Phoenix Health Fund

Member Guide | 1 April 2025

At Phoenix Health, we proudly put members first, and for over 70 years we've continued to offer members quality and affordable, personal health insurance.

We're not for profit! We're owned by members – run by members – for the benefit of our members. So, what this means is we are able to invest member contributions back into the fund, providing more back in benefits to our members, rather than paying back into shareholders pockets.

Happy members make us happy!

Our members are at the forefront of everything we do, and supporting their health and wellbeing is our priority – it is our commitment to you to ensure that through personal care and service, we are there for you not only in times of sickness, but through maintaining health as well.

Looking after our members for over 70 years

At Phoenix Health Fund, we've been providing personal health insurance for over 70 years, so you could say we're the best kept secret in health insurance!

While a lot has changed in the time we've been around, the one thing that has remained the same is our focus on protecting every one of our members.

Phoenix Health was originally established in 1953 exclusively for the employees of Stewarts & Lloyds. Through the years we have continued to provide health insurance to the many companies that represent Stewarts and Lloyds and are now proudly operating to provide Private Health Insurance to all Australians.

Owned by members, run by members, for the benefit of members.

Contents

A few reasons why you'll love Phoenix Health

Committed to our member's health and wellbeing

Our members are at the forefront of everything we do... supporting their health and wellbeing is our priority. We love to help and pride ourselves on providing the best in personal health insurance - we're here for you!

Your preferred provider is our preferred provider too

There's nothing much more personal than your health, so instead of a preferred provider network, we think it's important that you're free to be treated by whoever you choose and still get the same generous benefits.^

Swipe your member card with confidence

We're ending the `swipe and hope'! With set percentage benefits on our Extras covers, you can be confident in knowing how much you'll get back for a treatment whenever you swipe your card.

Ambulance Cover... because accidents happen

We get that sometimes accidents happen, and that's why we cover Ambulance treatment and transport where medically necessary, Australia-wide - so you're ready to expect the unexpected.*

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 may reduce the length of time you might wait for treatment in the public system and also avoid possible Government penalties like the Medicare Levy Surcharge or Lifetime Health Cover loading.

With Phoenix Health Extras Cover, you can enjoy further savings on everyday services like dental, optical and physiotherapy treatment.

Keeping our members safe

At Phoenix Health, we care about your security and are committed to ensuring that you feel safe and protected. As part of this commitment, we may need to verify your identity when you join and occasionally thereafter, in line with our Fund Rules and Privacy Policy. This helps us keep your personal information secure, prevent unauthorised access, and reduce the risk of fraud or misuse. **For more information please refer to our Privacy Policy available on our website.**

Membership

Switching to Phoenix Health

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 19 or for information on government surcharges see page 21.

Ready to love Phoenix?

Joining is easy and takes less than five minutes.
Simply visit **phoenixhealthfund.com.au** to join online or call **1800 028 817** to join over the phone.

Phoenix membership is open to all Australian residents, and those who have Medicare eligibility.

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 Phoenix have paid you a claim, premiums will only be refunded from the day after the date of the service.

Any refunds of premiums within the 30 day cooling off period will be processed to the same credit card or bank account the payment was taken from.

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 028 817 – we're happy to help.

*^ Benefits are payable at registered providers only. *One (1) day waiting period applies to emergency and non-emergency Ambulance cover. Medically necessary means on-site treatment or transport to the closest hospital or emergency department for treatment of an acute medical condition or accident. Waiting periods, limits and exclusions apply, please refer to Cover Information sheet for specific product information and eligibility. Any additional treatments will be payable according to your level of cover.*

Phoenix Health Rewards

Get more from your membership with Phoenix Health Rewards

At Phoenix Health we want you to be getting the most value from your membership and you deserve to be getting additional perks... just for being a member. That's where Phoenix Health Rewards comes in! Included with your Phoenix Health membership, you'll have access to discounted gift cards and member exclusive offers - so you can save everyday.

What is the Phoenix Health Rewards program?

Great value cover with awesome benefits is a given with Phoenix Health; but we want you to be getting the most value from your membership everyday - not just when you need to claim.

By helping you save money on your usual everyday purchases, gifts and even holidays, Phoenix Health Rewards mean we can be there for you in more ways.

How can I save with Phoenix Health Rewards?

Phoenix Health Rewards unlocks a world of discounts and offers - available exclusively to you, our members.

Including access to special member offers like 10% off at Amcal Pharmacies online, up to 12c off per litre on petrol at EG Ampol and discounted e-gift cards at Coles, Woolworths, Dan Murphy's Target and more - you'll be able to save on your everyday purchases.

How do I get started with Phoenix Health Rewards?

