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Member Guide

May 2021

Contents

Information in this Member Guide is correct as at 1 May 2021 and should be read and retained together with the product information sheets, the Fund's website and the iSelf Fund Rules. Please ensure you keep a copy of this Member Guide for your records.

Why have Private Health Insurance?

Everyone has their own reason to take out and maintain private health insurance, with a major one being for peace of mind. If the unexpected happens you know that you have choices; the hospital, the surgeon, and when and where you are treated.

By taking private hospital cover, you can also reduce the length of time you might wait for treatment in the public system and also avoid possible penalties like the Medicare Levy Surcharge or Lifetime Health Cover loading.

Plus by adding iSelf Extras to your Hospital cover policy, you can enjoy further savings on everyday services like dental, optical and physiotherapy treatment.

Membership

Switching to iSelf

Once you make the decision to join us, we request a Transfer Certificate (also known as a Clearance Certificate) from your previous fund. This certificate provides all the information we need about your level of cover, any waiting periods, government surcharges and your claims history. Your Transfer Certificate is used to determine what waits we can (and cannot) waive on your membership.

For more information on waiting periods when switching funds see page 15 or for information on government surcharges see page 16.

Ready to join iSelf?

Joining is easy and takes less than five minutes. Simply visit **iself.com.au** to join online or call **1800 467 353** to join over the phone.

Cooling off period

Changed your mind? You have a 30-day cooling off period from the commencement date of your cover to change your mind or your cover choice. This allows you to review your cover and be sure you have made the right decision.

If you cancel your membership during the 30-day cooling off period, you will receive a full refund of any premiums you have paid as long as we haven't processed and paid any claims during that period. If iSelf have paid you a claim, premiums will only be refunded from the day after the date of the service.

If you're already a member and change your level of cover, then change your mind, you can revert back to the previous cover level held within the 30-day cooling off period.

If at any stage during the 30-day cooling off period you want to discuss or review your cover, call us on **1800 467 353** – we're happy to help.

Membership types

Single	the Policy Holder.
Couple	the Policy Holder and their Partner.
Family	the Policy Holder, their Partner and at least one Child or Student Dependant.
Single Parent Family	the Policy Holder and at least one Child or Student Dependant.

Who can be on my membership?

Policy Holder	the first person listed on a membership, they are the primary member and are responsible for the membership and payments.
Partner	the spouse or defacto Partner of the Policy Holder.
Child Dependant	a child of the Policy Holder or Partner, who is under the age of 21 and who is not married or in a defacto relationship.
Student Dependant	a child of the Policy Holder or Partner, who is over the age of 21 (and under 25), who is not married or in a defacto relationship, is enrolled at an educational facility as a full-time student and has registered their status with iSelf.

Delegation of Authority

As the Policy Holder, you can nominate someone to have access to your membership on your behalf. This can be your Partner, an Adult Dependant or a third party. To set up a Delegation of Authority complete a Delegation of Authority form available from our website or call us to add them over the phone.

A nominated Delegated Authority can enquire about the membership, add or remove dependants, change your level of cover, change direct debit details (not direct credit) and request membership documentation. They are not authorised to cancel the membership on your behalf.

You may wish to nominate other parties to have authority over the membership, for example, if a current Power of Attorney or Public Trustee order is in place. Please contact the iSelf Team for more information.

Adding or removing members on your policy

We understand that every now and then life changes, and your private health insurance will need to change with you.

Only the Policy Holder, or an authorised member (who has delegation of authority) can add or remove people from the membership; or make changes to the level of cover. The Policy Holder is the only person authorised to cancel the membership, but anyone over the age of 18 can request to remove themselves from a family membership.

To add or remove someone from a membership, please contact us – we can do this over the phone or send your request to **iself@phoenixhealthfund.com.au**.

A new person added to a membership may be subject to waiting periods. Please refer to the Waiting Periods information on page 14 for more information.

Updating contact details

It is a legislative requirement and a condition of membership that we hold a current residential address for each policy and that these details are kept up to date. You can update your details at any time by logging in to the Online Members Services (OMS) portal, or by contacting us via email or phone.

Premiums are subject to State-Based-Pricing, so it is a requirement of iSelf membership that you contact us should your residential circumstances change.

Changing your level of cover

Membership cover can be changed by logging into Online Member Services (OMS) or emailing your request to **iself@phoenixhealthfund.com.au**.

If you are upgrading your cover, waiting periods will apply before benefits are paid at the new insured level of cover.

If you are downgrading your cover, ensure that you are aware of any services you may be excluding or restricting in doing so, as these services will be subject to waiting periods for future upgrades and changes.

Your contributions

When joining iSelf, you agree that contributions will always be paid up to date. Contributions are paid in advance and can be paid up as far as either 12 months in advance, or to 30 June of the following tax year.

Contributions can be paid by Direct Debit out of your bank account, Visa or Mastercard, and can be deducted weekly, monthly or quarterly. You can manage your Direct Debit through iSelf Online Member Services (OMS).

> **Note:** As iSelf is brought to you by Phoenix Health Fund, any direct debit deductions will appear on your bank statement as Phoenix Health.

Arrears

Benefits and services are not payable while your membership is in arrears. Claims for services received during the period your membership is unfinancial will only be payable once your contributions are up to date.

If your membership falls into arrears of 90 days or more, your membership may be terminated from the last financial date, and all waiting periods will apply on re-joining.

Cancelling your membership

Only the Policy Holder is authorised to cancel a membership. This can be done via email or contacting an iSelf team member.

A membership can be cancelled from either the financial date of the policy, the day after your last claim or a nominated future financial date of the cover. Any contributions paid in advance of your cancellation date will be refunded to you.

