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Department of Health

OUTCOMES FROM THE CONSULTATION ON THE CLINICAL CATEGORIES

The Department of Health sought feedback from medical colleges and the Private Health Ministerial Advisory Committee (PHMAC), which includes representatives of consumers, insurers, hospitals and clinicians. Below is a summary of the feedback received and outcomes from the consultation process.

Background

In October 2017, the Minister for Health, the Hon Greg Hunt MP, announced a wide-ranging package of reforms for private health insurance, including standardising clinical definitions for hospital insurance policies.

From 1 April 2019, all insurers will be required to use these clinical terms and no others in their promotional material to provide consistency and give consumers certainty about coverage. If an insurer lists a clinical category as an inclusion in an insurance product, cover must be provided for all conditions listed in the category - partial cover of a clinical category will not be permitted.

The Clinical Definitions Working Group, established by PHMAC, developed a list of clinical categories and agreed there should be a list of possible procedures for each category. The list of procedures will assist consumers in making an informed choice about private health insurance and what services different products do and do not cover.

The department worked with medical advisers to develop the list of procedures, consisting of Medicare Benefits Schedule (MBS) items.

More information on the Clinical Definitions Working Group is available on the PHMAC webpage of the department's website at: www.health.gov.au

Consumer testing

In March 2018, the department conducted consumer focus group testing on the clinical categories. The categories were tested for comprehension and usability.

A key concern for consumers was differing terminology used to describe the same condition or service between funds. For example: weight loss surgery, bariatric surgery and gastric banding are used interchangeably across different private health insurance policies. The introduction of common terminology was seen as a welcome step in making it easier for people to compare health insurance policies.

Industry consultation

In April 2018, the department requested feedback from all medical colleges and PHMAC on the draft list of clinical categories and MBS items. The feedback was mixed, with opposing views on several issues. In responding to the feedback, the department has focused on the most appropriate outcome to benefit consumers.



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Summary of outcomes

1. General comments

- i. For ease of reading, it was recommended that category titles should be concise and simple. The department has amended all category titles accordingly. For example, '*Management of ongoing (chronic) pain*' has been amended to '*Chronic pain*'. A list of the revised titles is in Appendix A.
- ii. To improve consumer comprehension, the clinical categories have been amended to better reflect common medical conditions instead of surgical procedures. For example, reference to 'denervation' under the '*Chronic pain*' category has been amended to 'treatment for nerve pain'.
- iii. The list of 37 categories has been reduced to 36. Some clinical categories have been combined, while others have been split. These changes reflect consumer understanding of medical conditions instead of the medical specialist who would provide the service. For example: heart, lung and vascular procedures have been combined into one category (see Section 2. *Amendments to the list of clinical categories*).
- iv. The clinical categories do not include an exhaustive list of MBS items.
A number of surgical procedures are not limited to one clinical area as they can be used to treat more than one condition. For example, treatment for multiple cancers may require the excision of axillary lymph nodes (MBS item 30336).
The clinical categories have been amended to include only an indicative list of procedures that must be covered by the category. Insurers must cover all procedures related to a condition in the scope of cover, even if the procedure (MBS item) is not specified in the list of procedures.
In the above example, MBS item 30336 is not listed under a clinical category but the procedure will be covered by the '*Breast Cancer*' category if it is provided to treat breast cancer.
- v. Under current policies, patients may not be covered for all procedures arising from a particular incident or illness. The '*General note*' has been amended to clarify that an episode of care is covered completely by the category treating the primary condition. For example, treatment for melanoma is covered by the '*Skin*' category. This includes associated services to close the wound, despite plastic and reconstructive procedures being listed in a separate category.
- vi. A question was raised regarding how patients would be covered if during surgery a condition was found to have been misdiagnosed. For example, suspicion of appendicitis turns out to be ovarian torsion.

The scope of cover specifies that the clinical category covers both the investigation as well as the treatment of a condition. A patient who has cover for appendicitis will be covered for the investigation and treatment they receive during surgery, even if the suspected appendicitis is found to be ovarian torsion. However, if the ovarian torsion is treated as a separate episode of care, the insurer does not have to cover the second procedure unless the patient has cover for gynaecology as well.



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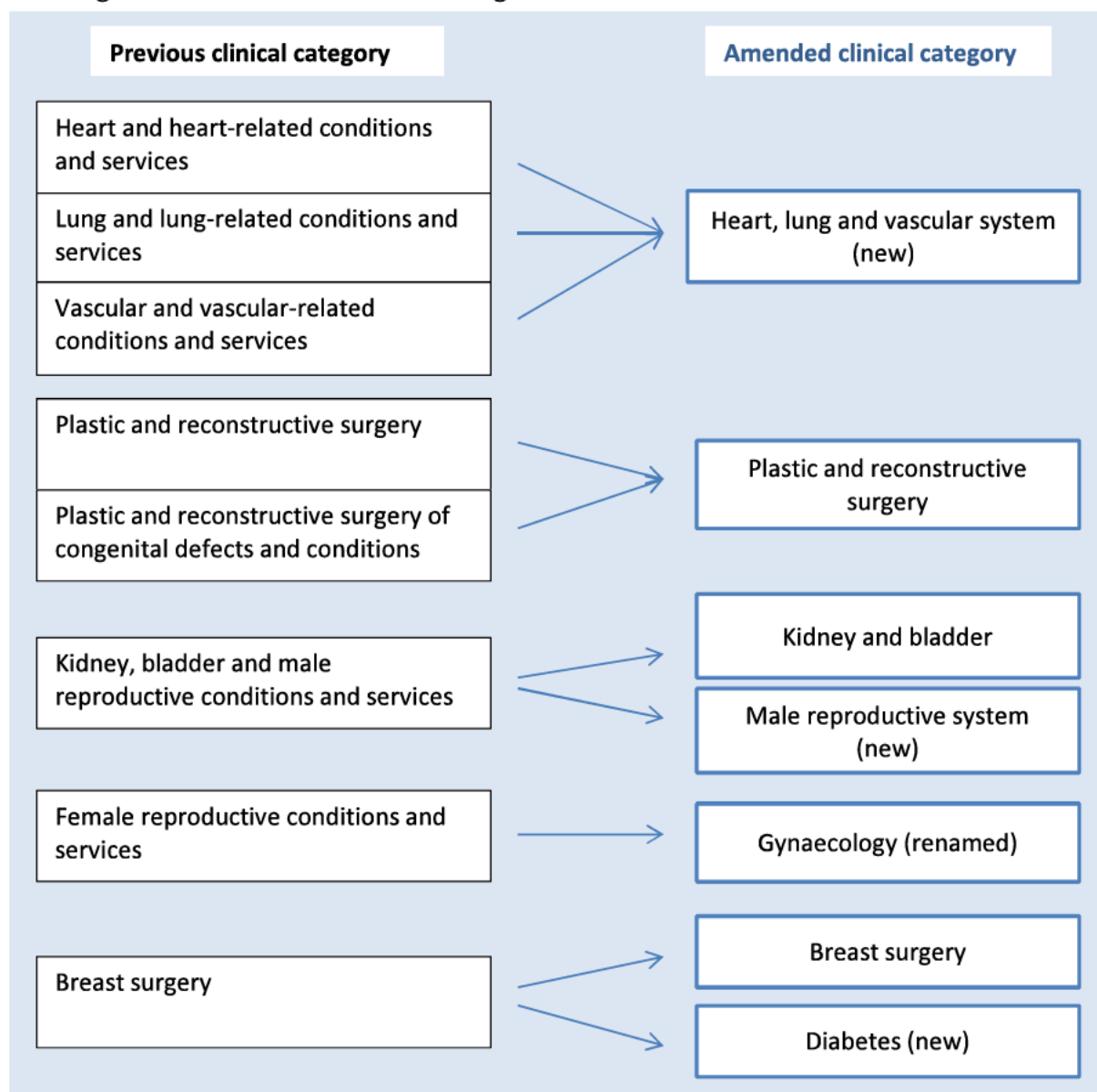
Department of Health

- vii. Following implementation, an independent committee will evaluate the effectiveness of the clinical categories. The committee will also review any concerns of consumers, doctors, insurers or other stakeholders. The reviews are scheduled for April 2020 and April 2021.