Did you know you can manage your membership and access Phoenix Health Rewards all in the one spot - how easy is that!

Visit **members.phoenixhealthfund.com.au** and log into your Online Member Services portal, then follow the link to Phoenix Health Rewards.

Note: the first time you log in you may need to verify your account for added security.

Start saving today... visit rewards.phoenixhealthfund.com.au

Phoenix Health is working in conjunction with Member Benefits Australia (MBA) to bring you the Phoenix Health Rewards program, and does not recommend or endorse any merchants, offerings or services advertised. Stores, offerings and services are subject to their own individual terms and conditions, and may change from time to time.

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.
Non-Student 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 Phoenix Health.
Adult 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, and is not enrolled at an educational facility as a full-time student. Adult Dependants can remain covered on the family policy, for an additional cost, with our *Extended Dependant Cover.*

Membership types

Single	the Policy Holder.
Couple	the Policy Holder and their Partner.
Family	the Policy Holder, their Partner and at least one Dependant (excluding Adult Dependants).
Single Parent Family	the Policy Holder and at least one Dependant (excluding Adult Dependants).
Extended Dependant Cover	for an additional cost, dependants who are not studying and are over the age of 21 (and under 25), can stay on a Family or Single Parent Family membership. Extended Dependant cover is available on most levels of cover (except Extras only policies); to find out if your level of cover is eligible, please contact the Phoenix Health team.

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 Phoenix Health Team 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 Phoenix Health membership that you contact us should your residential circumstances change.

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 **info@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 19 for more information.

Changing your level of cover

Membership cover can be changed by logging into Online Member Services (OMS) or emailing your request to **info@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 Phoenix Health, 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 Phoenix Health Online Member Services (OMS).

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 the Phoenix Health Team.

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, to the credit card or bank account used to pay your premiums by direct debit at the time of cancellation.

Termination of your membership

Phoenix Health 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 get in contact with 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 inappropriate behaviour to Phoenix Health staff, providers or other members; 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 Phoenix Health prior to your departure from Australia by completing a *Temporary Suspension of Membership – Overseas Travel Form* available from our website or by calling the Phoenix Health 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.

Temporary Suspension of Membership due to Financial Hardship

Phoenix Health 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 and case by case 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 a membership is suspended.
For full suspension terms, conditions and eligibility criteria, for overseas suspensions refer to the Temporary Suspension of Membership – Overseas Travel Form and for financial hardship suspensions, please contact the Phoenix Health Team.

Need Travel Insurance?

Head to **phoenixhealthfund.com.au/travel-insurance** for more information.

Celebrating 70 years of looking after your health and wellbeing

Having recently celebrated our 70th birthday it's timely that we reflect and recognise the history and legacy created by us by the employees of Stewart & Lloyds who founded Phoenix Health. We've come a long way, but one thing has remained the same; we're owned by members and run by members for the benefit of our members.

We're proud of the history our members have helped us create and continue to celebrate this important milestone with your memories. We've been delighted to hear so many heart-warming stories from some of Phoenix Health's long-term friends. You can discover more about our history and read members stories at

phoenixhealthfund.com.au/celebrating-with-your-stories

Hospital Cover

What does Hospital Cover include?

Hospital Cover provides a benefit towards services you receive when you are admitted into hospital as an in-patient for treatment, such as:

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,
- Treatment that does not have a Medicare item number,
- For services rendered in conjunction with a hospital stay where an extras item number is raised - for example, when you're admitted to hospital for dental surgery and a dental item number is billed (ie. for wisdom teeth removal), the hospital stay (accommodation and theatre fees) and medical items will be paid under your hospital cover and a relevant level of Extras cover would be required to receive a benefit on any dental item numbers, and
- For any pharmaceuticals or medications supplied on discharge from a hospital admission.

Dental Surgery

On hospital covers where treatment for Dental Surgery is included, extras cover with dental benefits may also be required to claim treatment without significant out of pocket expenses. If you are planning on receiving dental surgery, contact the Phoenix Health team so we can guide you through the process.

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 – 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	x	✓	✓
Lung and chest	RCP	x	✓	✓
Blood	RCP	x	✓	✓
Back, neck and spine	RCP	x	✓	✓
Plastic and reconstructive surgery (medically necessary)	RCP	x	✓	✓
Dental surgery	RCP	x	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	RCP	x	✓	✓
Implantation of hearing devices	RCP	x	✓	✓
Cataracts	RCP	x	x	✓
Joint replacements	RCP	x	x	✓
Dialysis for chronic kidney failure	RCP	x	x	✓
Pregnancy and birth	RCP	x	x	✓
Assisted reproductive services	RCP	x	x	✓
Weight loss surgery	RCP	x	x	✓
Insulin pumps	RCP	x	x	✓
Pain management with device	RCP	x	x	✓
Sleep studies	RCP	x	x	✓

✓

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.

x

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 480 private hospitals throughout Australia, so you can feel confident knowing we cover a hospital close to you, wherever you are.