Termination of your membership

iSelf reserves the right to terminate your membership in the following instances:

- Your membership contributions fall into 90 days or more arrears (and we have not been able to contact you);
- We believe there has been improper conduct – for example, giving false or misleading information when completing an application, lodging a claim or answering a request for information from the fund;
- We believe a member has attempted to obtain advantage or monetary gain;
- Where there has been a pattern of inappropriate behaviour; or
- We believe a member has attempted fraudulent activity.

Under legislation we are required to notify you and our regulator APRA should we have to terminate your membership in the above circumstances with the exception of cancellation due to arrears.

Suspending your cover

Temporary Suspension of Membership due to Overseas Travel

If you are travelling overseas for a minimum of 21 days, up to a maximum of 2 years you can apply for a *Temporary Suspension of Membership due to Overseas Travel*.

Your application to suspend your cover must be approved by iSelf prior to your departure from Australia by completing a *Temporary Suspension of Membership – Overseas Travel Form* available from our website or by calling the iSelf Team.

To be eligible to suspend your membership, you must have been an active and financial member for a minimum of 6 months and your contributions will need to be paid up to the date of departure.

When you return home, we will require proof of your travel – e-tickets or boarding passes showing your exit and re-entry back in to Australia – within 30 days of your return or suspension end date to reactivate your membership.

Failure to re-activate your membership or provide confirmation of travel may result in the cancellation of your suspension and/or termination of your membership from the suspension commencement date.

Any days a Membership is suspended do not count towards waiting periods and are not eligible for the Medicare Levy Surcharge exemption. Benefits are not claimable for the period the membership is suspended. Please refer to the *Temporary Suspension of Membership – Overseas Travel Form* for full details and eligibility criteria.

Temporary Suspension of Membership due to Financial Hardship

iSelf offers temporary suspension of membership to members who are experiencing genuine financial hardship for a minimum of 1 month, up to a maximum period of 12 months.

Temporary Suspension of Membership due to Financial Hardship applications are assessed by the fund on an individual basis for eligibility.

A member must have been a Financial Member of the Fund for at least 2 years prior to eligibility for Financial Hardship Suspension. If at the end of the suspension period the member cancels their policy, the membership will be cancelled from the suspension start date.

Any days a membership is suspended, do not count towards waiting periods and are not eligible for the Medicare Levy Surcharge exemption. Benefits are not claimable for the period the membership is suspended. If you are experiencing financial hardship, please contact an iSelf team member to discuss your options and for full terms and conditions.

Hospital Cover

What does Hospital Cover include?

Day surgery	Overnight accommodation
Theatre fees	Intensive care unit
Medicare recognised procedures	Private room (where available)
Specialist Surgeons, Anaesthetists and Assisting or Attending Doctors fees	In-hospital Pharmacy
In-hospital Pathology	In-hospital medical supplies

When you're admitted into a Public Hospital it's your choice whether you elect to be admitted as a public patient (your stay will be covered by Medicare), or a private patient (your admission will be covered by your private health insurance). Where you elect to be covered as a private patient in a public hospital, you will be eligible for accommodation benefits paid at a shared ward rate. This means should you be given a private room, you may end up with out of pocket expenses.

What treatments are covered under your membership will depend on the level of cover you have selected, so you should always refer to your individual cover information sheet to find out what you are specifically covered for, and if you are ever not sure, contact us and we can check your cover and make sure you have served all waiting periods prior to your admission.

Is there anything that my Hospital Cover won't cover?

Private Hospital Cover can only provide benefits towards services received when you are admitted into hospital, or where the fund has arrangements with providers for services such as Chronic Disease Management and Obstetric programs. There are some services that your hospital cover does not provide benefits for:

- Medical benefits for treatment received while not admitted into hospital. – i.e. outpatient services, GP and Specialists visits,
- Treatment received in the Emergency Department of a hospital, including emergency department facility fees, and
- Treatment that does not have a Medicare item number.

Exclusions and restrictions

What is an exclusion?

When a service is excluded under your hospital cover there will be no benefit payable where the service is the primary reason for admission in a private or public hospital.

What is a restriction?

Restricted cover provides cover in a public hospital as a private patient. If you have restricted services and you are admitted to a private hospital, there will be no benefit payable for any theatre fee charges and a reduced benefit will apply towards your accommodation fees. This means you may be faced with considerable out-of-pocket costs in a private hospital.

Hospital Treatment Product Tiers

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

✓

Indicates the clinical category is a minimum requirement of the product tier. The clinical category must be covered on an unrestricted basis.

✓R

Indicates the clinical category is a minimum requirement of the product tier. The clinical category may be offered on a restricted cover basis in Basic, Bronze and Silver tiers only.

RCP

Restricted cover permitted: Indicates the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories on a restricted or unrestricted basis.

✘

An X indicates that the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories, however it must be on an unrestricted basis.

Clinical categories

All hospital covers are required to include the minimum clinical services, as set out above, to meet the categories of Gold, Silver, Bronze or Basic. Where a Silver or Bronze cover includes additional clinical services it maybe classified as Silver Plus or Bronze Plus and these categories must be included in the product name to ensure that consumers have a clear guide for easy product comparison.

What hospitals am I covered in?

We have agreements with over 550 private hospitals throughout Australia. So you feel confident knowing we cover a hospital near you.

Are there particular doctors I have to see, and if so, how can I obtain a quote for their services?

Having iSelf Hospital Cover is all about giving you choice. You have more choice and flexibility in choosing your Doctor and where and when you are treated.

As an iSelf member you have access to over 36,000 Doctors who participate in the Access Gap Cover Scheme. Where your Doctor agrees to participate in Access Gap for your procedure, you will either reduce or eliminate any out-of-pocket costs that may otherwise be incurred during your hospital admission.

Will I have to pay anything towards my treatment in hospital?

