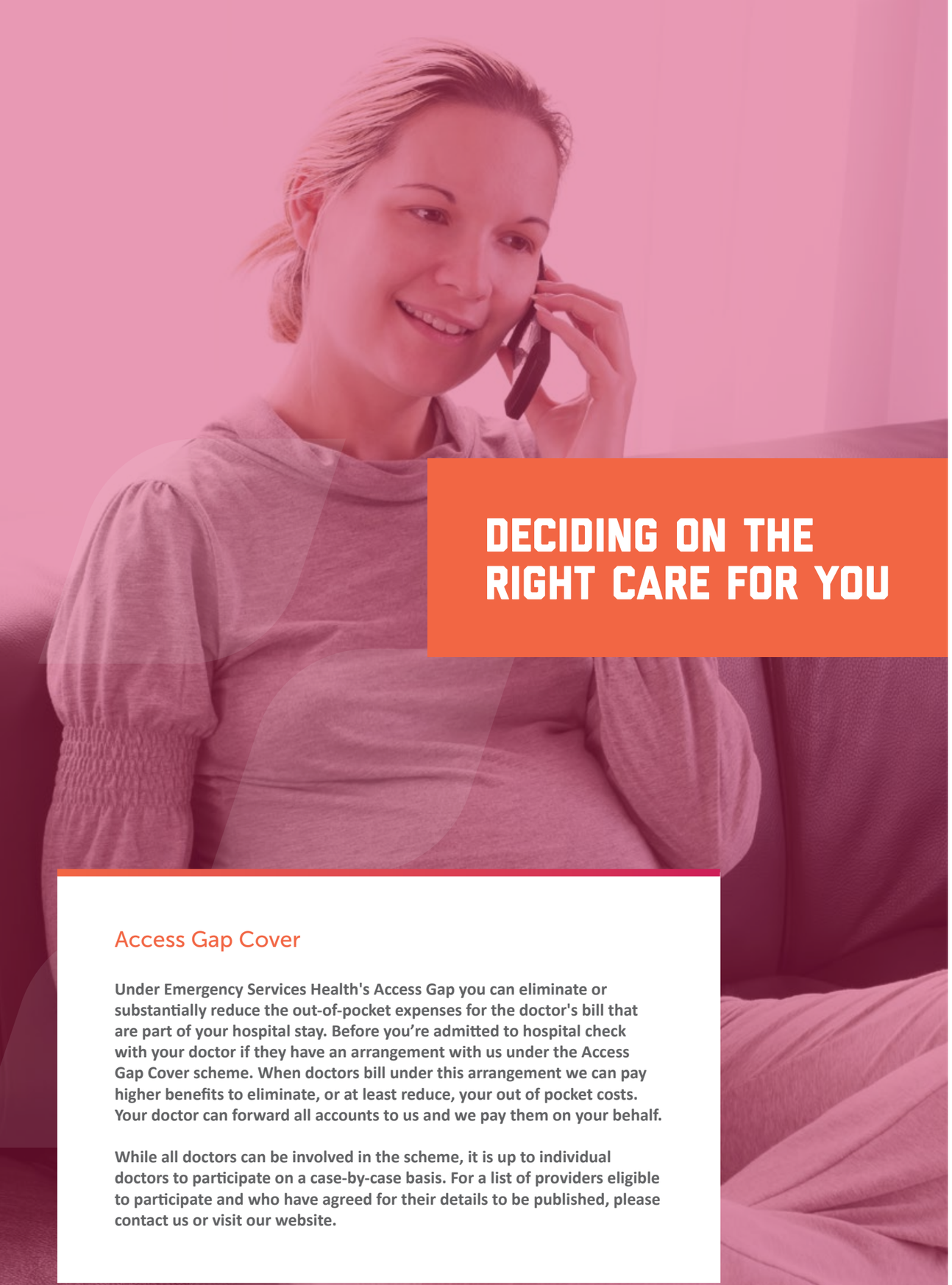
Rolling Extras Benefits

- ✓ **80% Back#**
  For the majority of services provided by recognised providers, we pay a generous 80% of the cost up to the item limit.
- ✓ **Rollover Benefits#**
  Emergency Services Health provides a unique Rollover Benefit. This means that for many Extras services, any unused Annual Maximum benefit that is not claimed during one calendar year can be rolled over to the following year, so you can get more from your cover.
- ✓ **Your Choice of Provider#**
  Visit the health provider of your choice.
- ✓ **Highlights#**
  Extras you might find particularly useful through pregnancy and beyond;
  - Physiotherapy
  - Dietary
  - Podiatry
  - Pharmaceutical
  - General Dental
  - Optical

What's not covered?

- Any additional ‘management’ fees charged by your Obstetrician or Doctor that is not covered by Medicare or private health insurance.
- Accommodation costs for ‘luxury’ suites
- The cost of Outpatient services
- Services in Hospitals not recognised by us. In the rare instance that a Hospital isn’t recognised by us, it’ll be listed on our website.
- Paediatrician fees where the baby has not been admitted to hospital.
- Boarder fees

*Subject to Waiting Periods and other conditions, full cover applies to recognised hospitals where an agreement is in place. # Subject to Waiting Periods, Annual Maximums and other conditions, providers must be recognised by Emergency Services Health.



DECIDING ON THE RIGHT CARE FOR YOU

Access Gap Cover

Under Emergency Services Health's Access Gap you can eliminate or substantially reduce the out-of-pocket expenses for the doctor's bill that are part of your hospital stay. 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.