Visit **phoenixhealthfund.com.au/doctor-hospital-search** to find a provider near you.

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, Phoenix Health 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: How to reduce or eliminate your hospital gap

Having Phoenix Health 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 a Phoenix Health member you have access to 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.

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?
Or want to check out what hospitals we have agreements with?
You can quickly search for a doctor, specialist or hospital by visiting our search tool at **phoenixhealthfund.com.au/doctor-hospital-search.**

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 Phoenix Health 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. Where you choose to be a private patient, a private patient election form will need to be completed at the hospital by yourself or by someone who is recorded as an **Authorised Person on your membership** (this may be a partner, family member or other trusted individual who you have nominated on your Phoenix Health membership to sign on your behalf) and any out of pocket costs associated with being a private patient will become your responsibility.

Where you elect to be covered as a private patient in a Public Hospital, you will be eligible for accommodation benefits paid at the rate applicable to the state you are being treated in. This means if you are given a private room, depending on the state the hospital you're being treated in is, **you may end up with out of pocket costs.**

If you're feeling pressured to make a choice, contact us– we're here to support you throughout your hospital journey.

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 Phoenix Health 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 and overnight hospital admissions once per person, per calendar year.

Here's an example of how the excess works:

Excess example: You have Phoenix Health Bronze Plus Essentials Hospital with a $750 Excess

On admission to hospital you pay your $750 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 dependants on your membership.

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 us to confirm your eligibility for this benefit or visit the website for further information.

Health Support Programs: Before, during and after admission care

Before-During-After Hospital Programs

At Phoenix Health 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.

To find out more or to see if you qualify for assistance talk to a Phoenix Health Team Member.

Health Support Programs

Health Support Programs
Phoenix Health isn't just there to pay benefits for when you need to go to hospital – supporting you through your entire health journey is just as important to us. Whilst paying hospital claims is the biggest part of what we do, we want to be there for you before the need for a hospitalisation occurs; so we've developed a range of Health Support Programs to help you manage your health and wellbeing, so you can get on with doing the things you enjoy in life.

Whether you're having a baby, looking to better manage your weight, interested in diabetes education, need a little extra support for your mental health or require joint care; we've partnered up with providers who specialise in these areas to help you through your health journey – whatever stage of life you're at. Our programs are delivered by health professionals, often in conjunction with your treating Doctors, and are available to members who hold hospital cover with us.

Our range of programs currently include:

- Bumps & Bubs
- Mental Health Coaching
- Short Stay Joint Replacement Program
- Cancer Care Complete
- Diabetes Support
- Osteoarthritis Care
- Spinal Care

Find out all the details about our Health Support Programs at **phoenixhealthfund.com.au/health-support-programs** or get in touch with the Phoenix Health Team to check waiting periods and your eligibility.

We're always looking for ways to support you, so if there's a program you feel could benefit yourself or manage a particular condition, let us know and we can look into it for you.
Email programs@phoenixhealthfund.com.au

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.**

Visit phoenixhealthfund.com.au/going-to-hospital for more information to help you understand how your Phoenix Health cover can support you through your hospital journey.

Having a Baby & Your Phoenix Health Cover

Whether you've started thinking about having a child, or you're already expecting, it's an exciting time... and perhaps even a little scary!

We've put together all of the information you need to know about when it comes to having a baby and your Phoenix Health cover - because the last thing you want to be worrying about is your health insurance.

Head to **phoenixhealthfund.com.au/having-a-baby** for more information.

Bumps & Bubs Program

The Phoenix Health Bumps & Bubs Program has been designed to support you from the time you learn you're expecting, through the first three years of your baby's life.

The program includes services such as:

- **Access to the Nourish Baby Online Learning Hub**
- **Personalised emails** tailored to your stage of pregnancy or parenthood, with links to learning modules and more;
- **Sleep and Settling Support** through phone calls from accredited professionals

For more information and to enrol now, visit **phoenixhealthfund.com.au/health-support-programs/bumps-and-bubs**

‘Best Health Insurance’ as reviewed by our members!

We’re super excited to share that Phoenix Health were awarded Best Health Insurance in 2024 at ProductReview.com.au, because of all of the reviews and feedback our members have provided.

Helping our members understand their health insurance, so they can get the most from their membership is what we love to do, and after winning this award in 2021, we were blown away to receive it again in 2024.

