Private Health Insurance (Complying Product) Rules 2008 (No. 1)

I, VERONICA HANCOCK, delegate of the Minister for Health and Ageing, make these Rules under item 3 of the table in section 333-20 of the *Private Health Insurance Act 2007*.

Dated 19th March 2008

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Veronica Hancock
Assistant Secretary
Private Health Insurance Branch
Acute Care Division
Department of Health and Ageing

Federal Register of Legislative Instruments F2008L00940

Contents

Part 1 Preliminary

1. Name of Rules

These Rules are the *Private Health Insurance (Complying Product) Rules 2008 (No. 1)*.

2. Commencement

These Rules commence on 20 March 2008.

3. Revocation

The *Private Health Insurance (Complying Product) Rules 2007 (No. 3)* are revoked.

4. Definitions

Note: Unless the contrary intention appears, terms used in these Rules have the same meaning as in the Act—see section 13 of the *Legislative Instruments Act 2003*. These terms include:

applicable benefits arrangement
complying health insurance policy
complying health insurance product
cover
dependent child
general treatment
hospital-substitute treatment
hospital treatment
medicare benefit
policy holder
private health insurer
product subgroup
rules [of an insurer]
standard information statement
waiting period

In these Rules:

Act means the *Private Health Insurance Act 2007*.

insurer means a private health insurer.

policy means a complying health insurance policy.

private hospital means a hospital in respect of which there is in force a statement under subsection 121-5 (8) of the Act that the hospital is a private hospital.

Note: Section 15 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* deals with the status of certain hospitals for which a declaration had been made before the commencement of the Act.

public hospital means a hospital in respect of which there is in force a statement under subsection 121-5 (8) of the Act that the hospital is a public hospital.

Note: Section 15 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* deals with the status of certain hospitals for which a declaration had been made before the commencement of the Act.

Part 2 General

5. Insured groups

(1) For the purposes of paragraph 63-5 (2A) (b) of the Act, the following insured groups are specified:

(a) for policies other than a non-student policy or a policy referred to in paragraph (c), the insured groups are:

(i) only one person;

(ii) 2 adults (and no-one else);

(iii) 2 or more people, none of whom is an adult;

(iv) 2 or more people, only one of whom is an adult;

(v) 3 or more people, only 2 of whom are adults;

(vi) 3 or more people, at least 3 of whom are adults;

(b) for policies that are a non-student policy, the insured groups are:

(i) 2 or more people, only one of whom is an adult;

(ii) 3 or more people, only 2 of whom are adults;

(c) for policies that before 31 December 2008 cover a dependent child non-student (***non-student***) which have as conditions of the policy that the non-student is not covered for general treatment, other than hospital-substitute treatment, and must have his or her own policy with the same insurer covering general treatment (other than hospital-substitute treatment), the insured groups are:

(i) 2 or more people, only one of whom is an adult;

(ii) 3 or more people, only 2 of whom are adults.

(2) In this rule:

dependent child non-student means a person who:

(a) is aged between 18 and 24 (inclusive) and was born before 1991; and

(b) is a dependent child under the rules of the insurer that insures the person as referred to in subparagraph (a) (ii) of the definition of 'dependent child' in the Act, whether or not the person is wholly or substantially dependent on an adult insured under the same health insurance policy; and

(c) does not have a partner; and

(d) is not receiving full-time education at a school, college or university.

Note: A 'dependent child non-student' is therefore a 'dependent child' as defined in the Act.

non-student policy is a health insurance policy that:

(a) is issued before 31 December 2008; and

(b) before 31 December 2008, covers one or more dependent child non-student; and

(c) for which the premium for the policy, not taking account of any amounts referred to in paragraph 66-5 (1) (c) of the Act, is:

(i) less than the amount worked out under paragraph (3) (a); and

(ii) more than the amount worked out under paragraph (3) (b).

(3) For the definition of 'non-student policy':

(a) work out the premium that would apply under the relevant product subgroup by reference to the relevant insured group in paragraph (1) (a) as follows:

(i) if the policy covers one adult only, one or more dependent child non-student and any other dependent child, by adding together the premiums for the insured groups in subparagraphs (1) (a) (i) and (iv);

(ii) if the policy covers one adult only, one or more dependent child non-students and no other dependent child, by adding together the premiums for the insured groups in subparagraphs (1) (a) (i) and (ii);

(iii) if the policy covers two adults, one or more dependent child non-student and one or more other dependent child, by adding together the premiums for the insured groups in subparagraphs (1) (a) (i) and (v);

(iv) if the policy covers two adults, one or more dependent child non-student and no other dependent child, by reference to the insured group in subparagraph (1) (a) (vi) or, if the insurer does not cover this type of insured group, by adding together the premiums for the insured groups in subparagraphs (1) (a) (i) and (ii);

(b) work out the premium that would apply under the relevant product subgroup determined by reference to the relevant insured group in paragraph (1) (a) if any dependent child non-student covered under the policy was treated as a dependent child who is not a dependent child non-student.