2. *Amendments to the list of clinical categories*

The department received feedback on the useability of the list of clinical categories. As a result, category names have been amended, some categories have been combined and new categories have been established.

The diagram below summarises the changes.





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3. *Outcomes from the 'Alignment of procedures' questionnaire*

During the development of the clinical categories, the department received advice from stakeholders on the alignment of procedures. As part of the consultation process the department sought wider industry feedback on specific procedures and their alignment with the clinical categories.

A summary of the outcomes is in the table below.

Issue	Outcome
1. Grommet surgery	Grommet surgery will remain under <i>'Tonsils, adenoids and grommets'</i> to support access to these services in lower cost products.
2. Blepharoplasty	Blepharoplasty (eyelid surgery) will move from <i>'Eye'</i> to <i>'Plastic and reconstructive surgery'</i> .
3. Spinal fusions	Spinal fusion procedures will remain in <i>'Joint replacements and spinal fusion'</i> .
4. Arthroscopy	Arthroscopic procedures will be moved from <i>'Joint reconstructions'</i> to <i>'Bone, joint and muscle'</i> .
5. Joint reconstructions	<i>'Joint reconstructions'</i> will remain as a separate clinical category and will not be combined with <i>'Bone, joint and muscle'</i> .
6. Insulin pumps	There were no appropriate surgical MBS items recommended for this category. The category will cover the provision of an insulin pump in a hospital setting without specifying MBS items.
7. Haematology	A category for blood conditions will be established.

4. *Mapping of MBS items*

- i. There were concerns that some MBS items were missing from the list of procedures. MBS items that were unintentionally excluded from a clinical category have been added to the relevant category.

Some MBS items are relevant to multiple clinical categories, such as diagnostic and pathology items. The department has not included these MBS items under a clinical category. Instead, the *'General note'* clarifies how these procedures are to be covered. That is, an episode of care is covered completely by the category treating or investigating the primary condition.

Diagnostic and pre-surgery items were only mapped to a clinical category if they were relevant to only one category. For example, diagnostic imaging services for pregnancy or pregnancy complications (MBS items 55700-55775) were mapped to the *'Pregnancy and birth related services'* category.

Due to the lack of consistency on how associated miscellaneous services were mapped to the clinical categories, the list of MBS items was simplified. The list of procedures has been amended to only include an indicative list of treatments.



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The following services are not mapped to a clinical category, but are addressed by the 'General note':

- consultations;
 - diagnostic services;
 - diagnostic imaging;
 - pathology;
 - pre-operative assessments;
 - provision of anaesthesia and regional nerve blocks; and
 - attendance at an operation by a physician and assistant.
- ii. MBS items described as services for non-admitted patients have been excluded from the list of procedures.
- iii. There was a question regarding which clinical category amputations would be covered under. The '*Bone, joint and muscle*' scope of cover has been amended to clarify that amputations are covered by this category, regardless of whether the procedure is performed by an orthopaedic or vascular surgeon.
- iv. It was suggested that the list of procedures under each clinical category should include other codes, such as Diagnosis Related Groups (DRGs) or Australian Classification of Health Interventions (ACHI), as well as MBS items.

The department will consider the inclusion of additional codes for future revisions of the clinical categories.

Next steps

The department has engaged an independent expert to review the revised set of clinical categories.

The clinical categories circulated in the Exposure Draft of the *Private Health Insurance (Comply Product) Rules 2018* will be informed by this independent review. Stakeholders are invited to provide feedback on the draft Rules at that time.



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Appendix A

Former clinical definition title	Amended clinical category
Rehabilitation	Rehabilitation
Psychiatric services	Hospital psychiatric services
Palliative care	Palliative care
Brain and brain-related conditions and services	Brain
Eye and eye-related conditions and services (cataracts listed separately under cataract procedures)	Eye
Cataract procedures	Cataracts
Heart and heart-related conditions and services Lung and lung-related conditions and services Vascular and vascular-related conditions and services	Heart, lung and vascular system (<i>new</i>)
Ear, nose and throat conditions and services (hearing loss listed separately and tonsils, adenoids and grommets are listed)	Ear, nose and throat
Implanted devices for hearing loss surgery	Implantation of hearing devices
Tonsils, adenoids and grommet surgery	Tonsils, adenoids and grommets
Back, neck and spine conditions and services (spinal fusion is listed separately under Joint replacements and spinal fusion)	Back, neck and spine
Bone and joint conditions and services (joint replacements are listed as a separate category, joint reconstructions are listed separately and spine is listed separately under back, neck and spine)	Bone, joint and muscle
Joint reconstructions	Joint reconstructions
Joint replacements and spinal fusion	Joint replacements and spinal fusion
Digestive system conditions and services (hernia and appendicectomy is listed separately)	Digestive system
Endoscopy	Gastrointestinal endoscopy



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Former clinical definition title	Amended clinical category
Hernia repair and appendicectomy	Hernia and appendix
Kidney, bladder and male reproductive conditions and services (dialysis is listed separately under dialysis for chronic kidney disease)	Kidney, adrenals and bladder
Dialysis for chronic kidney disease	Dialysis for chronic kidney disease
-	Male reproductive system (<i>new</i>)
Female reproductive conditions and services	Gynaecology
Pregnancy and birth related conditions and services (neonates are covered under this category for single parent and family policies, terminations and miscarriages are listed separately)	Pregnancy, birth and neonates
Assisted reproductive services	Assisted reproductive services
Miscarriages and termination of pregnancy services	Miscarriage and termination of pregnancy
Breast surgery (non-medically necessary cosmetic surgery is not covered under private health insurance)	Breast surgery (medically necessary)
Plastic and reconstructive surgery (non-medically necessary cosmetic surgery is not covered under private health insurance)	Plastic and reconstructive surgery (medically necessary)
Plastic and reconstructive surgery of congenital defects and conditions	
Surgery for skin and skin lesions	Skin
Weight loss surgery	Weight loss surgery
Chemotherapy and radiotherapy for cancer	Chemotherapy, radiotherapy and immunotherapy for cancer
	Blood (<i>new</i>)
	Diabetes (<i>new</i>)
Insulin pumps	Insulin pumps
Management of ongoing (chronic) pain	Chronic pain