As a not-for-profit health fund, our members are the focus of everything we do and we pride ourselves on our personal health insurance because when it comes to choosing a health fund to look after your wellbeing, it makes sense to go with one that real people, like you, have chosen and have shared their experiences on.

You can learn more about our productreview.com.au award, how to check out what our members have to say and even leave your own review by visiting **phoenixhealthfund.com.au/product-review**.

PRODUCT REVIEW .COM.AU 2024 AWARDS WINNER

PHOENIX HEALTH FUND

Extras Cover

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 Phoenix Health 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.

At Phoenix Health, your preferred provider is ours too!

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 Phoenix Health, any services you have claimed in the current calendar year will be subject to your new annual limit with Phoenix Health.

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.

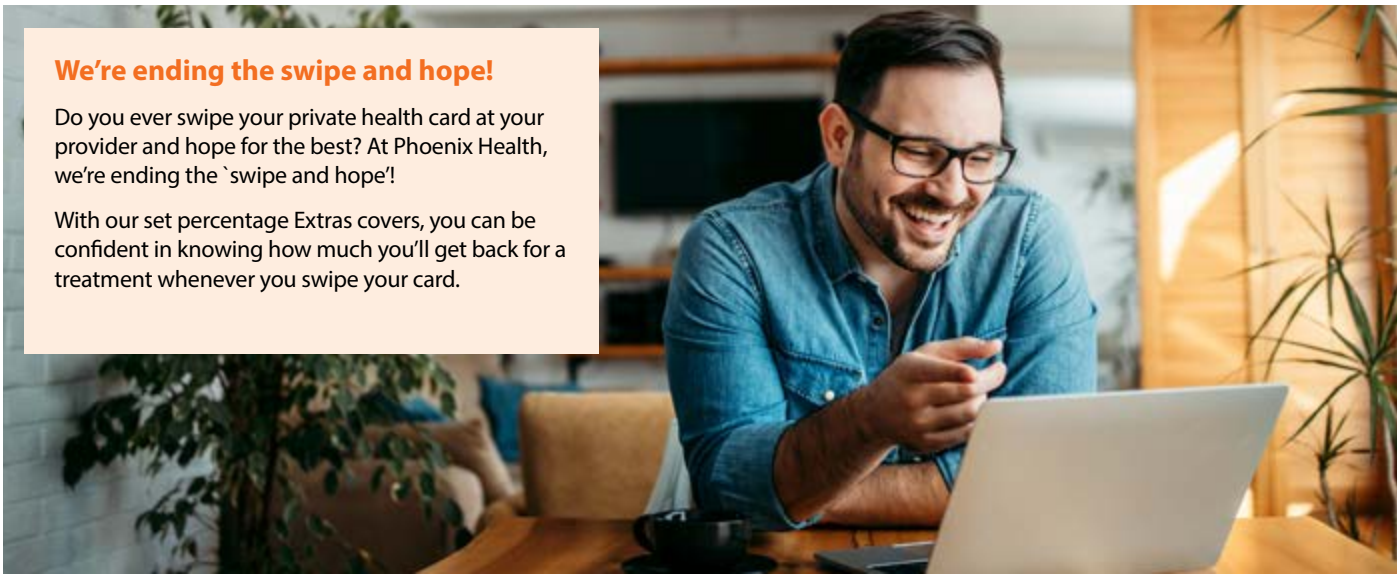
Are there any times I can't claim on my Extras cover?

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
- for services rendered in conjunction with a hospital stay where an extras item number is raised - for example, when you're admitted to hospital for dental surgery, and a dental item number is billed (ie. for wisdom teeth removal), the dental items will be paid under your Extras cover and a relevant level of Hospital cover would be required to receive a benefit on the hospital stay (accommodation and theatre fees) and any medical items
- towards experimental treatments or clinical trials
- where the service was provided free of charge
- where a service is provided online
- where a treatment is provided by a family member/relative, business partner or self
- where you have a commercial interest in the practice or business
- where a provider is not registered with us
- 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've not served the relevant waiting period
- where you've reached your limits
- where you're not covered on your membership for a specific treatment or service
- where you've not provided relevant supporting documentation
- where your membership payments are in arrears
- where a service or treatment can be claimed through a third party
- where your claim contains false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
- where the item you're claiming is otherwise excluded by our Fund Rules.



We're ending the swipe and hope!

Do you ever swipe your private health card at your provider and hope for the best? At Phoenix Health, we're ending the `swipe and hope'!

With our set percentage Extras covers, you can be confident in knowing how much you'll get back for a treatment whenever you swipe your card.