For all Hospital procedures covered by Private Health Insurance, Medicare sets a scheduled fee.

When a Member has a procedure as a Private Patient, iSelf and Medicare will cover 100% of this scheduled fee.

Often though, Doctor's charges will exceed this scheduled fee and as such it becomes the Member's responsibility to pay any Gap that is in excess of the Medicare Scheduled Fee, unless the Doctor participates on our gap cover scheme.

Whenever you require hospitalisation as a Private Patient, your Doctor will need to obtain your Informed Financial Consent, which outlines the fee structure for their services, including any out of pocket expenses that are your responsibility.

We always recommend asking your Doctor if they will participate in the Access Gap Cover Scheme and remember to contact us prior to seeing your specialist or booking hospitalisation so that we can assist you, answer any questions so you can make the best decision for yourself.

Access Gap Cover Scheme

iSelf members with private hospital cover can eliminate or reduce out-of-pocket expenses for in-patient hospital treatment where the doctor agrees to participate in our Access Gap Cover Scheme for a particular procedure.

We currently have agreements with over 36,000 doctors who can participate in Access Gap. It is however each doctor's choice whether to participate and is decided on a case by case, patient by patient basis.

Effective 1 July 2020, the maximum gap a participating Doctor will be able to charge is $500.

Before booking any treatment, you should ask your doctor to explain the costs involved for your hospital admission, any fees or gaps you may be charged, including anaesthetist and assistant surgeons. If there are any gaps for you to pay, ask for a written cost estimate. This is known as Informed Financial Consent.

Looking for a doctor that participates in the Access Gap Cover Scheme? You can quickly search for a doctor or specialist by visiting our search tool **iself.com.au/providers**.

What questions should I ask my doctor?

Before any treatment, we recommend you ask your doctor these 3 questions;

1. Will you participate in the iSelf Access Gap Cover Scheme for my procedure?
2. Will I have any out-of-pocket expenses, and if so, please provide a written estimate of how much?
3. Will any assisting doctors also use Access Gap Cover and if so, how can I obtain a quote for their services?

Your rights in a public hospital

If you find yourself admitted to a public hospital, it's your choice to be treated as a private or public patient. If you're feeling pressured to make a choice, contact us – we're here to support you throughout your hospital journey.

Going to Hospital?

This is what we know and where we can really help you out. As soon as you find out you'll need a hospital admission contact us so you can be confident in what to expect. We'll talk you through minimising doctor's fees and any other out-of-pocket costs as well as check your cover and discuss any pre or post-hospital support programs that we may have available for you.

Let us help you, so you can focus on what's important; we're here for you.

Hospital Excess

An Excess is an amount you agree to pay towards your treatment if you are hospitalised, usually to reduce the premium of your cover without compromising what you are covered for.

On most iSelf hospital covers you have the option to choose your excess level to suit your situation, and potentially reduce your premiums.

An Excess is payable on same day (day surgery) and overnight hospital admissions once per person, per calendar year.

Here's an example of how it works with one iSelf hospital cover:

Excess example: You have iSelf Gold Class Hospital cover with a $500 Excess

On admission to hospital you pay your $500 excess to the hospital for your first admission.

If you are re-admitted in the same calendar year, you will not have to pay your excess again.

The Excess does not apply to dependant children on your membership.

Hospital Co-Payment

A Co-payment is an amount in addition to your nominated excess, that is payable by you every time you are admitted to hospital for a minimum of one night (i.e. not day surgery).

Co-payments apply to selected iSelf Hospital covers, see the examples listed here, or the website for more information.

Here's an examples of how it works with an iSelf hospital cover:

Co-payment example: You have iSelf Gold Class Hospital 500 Excess & CoPay which has a $500 Excess and $500 Co-payment.

On admission to hospital you pay your $500 excess and you stay for one night, and therefore are also required to pay your $500 co-payment.

If you are re-admitted in the same calendar year (again for one night), you will not have to pay your excess, however you will still be required to pay a $500 co-payment.

The co-payment is capped at $1,000 per person, per calendar year so if you are readmitted again in the same calendar year you will not need to pay your excess or co-payment.

Co-payments do not apply to day surgery admissions or to dependent children on your membership.

Still have questions?

If you're planning a hospital admission and aren't sure how the Excess and Co-payment applies to your chosen cover, contact the iSelf Team prior to being admitted to hospital; **we're here to help.**

Hospital Care programs

Before-During-After Hospital Programs

At iSelf we understand that our members may also need assistance pre or post a hospital admission and that's why we offer before, during and after hospital assistance, mental health and chronic disease management programs.

Member Care Programs

Because we care about our members, we offer services beyond hospitalisation to keep you well when you need it most. Our before, during and beyond program provides services such as rehabilitation in the home, early hospital discharge programs, diabetes support and education and mental health support.

These programs are provided by trained health professionals in co-ordination with your GP or Specialist.

To find out more about Before-During-After Hospital Programs and Member Care Programs, including eligibility criteria and how to enrol, contact us.

Hospital Assistance Package

Our Hospital Assistance Packages recognise the need for benefits in rural and regional areas.

If you, a spouse or dependant have Hospital Cover and are required to travel over 300 kilometre's return for medical treatment, a benefit up to $200 for travel expenses can be claimed.

In addition, if you, a spouse or dependant is admitted to a private hospital for treatment a benefit of $60 per night for the duration of hospitalisation can be claimed to assist with parent/spouse accommodation costs.

Please contact the iSelf Team to confirm your eligibility for this benefit or visit the website for more information.

Hatchling Program

Preparing to welcome a child into the world is the beginning of a new, exciting stage in your life. With this in mind, we offer the Hatchling Support Program to provide ongoing support from the time of your pregnancy to the first 8 weeks of your baby's life.