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Former clinical definition title	Amended clinical category
Podiatric surgery provided by an accredited podiatric surgeon	Podiatric surgery (provided by an accredited podiatric surgeon)
Sleep studies	Sleep studies
Dental surgery	Dental surgery

[illegible]

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s22					
Australian Association of Podiatric Surgeons (AAPS)	Clinical categories	Schedule 3[3] Schedule 4	Tier inclusions Podiatric surgery - The AAPS seeks that regulations be change to require insurers to pay theatre fees and surgeon's fees in relation to podiatric surgery. AAPS site the Department's previous advise that payment of theatre and surgeon's fees will be discretionery for insurers despite Rule 11E(3) providing that for each clinical category covered by a policy, the policy must cover (i) consultation, (ii) pre-operative assessment, (iv) attendance at an operation by a phycician and assistant.	Such a change would be outside the scope of the policy reforms announced by Government. As there is no Medicare item number for a podiatric surgeon's services or the associated anaesthetist's service, it is not mandatory for a health fund to pay benefits from their hospital tables for these medical costs. Medicare will not provide a benefit toward the surgeon and anaesthetist's fees. <u>Need to review the current drafting in the Rules on this issue to ensure it is clear that only</u>	Noted - no further action
s22					
Australian Orthopaedic Association (AOA)	Clinical categories	Schedule 4	Podiatric surgery - Category should be removed as podiatric 'surgeons' are not surgeons with proper qualifications and do not have access to the MBS.	> (previously stated) The Private Health Insurance Act 2007 includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. > Further consideration regarding re-wording of definitions	Noted - no further action
s22					
Australian Society of Orthopaedic Surgeons (ASOS)	Clinical categories	Schedule 4	Podiatric surgery - surgical procedures should be performed by a qualified surgeon ie orthopaedic surgeon. > patients should be made aware the difference between a podiatric surgeon and an orthopaedic surgeon	> (previously stated) The Private Health Insurance Act 2007 includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. > Further consideration regarding re-wording of definitions	Noted - no further action

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HCF	Clinical categories	Schedule 4	Podiatric surgery - Category should be removed as podiatric 'surgeons' are not surgeons with proper qualifications and do not have access to the MBS. > current structure of product tiers will be mean an accredited podiatric surgeon will be able to perform them on a Silver tiered product where an orthopaedic surgeon will not.	> (previously stated) The Private Health Insurance Act 2007 includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. > Further consideration regarding re-wording of definitions	Noted - no further action

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Medibank	Clinical categories	Schedule 4	Podiatric - Category should be removed as a mandatory requirement as podiatric 'surgeons' are not surgeons with proper qualifications and do not have access to the MBS. > current structure of product tiers will be mean an accredited podiatric surgeon will be able to perform services on a Silver tiered product while an orthopaedic surgeon's services are only covered in gold.	> (previously stated) The Private Health Insurance Act 2007 includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. > Further consideration regarding re-wording of definitions	No further action

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NIB	Clinical categories	Schedule 4	Podiatric surgery - Are insurers required to pay more than the minimum benefits?	Further consideration regarding re-wording of definitions	Rules re-draft
s22					

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s22					
PHA	Clinical categories	Schedule 4	Podiatric surgery - (previously stated) should not be included in the clinical categories and will mislead consumers about the availability of services. No MBS items. Few accredited practitioners. > wording in Rules suggests expanding the current requirement to only cover prosthesis. Difficult to implement this as there is no relevant MBS items.	> (previously stated) The Private Health Insurance Act 2007 includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. > Further consideration regarding re-wording of definitions	Rules re-draft

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Australasian College of Podiatric Surgeons (ACPS)	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - The ACPS strongly supports the inclusion of podiatric surgery as a coverage requirement of Silver and Gold products.		Noted - no further action
s22					
Australian Association of Orthopaedic Surgeons (ASOS)	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - The ASOS does not support the inclusion of podiatric surgery as a clinical category on the basis that these providers do not have a medical surgical fellowship. They do not support the payment of prostheses benefits for these services.	Podiatric surgical falls within the meaning of hospital treatment under the Private Health Insurance Act. This has been the case since 2005.	Noted - no further action
s22					
Australian Association of Podiatric Surgeons (AAPS)	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - The AAPS seeks that podiatric surgery be made a minimum coverage requirement for Bronze products.	This would not reflect the existing product market.	Noted - no further action
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Australian Orthopaedic Association (AOA)	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - The AOA is very concerned by the inclusion of the podiatric surgery category. It considers podiatric surgeons, an anomalous group of allied health professionals, were granted surgeon status by the Government despite having no medical training or qualifications. The AOA claims that 15% of podiatric surgeons registered with AHPRA have had major adverse findings made by the Board about their clinical practice.	Podiatric surgical falls within the meaning of hospital treatment under the Private Health Insurance Act. This has been the case since 2005.	Noted - no further action
Australian Podiatry Association	Product tier	Schedule 3[3] Schedule 4	Tier inclusions Podiatric surgery - APoDA would also encourage further reforms to see rebates for anaesthesia services required during the admission for podiatric surgery.	Such a change would be outside the scope of the policy reforms announced by Government. As there is no Medicare item number for a podiatric surgeon's services or the associated anaesthetist's service, it is not mandatory for a health fund to pay benefits from their hospital tables for these medical costs. Medicare will not provide a benefit toward the surgeon and anaesthetist's fees. Need to review the current drafting in the Rules on this issue to ensure it is clear that only accomodation and prostheses need to be covered as a minimum.	Noted - no further action
Australian Podiatry Association (APoDA)	Product tier	Schedule 3[3] Schedule 4	Tier inclusions Podiatric surgery - The ACPS would like to see further changes to ensure that insurers provide rebates for anaesthesia services provided during an admission for podiatric surgery.	Such a change would be outside the scope of the policy reforms announced by Government. As there is no Medicare item number for a podiatric surgeon's services or the associated anaesthetist's service, it is not mandatory for a health fund to pay benefits from their hospital tables for these medical costs. Medicare will not provide a benefit toward the surgeon and anaesthetist's fees. Need to review the current drafting in the Rules on this issue to ensure it is clear that only accomodation and prostheses need to be covered as a minimum.	Noted - no further action
Australian Podiatry Association (APoDA)	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - The APoDA is delighted to see the proposed reforms placing podiatric surgery in the silver and gold hospital treatment product tiers.		Noted - no further action