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 orthodontic benefits has per person, yearly and lifetime limits. Claims can be submitted by completing a claim form, via the Phoenix Health app or OMS with copy of the itemised invoice.

For all the information you need to know, check out our guide to claiming Orthodontics here:
phoenixhealthfund.com.au/extras-claiming/orthodontics

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

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.

Non-PBS Pharmaceuticals

Non-PBS Pharmaceutical benefits are payable for approved private pharmaceuticals, as defined in the Fund Rules and not already subsidised by the Pharmaceutical Benefits Scheme (PBS).

Prescriptions can be purchased at any registered Pharmacy. To claim you'll 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 $31.60 effective 1 January 2025), 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.

From 1 June 2024, benefits will only be payable towards Schedule S4 (prescription only) and Schedule S8 (controlled drugs) medicines, where they are approved by the Therapeutic Goods Administration (TGA) for the exact medical condition being treated.

Benefits will not be payable where the pharmaceutical isn't approved for supply in Australia by the TGA and isn't included as a registered medication in the Australian Register of Therapeutic Goods; is generally prescribed for purposes unrelated to the management of illness or disease - including reproductive and contraceptive medicines (unless prescribed to treat a medical condition as detailed in a medical certificate provided by your treating Doctor) or are medicines intended to enhance sporting or sexual performance.

Psychology & Mental Health Services

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 Phoenix Health Extras policy. You can claim for treatment with a Psychologist or Counsellor under your Extras policy where there is no Medicare rebate or there is no Medicare item number raised on the account.

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 and CPAP machines. If you require a particular Aid, please contact the Phoenix Health Team to check your eligibility criteria.

No benefits are payable towards the hire of aids or appliances, rentals, second hand goods other parts, medical reporting or consumables. CPAP benefits are payable on machines and replacement masks only.

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.

Benefit rules (continued)

Healthy Lifestyle

Benefits are payable towards approved services and programs designed to manage a specific health condition as recommended by a doctor or health professional.

Healthy Lifestyle includes benefits for:

Health Education
Benefits are payable towards approved education courses and programs:

- **Quit smoking courses** - including Quit Smoking, Smokenders and organisations registered in Australia who charge a fee. No benefits are payable towards laser therapy or on consumables provided as part of a program.
- **Weight management programs** - for programs with approved providers, including Weight Watchers and CSIRO. No benefits are payable towards laser therapy or on food, supplements or consumables.
- **Asthma management** - including programs provided by organisations associated with the Asthma Foundation or an accredited educator.
- **Diabetes education** - including classes or programs provided by organisations associated with Diabetes Australia or providers registered with The Australian Diabetes Educators Association.

Health Screenings
A benefit is payable for diagnostic testing services where a Medicare benefit is not claimable, and can include bone density tests, mammograms, OCT scans, bowel cancer test kits and more.

No benefits are available where the test is covered by Medicare, including x-rays, breath testing and medical exams.

Health Management
Benefits are payable towards approved programs designed and recommended by your health care professional, to manage a chronic health condition - for example asthma, joint conditions or weight management.

Health Management benefits include gym and fitness memberships and swimming classes (at AUSTSWIM or Swim Australia swim centres).

To claim a Health Management benefit a Healthy Lifestyle Treatment Plan must be completed by your treating health professional and submitted to Phoenix Health for assessment.

The Healthy Lifestyle Treatment Plan will include details from your Doctor including the program they have recommended and what condition it is designed to treat.

You can download a Healthy Lifestyle Treatment Plan here: **phoenixhealthfund.com.au/extras-claiming/healthy-lifestyle**

Claiming Healthy Lifestyle Benefits

Want to know if a particular program or treatment is covered, if a provider is approved for Healthy Lifestyle benefits or if you can claim for a certain diagnostic test? Visit **phoenixhealthfund.com.au/extras-claiming/healthy-lifestyle** or get in touch with a Phoenix Health Team member; we're happy to help.

Ambulance

At Phoenix Health, we understand that sometimes things in life just happen, and we want to give you peace of mind that you're 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 the closest hospital or emergency department for treatment of an acute medical condition or accident.

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

Where you hold a combined hospital and extras policy with Phoenix Health, if you need to claim for an Ambulance service, the benefit will be paid out of your hospital cover.

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 Phoenix Health 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 Phoenix Health 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 Phoenix Health.

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

Extras Claiming

At Phoenix Health, we make claiming easy!

The quickest and easiest way to claim your Extras services is to carry your Phoenix Health 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 Phoenix Health 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:
- email: **claims@phoenixhealthfund.com.au**
- post: **PO Box 156 Newcastle NSW 2300**

When submitting a claim to us, we will need you to provide the 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 Phoenix Health 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 Phoenix Health as soon as 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.