The program includes services such as:

- ✔ 2 gap-free midwife consultations
- ✔ Post-natal advice on a range of topics
- ✔ Baby development and what to expect
- ✔ First Aid for babies
- ✔ General parenting support

This program is available to members to who qualify for pregnancy benefits (please refer to waiting periods on page 14). You can enrol in The Hatchling Program by completing the enrolment form on our website and emailing it to iSelf.

Extras Cover

iSelf Extras cover is available for purchase in conjunction with an iSelf Hospital cover product.

What does Extras cover include?

Extras cover provides benefits towards services where there is no Medicare rebate – for example, everyday treatment like dental, optical and physiotherapy.

The services and benefits you can claim will depend on your level of cover, so it's important that you choose the cover that suits your needs. Please refer to your individual cover information sheet for more information or visit our website for information about available levels of cover.

Can I visit a provider of my choice?

Do you love your current physio, dentist or health professional? At iSelf your preferred provider is ours too. We don't lock you into any preferred provider schemes – we believe that the choice is yours- you'll get the same great benefits no matter who you choose to treat you.

That's why at iSelf, it's all about you!

Limits

Unless otherwise detailed on your cover information sheet, benefit limits are per person, per calendar year, and as such reset on 1 January each year.

Benefit limits are transferrable between funds, so when you transfer to iSelf, any services you have claimed in the current calendar year will be subject to your new annual limit with iSelf.

Sub-limit

Some benefits have overall limits and a sub-limit. A sub-limit is part of an overall limit and indicates the total amount claimable for that particular service or group of services.

Combined limit

Some services have combined limits, meaning they share their overall limit, and or a sub-limit with one or more other services.

Lifetime limit

Some services, such as Orthodontic treatment, have a lifetime limit. This means that the particular service has one limit for last the lifetime of the membership and does not refresh each calendar year.

Are there any times I can't claim on my Extras cover?

There are some instances where a benefit is not payable under your Extras cover, these include:

- where a service attracts a Medicare benefit
- where treatment is received outside of Australia
- where a treatment is received while admitted in hospital
- towards experimental treatments or clinical trials
- where the service was provided free of charge
- where a service is provided over the phone or online
- where a treatment is provided by a family member/relative or business partner
- where a provider is not registered
- where multiple services are rendered on the same day by the same provider for the same condition (benefits will only be payable towards the first service)

Benefits are not claimable when:

- you have not served the relevant waiting period
- where you have reached your limits
- were you are not covered on your membership for a specific treatment or service
- where you have not provided supporting documentation where relevant
- your membership payments are in arrears
- where a service or treatment can be claimed through a third party.

Pay nothing for preventative dental

Gap free dental comes as standard as a part of the General Dental limits on all current levels of Extras Cover.

And because we don't lock you into any preferred providers, you can keep smiling all year round with 100% back on selected services like a check-up and clean twice a year at a Dentist of your choice!*

*Gap free services include but are not limited to oral examinations, scale and cleans and fissure seals. For a full list of eligible item numbers see individual product information sheets available on the website or contact the iSelf Team. Limits and exclusions apply. Preventative Dental is included in General Dental limits and as such, Gap Free benefits will be paid where there are available General Dental limits remaining.

Benefit Rules

The following benefits do not apply to all levels of cover, please refer to the information sheet specific to your cover for eligibility.

Orthodontics

Cover that provides orthodontics has per person, annual and lifetime limits. Claims for this service can be submitted by completing a claim form or via the iSelf App. The claim must include a copy of the itemised invoice. When claiming orthodontics for the first time, the initial claim must include the supporting treatment plan from your Orthodontist.

Optical

Optical benefits apply to prescription spectacles, prescription sunglasses, or contact lenses. No benefit is payable towards glasses where a prescription for sight correction is not required.

Non-PBS Pharmaceuticals

Non-PBS Pharmaceutical benefits are payable on any private prescriptions that are not listed or subsidised by the PBS. Prescriptions can be purchased at any registered Pharmacy. To claim you will need to pay for the prescription in full and send in a claim, including the itemised invoice for the purchase.

Your benefit will be applied, as per your level of cover after the PBS member co-payment (currently $41.30 effective 1 April 2021), up to your annual limits.

Pharmaceutical benefits do not apply to items purchased over the counter, or prescriptions priced under the PBS member co-payment amount.

Orthotics

Podiatric orthotic devices are only claimable when custom-made through a podiatrist or registered orthotist. No benefit applies to orthotics purchased over the counter.

Psychology

Medicare benefits are available under the Government's Mental Health Care Plan when a doctor's referral and Care Plan is initiated for treatment provided by a registered psychologist. Where this service is provided through a Care Plan, you cannot claim any out of pocket charges under your iSelf Extras policy.

You can claim for psychology treatment under your Extras policy where there is no Medicare rebate or there is no Medicare item number raised on the account.

24/7 Claiming with iSelf

If you can't swipe your card at the time of your treatment, download the iSelf App from the App Store or Google Play or login to the iSelf Online Member Service (OMS) portal at **members.iSelf.com.au** and take a photo of your itemised account to submit your claim.

Aids to Recovery

Benefits are payable on the purchase of a number of aids and appliances that assist in recovery after treatment for a chronic medical condition as a hospital inpatient or where a medical practitioner states the appliance is required. For example: blood pressure monitors, blood glucose monitors, nebulisers, toilet seat raisers, wigs, bras or swimsuits after mastectomy(s), pregnancy recovery pants, shower chairs. If you require a particular Aid, please contact the iSelf Team to check your eligibility criteria.

No benefit is payable towards the hire of aids or appliances, or for second hand goods or consumables.

Aids or appliances must be purchased from an Australian healthcare provider, and the claim must be accompanied by a referral from your doctor outlining the condition associated for the aid or appliance or supported by a hospital admission in the previous 6 months prior to purchase.

