Private Health Insurance (Reforms) Amendment Rules 2018

I, **[INSERT NAME]**, delegate of the Minister for Health, make the following rules.

EXPOSURE DRAFT JULY 2018

Dated

[INSERT NAME] **DRAFT ONLY—NOT FOR SIGNATURE**
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. Schedule 3	1 April 2019	1 April 2019
6. Schedule 4	1 January 2019	1 January 2019
7. Schedule 5	1 April 2019	1 April 2019
8. Schedule 6	1 April 2019	1 April 2019

Note: This table relates only to the provisions of this instrument as originally made.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Each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.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:

(a) subject to paragraph (c), if the policy provided age-based discounts at the date the person became insured—that date; and

(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; and

(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 subrule 11B (c).

retained age-based discount policy means an insurance policy:

(a) that is an age-based discount policy; and

(b) that provides that if a person transfers from another age-based discount policy (the ***old policy***) to the policy, the person is entitled to retain the age-based discount (if any) they were receiving under the old 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 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 to zero in relation to each such person insured under the policy in accordance with rule 11C; 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

(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%

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] 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 private health information statements, for the purposes of subsection 93-5 (1) of the Act; 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

For subsection 93-5 (1) of the Act, for a product subgroup of a complying health insurance product, the information and form is:

(a) the information and form set out in Schedule 1; and

(b) if policies that belong to the product subgroup cover hospital treatment—the additional information, and the form, set out in Schedule 2; and

(c) if policies that belong to the product subgroup cover general treatment—the additional information, and the form, set out in Schedule 3.

13. Transitional provision for standard information statements

(1) 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.

(2) 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.

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.

[2] Schedules 1, 2, 3 and 4

Repeal the Schedules, substitute:

Schedule 1—Information and form for standard information statement—all product subgroups

1 Information and form for standard information statement—all product subgroups

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

Information and form for standard information statement—all product subgroups

Item	Information and form
1	**Date of issue** The date on which the content of the statement was issued or updated, in the format: dd/month in words/yyyy
2	**Name of private health insurer** The trading or brand name of the private health insurer in the State or Territory in which the product subgroup is being made available.
3	**Disclaimer for restricted access insurers** If policies that belong to the product subgroup are offered by a restricted access insurer—the following statement: "Membership of this insurer is restricted to" followed by the details.
4	**Contact details**

Information and form for standard information statement—all product subgroups

Item	Information and form
	A contact phone number and website address of the private health insurer.
5	**Jurisdiction available in** The States and Territories in which the product subgroup is available, expressed as either: (a) if every feature of each product subgroup of the product (including the monthly premium referred to in item 7) is identical—"All States"; or (b) otherwise—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	**Product name** The name of the complying health insurance product.
7	**Monthly premium** The total monthly premium payable before any rebate, loading or discount is applied. Note: This item does not limit the information that a private health insurer may give to an insured person with regard to premium payable after rebate, loading and/or discounts are applied.
8	**Corporate products** If the product subgroup 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]"; or (b) "Employees/members of organisations with arrangements with this health insurer".
9	**Closed products** If the product subgroup of the complying health insurance product is closed so that it is no longer available to anyone except those persons who, at the time of closing, were insured under a policy forming part of the product—the following words: "This product subgroup is closed to new members.".
10	**Unique identifier** The unique identifier for the standard information statement for the product

Information and form for standard information statement—all product subgroups	
Item	**Information and form**
	subgroup that is generated by the privatehealth.gov.au system.
11	**Who is covered** Who may be covered by policies that belong to the product subgroup, expressed as whichever of the following is applicable: (a) "One adult"; (b) "Two adults"; (c) "Dependants only"; (d) "One adult & dependants only"; (e) "Two adults & dependants"; (f) "Two adults & any dependants"; (g) "At least 3 adults & and any dependants". Note: 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.
12	**Date available** If, and only if, the complying health insurance product is not yet available—the date from which it will be available.

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

1. Additional information and form—hospital treatment

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

Additional information and form—hospital treatment	
Item	**Additional information and form**
2	**Statement indicating whether policies that belong to the product subgroup exempt 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 policies that belong to the product subgroup, consisting of the words: "This product subgroup includes cover for"

Additional information and form—hospital treatment	
Item	**Additional information and form**
	followed by the relevant treatments; and (b) treatments that are not covered by policies that belong to the product subgroup, consisting of the words: "This product subgroup does not include cover for" followed by the relevant treatments.
4	**Waiting periods for new and upgrading members** The waiting periods that apply under policies that belong to the product subgroup before a policy holder can claim, expressed in the following format, with the bracketed text replaced with the appropriate figures: (a) "[the number of months (up to 2)] months for palliative care, rehabilitation and psychiatric treatments"; (b) "[the number of months (up to 12)] months for pre-existing conditions"; (c) if, and only if, the product subgroup covers pregnancy, birth and neonates—"[the number of months (up to 12)] months for pregnancy, birth and neonates"; (d) "[the number of months (up to 2)] months for all other treatments". Note: This item does not limit the information that a private health insurer may provide with regard to an individual's policy.
5	**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."; (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