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Australian Society of Orthopaedic Surgeons	Product tier	Schedule 3 [3] Schedule 5	Tier inclusions - Podiatric Surgery Patients of foot and ankle surgeons with medical fellowship must have Gold cover while 'podiatric surgery' is covered in Silver - the only conclusion to draw is that the government supports the cutting of human bone and tendon without need for medical surgical fellowship.	Podiatric surgical falls within the meaning of hospital treatment under the Private Health Insurance Act. This has been the case since 2005.	Noted - no further action
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Australian Unity	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - If podiatric surgery is to remain as a clinical category, it should only be available on Gold levels.		Noted - no further action
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HCF	Product tier	Schedule 3 [3] Schedule 5	Tier inclusions - Podiatric Surgery should not be a hospital treatment category. Podiatric surgeons do not have Medicare provider registration and as such no benefits are payable for r their services, leaving large out of pockets costs for the surgeon's fees.		Noted - no further action
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Medibank	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - Medibank notes that these Podiatric surgeons are unable to bill Medicare and customers can incur large out-of-pockets. They consider this service should remain an optional inclusion and not a mandatory coverage requirement for Silver.		Noted - no further action
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s22					
Private Healthcare Australia	Product tier	Schedule 3[3] Schedule 5	Tier inclusions Podiatric surgery - PHA does not support the inclusion of podiatric surgery within the minimum product requirements. It is noted there are no MBS items for this category and very few practioners who meet the identified accreditation. The inclusion of this service in Silver has the potential to mislead consumers around the availability of these services. It will also significantly expand funds obligations to cover this service. Including cover for podiatric surgery services in Silver would appear inconsistent with the coverage requirement for other similar services delivered by an orthopaedic surgeon which are a gold coverage requirement ('Joint replacements and spinal fusion').		Noted - no further action

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Clinical Categories

Private health insurers will be required to use the clinical categories to inform customers of treatments and services included in their hospital insurance policies within all product material.

At a minimum, the Medicare Benefit Schedule (MBS) items listed must be covered if the clinical category is listed as an inclusion in the insurance policy.

General notes

¹ If a patient is admitted for an investigative surgery that procedure and any treatment provided during the surgery is covered even if the investigation reveals a condition not included in the scope of cover.

² The following procedures are also covered by a clinical category if they are provided to an admitted patient as part of the treatment of a primary condition or service: consultation, diagnostic service and diagnostic imaging, pathology, pre-operative assessment, anaesthesia and regional nerve block, attendance at an operation by a physician and assistant, associated miscellaneous services related to the principal service, and management of complications related to the principal service.

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Rehabilitation	Admission for physical rehabilitation for a patient recovering from surgery or illness. For example: inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.	Any episode of hospital treatment for the physical rehabilitation of a patient recovering from surgery or illness treated in hospital.
Hospital psychiatric services	Admission for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.	Any episode of hospital treatment for the investigation and treatment of a psychiatric condition, including (but not limited to) those referred to in the scope of cover. Electroconvulsive therapy (MBS item 14224) is also covered.

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Palliative care	Admission for care where the intent is primarily providing quality of life for a patient with a terminal illness.	Any episode of hospital treatment for the care of a patient with a terminal illness. Relevant pain relief is also covered.
Brain	Admission for the investigation and treatment of the brain, brain-related conditions, central nervous system and peripheral nervous system. For example: stroke, brain tumours, head injury, epilepsy and Parkinson's disease. Spinal conditions are included under <i>Back, neck and spine</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the brain and brain-related condition, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 35000-35012; 35412-35414; 39000-39018; 39300-39330; 39333; 40000-40015; 40100-40118; 40339; 40342; 40600-40905; 43521; 52800-52832
Eye	Admission for the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye. Cataract procedures are listed separately as <i>Cataracts</i>. Eyelid procedures are included under <i>Plastic and reconstructive surgery</i>.	Any episode of hospital treatment for the investigation and treatment of the eye and eye-related condition, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30061; 42503-42695; 42719-43023

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Ear, nose and throat	Admission for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, mouth, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy, maxillofacial injuries, and throat cancer. Tonsils, adenoids and grommets are listed separately as <i>Tonsils, adenoids and grommets</i>. The implantation of a hearing device is listed separately as <i>Implanted devices for hearing loss surgery</i>. Orthopaedic neck conditions are included under <i>Back, neck and spine</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the ear, nose, throat and related areas of the head and neck, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30104-30105; 30244-30297; 30306-30320; 30326; 30618; 31400-31438; 41500-41599; 41608-41615; 41620-41629; 41635-41787; 41804-41910; 45632-45646; 45650-45653; 45659; 45675; 45714-45716; 45788; 45578-45581; 47735-47741; 52021-52035; 52108-52141; 52147-52158
Tonsils, adenoids and grommets	Admission for the investigation and treatment of the tonsils, adenoids and grommets.	Any episode of hospital treatment for the investigation and treatment of tonsils, adenoids and grommets. Any episode of hospital treatment including (but not limited to) the following MBS items: 41632; 41789-41801
Bone, joint and muscle	Admission for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, bone spurs, osteomyelitis and bone cancer. Joint reconstructions are listed separately as <i>Joint reconstructions</i>. Joint replacements and spinal fusions for conditions other than scoliosis are listed separately as <i>Joint replacements and spinal fusion</i>. Spinal conditions are included under <i>Back, neck and spine</i>. Rib surgery is included under <i>Heart, lung and vascular system</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the musculoskeletal system, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 18365; 30068; 30075-30078; 30099-30103; 30107-30114; 30224-30244; 30672; 39331-39333; 43500-43524; 44325-44376; 46300-46307; 46327-46342; 46348-46405; 47003-47678; 47703; 47726-47732; 47900-47982; 48118-48242; 48400-48427; 48500-48512; 48900-48903; 48912; 48927-48957; 49100-49112; 49118-49206; 49212; 49218-49306; 49360-49512; 49545; 49566-49712; 49718-49854; 49860-50121; 50130-50239; 50300-50312; 50336-50345; 50357-50408; 50426-50476; 50500-50588; 50650-50658; 52056-52087; 52092; 52180-52186

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Joint reconstructions	Admission for investigation and joint reconstruction procedures. For example: torn tendons, rotator cuff tears and damaged ligaments. Joint replacements and spinal fusions for conditions other than scoliosis are listed separately as <i>Joint replacements and spinal fusion</i>. Bone fractures and joint fusions are included under <i>Bone, joint and muscle</i>.	Any episode of hospital treatment for the investigation and reconstruction of a joint, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 46345; 46408-46535; 48906-48909; 48960; 49215; 49536-49542; 49548-49551; 49557-49564; 50333
Kidney and bladder	Admission for the investigation and treatment of the kidney, adrenal gland and bladder. For example: kidney stones, adrenal gland tumour and incontinence. Dialysis is listed separately under <i>Dialysis for chronic kidney disease</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the kidney, adrenals and bladder, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 11900-11921; 12524-12527; 18375; 18379; 30097; 30324; 36500-37053; 37300-37390; 37444; 37800-37801; 37845-37854; 43984
Male reproductive system	Admission for the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the male reproductive system, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30628-30635; 30640-30644; 30649-30666; 37200-37245; 37393-37438; 37601-37604; 37613-37623; 37803-37842

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Digestive system	Admission for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids. Endoscopy is listed separately as <i>Gastrointestinal endoscopy</i>. Hernia and appendectomy procedures are included under <i>Hernia and appendix</i>. Bariatric surgery is listed separately as <i>Weight loss surgery</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the digestive system, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13506; 13757; 14212; 30373-30472; 30483; 30492; 30495-30566; 30575-30608; 30611; 30619; 30621-30627; 30636-30639; 30676-30679; 31450-31472; 31591-32021; 32024-32069; 32096-32221; 43900-43936; 43942-43978; 43990-44105
Hernia and appendix	Admission for the investigation and treatment of a hernia or appendicitis. Digestive conditions are included under <i>Digestive system</i>.	Any episode of hospital treatment for the investigation and treatment of a hernia or appendicitis. Any episode of hospital treatment including (but not limited to) the following MBS items: 30403-30405; 30571-30574; 30609; 30614-30615; 30645-30646; 43835-43838; 43841; 43939; 44108-44114
Gastrointestinal endoscopy	Admission for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP). Non-endoscopic procedures for the digestive system are included under <i>Digestive system</i>.	Any episode of hospital treatment for the investigation and treatment of the digestive system using an endoscope, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 11820-11823; 30473-30479; 30481-30482; 30484-30485; 30488-30491; 30494; 30568-30569; 30680-30694; 32023; 32072-32095