Healthy Lifestyle Programs

Benefits are payable towards healthy lifestyle programs that form part of a health management program and must be designed to manage a specific health condition as recommended by a doctor or health professional.

Healthy Lifestyle Programs include:

- Health screening: a benefit is payable for diagnostic testing services where a Medicare benefit is not claimable. Contact the iSelf Team for a full list of covered diagnostic tests.
- Health Education Programs:
  - **Quit smoking courses:** Benefits are payable for courses such as: quit smoking, smoke enders or organisations registered in Australia and who charge a fee. There is no benefit for laser therapy.
  - **Weight Management programs:** Benefits are payable for Weight Watchers and Jenny Craig, no benefit is payable for food or supplements or for laser therapy.
  - **Asthma management courses:** provider must have an association with the Asthma Foundation or be an accredited educator.
  - **Diabetes classes:** provider must have an association with Diabetes Australia or a be registered with the Australian Diabetes Educators Association.

To claim for the following services a Healthy Lifestyle Program Treatment Plan must be completed by your treating health professional and submitted to iSelf. You can download a Healthy Lifestyle Treatment Plan Form from our website or contact the iSelf Team.

- Health Programs: such as gym and fitness memberships, as recommended and designed by your health care professional to manage chronic health conditions.
- Swimming Classes: for dependant children at AUSTSWIM or Swim Australia swim centres to assist with a medical condition. i.e. asthma, joint conditions.

Ambulance

At iSelf, we understand that sometimes things in life just happen, and we want to give you peace of mind that you are covered when you need it.

That's why, on all of our Hospital covers, we provide unlimited cover for all medically necessary emergency and non-emergency ambulance treatment and transport across Australia - road, sea and air.

Some Extras only covers have limited ambulance services, so make sure you refer to the individual cover information sheets for the limits available.

Ambulance cover only has a 1 day waiting period, so you can feel confident in knowing we've got you covered.

Medically necessary means on-site treatment or transport to your closest hospital or emergency department for treatment of an acute medical condition or accident.

Where an Ambulance is claimable through another source, including a state Ambulance subscription, the service should be claimed through the other source first.

Claiming

Hospital Claiming

Where an Excess applies you will be required to pay this directly to the hospital prior to admission or on discharge from hospital.

Where you are admitted to hospital the account will, in most cases, be sent directly to iSelf for payment.

For in-patient specialist claims, if the doctor is participating in the Access Gap Scheme, the doctor in most cases will send the accounts directly to iSelf to be processed. Your doctor will invoice you for any known gap for you to pay.

If your specialist is not participating in the Access Gap Scheme, you may be required to submit the account directly to Medicare before claiming from iSelf.

In some instances, after a hospital admission, you may receive accounts for services you received while in hospital. If this occurs, call the iSelf Team and we can assist you on the process to submit a claim.

Extras Claiming

The quickest and easiest way to claim your Extras services is to carry your iSelf member card with you and swipe it at the time of your treatment. Then all you need to do is pay the difference… if there is one!

If you don't use your member card to claim benefits on-the-spot you can submit your claim via:

- **The iSelf mobile claiming app** – register or log in, take a photo of your invoice and submit.
- **Filling in a Claim Form.** Download a Claim Form from our website and send the completed form with a copy of your invoice to: **iself@phoenixhealthfund.com.au**

When submitting a claim to us, we will need you to provide following information:

- your itemised invoice and/or receipt showing the date of service, who the service was for, the item number(s) and what service was provided,
- your iSelf membership number,
- the details of the service provider and
- whether or not the account has been paid.

Benefits are paid into your nominated bank account. Simply register your details online via the Online Member Services (OMS) if you haven't already. Claims generally take 3-5 business days to be processed and credited into your bank account with confirmation of the payment.

Claims must be submitted and assessed within 2 years of the date of service. Claims older than 2 years are not payable.

When processed, benefits will apply to; and are deducted from the yearly limits of the year in which the service was received.

Compensable Claims

Benefits are not payable where a member is eligible to receive compensation for the treatment, service or item.

Where there is a possibility that a member may have the right to receive compensation for a claim, they must inform iSelf as soon practical. Benefits will still be payable however the fund may request an irrevocable authority be completed and the fund should be kept informed on the progress of the compensation claim and notified of any outcome.

iSelf has the right to request further information and evidence in cases where the claim may be compensable through a third-party source.

For full details of Compensation Damages and Provisional Payment of Claims, refer to the Phoenix Health Fund Rules.

Waiting Periods

Waiting periods apply to cover before a claim can be made, they vary from 2 months up to 12 months depending on the service. New members to private health insurance will have to serve the relevant waiting periods before claims can be paid.

New members transferring from another health insurer who have previously qualified for benefits will not be required to re-serve waiting periods for equivalent cover.

Waiting periods apply if you are new to Private Health Insurance, when you upgrade your cover, to any exclusions you may have had with a previous fund, or if you haven't completed your waiting periods. The waiting times that may apply are detailed below.

Hospital cover

Pre-existing conditions (Excluding Hospital Psychiatric services, Rehabilitation and Palliative care)	12 months
Pregnancy and birth and assisted reproductive services	
Hospital Psychiatric services, Rehabilitation and Palliative care (Regardless of whether they are pre-exiting or not)	2 months
All other conditions requiring a hospital admission, that are not considered pre-existing	
Hospital Care programs	
Accident cover	No waits

Extras cover

Major Dental, Orthodontics, Aids to Recovery and Hearing Aids	12 months
Optical	6 months
All other services	2 months

Ambulance

Ambulance	1 day

Waiting periods for pregnancy and birth related services

When you join or change your cover to include pregnancy and birth related services, there is a 12-month waiting period from that date before benefits are payable. The twelve-month waiting period applies to the delivery date of the baby (not the expected due date).