Additional information and form—hospital treatment

Item	Additional information and form
	limited to a maximum of $[number] per policy per year."; and (ii) if applicable—"Excess payments do not apply to hospital admissions for accidents, of child dependants, or for day surgery", with any of "accidents", "child dependants" and "day surgery" that do not apply deleted, but with the order of those terms otherwise unchanged.
6	**Extra cost per day (co-payments)** If there are no co-payments—the statement "No co-payments". If there are co-payments: (a) the statement "Every time you go to hospital you will have to pay", followed by (with the bracketed text replaced with the appropriate figures): (i) either: (A) the statement "$[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".
7	**Restrictions** A list of all restrictions (if any) that apply.
8	**Note on out of pocket costs/doctors' fees** The following statement: "Before you go to hospital, you should ask your doctor, hospital and health insurer about any out-of-pocket costs that may apply to you.".
9	**Note on information relating to contracts between hospitals and insurers** The following statement:

Additional information and form—hospital treatment	
Item	**Additional information and form**
	"The benefits paid for hospital treatment will depend on the type of cover you purchase and whether your fund has an agreement in place with the hospital in which you are treated. See 'Agreement Hospitals' on privatehealth.gov.au for which hospitals have arrangements with your insurer.".

Schedule 3—Additional information, and form, for standard information statement—general treatment

1. Additional information and form—general treatment

For paragraph 12 (c) of these Rules, the additional information and form is set out in the following table:

Additional information and form—general treatment	
Item	**Information and form**
1	**Information relating to policies that are available only with a hospital policy** If policies that belong to the product subgroup are available only with a policy that covers hospital treatment—whichever of the following is applicable: (a) if policies that belong to the product subgroup may be purchased with any policy that covers hospital treatment offered by the insurer—the statement "must be purchased with a hospital policy"; (b) if there is a set range of policies that cover hospital treatment with which policies that belong to the product subgroup may be combined—the statement "must be purchased with certain hospital policies".
2	**Preferred service provider arrangements** Whichever of the following is appropriate: (a) if the private health insurer has preferred service provider arrangements—either: (i) a brief outline of the appropriate arrangements; or (ii) the following statement, with the bracketed text replaced with the appropriate text: "By using [insert name of insurer]'s 'preferred providers' you may have lower out of pocket costs on [insert services or use "many allied health"] services and have access to more 'no gap' services. A list of 'preferred providers' is available from the health insurer."; (b) otherwise—the following statement, with the bracketed text replaced with the appropriate text: "[Insert name of insurer] does not operate a preferred provider scheme.".

Additional information and form—general treatment	
Item	**Information and form**
3	**Services covered by the product subgroup** A complete list of treatments that are covered by the product subgroup, expressed in terms of the following: (a) general dental; (b) major dental; (c) endodontic; (d) orthodontic; (e) optical; (f) non PBS pharmaceuticals; (g) physiotherapy; (h) chiropractic; (i) podiatry; (j) psychology; (k) acupuncture; (l) remedial massage; (m) hearing aids; (n) blood glucose monitors.
4	**Services not covered by the product subgroup** A complete list of services that are not covered by the product subgroup, expressed in terms of the treatments listed in item 3.
5	**Waiting period (months)** For each treatment that is covered by policies that belong to the product subgroup—whichever of the following is applicable, with the bracketed text replaced with the appropriate text: (a) if there is a waiting period: (i) for a short term waiting period for ambulance cover—"[x] days"; and (ii) otherwise—"[Number] months"; (b) if there is no waiting period for the treatment—"None". Note: If an insured person has already served all applicable waiting periods, this item does not limit the information that a private health insurer may provide with regard to the individual's policy.
6	**Benefit limits (per 12 months)** For each treatment that is covered by a policy that belongs to the product subgroup—if there is no annual limit on the benefits that can be paid, the statement "No annual limit". Otherwise—the following statements, as applicable, with the bracketed text replaced with the appropriate figures or text:

Additional information and form—general treatment	
Item	**Information and form**
	(a) either: (i) any of the following statements: (A) "$[number] per person"; (B) "$[number] per service"; (C) "$[number] per policy"; or (ii) any combination of the statements set out in subparagraph (a) (i), linked by the words "up to"; (b) if there is a limit on claims per specified number of years—whichever of the following is applicable: (i) "[number] appliance(s) every [specified number] years"; (ii) "[number] service(s) every [specified number] years"; (c) in the case of combined limits: (i) for the treatment against which the combined limit is listed—"(combined limit for [list treatments listed in item 3 in relation to which limit is combined])"; and (ii) for the other treatments in relation to which the limit is combined—"(combined limit – see [treatment against which the combined limit is listed])"; (d) in the case of limits for individually grouped services—whichever of the following statements is applicable: (i) "$[number] per person (combined limit for [whichever of general dental, major dental, endodontic & orthodontic is applicable])"; (ii) "$[number] lifetime limit for [whichever of general dental, major dental, endodontic & orthodontic is applicable]"; (e) if a sub-limit applies on any treatment—the statement "**Sub-limits apply**" (in bold font); (f) if: (i) there is a limit on general dental; but (ii) there is no limit on preventative dental; the statement "(no limit on preventative dental)". Note: If an insured person has used a portion of lifetime limits, this item does not limit the information that a private health insurer may provide with regard to the individual's usage of lifetime limit amounts.
7	**Examples of maximum benefits—general dental, major dental, endodontic and orthodontic** For each treatment listed in paragraphs (a) to (d) of item 3 (whether or not covered by the policy): (a) the following treatments, broken down into the following dental item numbers: (i) for general dental: (A) "Periodic oral examination"—012; and (B) "Scale & clean"—114; and (C) "Fluoride treatment"—121; and (D) if covered under general dental—"Surgical tooth extraction"—322;