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Gynaecology	Admission for the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer. Fertility treatments are listed separately under <i>Assisted reproductive services</i>. Pregnancy and birth-related conditions are included under <i>Pregnancy, birth and neonates</i>. Miscarriage or termination of pregnancy is listed separately as <i>Miscarriage and termination of pregnancy</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the female reproductive system, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30062; 35410; 35500-35638; 35641; 35644-35673; 35680-35759
Miscarriage and termination of pregnancy	Admission for the investigation and treatment for a miscarriage or termination of pregnancy.	Any episode of hospital treatment for the investigation and treatment for a miscarriage or termination of pregnancy. Any episode of hospital treatment including (but not limited to) the following MBS items: 35640; 35643; 35674-35678
Chemotherapy, radiotherapy and immunotherapy for cancer	Admission for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours. Surgical treatment of cancer is listed separately under each body system.	Any episode of hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13915-13948; 13760; 14245-16018; 35404-35408; 34521-34534; 34539-34540; 50950-50952

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Skin	Admission for the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. For example: melanoma, minor wound repair and abscesses. Plastic surgery relating to the treatment of a skin-related condition is also included. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for skin and skin-related conditions, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13020; 30023-30055; 30061; 30064-30071; 30180-30216; 30223-30225; 31000-31250; 31340; 31356-31376; 44136; 47904-47918 51900-51902; 52000-52009
Breast surgery (medically necessary)	Admission for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy. For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia. These forms of treatment are considered medically necessary, rather than cosmetic. Cosmetic surgery is not covered under private health insurance. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of breast disorders, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30299-30303; 31500-31566; 45520-45559
Diabetes	Admission for the investigation and treatment of diabetes. For example: contour problems due to insulin injections. Surgical procedures for diabetes-related complications are listed separately, according to the body system affected. For example, treatment for diabetes-related eye conditions is included under <i>Eye</i>. Implantation of insulin pumps is listed separately under <i>Insulin pumps</i>.	Any episode of hospital treatment for the investigation and treatment of diabetes, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 31346

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Heart, lung and vascular system	Admission for the investigation and treatment of heart-related conditions, lung-related conditions, the chest and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, lung cancer, respiratory disorders, varicose veins and endarterectomy. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the heart, lungs, chest and vascular system, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13400; 14209; 30090; 30600-30601; 30696-30710; 32500-34518; 34800-34833; 35100-35363; 38200-38456; 38462-38812; 43900-43915
Blood	Admission for the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants. Treatment for cancers of the blood is included under <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of blood and blood-related conditions, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13700
Back, neck and spine	Admission for the investigation and treatment for the back, neck and spine. For example: sciatica, spinal cord tumours, prolapsed or herniated disc, scoliosis and lordosis (including spinal fusion). Spinal fusion for other conditions is listed separately as <i>Joint replacements and spinal fusion</i>. Management of chronic back pain is included under <i>Chronic pain</i>. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of the back, neck and spine, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 14227-14242; 39140; 40018; 40309-40318; 40330-40351; 43509; 43518; 44133; 47681-47702; 47705-47723; 48600-48632; 50600

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Plastic and reconstructive surgery (medically necessary)	Admission for the investigation and treatment of any physical deformity, whether acquired as a result of illness, accident or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma. These forms of treatment are considered medically necessary, rather than cosmetic. Cosmetic surgery is not covered under private health insurance. Chemotherapy and radiotherapy for cancer is listed separately as <i>Chemotherapy, radiotherapy and immunotherapy for cancer</i>.	Any episode of hospital treatment for the investigation and treatment of any physical deformity, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30003-30020; 30176; 30213-30214; 31350-31355; 38457-38458; 43843-43882; 45000-45519; 45560-45588; 45590-45647; 45650; 45656; 45660-45996; 47000; 47735-47789; 50315-50330; 50348-50354; 50411-50423; 51904-51906; 52018; 52036-52054; 52090-52131; 52144; 52300-52636; 75024-75027
Dental surgery	Admission for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery.	Any episode of hospital treatment for surgery to the teeth and gums, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 75200-75615
Podiatric surgery (provided by an accredited podiatric surgeon)	Admission for investigation and treatment of conditions affecting the foot and/or ankle, provided by an accredited podiatric surgeon.	Any episode of hospital treatment for the investigation and treatment of conditions affecting the foot and/or ankle, provided by an accredited podiatric surgeon. Insurers are required to pay benefits for accommodation for a surgical procedure provided by a podiatric surgeon and the cost of the prosthesis as listed in the prostheses list.
Implantation of hearing devices	Admission for the treatment to correct hearing loss, including implantation of a prosthetic hearing device. Stapedectomy is included under <i>Ear, nose and throat</i>.	Any episode of hospital treatment for the implantation of a prosthetic hearing device. Any episode of hospital treatment including (but not limited to) the following MBS items: 41603- 41604; 41617-41618

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Cataracts	Admission for surgery to remove cataract and replace with an artificial lens.	Any episode of hospital treatment for the treatment of cataracts, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 42698-42716
Joint replacements and spinal fusion	Admission for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses, and spinal fusions for conditions other than scoliosis. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint, spinal disc replacement. Other spinal treatments, including spinal fusions for scoliosis, are included under <i>Back, neck and spine</i> . Joint fusions are included under <i>Bone, joint and muscle</i> .	Any episode of hospital treatment for the replacement of a joint, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 40300-40306; 40321-40327; 46309-46325; 48636-48694; 48915-48924; 49115-49117; 49209-49211; 49315-49346; 49515-49534; 49554; 49715-49717; 49839-49842; 49857; 50127; 50604-50644
Dialysis for chronic kidney disease	Admission for dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.	Any episode of hospital treatment for dialysis treatment for chronic kidney failure, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13100-13112
Pregnancy, birth and neonates	Admission for investigation and treatment of conditions associated with pregnancy, child birth and its complications. Neonates are covered under this category for single parent and family policies. Female reproductive conditions are included under <i>Gynaecology</i> . Fertility treatments are listed separately under <i>Assisted reproductive services</i> . Miscarriage and termination of pregnancy is listed separately as <i>Miscarriage and termination of pregnancy</i> .	Any episode of hospital treatment for the investigation and treatment of conditions associated with pregnancy, child birth, and neonates, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13300-13319; 16399-16627

Clinical category	Scope of cover ¹	Treatments for which benefits must be paid ²
Assisted reproductive services	Admission for fertility treatments or procedures. For example: retrieval of eggs or sperm, <i>In vitro</i> Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT). Treatment of the female reproductive system is included under <i>Gynaecology</i>. Pregnancy and birth-related services are included under <i>Pregnancy, birth and neonates</i>.	Any episode of hospital treatment for fertility procedures, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 13200-13209; 13212-13292; 37605-37606
Weight loss surgery	Admission for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.	Any episode of hospital treatment for a bariatric procedure, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 30165-30172; 30177-30179; 31569-31591
Insulin pumps	Admission for the implantation and replacement of insulin pumps for treatment of diabetes.	Any episode of hospital treatment for implantation and replacement of insulin pumps for treatment of diabetes.
Chronic pain	Admission for the treatment of chronic pain. For example: nerve pain, chronic back pain, and chronic pain caused by coronary heart disease.	Any episode of hospital treatment for chronic pain, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 14218; 39100-39139
Sleep studies	Admission for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.	Any episode of hospital treatment for the investigation of sleep patterns and anomalies, including (but not limited to) those referred to in the scope of cover. Any episode of hospital treatment including (but not limited to) the following MBS items: 12203-12250



Private Health Insurance (Reforms) Amendment Rules 2018

I, Susan Azmi, delegate of the Minister for Health, make the following rules.