Waiting periods for newborns and adopted or foster children

When a newborn is added to a family membership within 60 days of their birth, they are deemed to be covered from their birth date. Adopted or foster children can receive immediate cover (except for pre-existing conditions for Hospital cover and the standard Extras waiting periods), providing they are added to the family membership within 60 days of the legal guardianship date, and the relevant documentation is provided.

Transferring from another fund?

When you transfer between health insurers, you don't have to re-serve waiting periods already completed for equivalent cover. However, in the following circumstances waiting periods would still apply:

- Where you have had a gap in cover of 30 days or more between cancelling with your previous fund and joining iSelf, full waiting periods will apply.
- For any services or benefits that were not covered, excluded or restricted under your previous cover.
- To any upgrade in cover – including benefits or limits or excess amounts – when joining iSelf.
- Where you haven't fully qualified for benefits with your previous fund, you will need to complete the waiting period before you can have access to claim.

When you transfer from another fund to iSelf, we take care of your cancellation and request a copy of your Transfer Certificate. This certificate confirms waiting periods or Lifetime Health Cover loadings that may apply to your policy.

Any limits you have accessed with your previous insurer will be deducted from the limits of your iSelf membership for the current calendar year.

Pre-existing conditions

Pre-existing conditions (PEC) are subject to a 12-month waiting period from the commencement date of hospital cover, or an upgrade in level of cover. Psychiatric services, rehabilitation and palliative care are an exception to this rule, in which a 2-month waiting period will apply, regardless of whether they are pre-existing or not.

What is a pre-existing condition?

A pre-existing condition is any illness or ailment that, in the opinion of a Medical Practitioner, existed at any point in the 6 months prior to taking out cover or upgrading.

If you require hospitalisation within the first 12 months of commencing hospital cover or upgrading your level of cover, and have served the general 2 month waiting period, the fund may request a pre-existing form to be completed by your regular GP and Specialist. This information would then be assessed by an independent Medical Practitioner appointed by the fund who will determine if the condition is pre-existing or not.

Always contact iSelf prior to any hospital admission, so that we can do a check on your policy, and assist you in the process, to ensure that we will have time to complete the PEC process if you are within the 12-month waiting period. The PEC process can take up to 10 business days, but we will always try to do our best to get the result to you as soon as possible.

If your condition is deemed not pre-existing benefits will be paid at your insured level of cover.

If your condition is deemed pre-existing, please consider the following options:

- If practical, you can wait to have your procedure on completion of your 12-month waiting period,
- You can self-fund your private admission – no private health insurance benefit would apply to your admission; or
- You can speak to a Doctor about having the procedure done as a public patient in a public hospital (speak to your doctor about waiting list times).

Psychiatric upgrade waiver

To improve access to mental health treatment in Australia, the Government have introduced mandatory Psychiatric Hospital upgrade waiver rules.

Where a cover has restrictions or exclusions for hospital psychiatric services and you have served your initial 2 month waiting period, you have the option to upgrade to a cover that provides full hospital psychiatric cover, without having to serve any additional waiting periods on the upgrade for that treatment.

This psychiatric upgrade waiver is available once per person, per insured lifetime and is transferrable between funds and is detailed on a Transfer Certificate.

The waiver does not apply to any excess that may apply on upgrading cover. All other waiting periods still apply.

Please refer to the compensable claims section on page 13.

Accidents

Where a member is within waiting periods for hospital cover and hospitalised as a result of an accident, the mandatory waiting period for that condition will be waived and benefits payable for a private hospital admission where the service is not excluded under the level of cover, excesses are not waived for accidents.

For accident benefits to be assessed, an accident report must be submitted to iSelf along with any other supporting documentation as requested. Please contact iSelf as soon as you are able, and we can guide you through the Accident Cover claiming process.

Waiting periods are not waived where the admission is to a public hospital as a result of an accident.

Benefits are not payable for Accident Cover where they are claimable through compensation or damages, or through another third party insurance policy.

Government incentives and surcharges

Australian Government Rebate on Private Health Insurance

The Australian Government Rebate on Private Health Insurance is a Government incentive that applies towards the cost of Private Health Insurance cover as a reduction of premiums based on your age and income. The table below details the rebate tiers.

Single	≥ $90,000	$90,0001 – $105,000	$105,001 – $140,000	≥ $140,001
Families	≥ $180,000	$180,001 – $210,000	$210,001 – $280,000	≥ $280,001
Rebate				
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.608%	16.405%	8.202%	0%
Age 65-69	28.710%	20.507%	12.303%	0%
Age 70+	32.812%	24.608%	16.405%	0%

These rebate levels are applicable 1 April 2020 to 30 June 2022. The income thresholds are indexed and will remain the same to 30 June 2021. Single parents and couples (including defacto couples) are subject to family tiers. For families with children, the thresholds are increased by $1,500 for each child after the first.

There are a couple of ways you can claim the Government Rebate:

- As a reduction in your iSelf premiums; or
- As a tax offset when lodging your tax return. This would mean your iSelf premiums would have no Rebate applied, and you would pay the full rate, and claim the Rebate portion back through the ATO.

If you nominate the incorrect tier when claiming the Rebate as a reduction in your premiums, either by mistake, or you miscalculate your estimated income for the year, it will all be adjusted when you lodge your tax return. If you are unsure of which Government Rebate you are eligible for, you should contact the Australian Tax Office on 132 861.

Medicare Levy Surcharge (MLS)

The Medicare Levy Surcharge (MLS) is an additional levy paid by Australian tax payers who earn in excess of the thresholds below and do not hold private hospital cover. The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on public hospital admissions.

The surcharge is calculated between 1% to 1.5% of your income for Medicare Levy Surcharge purposes. It is additional to the Medicare Levy of 2%, which is paid by most Australian taxpayers. The table below details the different MLS levels.