Additional information and form—general treatment	
Item	**Information and form**
	(ii) for major dental treatment: (A) if covered under major dental—"Surgical tooth extraction"—322; and (B) "Full crown veneered"—615; and (iii) for endodontic treatment—"Filling of one root canal"—417; (iv) for orthodontic treatment—"Braces for upper and lower teeth, including removal plus fitting of retainer"—881; and (b) if the dental item number is covered by the policy—an example of the maximum benefit that is payable when an insured person visits a practitioner who is not a preferred service provider, expressed using whichever of the following is applicable: (i) "$[number]", with the bracketed text replaced by the appropriate figure, if: (A) the benefit is a dollar figure; or (B) the insurer pays a benefit that is a percentage of the charge up to a dollar limit that is specified for the item separately from an annual limit; (ii) if the only benefit limit for the item is an annual limit—"[number]% of charge", with the bracketed text replaced by the appropriate figure; and (c) if the dental item number is not covered by the policy— the statement "n/a". For this item: (d) if: (i) the dental item number is provided by orthodontists and general dentists; and (ii) different benefits are offered for orthodontists and general dentists; the maximum benefit for the orthodontist must be used; and (e) if examples are given for initial and subsequent visits, examples must be for individual sessions.
8	**Examples of maximum benefits—other** For each treatment listed in paragraphs (e) to (n) of item 3 that is covered by the policy—examples of the maximum benefits that are payable when an insured person visits a practitioner who is not a preferred service provider expressed using whichever of subparagraphs (b)(i) and (ii) of item 7 is applicable. For this item: (a) if examples are given for initial and subsequent visits, examples must be for individual sessions; and (b) if: (i) optical treatment is covered; and

Additional information and form—general treatment	
Item	**Information and form**
	(ii) benefits for frames and lenses are paid separately; the example must be expressed as the sum of the benefit for each component.
9	**Ambulance cover** The following must be specified: (a) whether ambulance cover is included in policies that belong to the product subgroup; (b) if ambulance cover is included: (i) the waiting period (if any); (ii) whether the cover is emergency only or emergency and non-emergency; (iii) any limits on cover (dollar amount or service); (iv) any call-out fees (if applicable).

Part 2—Amendments commencing on 1 April 2019

Private Health Insurance (Complying Product) Rules 2015

[3] Part 3 (note to the Part heading, after the first bullet point)

Insert:

- the information and form for private health information statements, for the purposes of subsection 93-5 (1) of the Act; and

[4] Rule 13

Repeal the rule, substitute:

13. Information provided to insured persons

(1) For paragraph 63-10 (g) of the Act, an insurance policy must provide that, when giving a person a copy of a private health information statement in accordance with section 93-15 or subsection 93-20 (1) of the Act, the private health insurer will inform the person of the following:

(a) the name of each person who is covered by the policy;

(b) if the product subgroup to which the policy belongs covers hospital treatment—the following statements for each adult who is covered by the policy and to whom a lifetime health cover loading applies, with the bracketed text replaced with the appropriate amounts:

(i) "Your Lifetime Health Cover Loading is [Number]%.";

(ii) "You have [Number] years remaining until you have reached 10 continuous years of cover and your loading is removed.".

(2) This rule does not limit the information that a private health insurer may give to an insured person.

Example: An insurer may also inform an insured person of:

- the premium for hospital treatment and for general treatment that applies in relation to each adult insured under the policy, taking account of matters such as loadings, rebates and discounts; and
- the remaining portion (if any) of the waiting period for any or each treatment covered by the policy.

[5] Clause 1 of Schedule 1 (table item 6)

Repeal the item, substitute:

6	**Product name** The name of the complying health insurance product. Note: See rules 11G and 11H for rules governing the naming of products that cover hospital treatment and the naming of products that cover general treatment.

[6] Clause 1 of Schedule 2 (after the table heading)

Insert:

1 **Level of cover**

Whichever of "Gold", "Silver", "Bronze" or "Basic" is applicable.

[7] Clause 1 of Schedule 2 (table item 3)

Repeal the item, substitute:

3 **What's included and what's not included in the policy**

An indication of:

(a) treatments that are covered by policies that belong to the product subgroup, consisting of the words:

"This product subgroup includes cover for"

followed by the relevant clinical categories as specified in Schedule 4; and

(b) treatments that are not covered by policies that belong to the product subgroup, consisting of the words:

"This product subgroup does not include cover for"

followed by the relevant clinical categories as specified in Schedule 4.

[8] Clause 1 of Schedule 2 (table item 7)

Repeal the item, substitute:

7 **Restrictions**

A list of all clinical categories (if any) in respect of which restrictions apply.