Dated 11 October 2018.

s47F

Susan Azmi
Delegate of the Minister for Health

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1 Name

This instrument is the *Private Health Insurance (Reforms) Amendment Rules 2018*.

2 Commencement

- (1) Each provision of this instrument specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

Commencement information		
Column 1	Column 2	Column 3
Provisions	Commencement	Date/Details
1. Sections 1 to 4 and anything in this instrument not elsewhere covered by this table	The day after this instrument is registered.	
2. Schedule 1	1 April 2019	1 April 2019
3. Part 1 of Schedule 2	1 January 2019	1 January 2019
4. Part 2 of Schedule 2	1 April 2019	1 April 2019
5. Part 3 of Schedule 2	1 April 2020	1 April 2020
6. Part 1 of Schedule 3	1 April 2019	1 April 2019
7. Part 2 of Schedule 3	1 April 2020	1 April 2020
8. Schedule 4	1 January 2019	1 January 2019
9. Schedule 5	1 April 2019	1 April 2019
10. Schedule 6	1 April 2019	1 April 2019
11. Schedule 7	The day after this instrument is registered.	

Note: This table relates only to the provisions of this instrument as originally made. It will not be amended to deal with any later amendments of this instrument.

- (2) Any information in column 3 of the table is not part of this instrument. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

3 Authority

This instrument is made under section 333-20 of the *Private Health Insurance Act 2007*.

4 Schedules

Each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

Schedule 1—Amendments to implement age-based discounts

Private Health Insurance (Complying Product) Rules 2015

[1] Rule 4 (note at the end of the rule)

Insert, in the appropriate alphabetical position in the list of terms that have the same meaning as in the Act, the following terms:

- (a) adult;
- (b) hospital cover.

[2] Subrule 6(3)

Omit “(e)”, substitute “(ea)”.

[3] Subrule 6(5)

Omit “The following costs are excluded from the calculation of net premium in subrule (4):”, substitute “For the purposes of this rule, disregard:”.

[4] At the end of subrule 6(5)

Insert:

; and (c) any age-based discount that might apply in relation to the policy (see Part 2A).

[5] After Part 2

Insert:

Part 2A Age-based discounts

Note 1: See paragraphs 63-10 (g) and 66-5 (3) (ea) of the Act.

Note 2: Nothing in this Part requires a private health insurer to:

- make age-based discounts available under any product; or
- if age-based discounts are available under a product:
 - make such discounts available for all ages between 18 and 29 (inclusive); or
 - continue to make age-based discounts available under the product.

Instead, an age-based discount policy may specify the ranges of ages, between 18 and 29 (inclusive), for which such discounts will be available (see subparagraph 11B (c) (i)).

However, under this Part:

- if a person is receiving an age-based discount, the person is entitled to continue to receive the full discount until the person turns 41 (unless the insurer chooses to discontinue age-based discounts under the product, or the person transfers to a different insurance policy), and might be entitled to receive a reduced discount for a number of years after turning 41; and
- if age-based discounts are available in relation to particular ages or particular ranges of ages for a particular product, they must be available in relation to those ages or ranges on the same terms and conditions for all insurance policies under that product (see section 63-5 of the Act).

11A. Definitions

In this Part:

age-based discount policy means an insurance policy that provides age-based discounts.

discount assessment date, in relation to a person who is insured under an age-based discount policy, means whichever of the following is applicable:

- (a) subject to paragraph (c), if the policy provided age-based discounts at the date the person became insured—that date;
- (b) if the policy provided age-based discounts at a date after the person became insured—the date the person was first eligible for an age-based discount under the policy;
- (c) if:
 - (i) the person transferred to the policy (the **new policy**) from another age-based discount policy (the **old policy**); and
 - (ii) at the time of the transfer, the new policy was stated to be a retained age-based discount policy; and
 - (iii) the person was not a dependent child under the old policy; the person's discount assessment date under the old policy.

eligible person, in relation to an age-based discount policy, means a person to whom a discount applies in accordance with paragraph 11B (c).

retained age-based discount policy means an insurance policy:

- (a) that is an age-based discount policy; and
- (b) that states that it is a retained age-based discount policy.

11B. Requirements for age-based discount policy to be complying health insurance policy

For paragraph 63-10 (g) of the Act, an insurance policy must not provide for an age-based discount (the **discount**) unless:

- (a) the policy covers:
 - (i) hospital treatment; or
 - (ii) hospital treatment and general treatment; and
- (b) the discount will be a reduction in the amount that would otherwise be payable by the person for the policy, equal to the dollar amount calculated in accordance with rule 11C; and
- (c) the discount will apply to each person insured under the policy who, on the discount assessment date for the person:
 - (i) was within one or more ranges of ages, between 18 and 29 (inclusive), that are specified in the policy as eligible for the discount; and
 - (ii) was not a dependent child under the policy; and
- (d) while age-based discounts are available under the policy, the discount will continue to apply until it is reduced, in accordance with rule 11C, to zero in relation to each such person insured under the policy; and
- (e) the policy states whether it is a retained age-based discount policy.

Note: For paragraph (c), an insurer is not required to provide discounts for all ages between 18 and 29 (inclusive).

11C. Calculation of age-based discount

Note: This rule deals only with the calculation of the age-based discount. The premium that is payable in respect of a particular insurance policy is also affected by other provisions of the Act (including Part 2-3 of the Act, which deals with lifetime health cover) and rules made under the Act (including these Rules).

- (1) For paragraph 11B (b), the total age-based discount that applies under an age-based discount policy for a particular period is equal to the sum of the applicable discounts to which each eligible person who is insured under the policy is entitled for that period.
- (2) An eligible person is entitled to an *applicable discount* calculated in accordance with the following formula:

$$\text{applicable discount} = \frac{\text{base rate for hospital cover} \times \text{applicable percentage}}{\text{number of adults insured}}$$

where:

applicable percentage, for a particular period, is the greater of:

- (a) the person's percentage for the period, determined in accordance with the table to subrule (3); and
- (b) zero.

base rate for hospital cover is the amount of premiums that would be payable for hospital cover under the policy if:

- (a) the premiums were not increased under Part 2-3 of the Act (lifetime health cover); and
- (b) there were no discounts of the kind allowed under subsection 66-5 (2) of the Act (including under this Part of these Rules).

number of adults insured is the number of adults insured under the policy.