Single	≥ $90,000	$90,0001 – $105,000	$105,001 – $140,000	≥ $140,001
Families	≥ $180,000	$180,001 – $210,000	$210,001 – $280,000	≥ $280,001
Medicare Levy Surcharge				
All ages	0.00%	1.00%	1.25%	1.50%

Source: Australia Tax Office. These thresholds apply for the 2020/21 financial year. The income thresholds are indexed and will remain the same to 30 June 2021. Single parents and couples (including defacto couples) are subject to family tiers. For families with children, the thresholds are increased by $1,500 for each child after the first.

For more information on the Australian Government Rebate on Private Health Insurance and the Medicare Levy Surcharge, visit **ato.gov.au** or **privatehealth.gov.au**

Lifetime Health Cover (LHC)

Lifetime Health Cover (LHC) is a Government initiative designed to encourage people to take out Private Hospital cover earlier in life and maintain it. If you purchase hospital cover before your 31st birthday and keep it, you will pay lower premiums compared to someone who joins when they are older. The extra amount is called 'LHC loading'.

LHC Loadings only apply to private hospital cover.

If you take out private hospital cover after 1st July following your 31st birthday, you will pay an additional Loading of 2% per year on top of the base premium, for each year you are over 30.

For example, if you are 40 when you take out Hospital cover you may pay an additional 20% on top of your base Hospital contribution rate. The maximum loading is 70%.

On Couple or Family policies, the Loading is calculated as an average of both adults Loadings. For example, if the policy holder has a 20% Loading and the partner/spouse has a 0% Loading, the overall Loading applied to the membership would be 10%.

Lifetime Health Cover Loadings are transferrable between all Australia Private Health Insurers, and as such if you are transferring to iSelf, we will require a copy of your Transfer Certificate from your previous insurer to confirm your LHC details.

Certified Age of Entry (CAE)

In most cases, your CAE is the age you were on 1 July before you first joined private hospital cover. Your CAE is used to calculate your Loading. The minimum Certified Age of Entry for Lifetime Health Cover purposes is 30.

Exemptions

There are some circumstances in which you may be exempt from the LHC loading:

- If you were born on or before 1 July 1934, you can join a health insurer at any time and pay the same premium as someone who takes out cover at age 30.
- You have been living overseas since before 1 July 2000 or since 1 July following your 31st birthday.
- You have migrated to Australia and became eligible for Medicare in the last 12 months.
- You hold, or have held a Gold Card.
- You are an active member of the Australian Defence Force.

If any of the above exemptions apply, we will require documents providing proof of exemption – for example an International Movement Statement if you have been overseas, or Statement of Medicare Eligibility if you are a new migrant to Australia.

Permitted Days

Permitted Days (or Absent Days) are the days in which you can cancel your hospital cover without your Certified Age of Entry changing when re-joining. Permitted Days are only accessible if you hold hospital cover and locked in your Certified Age of Entry.

You can cancel your hospital cover for a total accumulative period of 1094 days (3 years less one day). Once you have exceeded 1094 days, a 2% Loading will then be applied for each year to your Certified Age of Entry.

You can cancel your hospital cover without using your Permitted Days or affecting your Certified Age of Entry or Lifetime Health Cover Loading when:

- You have suspended your membership, or
- You are overseas for at least 12 consecutive months. You are eligible to return to Australia for up to 90 days at a time and still be considered overseas. Any periods of more than 90 days you spend in Australia will be deducted from your 1094 Permitted Days.

Removal of LHC Loading after 10 years

If you have LHC loading, it can be removed once you have held private hospital cover for 10 continuous years.

Once 10 years of continuous hospital cover is completed, you are entitled to use the 1094 Permitted Days – if you haven't done so already. If you exceed 1094 Permitted (Absent) Days, the loading will be applied at 2% for each year. This loading will apply again for 10 years.

Age-based Discount

If you are aged between 18-29 you may be entitled to a discount of up to 10% on the hospital component of your premiums. This discount was introduced to private health insurance on 1 April 2019 and is optional for all insurers and is available on all open levels of iSelf Hospital cover.

The Age-based discount is calculated at 2% to a maximum discount of 10% depending on the age you join an eligible hospital cover and it is retained until the age of 40. After the age of 40 the discount will reduce by 2% per year.

On Couples or Family policies, the discount is calculated as an average between the individual discount of the two adults. For example, if one person has a 10% discount and the other person has a 6% discount, the total discount applied to the policy is 8%.

For more information about the Lifetime Health Cover loading or the age-based discount, visit **ato.gov.au**, **privatehealth.gov.au**

Code of Conduct

Self Assured (branded iSelf) is proudly a member of the Private Health Insurance Intermediaries Association (PHIIA). Being bound by their code of conduct, our undertaking to you, the customer, is to ensure we are putting your best interests first and providing the highest quality of service and professionalism.

iSelf is issued by Phoenix Health Fund Limited who is a signatory to the Private Health Insurance Code of Conduct. The Private Health Insurance Code of Conduct was developed by the industry to promote informed relationships between insurers, consumers and intermediaries.

The Code is designed to assist you by ensuring that:

- Any information you receive is transparent and easy to understand and provided in plain English;
- You will receive the correct information on private health insurance from adequately trained iSelf (and Phoenix Health) employees;
- All information between you, Self Assured (branded iSelf) is protected in accordance with national Privacy Principles;
- You have access to an internal and external dispute resolution process, in the event that you have a dispute with us Code of Conduct.

For more information about the PHIIA Code of Conduct, visit **phiia.com.au**

To learn more about the PHI Code of Conduct, visit **privatehealthcareaustralia.org.au/codeofconduct**

Privacy Statement

At iSelf we are committed to protecting and maintaining the privacy of all our members and people who deal with us. We are also committed to complying with the Privacy Act 1988 (Cth) (the Privacy Act) and the Australian Privacy Principles (APPs).