[9] Amendments of listed provisions—private health information statements

Further amendments

Item	Provision	Omit	Substitute
1	Rule 4 (note at the end of the rule)	standard information statement	private health information statement
2	Paragraph 9AA (2) (a)	standard information statement	private health information statement
3	Part 3 (heading)	Standard information statements	Private health information statements
4	Rule 12 (heading)	Standard information statements	Private health information statements
5	Schedule 1 (heading)	standard information statement	private health information statement
6	Schedule 1, clause 1 (heading)	standard information statement	private health information statement
7	Schedule 1, clause 1 (table heading)	standard information statement	private health information statement
8	Schedule 1, clause 1, table item 10	standard information statement	private health information statement

Further amendments

Item	Provision	Omit	Substitute
9	Schedule 2 (heading)	standard information statement	private health information statement
10	Schedule 3 (heading)	standard information statement	private health information statement

Schedule 3—Product tiers and related amendments

Private Health Insurance (Complying Product) Rules 2015

[1] Rule 4

Insert:

basic policy means an insurance policy that:

(a) covers hospital treatment; and

(b) covers at least the treatments in all of the clinical categories indicated for a basic policy in Schedule 5; and

(c) is not a gold, silver or bronze policy.

bronze policy means an insurance policy that:

(a) covers hospital treatment; and

(b) covers at least the treatments in all of the clinical categories indicated for a bronze policy in Schedule 5; and

(c) is not a gold or silver policy.

clinical category, for hospital treatment, means a clinical category that is set out in Schedule 4.

gold policy means an insurance policy that:

(a) covers hospital treatment; and

(b) covers the treatments in all of the clinical categories indicated for a gold policy in Schedule 5.

silver policy means an insurance policy that:

(a) covers hospital treatment; and

(b) covers at least the treatments in all of the clinical categories indicated for a silver policy in Schedule 5; and

(c) is not a gold policy.

[2] After Part 2A

Insert:

Part 2B Requirements relating to product tiers for, and names of, insurance policies

Note: This Part specifies additional requirements that an insurance policy must meet in order to be a complying health insurance policy, for the purposes of paragraph 63-10 (g) of the Act.

11D. Product tiers for insurance policies that cover hospital treatment

(1) For paragraph 63-10 (g) of the Act, this rule applies to an insurance policy that covers hospital treatment (whether or not the policy also covers general treatment).

(2) The policy must be one of the following:
  (a) a gold policy;
  (b) a silver policy;
  (c) a bronze policy;
  (d) a basic policy.

11E. Clinical categories for insurance policies that cover hospital treatment

(1) For paragraph 63-10 (g) of the Act, this rule applies to an insurance policy that covers hospital treatment (whether or not the policy also covers general treatment).

(2) The policy must use the clinical categories to indicate the hospital treatments it covers and does not cover.

(3) For each such clinical category, the policy must cover:
  (a) all hospital treatments that are within the scope of cover of that treatment indicated in Schedule 4; and
  (b) all hospital treatments for which benefits must be paid that are listed against that clinical category in Schedule 4; and
  (c) each of the following procedures, if provided to an admitted patient as part of the treatment of a primary condition or service that is performed in relation to a hospital treatment that is covered by the policy:
    (i) consultation;
    (ii) diagnostic services and diagnostic imaging;
    (iii) pathology;
    (iv) pre-operative assessment;
    (v) anaesthesia and regional nerve block;
    (vi) attendance at an operation by a physician and assistant;
    (vii) associated miscellaneous services related to the principal service;
    (viii) management of complications related to the principal service.

(4) If investigative surgery is within the scope of cover of any clinical category, the policy must cover the surgery, and any treatment that is provided during the surgery, even if the investigation reveals a condition the treatment of which is not covered by the policy.

11F. Provision of restricted and unrestricted cover

Gold policies

(1) A gold policy must provide unrestricted cover for all hospital treatments in all clinical categories.

Silver policies and bronze policies

(2) A silver policy or a bronze policy:

(a) must provide restricted cover or unrestricted cover for all hospital treatments in the following clinical categories:
(i) rehabilitation;
(ii) hospital psychiatric services;
(iii) palliative care; and
(b) must provide unrestricted cover for all hospital treatments in:
(i) the other clinical categories that a silver policy or a bronze policy, as appropriate, is required to cover; and
(ii) any other clinical categories that the policy covers.

Basic policies

(3) A basic policy must provide restricted cover or unrestricted cover for all hospital treatments in:
(a) all of the clinical categories that a basic policy is required to cover; and
(b) any other clinical categories that the policy covers.

11G. Naming of insurance policies that cover hospital treatment

(1) For paragraph 63-10 (g) of the Act, this rule applies to an insurance policy that covers hospital treatment (whether or not the policy also covers general treatment).

(2) The policy must include a name that contains the policy's product tier.

(3) If the policy covers hospital treatments additional to those required for a policy of that product tier in Schedule 5, the name may also contain "plus" or "+".

(4) The name must not contain:
(a) the name of any other metal; or
(b) the name of any gemstone or any semi-precious stone; or
(c) unless permitted by subrule (3)—either "plus" or "+".

(5) For this rule, the ***product tiers*** are the following:
(a) for a gold policy—"gold";
(b) for a silver policy—"silver";
(c) for a bronze policy—"bronze";
(d) for a basic policy—"basic".

11H. Naming of insurance policies that do not cover hospital treatment

(1) For paragraph 63-10 (g) of the Act, this rule applies to an insurance policy that covers general treatment only.