Phoenix Health 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, please see section 8.8 of the Phoenix Health Fund Rules.

24/7 Claiming

If you can't swipe your card at the time of your treatment, download the **Phoenix Health App** from the App Store or Google Play and take a photo of your itemised account to submit your claim.

Plus, you can now get your benefits even quicker with our **Fast Claims** option. Download the App now!

Waiting Periods

A waiting period is the time you'll need to wait after joining cover or changing level of cover before you can claim a benefit. Waiting periods vary from 2 to 12 months, depending on the service and exist to protect our members so we are able to keep premiums as low as possible.

Waiting periods can apply if you're new to private health insurance, where you are transferring to Phoenix Health from another fund and when you are a current member changing your level of cover. You can read more about waiting periods below and on our website at **phoenixhealthfund.com.au/waiting-periods**.

Hospital cover

Pre-existing conditions *Excluding Hospital Psychiatric services, Rehabilitation and Palliative care*	12 months
Pregnancy and Birth	
Hospital Psychiatric services, Rehabilitation and Palliative care *Regardless of whether they are pre-existing or not*	2 months
All other conditions requiring a hospital admission, that are not considered pre-existing	
Hospital Care programs	
Hospital treatment as a result of an accident	No waiting periods

Extras Cover

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

Ambulance Cover

Ambulance	1 Day

Waiting periods for newborns

A newborn will be covered from their date of birth with no waiting periods, where they are added to a membership (on to a family or single parent family cover), within 60 days of their date of birth. After this 60 day period, waiting periods will apply.

Waiting periods for adopted or foster children

Adopted or foster children can be added to a family or single parent family membership by supplying us with supporting documentation that shows the member's parental responsibility for the child and what date this came into effect. When the child is added within 60 days of their legal guardianship date, we'll waive the child's waiting periods in the following instances:

- **Hospital only policies** - we'll waive the standard 2 month hospital waiting period, which means that if the child needs in-hospital treatment for a condition that is not considered pre-existing, they'll be covered straight away. Pre-existing conditions will still have the standard 12 month waiting period applied.
- **Combined Hospital and Extras policies** - we'll waive the standard 2 month hospital and extras waiting periods. Benefits will be available straight away for things like general dental, physiotherapy and chiropractic as well as in-hospital treatment for a conditions that aren't considered pre-existing. 6 and 12 month waiting periods will still apply on the extras and for hospital, the standard 12 month waits will still apply to pre-existing conditions.
- **Extras only policies** - full waiting periods will apply when you add an adopted or foster child on to an Extras only policy.

Supporting documentation can include (one of): a letter from the Department of Family and Community Services, a Court Order from Children's or Family Court, Centrelink communication confirming that support payments are received by the member, for the child.

For more information on how to add a newborn, or an adopted or foster child to your membership, please get in touch with the Phoenix Health team.

New to Private Health Insurance?

If you're new to private health or you've been without cover for more than 30 days when you join Phoenix Health, you'll need to serve full waiting periods before you are able to claim on your membership.

Transferring from another fund?

When you switch to Phoenix Health from another Australian health fund, any waiting periods you've served with your previous insurer will switch with you, so there's no starting again.

There may be times though where you will be required to serve waiting periods:

- Where there's been a gap in cover of 30 days or more between cancelling with your previous fund and joining Phoenix Health.
- Where services or benefits were not covered, excluded or restricted under your previous cover, waiting periods will apply to these services.
- Where you join Phoenix Heath on a level that is considered an upgrade in cover from your previous fund- waiting periods will apply to the upgrade in any benefits, limits or excess/ co-payment amounts.
- Where you haven't fully served your waiting periods or qualified for benefits with your previous fund, you'll need to complete the remainder of your waiting periods before you can claim on your Phoenix Health cover.

When you switch to Phoenix Health, we'll contact your previous fund, take care of your cancellation and request a copy of your Transfer Certificate (also known as Clearance Certificate), so that you don't have to. Your Transfer Certificate confirms waiting periods or Lifetime Health Cover loadings and any other Government incentives or surcharges that may apply to your policy.

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

Transferring between Phoenix Health memberships?

When you transfer from one Phoenix Health membership to another (whether you have removed yourself, have been removed by the policy holder or if you are an overage dependent) where you join and have a gap in cover of less than 30 days, you won't need to re-serve waiting periods for equivalent cover.

Waiting periods will still apply where you have a gap in cover of more than 30 days, for any services or benefits that were not covered, excluded or restricted under your previous cover, to any upgrades in cover - including benefits, limits or excess amounts, or where you haven't fully served your waiting periods with Phoenix Health.