- (3) For paragraph (a) of the definition of *applicable percentage* in subrule (2), the table is:

If, for that period, the person is aged:	the person's percentage for the period is:
18 or older, but under 41	the person's base percentage
41	the person's base percentage minus 2 percentage points
42	the person's base percentage minus 4 percentage points
43	the person's base percentage minus 6 percentage points
44	the person's base percentage minus 8 percentage points
45 or older	zero

- (4) For subrule (3), a person's *base percentage* is equal to:
 - (a) for an eligible person under the policy—the percentage, as given by the following table, corresponding to the person's age at the discount assessment date; and

Note: See paragraph 11B (c).
(b) otherwise—zero.

Person's age at discount assessment date	Percentage
18 or older, but under 26	10%
26	8%
27	6%
28	4%
29	2%

11D. Circumstances in which a person is entitled to age-based discount

For paragraph 66-5 (3) (ea) of the Act, a person is entitled to an age-based discount for a particular period if:

- (a) the person is insured under an age-based discount policy during that period; and
- (b) the person is an eligible person in relation to that policy; and
- (c) the person's applicable discount for that period, as calculated in accordance with subrule 11C (2), is not equal to zero.

Schedule 2—Standard information statements and private health information statements

Part 1—Amendments commencing on 1 January 2019

Private Health Insurance (Complying Product) Rules 2015

[1] Rule 4

Insert:

State, when used in Schedule 1, Schedule 2 or Schedule 3, means a risk equalisation jurisdiction.

Note: The risk equalisation jurisdictions are set out in the *Private Health Insurance (Health Benefits Fund Policy) Rules 2015*. Under those rules, the area specified in each of the following paragraphs is a risk equalisation jurisdiction:

- (a) Australian Capital Territory, Norfolk Island and New South Wales;
- (b) Northern Territory;
- (c) Queensland;
- (d) South Australia;
- (e) Tasmania;
- (f) Victoria;
- (g) Western Australia and the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands.

[2] Rule 4 (note at the end of the rule)

Insert, in the appropriate alphabetical position in the list of terms that have the same meaning as in the Act, “risk equalisation jurisdiction”.

[3] Part 3

Repeal the Part, substitute:

Part 3 Standard information statements and other information that must be given

Note: This Part deals with:

- the information and form for standard information statements, for the purposes of subsection 93-5 (1) of the Act, and methods by which standard information statements are made available; and
- information that must be provided to the Private Health Insurance Ombudsman relating to changes in premiums.

This Part does not limit the information that a private health insurer may give to an insured person.

12. Standard information statements

Note: See rule 20 for a transitional provision relating to this rule that applies until 31 March 2020.

- (1) For subsection 93-5 (1) of the Act, the information to be contained in a standard information statement, and the form, for a product subgroup of a complying health insurance product, are:
 - (a) the information and form of words set out in Schedule 1; and

-
- (b) if policies that belong to the product subgroup cover hospital treatment—the additional information, and the form of words, set out in Schedule 2; and
 - (c) if policies that belong to the product subgroup cover general treatment—the additional information, and the form of words, set out in Schedule 3.
- (2) However, paragraph (1)(c) does not apply if the only general treatment provided is ambulance cover.

13. Method of making standard information statements available

- (1) This rule is made for the purposes of subsection 93-5 (2) and paragraph 93-15 (1) (a) of the Act.
- (2) If:
 - (a) the standard information statement is accompanied by information additional to the information and form of words that are required by subrule 12 (1); and
 - (b) the standard information statement and the additional information are set out in the same document;
 the additional information must not obscure or contradict the information and form of words that that are required by subrule 12 (1).

Example: The document on which a standard information statement is provided might include information about ambulance cover that is additional to the information required by item 10 of the table to clause 2 of Schedule 1. The additional information could be included adjacent to the required information, so long as the additional information did not obscure or contradict the required information.

14. Information relating to changes to premiums to be provided to Private Health Insurance Ombudsman

- (1) This rule is made for the purposes of section 96-25 of the Act.
- (2) This rule applies if the Minister has approved a proposed change to the premiums charged under a complying health insurance product of a private health insurer under subsection 66-10 (3) of the Act.
- (3) The private health insurer must notify the Private Health Insurance Ombudsman of:
 - (a) the premiums that applied before the approval; and
 - (b) the premiums that apply after the approval.
- (4) The insurer must give this information to the Ombudsman by the earlier of:
 - (a) the day 14 days after the date of the Minister's approval for the change; and
 - (b) 1 April of the year in which the Minister approved the change.

[4] After rule 19

Insert:

20. Transitional provision relating to the *Private Health Insurance (Reforms) Amendment Rules 2018*—standard information statements

Application of rule

- (1) This rule applies until 31 March 2020.

Transitional provision

- (2) A standard information statement that is in the old form is taken to contain the information, and be in the form, set out in these Rules.
- (3) For this rule, a standard information statement is in the *old form* if it contains the information, and is in the form, set out in these Rules as in force immediately before the commencement of Part 1 of Schedule 2 to the *Private Health Insurance (Reforms) Amendment Rules 2018*.

Note: Part 1 of Schedule 2 to the *Private Health Insurance (Reforms) Amendment Rules 2018* commenced on 1 January 2019.

[5] Schedules 1, 2, 3 and 4

Repeal the Schedules, substitute:

Schedule 1—Information and form of words for standard information statement—all policies

1. Interpretation

In this Schedule, a reference to a *policy* is a reference to a policy that forms part of the relevant product subgroup.

2. Information and form of words for standard information statement—all policies

For paragraph 12 (1) (a) of these Rules, the information and form of words are set out in the following table:

Information and form of words for standard information statement—all policies	
Item	Information and form of words
1	Policy name The name of the policy.
2	Name of private health insurer The trading or brand name of the private health insurer in the State in which the policy is being made available, together with any associated branding that the insurer elects to include.
3	Disclaimer for restricted access insurers If the policy is offered by a restricted access insurer—the following statement: “Membership of this insurer is restricted to”

Information and form of words for standard information statement—all policies

Item Information and form of words

followed by the details.

4 Contact details

A contact phone number and website address of the private health insurer.

5 State/s available in

The States in which the product is available, expressed as either:

- (a) if:
 - (i) the product is offered in all States; and
 - (ii) every feature of the product (including the monthly premium referred to in item 6) is the same in each State;

“All States”; or
- (b) otherwise—the State or States in which the product is available, expressed as whichever of the following is applicable:
 - (i) “NSW & ACT”;
 - (ii) “Northern Territory”;
 - (iii) “Queensland”;
 - (iv) “South Australia”;
 - (v) “Tasmania”;
 - (vi) “Victoria”;
 - (vii) “Western Australia”.

6 Monthly premium

The total monthly premium payable before any rebate, loading or discount is applied.

The following words must be inserted before or following the premium amount: “before any rebate, loading or discount”.

Note: This item does not limit the information that a private health insurer may give to an insured person with regard to the premium payable after any rebate, loading and/or discount is applied.