(2) The policy must include a name that does not contain:
(a) the name of any metal; or
(b) the name of any gemstone or any semi-precious stone.

[3] After Schedule 3

Add:

Schedule 4—Clinical categories

Note: See rule 4 and rule Part 2B of these Rules.

1 Interpretation

In this Schedule, a reference to an MBS item is a reference to an item in any of the following:

(a) the general medical services table, made under section 4 of the *Health Insurance Act 1973*;

(b) the diagnostic imaging services table, made under section 4AA of the *Health Insurance Act 1973*;

(c) the pathology services table, made under section 4A of the *Health Insurance Act 1973*.

2 Clinical categories

For rule 4 and Part 2B of these Rules, the clinical categories are set out in the following table.

Note 1: If a patient is admitted for investigative surgery, that procedure, and any treatment provided during the surgery, is covered even if the investigation reveals a condition outside the scope of cover.

Note 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 that is covered by a clinical category:

- consultation;
- diagnostic services 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;
- management of complications related to the principal service.

Clinical category	Scope of cover	Treatments for which benefits must be paid
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.

Clinical category	Scope of cover	Treatments for which benefits must be paid
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.
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 *Back, neck and spine*. Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer*.	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 *Cataracts*. Eyelid procedures are included under *Plastic and reconstructive surgery (medically necessary)*.	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	Treatments for which benefits must be paid
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 *Tonsils, adenoids and grommets*. The implantation of a hearing device is listed separately as *Implantation of hearing devices.* Orthopaedic neck conditions are included under *Back, neck and spine*. Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Joint reconstructions*. Joint replacements and spinal fusions for conditions other than scoliosis are listed separately as *Joint replacements and spinal fusion*. Spinal conditions are included under *Back, neck and spine.* Rib surgery is included under *Heart, lung and vascular system*. Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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
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 *Joint replacements and spinal fusion.* Bone fractures and joint fusions are included under *Bone, joint and muscle.*	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 *Dialysis for chronic kidney disease.* Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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
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 *Gastrointestinal endoscopy*. Hernia and appendicectomy procedures are included under *Hernia and appendix*. Bariatric surgery is listed separately as *Weight loss surgery.* Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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 *Digestive system.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Digestive system*.	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
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 *Assisted reproductive services*. Pregnancy and birth-related conditions are included under *Pregnancy, birth and neonates*. Miscarriage or termination of pregnancy is listed separately as *Miscarriage and termination of pregnancy*. Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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
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 *Chemotherapy, radiotherapy and immunotherapy for cancer*.	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 *Chemotherapy, radiotherapy and immunotherapy for cancer*.	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Eye*. Implantation of insulin pumps is listed separately under *Insulin pumps*.	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
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 *Chemotherapy, radiotherapy and immunotherapy for cancer*.	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 *Chemotherapy, radiotherapy and immunotherapy for cancer*.	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Joint replacements and spinal fusion.* Management of chronic back pain is included under *Chronic pain*. Chemotherapy and radiotherapy for cancer is listed separately as *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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
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 *Chemotherapy, radiotherapy and immunotherapy for cancer.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Ear, nose and throat.*	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
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 *Back, neck and spine*. Joint fusions are included under *Bone, joint and muscle.*	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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 *Gynaecology*. Fertility treatments are listed separately under *Assisted reproductive services*. Miscarriage and termination of pregnancy is listed separately as *Miscarriage and termination of pregnancy*.	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
Assisted reproductive services	Admission for fertility treatments or procedures. For example: retrieval of eggs or sperm, *In vitro* Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT). Treatment of the female reproductive system is included under *Gynaecology*. Pregnancy and birth-related services are included under *Pregnancy, birth and neonates*.	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

Clinical category	Scope of cover	Treatments for which benefits must be paid
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

Schedule 5—Product tiers and treatments

Note: See rule 4 and Part 2B of these Rules.

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	RCP	✓	✓	✓
Eye	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	✓	✓	✓
Skin	RCP	✓	✓	✓
Breast surgery (medically necessary)	RCP	✓	✓	✓
Diabetes	RCP	✓	✓	✓
Heart, lung and vascular system	RCP		✓	✓
Blood	RCP		✓	✓
Back, neck and spine	RCP		✓	✓
Plastic and reconstructive surgery (medically necessary)	RCP		✓	✓
Dental surgery	RCP		✓	✓
Podiatric surgery (provided by an accredited podiatric surgeon)	RCP		✓	✓
Implantation of hearing devices	RCP		✓	✓
Cataracts	RCP			✓
Joint replacements and spinal fusion	RCP			✓
Dialysis for chronic kidney disease	RCP			✓
Pregnancy, birth and neonates	RCP			✓
Assisted reproductive services	RCP			✓
Weight loss surgery	RCP			✓
Insulin pumps	RCP			✓

Hospital treatments by clinical category	Basic	Bronze	Silver	Gold
Chronic pain	**RCP**			✓
Sleep studies	**RCP**			✓

✓	Indicates the treatment/service is a minimum requirement of the product category. The service must be covered on an unrestricted basis.
✓**R**	Indicates the treatment/service is a minimum requirement of the product category. The service may be offered on a restricted cover basis in Basic, Bronze and Silver product tiers only.
RCP	Restricted cover permitted: indicates the treatment/service is not a minimum requirement of the product category. Insurers may choose to offer these as additional services on a restricted or unrestricted basis.
	A blank cell indicates that the treatment/service is not a minimum requirement of the product category. Insurers may choose to offer these as additional services; however it must be on an unrestricted basis.