Freedom to choose

There are an abundance of care options available to expecting mothers in Australia. As a private patient you have a number of choices to make about where to give birth and who you would like to care for you during this exciting time.

Emergency Services Health gives you the freedom to choose who treats you and where. We don't restrict you to a particular hospital, doctor or healthcare provider – our full benefits apply for all recognised hospitals, services and providers.

Some things that may influence your decisions include;

- Where you live
- Your health
- Culture and values
- Previous pregnancy experiences

Find out what pregnancy care options you have available to you in your local area, and decide what path is best suited to you and your needs.

Where to start?

Visit your GP to discuss your situation and options. Your GP will be able to facilitate early medical tests and arrange a referral, whether that be to a local Obstetrician, midwife program or IVF clinic. You may like to have an initial discussion with your GP, then take some time to research the options you're considering before going back to finalise a referral.

Choosing your Hospital and Obstetrician

When it comes to choosing a Hospital and an Obstetrician, you will need to prioritise one choice over the other because Obstetricians only deliver babies at hospitals they are affiliated with. If you choose your Obstetrician first they will let you know which hospitals they deliver at. If you choose your hospital first you'll be able to select your obstetrician from an approved list.

When assessing hospitals you may like to consider things like:

- What birthing and nursery facilities are available?
- Is your pregnancy considered high or low risk and does the hospital cater adequately to you?
- How long will you stay in hospital after giving birth?
- If you'd like a specific obstetrician do they deliver at the hospital?
- Are you happy with the accommodation options?
- Can your partner or other children stay with you in hospital if you choose?
- What post-natal care does the hospital provide?
- Do the values of the hospital align with your own?
- Does the hospital provide pre-natal classes to help you prepare for birth?
- Would you like a tour of the hospital's maternity area before you choose them?
- Is the hospital conveniently located for you?
- What does the hospital charge (ask them for an estimate) and how much is covered by health insurance?

When assessing Obstetricians you may like to consider things like:

- Do they deliver at a hospital near you?
- Can they fit you in based on your due date? (Since they can't be in two places at once, they will only take on a limited number of patients with due dates in the same month)
- Are you happy with their level of experience and skills?
- Would you be comfortable talking openly with them about your needs and concerns?
- Are they open to following your wishes and birth plan, provided they deem it safe?
- Are they relatable and do you like their bedside manner?
- Have you heard good things about them? (You may like to talk to friends, family, your GP or seek out online testimonials)
- Are their consulting rooms conveniently located for you? (You'll be visiting them regularly during office hours throughout your entire pregnancy)
- What do they charge (ask them for an estimate) and how much is covered by Medicare or health insurance?

Please note providers must be recognised by Emergency Services Health to receive eligible benefits. If you're unsure about the eligibiliy of you doctor, hospital or other provider, get in touch. We're here to help.

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.

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 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, blood coagulation monitor and for pre-existing conditions.
- 12 months membership for Rollover Benefit and access to Rollover Maximum (2 years for Major Dental).
- 3 years membership for laser eye surgeries.

Waiting Periods Obstetrics:

Waiting periods of up to 12 months can apply for pregnancy and child birth services. If you're unsure whether you are on the right cover for your growing family, please give us a call on **1300 703 703.**

Ensure your newborn is covered!

If you are an expecting adult* on a Family, Couple or Single Parent Family policy that includes hospital cover:

- Your baby will be immediately covered for treatment provided the policy contributor has served the appropriate waiting periods.
- You need to officially add your baby to your policy within six months of birth for the baby to be eligible for cover as it applies to the contributor of the policy (i.e. any waiting periods served by the contributor covered by the same policy will also be taken as served by the new baby). The baby's cover will be backdated to the date of the birth, provided they are registered within those first six months. This will not affect your premiums.
- If the baby is not registered within six months of birth, the child will be treated as a new member and all waiting periods will apply.

** The term 'adult' refers only to the adults defined in the policy, therefore excluding child dependents on the policy regardless of their age.*

If you are the expecting adult on a Single policy that includes hospital cover:

- You will be covered for the birth of your baby, but your baby will not be covered for treatment unless your baby is added to your policy.
- To add your new baby to your policy, you will need to contact Emergency Services Health within 2 months of birth and update your policy to either Family cover or Single Parent Family cover in order for the baby to be eligible for cover as it applies to the Contributor (i.e. any waiting periods served by the Contributor covered by the same policy will also be taken as served by the new baby). Cover will be backdated to the date of birth, and any additional premiums will be payable from the date of birth.
- If the baby is not registered within two months of birth, the child will be treated as a new member and all waiting periods will apply.

UNDERSTANDING MEDICARE

Understanding who pays for what, whether it's your private health insurer, Medicare or a combination of both can be confusing.

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?

Recognised 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 other 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 Schedule Fee for medical services provided to people who have not been admitted to hospital.

How much does Medicare pay for in-patient medical services?

Medicare pays 75% of the Schedule 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 Medicare Schedule 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 Medicare Schedule 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 Medicare Schedule 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: https://www.humanservices.gov.au/individuals/medicare

EMERGENCY SERVICES HEALTH

This resource is intended as a brief outline of our health insurance benefits related to pregnancy and obstetrics.

For medical advice – please see your GP or other healthcare provider

For general information about health insurance and Obstetrics – visit the Obstetrics and Pregnancy page on the Commonwealth Ombudsman website.

Still have questions? Please get in touch. We're here to help.

Call	1300 703 703
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