Any limits you have accessed on your previous Phoenix Health membership will count towards your limits used on your new policy, for that calendar year.

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 (also known as a Clearance Certificate).

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

Phoenix Health don't currently offer an open level of Cover that provides un-restricted Benefits for Hospital Psychiatric Services for this waiver to be used.

Accidents

Where a member is within waiting periods for hospital cover, or holds a level of hospital cover that has exclusions, and is 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, regardless of whether the service is excluded on the member's level of cover or not.
Excesses and or co-payments are not waived for accidents.

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

An accident for the purpose of Accident Cover means an unplanned or unforeseen event, occurring by chance and caused by an unintentional and external source, resulting in bodily injury that requires immediate hospital treatment. The accident must occur after the member has joined Phoenix Health. An accident is not a condition that can be attributed to medical causes. The causing event of an accident must occur in Australia to be considered for Accident Cover.

For accident benefits to be assessed, the member must report to an emergency facility within 24 hours of the injury and a Doctor's report of this visit must be submitted to Phoenix Health along with any other supporting documentation as requested. All treatment relating to the injury must be initiated within 30 days and completed within 90 days of the accident.

Please contact the Phoenix Health Team as soon as you are able, and we can guide you through the Accident Cover claiming process.

Accident Cover benefits are not payable towards conditions relating to a pre-existing condition, pregnancy, drug and alcohol use, illegal activities or any condition resulting from a surgical procedure; and where they are claimable through compensation or damages, or through another third-party insurance policy. Please refer to the compensable claims section on page 17 for more information on claiming through a third party.

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, ailment or condition that existed or showed any signs or symptoms at any point in the 6 months prior to taking out or upgrading your hospital cover.

What happens if you need to go to hospital in the first 12 months?

If you need to go to hospital in the first 12 months of taking out hospital cover or upgrading your level of cover; where you've served your general 2 month waiting period, and you believe your condition is not pre-existing, get in touch with us as soon as possible so we are able to start the Pre-Existing Condition assessment process.

How are pre-existing conditions assessed?

We'll send you a copy of the Pre-Existing Condition: Medical Assessment Form which will need to be completed in full by you, your GP and your treating Specialist.

Once we have received your completed forms, an independent Medical Practitioner appointed by Phoenix Health will assess your forms and determine whether your condition is pre-existing or not.

The PEC process can take up to 10 business days once we have received your completed paperwork – we will do our best to get the result to you as soon as possible, however it is important to keep this in mind, as if you are admitted to hospital prior to the completion of your assessment, if your condition is deemed as pre-existing, no benefits will be payable by Phoenix Health for your admission and you will be responsible for all hospital and medical charges not covered by Medicare.

What does the outcome of the PEC assessment mean?

If the independent Medical Practitioner determines that your condition is **not pre-existing**, benefits will be payable according to your level of cover for this condition only.

Any additional treatments received or required within your waiting periods, that have not been through the PEC assessment and been deemed not pre-existing, will not be covered until your waiting periods have been served, or they themselves have been through the PEC assessment process and deemed not pre-existing.

If your condition has been assessed and deemed as being **pre-existing**, no benefits will be payable by Phoenix Health while you are within your waiting periods, and you will need to consider the following options:

- You can wait until you've completed your 12 month waiting period to have your procedure, where it's practical to wait for treatment;
- You can self-fund your private admission – which means no private health insurance benefits would apply to your admission and you would be responsible for all hospital and medical charges not covered by Medicare; or
- You can look into having the procedure done as a public patient in a public hospital - speak to your doctor for more information about how this would work and what the current waiting list times are.

Where you're within waiting periods because you've recently upgraded your hospital cover (you've recently transferred to Phoenix Health or you're a current member and changed cover) where you had fully served your waiting periods on your previous level of cover and were eligible for benefits; if your condition has been deemed pre-existing, benefits will be paid according to your previously insured level of cover until you have completed your waiting periods.

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.

1 April 2024 - 30 June 2025 Income Thresholds				
Singles	**≤ $97,000**	**$97,0001 – $113,000**	**$113,001 – $151,000**	**≥ $151,001**
Families	**≤ $194,000**	**$194,001 – $226,000**	**$226,001 – $302,000**	**≥ $302,001**
1 July 2025 - 31 March 2026 Income Thresholds				
Singles	**≤ $101,000**	**$101,001 – $118,000**	**$118,001 – $158,000**	**≥ $158,001**
Families	**≤ $202,000**	**$202,001 – $236,000**	**$236,001 – $316,000**	**≥ $316,001**
Rebate				
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
< Age 65	24.288%	16.192%	8.095%	0%
Age 65-69	28.337%	20.240%	12.143%	0%
Age 70+	32.385%	24.288%	16.192%	0%

These rebate levels are applicable until 30 June 2026. 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 Phoenix Health premiums; or
- As a tax offset when lodging your tax return. This would mean your Phoenix Health 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.