Schedule 4—Second tier administrative reforms

Private Health Insurance (Benefit Requirements) Rules 2011

[1] Clause 1 of Schedule 5

Repeal the clause, substitute:

1. Interpretation

(1) In this Schedule:

authorised officer means a departmental officer authorised by the Secretary of the Department to make a determination under subclause 1A (2), (3) or (4) or to review a determination under subclause 1B (3).

comparable has the meaning given by subclause 1A (6).

Hospital Casemix Protocol Data has the meaning given by rule 4 of the *Private Health Insurance (Health Insurance Business) Rules 2018.*

second-tier eligible hospital means a hospital in the class set out in rule 7A of the *Private Health Insurance (Health Insurance Business) Rules 2018*.

(2) In this Schedule, except in subclauses 1A (8) and (9), the Australian Capital Territory is taken to be part of New South Wales, and the Northern Territory is taken to be part of South Australia.

[2] After clause 1 of Schedule 5

Insert:

1A. Categorisation of private hospitals

(1) If, as at 1 January 2019, a departmental officer authorised by the Secretary of the Department for the purpose has, in anticipation of the commencement of this provision, caused to be published on the Department's website a list of all the hospitals for which a declaration is in force under subsection 121-5 (6) of the Act that places each hospital in a category set out in subclause (7), then each hospital is taken to be determined to be in that category.

(2) If such a list has not been published, then as soon as practicable an authorised officer must determine which category of hospital from the categories set out in subclause (7) each private hospital for which a declaration is in force under subsection 121-5 (6) of the Act is to be placed in, and cause a list of the hospitals in each category to be published on the Department's website.

Note: If a patient is admitted to a hospital between 1 January 2019 and 31 August 2019 insurers may continue to work out the average charge on the basis of the provisions of this Schedule as in force immediately before the commencement of Schedule 4 to the *Private Health Insurance (Reforms) Amendment Rules 2018*. However, insurers must use the Department's published list of hospitals under subclause (1) or (2) to determine to in which category a hospital claiming second-tier default benefits is placed.

(3) If a private hospital is declared under subsection 121-5 (6) of the Act after 1 January 2019, an authorised officer must determine which category of hospital from the categories set out in subclause (7) that private hospital is to be placed in.

(4) If a hospital has been placed in a category by a determination under this clause, an authorised officer may before 1 June of a particular year determine a different category of hospital from the categories set out in subclause (7) that the private hospital is to be placed in.

(5) A list of the hospitals in each category as of 1 August of each year must be published on the Department's website.

(6) Private hospitals are ***comparable*** if they are placed in the same category by a determination made under subclause (1), (2), (3) or (4).

(7) For the purposes of this clause, the categories are the following:
   (a) private hospitals that provide psychiatric care, including treatment of addictions, for at least 50% of the episodes of hospital treatment, and do not fall into category (g);
   (b) private hospitals that provide rehabilitation care for at least 50% of the episodes of hospital treatment, and do not fall into categories (a) or (g);
   (c) private hospitals that do not fall into categories (a), (b) or (g), with up to and including 50 licensed beds;
   (d) private hospitals that do not fall into categories (a), (b) or (g), with more than 50 licensed beds and up to and including 100 licensed beds;
   (e) private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, without an accident and emergency unit or a specialised cardiac care unit or an intensive care unit;
   (f) private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, with either (or any combination of) an accident and emergency unit or a specialised cardiac care unit or an intensive care unit;
   (g) private hospitals that provide episodes of hospital treatment only for periods of not more than 24 hours.

(8) If State or Territory legislation in the State or Territory where the private hospital is located regulates the number of beds or patients that a private hospital is permitted—in subclause (7), a reference to ***licensed beds*** is a reference to the beds or patients that a private hospital is permitted, under State or Territory legislation in the State or Territory where the private hospital is located.

(9) If State or Territory legislation in the State or Territory where the private hospital is located does not regulate the number of beds or patients that a private hospital is permitted—in subclause (7), a reference to ***licensed beds*** is a reference to the beds and bed equivalents the private hospital operates.

(10) An authorised officer must calculate proportions for the purposes of paragraphs (7) (a) and (b):

(a) if Hospital Casemix Protocol Data is available for the private hospital—using the most recent year of Hospital Casemix Protocol Data available to the Department for the private hospital; and

(b) otherwise—on the basis of any relevant information available to the Department about the episodes of hospital treatment at the private hospital.

1B. Internal review of a categorisation determination

(1) A private hospital subject to a determination made under subclause 1A (1), (2), (3) or (4) may request internal review of its categorisation by the determination.

(2) An application for internal review under subclause (1) must be made in writing within 28 days after the day the determination is notified to the hospital.

(3) If an application for internal review is made, an authorised officer (who must not be the authorised officer who made the original determination) must:

(a) review the determination; and

(b) either confirm the determination or make a fresh one within 28 days after the day on which the application was received by the Department.

[3] At the end of clause 2 of Schedule 5

Omit "facility", insert "second-tier eligible hospital that does not have a negotiated agreement with an insurer".