This is a summary of our Privacy Statement, which explains how we manage the personal information which we collect, hold, use and disclose. It also explains how to contact us if you have any further queries about our management of your personal information. This policy applies to you only to the extent that the collection and handling of your personal information by us is subject to the Privacy Act.

For more information about the iSelf Privacy Policy, visit **iSelf.com.au**

Your personal and sensitive information

Personal information is information about an individual, or from which the person is reasonably identifiable, and may include personal sensitive information.

We only collect personal information about you which is reasonably necessary for our functions or activities.

The type of personal and sensitive information we may collect, and can include but is not limited to:

- contact details such as your name, date of birth phone number, residential address and email address;
- government related identifiers such as your Medicare number;
- financial information such as your bank or credit card details;
- call recording and notes taken during conversations and interactions with you;
- details of products and services we have provided to you, you have enquired about;
- historical information such as your prior insurance claims.

All information we collect, and hold is done so in accordance with our Privacy Policy.

How do we collect your personal and sensitive information?

We only collect personal information about you in the manner permitted by the Privacy Act.

We may collect your personal information from you in a number of ways including in person, by phone, through our website or by email. We may also collect your personal information from third parties, such as from our health service providers. We may also collect your personal information from organisations engaged by us to carry out functions on our behalf such as claims administration.

For what purposes do we collect, hold and use your personal information?

We collect, hold and use your personal and sensitive information for the following purposes including but not limited to:

- to provide our products and services including private health insurance;
- to perform the functions and activities related to our business such as processing your claims and paying your benefits;
- in order to comply with legislative and regulatory provisions;
- to assist members in complying with taxation obligations;
- to manage our relationship with you including by contacting you about products or services, news or community events which we think may be of interest to you;
- to investigate and resolve complaints; and
- for marketing initiatives; to develop health insurance products, benefits and offerings.

Who do we disclose your personal information to?

For us to carry out the above-mentioned purposes, we may disclose your personal information to persons or organisations such as our health service providers, professional advisers and regulatory bodies, or third parties with whom we have retained to improve membership and offerings. We may also disclose your personal information to the organisations, such as health service providers and payment system processors, from whom we collect your information.

We may also disclose your personal information to other persons covered by your membership where they have been given the authority from you.

Marketing

We may use your personal information to contact you (including by phone, text message or email) about products or services which we think may be of interest to you. This may include our own, our related body corporate's or a third party's products or services. In particular, we may contact you about products and services we think may be of interest to you after you cease to hold a private health insurance policy with us. For example, we might contact you about renewing your old policy or taking out a new policy.

You may opt-out of receiving marketing information from us and our related bodies corporate by:

- calling us on **1800 GO SELF (1800 467 353)**,
- emailing **iself@phoenixhealthfund.com.au** or
- ticking the relevant box on the application form when applying for one of our products or services.

Please note that you cannot opt-out or unsubscribe from receiving correspondence directly relating to the maintenance of your membership.

What if you don't want to give us your personal information?

You're not required to give us your personal information. However, we may not be able to provide you with the products or services that you request of us. For example, it is a legislative requirement that all Private Health Insurance memberships hold a current residential address.

When you contact us, you generally have the right not to identify yourself, where it is lawful and practical for us to allow it. However, in not providing us with your personal identifying information we may not be able to assist you or aid in answering your query.

How can you access and seek correction of personal information held by us?

You can access or seek correction of your personal information by:

- calling us on **1800 GO SELF (1800 467 353)**;
- emailing us at **iself@phoenixhealthfund.com.au**

We will give you access to your personal information if practicable and will take reasonable steps to amend any personal information about you which is inaccurate or out of date.

We may refuse you access to, or we may refuse to correct, your personal information in certain circumstances permitted by the Privacy Act. In such a case, we will provide you with written notice of the reasons for our decision. We do not charge a fee to give you access to your personal information. However, we reserve the right to do so depending on the nature and extent of your request.

Your responsibilities

It is a condition of your iSelf membership that you keep your personal information correct and up to date, and that, as the Policy Holder, you make everyone listed on your membership aware of the iSelf Privacy Statement.

Feedback and making a complaint

We strive to provide you with the best, most personal health insurance experience possible, so if you would ever like to provide feedback, or if you need to raise a complaint in regard to your membership, please don't hesitate to contact us, so that we can receive your concerns and come to a resolution for you as quickly as possible.

Step one: Contact us

We appreciate and take your feedback seriously. If you have feedback, please contact us via the details below.

Call us

1800 GO SELF (1800 467 353)

Email us

iself@phoenixhealthfund.com.au

Step two: Escalation

Once you have contacted us as above, if you are not happy with the outcome the matter can be escalated internally to the Member Service Manager and if required the Chief Executive Officer.

Step three: External review

If, after our best efforts, you are still not satisfied with our review and result of your concern, you can escalate your issue to the Commonwealth Private Health Insurance Ombudsman (PHIO).

Online

ombudsman.gov.au

Phone

1300 362 072

We're here to help

Visit us online: iself.com.au
Phone us: 1800 GO SELF (1800 467 353)
Email us: hey@iself.com.au
Download the iSelf App: Available from the App Store or Google Play

Information is current at 1 May 2021. This iSelf Member Guide should be read and retained, in conjunction with the product information sheets, the iSelf website and iSelf Rules. Contact the Member Service Team on **1800 GO SELF (1800 467 353)** or email **iself@phoenixhealthfund.com.au** if you have any questions about your cover, or if you are requiring treatment.

iSelf

Phoenix Health Fund

iSelf is issued by Phoenix Health Fund