7 Corporate products

If the policy is part of a corporate product—a statement to that effect, indicating either of the following, with the bracketed text replaced with the appropriate information:

- (a) “Employees/members of [Company/Organisation]”;
- (b) “Employees/members of organisations with arrangements with this health insurer”.

8 Closed products

If the policy is closed so that it is no longer available to anyone except those persons who, at the time of closing, were insured under the policy—the following words:

“This policy is closed to new members.”.

Information and form of words for standard information statement—all policies

Item Information and form of words

9 Who is covered

The insured groups that may be covered, expressed as whichever of the following is applicable:

- (a) “only one person”;
- (b) “2 adults (and no-one else)”;
- (c) “2 or more people, none of whom is an adult”;
- (d) “2 or more people, only one of whom is an adult”;
- (e) “3 or more people, only 2 of whom are adults”;
- (f) “3 or more people, at least 3 of whom are adults”.

Note 1: The insured groups are set out in rule 5 of these Rules.

Note 2: This item does not limit the information that a private health insurer may give to an insured person with regard to the name/s of person/s covered by the policy.

10 Ambulance cover

The following information:

- (a) whether ambulance cover is included;
- (b) if so:
 - (i) the waiting period (if any); and
 - (ii) whether the cover is:
 - (A) emergency only; or
 - (B) emergency and non-emergency; and
 - (iii) any limits on cover (dollar amount or service); and
 - (iv) any call-out fees (if applicable);
- (c) for each State in which:
 - (i) the product is available; and
 - (ii) ambulance cover is not included;

the following information:

 - (iii) whether free ambulance services are available in that State;
 - (iv) if so—whether they are limited to services in that State;
- (d) if ambulance cover were to be provided by a person other than the private health insurer who prepared the statement—whether the policy would provide a benefit for that cover.

11 Date available

If, and only if, the policy is not yet available—the date from which the policy will be available.

12 Date statement issued or updated

The date on which the content of the statement was issued or updated, in the following format, with the bracketed text replaced with the appropriate information:

“Date statement [issued/updated]: [dd]/[month in words]/[yyyy]”

Information and form of words for standard information statement—all policies

Item Information and form of words

13 Unique identifier

The unique identifier for the standard information statement that is generated by the privatehealth.gov.au system.

Schedule 2—Additional information, and form of words, for standard information statement—hospital treatment

1. Interpretation

In this Schedule, a reference to a *policy* is a reference to a policy that forms part of the relevant product subgroup.

2. Additional information and form of words—hospital treatment

For paragraph 12 (1) (b) of these Rules, the additional information and form of words are set out in the following table:

Additional information and form of words—hospital treatment

Item Additional information and form of words

1 Information relating to policies that are available only with a general treatment policy

If the policy is available only with a policy that covers general treatment—whichever of the following is applicable:

- (a) if the policy may be purchased with any policy that covers general treatment offered by the insurer—the statement “must be purchased with a general treatment policy”;
- (b) if there is a set range of policies that cover general treatment with which the policy may be combined—the statement “must be purchased with certain general treatment policies”.

2 Whether the policy exempts holders from the Medicare Levy Surcharge

Whichever of the following is applicable:

- (a) “This policy exempts you from the Medicare Levy Surcharge”;
- (b) “This policy does not exempt you from the Medicare Levy Surcharge”.

3 What’s included and what’s not included in the policy

An indication of:

- (a) treatments that are covered by the policy, consisting of the words:
“This policy includes cover for”
followed by the relevant treatments; and
 - (b) treatments that are not covered by the policy, consisting of the words:
“This policy does not include cover for”
-

Additional information and form of words—hospital treatment

Item Additional information and form of words

followed by the relevant treatments.

4 Restrictions

A list of all restrictions (if any) that apply.

5 Waiting periods for new and upgrading members

The waiting periods that apply under the policy before a policy holder can claim, expressed either:

- (a) in the following format, with the bracketed text replaced with the appropriate figures:
 - (i) “[the number of months (up to 2)] months for palliative care, rehabilitation and psychiatric treatments”;
 - (ii) “[the number of months (up to 12)] months for pre-existing conditions”;
 - (iii) if, and only if, the policy covers pregnancy and birth (obstetrics)—“[the number of months (up to 12)] months for pregnancy and birth (obstetrics)”;
 - (iv) “[the number of months (up to 2)] months for all other treatments”;

or
- (b) if shown in a table—for all treatments covered by the policy, the appropriate figure for the relevant waiting period.

Note 1: This item does not limit the information that a private health insurer may provide with regard to an individual’s policy.

Note 2: The obstetrics waiting period of up to 12 months does not apply to treatment for neonatal care.

6 Excess

Whichever of the following is appropriate:

- (a) if there is no excess—the words “No excess”;
 - (b) if there is an excess:
 - (i) whichever of the following is appropriate, with the bracketed text replaced with the appropriate figure, and where the dollar amount for excess per admission is the excess for an overnight admission, if this is different from the excess for day surgery:
 - (A) “You will have to pay an excess of \$[number] per admission.”;
 - (B) “You will have to pay an excess of \$[number] per admission. This is limited to a maximum of \$[number] per year.”;
 - (C) “You will have to pay an excess on admission. This is limited to a maximum of \$[number] per year.”;
 - (D) “You will have to pay an excess of \$[number] per admission. This is limited to a maximum of \$[number] per person per year.”;
 - (E) “You will have to pay an excess on admission. This is limited to a maximum of \$[number] per person and \$[number] per policy per year.”;
-

Additional information and form of words—hospital treatment

Item Additional information and form of words

- (F) “You will have to pay an excess of \$[number] per admission. This is limited to a maximum of \$[number] per person and \$[number] per policy per year.”;
 - (G) “You will have to pay an excess on admission. This is limited to a maximum of \$[number] per policy per year.”; and
 - (ii) if applicable—“Excess payments do not apply to hospital admissions for accidents, of child dependants, or for day surgery”, with any of “accidents”, “child dependants” and “day surgery” that do not apply deleted, but with the order of those terms otherwise unchanged.
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7 Extra cost per day (co-payments)

If there are no co-payments—the statement “No co-payments”.

If there are co-payments:

- (a) the statement “Every time you go to hospital you will have to pay”, followed by (with the bracketed text replaced with the appropriate figures):
 - (i) either:
 - (A) the statement “\$[number] per day for overnight admissions”; or
 - (B) the statements:
 - “\$[number] per day for a shared room for overnight admissions”; and
 - if the policy covers accommodation in a private room—“\$[number] per day for a private room for overnight admissions”; and
 - (ii) as applicable, either:
 - (A) the statement “\$[number] for day surgery (no overnight stay)”; or
 - (B) the statement “No co-payment for day surgery (no overnight stay)”; and
 - (iii) the statement “– up to \$[number] per hospital stay”, placed, if applicable, and if the insurer so chooses, directly after the statements referred to in subparagraph (i); and
 - (b) if applicable—the statement “The maximum co-payment is \$[number] per year” (with the bracketed text replaced with the appropriate figures).
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8 Note on out of pocket costs/doctors’ fees

The following statement:

“Under this policy, you may have to pay out-of-pocket costs above what you get from Medicare or your private health insurer. Before you go to hospital, you should ask your doctors, hospital and health insurer about any out-of-pocket costs that may apply to you.”