[4] Subclause 3(3) of Schedule 5

Repeal the subclause, substitute:

(3) If a hospital ceases to be a second-tier eligible hospital for the purposes of this Schedule, the minimum benefit in relation to an episode of hospital treatment for an insured person who was an admitted patient at the hospital or booked for hospital treatment at the hospital (as opposed to merely being on the hospital's waiting list) before the day that the hospital ceased to be a second-tier eligible hospital is the minimum benefit that would have applied if the hospital continued to be a second-tier eligible hospital at the time the treatment was provided.

[5] Subclause 3(4) of Schedule 5

Repeal the subclause, substitute:

(4) Subject to subclauses (2) and (8), the minimum benefit payable by an insurer for an episode of hospital treatment at a second-tier eligible hospital for which the admission date was between 1 September of a particular year (the ***first year***) and 31 August of the next year is an amount no less than 85% of the average charge for the equivalent episode of hospital treatment, under that insurer's negotiated agreements as in force on 1 August of the first year, with all private hospitals:

(a) that:

(i) if the second-tier eligible hospital is on the list published on the Department's website under subclause 1A (5)—were comparable on 1 August of the first year with the second-tier eligible hospital; and

(ii) otherwise—are in the same category as the second-tier eligible hospital in the list published on the Department's website under subclause 1A (5) as at 1 August of the first year; and

(b) that are in the same State as the second-tier eligible hospital.

Note: See clause 4 for a transitional arrangement for admissions to second-tier eligible hospitals between 1 January 2019 and 31 August 2019.

[6] Subclause 3(6) of Schedule 5

Omit "facility", substitute "second-tier eligible hospital".

[7] Clause 4 of Schedule 5

Repeal the clause, substitute:

4. Transitional

(1) If a patient is admitted to a second-tier eligible hospital between 1 January 2019 and 31 August 2019:

(a) an insurer may instead work out the average charge on the basis of the repealed provisions; and

(b) if the insurer does so, ***comparable*** has the same meaning as in the repealed provisions.

(2) For subclause (1), the ***repealed provisions*** are the provisions of this Schedule as in force immediately before the commencement of Schedule 4 to the *Private Health Insurance (Reforms) Amendment Rules 2018*.

Note: For the purpose of determining which category the second-tier eligible hospital to which the patient was admitted is placed in, an insurer must use the Department's determination in respect of that hospital under subclause 1A (1), (2), (3) or (4).

Private Health Insurance (Health Insurance Business) Rules 2018

[8] Rule 3

Insert:

accredited means assessed as being fully compliant with the *National Safety and Quality Health Service Standards* by a body approved by the Australian Commission on Safety and Quality in Health Care to assess health service organisations against the *National Safety and Quality Health Service Standards*.

Note: Hospitals are not required to be assessed against the *National Safety and Quality Health Service Standards* until such time as their current accreditation expires or where new accreditation is sought.

Hospital Casemix Protocol Data means the data provided by hospitals to insurers that is the subject of rule 4.

informed financial consent: a hospital provides ***informed financial consent*** if it has procedures in place to inform a patient or nominee, in writing, of what hospital charges, insurer benefits and out-of-pocket costs (where applicable) are expected in respect of the hospital treatment. A patient or nominee must be informed:

(a) for scheduled admissions – at the earliest opportunity before admission for the hospital treatment; or

(b) for unplanned admissions – as soon after the admission as the circumstances reasonably permit.

minimum benefit means the minimum benefit calculated in accordance with clause 3 of Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules 2011*.

National Safety and Quality Health Service Standards means the standards developed by the Australian Commission on Safety and Quality in Health Care.

Note: Development of the *National Safety and Quality Health Service Standards* is a function of the Australian Commission on Safety and Quality in Health Care under paragraph 9 (1) (e) of *National Health Reform Act 2011*.

[9] After Part 2

Insert:

Part 2A Second-tier eligible hospitals class

7A. Second-tier eligible hospitals class

For the purposes of subsection 121-8 (1) of the Act, second-tier eligible hospitals constitutes a class of hospital (the ***second-tier eligible hospitals class***).

7B. Application fee

For the purposes of paragraph 121-8 (2) (b) of the Act, the application fee is $900 for each hospital that the application seeks to have included in the second-tier eligible hospitals class.

7C. Assessment criteria

For the purposes of subsection 121-8A (1) of the Act, to be included in the second-tier eligible hospitals class, a hospital must:

(a) be a private hospital; and

(b) be accredited; and

(c) not bill patients directly for the minimum benefit payable by the patient's insurer; and

(d) provide informed financial consent; and

(e) submit Hospital Casemix Protocol Data to health insurers electronically with every claim for second-tier default benefits.

Note: If a hospital is included in the second-tier eligible hospitals class by the Minister under section 121-8A of the Act, it will be a second-tier eligible hospital for the purposes of Schedule 5 to the *Private Health Insurance (Benefit Requirements) Rules 2011*, and therefore eligible to claim second-tier default benefits as specified in that Schedule.

7D. Notification of change in circumstances

A hospital that is included in the second-tier eligible hospitals class must notify the Department in writing of any change in circumstances that may prevent that hospital from continuing to meet the assessment criteria set out in rule 7C as soon as practicable.