1 April 2024 - 30 June 2025 Income Thresholds				
Singles	**≤ $97,000**	**$97,0001 – $113,000**	**$113,001 – $151,000**	**≥ $151,001**
Families	**≤ $194,000**	**$194,001 – $226,000**	**$226,001 – $302,000**	**≥ $302,001**
1 July 2025 - 30 June 2026 Income Thresholds				
Singles	**≤ $101,000**	**$101,001 – $118,000**	**$118,001 – $158,000**	**≥ $158,001**
Families	**≤ $202,000**	**$202,001 – $236,000**	**$236,001 – $316,000**	**≥ $316,001**
Medicare Levy Surcharge				
All Ages	0.00%	1.00%	1.25%	1.50%

Source: Australia Tax Office. 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 Phoenix Health, we will require a copy of your Transfer Certificate (also known as Clearance 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.

While we are waiting to receive your exemption proof, we may have to apply a Loading to your membership, which will be removed, and any payments made adjusted on receipt of your documentation.

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 Phoenix Health 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 privatehealth.gov.au or contact the Phoenix Health Team.

Code of Conduct

Phoenix Health are proudly signatories to the Private Health Insurance Code of Conduct.

The Private Health Insurance Code of Conduct is a self-regulatory and voluntary code to promote informed relationships between Private Health Insurers and consumers. Being bound by the code of conduct, our undertaking to you, the member, is to ensure we are putting your best interests first and providing the highest quality of service and professionalism.

As a signatory to the Code, Phoenix Health agree that:

- any information we give you is transparent, easy to understand and provided in plain English;
- you will receive the correct information on private health insurance from adequately trained employees;
- we will provide you with clear explanations of your policy documentation when requested;
- all policy documentation provided is full and complete;
- all information between you and Phoenix 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.

You can find more about the PHI Code of Conduct by visiting phoenixhealthfund.com.au/Code-Of-Conduct

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 and any complaints will be dealt with in accordance with our Dispute Resolution Policy.

Call
1800 028 817

Email
info@phoenixhealthfund.com.au

Write
PO Box 156, Newcastle NSW 2300

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 and/or Board of Directors.

Step three: External review

If after our best efforts, you're 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

24/7 access to your membership

Be in control of your Phoenix Health membership whenever you need from wherever you are.

Simply download the **Phoenix Health App** from the App store or Google Play or visit **members.phoenixhealthfund.com.au and** login to your **Phoenix Health Online Member Service (OMS) portal**.

Privacy Statement

At Phoenix Health we're committed to protecting and maintaining the privacy of our members and people who deal with us. We're 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 we collect, hold, use and disclose; and how to contact us if you have any questions 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.

A full copy of the Phoenix Health Privacy Statement is available at phoenixhealthfund.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;
- to verify your identity; 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 for the purposes of verifying your identity, help us identify and investigate illegal activities and prevent fraud or other misconduct, or 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 028 817,
- emailing info@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 028 817;**
- emailing us at **info@phoenixhealthfund.com.au**; or
- by mail at **PO Box 156, Newcastle NSW 2300**.

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 Phoenix Health 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 Phoenix Health Privacy Statement.

We're here to help

phoenixhealthfund.com.au

1800 028 817

info@phoenixhealthfund.com.au

PO Box 156, Newcastle NSW 2300

Facebook.com/Phoenixhealthfund

Download the Phoenix Health App from the App Store or Google Play

Sharon Waterhouse, Chief Executive Officer

Information in this Member Guide is correct as at 1 April 2025 and should be read and retained together with the product information sheets, the Fund's website and the Phoenix Health Fund Rules which contain full membership, claiming and eligibility rules. Benefits may vary according to level of cover. Please ensure you keep a copy of this Member Guide for your records.

Contact the Phoenix Health Team on **1800 028 817** or email **info@phoenixhealthfund.com.au** if you have any questions about your cover, Phoenix Health membership or if you're planning a hospital admission or receiving treatment; **we're here to help.**

A Members Health Fund

Phoenix Health is proud to be a part of the Members Health Fund Alliance; a group of health funds run for people not for profits.

Phoenix Health Fund

phoenixhealthfund.com.au

1800 028 817

info@phoenixhealthfund.com.au

PO Box 156, Newcastle NSW 2300

Like us on Facebook to stay up to date with health fund and industry news

PRODUCT REVIEW .COM.AU 2024 AWARDS WINNER

PHOENIX HEALTH FUND