7E. Transitional arrangements

(1) A hospital that is a facility for the purposes of clause 4 of Schedule 5 to the *Private Health Insurance (Benefit Requirements) Rules 2011* immediately before the commencement of this Schedule is taken to be included in the second-tier eligible hospitals class.

(2) A hospital referred to in subrule (1) is taken to be included in the second-tier eligible hospitals class until the eligibility expiry date for that hospital.

(3) Despite subrule (2), if the date on which a hospital's accreditation will expire falls within the 12 months following the hospital's eligibility expiry date, then the hospital is taken to be included in the second-tier eligible hospitals class until the day on which that hospital's accreditation will expire.

(4) In this rule:

eligibility expiry date means the date on which the hospital's approval on the list of second-tier eligible facilities existing on 1 January 2019 expires.

Note: Hospitals that are specified in the Second Tier Advisory Committee approved list on 1 January 2019 will be second-tier eligible hospitals for the purposes of Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules 2011*, and therefore eligible to claim second-tier default benefits as specified in that Schedule. Unless subrule (3) applies, when the approval under the pre-existing arrangements expires, the hospital will be required to apply under s 121-8 of the Act to be included in the second-tier eligible hospitals class.

Schedule 5—Removal of coverage of some natural therapies

Private Health Insurance (Health Insurance Business) Rules 2018

[1] Rule 3

Insert:

natural therapy treatment means any of the following treatments:

(a) Alexander technique;
(b) aromatherapy;
(c) Bowen therapy;
(d) Buteyko;
(e) Feldenkrais;
(f) herbalism;
(g) Western herbalism;
(h) homeopathy;
(i) iridology;
(j) kinesiology;
(k) naturopathy;
(l) Pilates;
(m) reflexology;
(n) Rolfing;
(o) shiatsu;
(p) tai chi;
(q) yoga.

[2] At the end of section 8

Add:

; and (e) natural therapy treatment.

[3] Rule 11

Repeal the rule, substitute:

11. General treatment—excluded treatment

(1) For paragraph 121-10 (3) (b) of the Act, the following treatments or classes of treatment are specified:

(a) treatment which primarily takes the form of sport, recreation or entertainment, other than treatment that is part of a chronic disease management program or a health management program if the programs have been approved by the private health insurer;
(b) natural therapy treatment.

(2) In this rule:

health management program means a program that is intended to ameliorate a person's specific health condition or conditions, but does not include treatment that is natural therapy treatment.

Schedule 6—Information provision

Private Health Insurance (Incentives) Rules 2012 (No. 2)

[1] Rule 4 (note)

Omit "standard information statement", substitute "private health information statement".

[2] Rule 4 (definition of *Australian Government Rebate on private health insurance*)

Repeal the definition, substitute:

Australian Government Rebate on private health insurance means:

(a) the premiums reduction scheme; or

(b) the private health insurance tax offset.

[3] Rule 7

Repeal the rule.

[4] Paragraph 8(1)(a)

Repeal paragraph 8(1)(a), substitute:

(a) if a participant in respect of a complying health insurance policy on issue from the insurer during any time in the previous financial year requests the following information from a participating insurer:

(i) the amount of the premium paid for the policy during the previous financial year;

(ii) the reduction, under the premiums reduction scheme, for the premium;

the participating insurer must issue to the participant a statement in accordance with rule 9.

[5] Subparagraph 8(1)(c)(ii)

Omit "annual".

[6] Rule 9

Repeal the rule, substitute:

(1) A statement under paragraph 8 (1) (a) must:

(a) be in writing; and

(b) set out, clearly and distinctly:

(i) if requested by the participant—the amount of the premium paid for the policy during a particular financial year; and

(ii) if requested by the participant—the amount of the reduction under the premiums reduction scheme for the premium; and

(c) be provided within 14 days of receipt of the request; and

(d) if practicable, be provided in the manner requested by the participant making the request.

(2) A statement under paragraph 8 (1) (a) may:

(a) be provided to the participant by giving the participant electronic access to the statement; and

Example: By sending the participant an email with a clearly identified hyperlink to the statement.

(b) be accompanied by any other information.

Private Health Insurance (Lifetime Health Cover) Rules 2017

[7] Subrule 8(1)

Repeal the subrule, substitute:

(1) For the purposes of paragraph 40 (1) (a) of the Act, the following requirements are specified:

(a) the insurer must provide information about increases under Part 2-3 in the amounts of premiums payable for the policy holder's hospital cover in respect of the policy holder, if requested by the policy holder;

(b) the insurer must provide the following information to a policy holder affected by section 34-1 or section 34-5 of the Act, if requested by the policy holder:

(i) the amount by which the policy holder's premiums payable for hospital cover are increased as a result of the operation of those sections;

(ii) the private health insurer's record of the number of days the policy holder has not had hospital cover since his or her lifetime health cover base day, other than days to which paragraph 34-20 (1) (a) of the Act applies.

Note: Paragraph 34-20 (1) (a) of the Act deals with permitted days without hospital cover.

[8] Subrule 8(3)

Repeal the subrule, substitute:

3) The information required to be provided by subrule 8 (1) must:

(a) if practicable, be provided in the manner requested by the policy holder making the request; and

(b) in the case of joint policy holders, set out the details applying to the joint policy holder making the request; and

(c) be provided to the policy holder within 14 days of receipt of the request.