6. Maximum percentage of discount

(1) For subparagraph 66-5 (1) (c) (ii) of the Act, the maximum percentage discount allowed is 12% per annum.

(2) The discount for a policy is the difference between the full premium and the net premium.

(3) The full premium for a policy is the premium that would be received by the private health insurer for a policy in the same product subgroup without any reduction due to the circumstances set out in paragraphs 66-5 (3) (a) to (e) of the Act.

(4) The net premium is the full premium less the cost, or the cost foregone, of any of the following:

(a) incentive payment;

(b) promotional payment;

(c) rebate; and

(d) any other inducement whatsoever,

made available by the insurer to another person, including to an insured person, in respect of the payment of the premium for the policy, including to induce a person to purchase or maintain a policy.

(5) The following costs are excluded from the calculation of net premium in subrule (4):

(a) a brokerage fee or commission paid in respect of the policy; and

(b) the cost of any discount, product, service, waiver or other thing (***promotion***) offered to a person at the time the person first purchases a policy from the insurer if:

(i) the cost of the promotion does not exceed 12% of the full premium, for a year, for the policy purchased; and

(ii) the promotion is provided in the first year after the person purchases the policy.

7. Benefits authorised to be provided under a policy

(1) In this rule, ***specified benefit*** means a benefit specified in subrule (3).

(2) If a person was entitled to a specified benefit under an applicable benefits arrangement or a table of ancillary health benefits in force at the commencement of the Act, the provision of the same specified benefit under the person's policy is authorised for the purposes of paragraph 69-1 (1) (b) of the Act as long as the person's policy continues to cover the same specified treatments and provide the same specified benefits.

Note: Section 10 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* deals with the status of existing applicable benefits arrangements and tables of ancillary benefits at the commencement of the Act.

(3) The specified benefits for this rule are:

(a) benefits paid in connection with the birth of a baby;

(b) funeral benefits;

(c) disability benefits.

(4) In this rule, ***ancillary health benefit*** means ancillary health benefits within the meaning of section 67 the *National Health Act 1953* as in force immediately before the commencement of the Act.

8. Complying products—coverage requirements

(1) For subsection 69-1 (2) of the Act, a policy of a kind specified in the following table must also cover any treatment as specified in the table.

Coverage requirements		
Item	**Kind of policy**	**Treatments the policy must cover**
1	A policy that includes cover for hospital-substitute treatment.	Hospital treatment for the same types of treatment covered by the policy for hospital-substitute treatment.
2	A policy under which a person is covered, wholly or partly, for hospital treatment where: (a) the treatment includes the provision of a prosthesis listed in the *Private Health Insurance (Prostheses) Rules* made under the Act; and (b) either: (i) a medicare benefit is payable in respect of the professional service associated with the provision of the prosthesis; or (ii) the provision of the prosthesis is associated with podiatric treatment by an accredited podiatrist.	The provision of the prosthesis.
3	A policy under which a person is covered, wholly or partly, for hospital-substitute treatment where: (a) the treatment includes the provision of a prosthesis listed in the *Private Health Insurance (Prostheses) Rules* made under the Act; and (b) a medicare benefit is payable in respect of the professional service associated with the provision of the prosthesis.	The provision of the prosthesis.

Note: The *Private Health Insurance (Prostheses) Rules* set out the benefit requirements for prostheses listed in those Rules.

(2) For the avoidance of doubt, a policy of a kind mentioned in the table may also be a policy that covers other types of treatment, unless excluded by rules made for the purpose of subsection 69-1 (3).

8A Benefit requirement—nursing-home type patients

(1) For paragraph 72-1 (1) (b) of the Act, the requirement in subrule (2) is a benefit requirement for a policy that covers hospital treatment.

(2) The requirement is that the amount of benefit payable under the policy in respect of hospital treatment at a hospital for a nursing-home type patient must not exceed an amount equal to the fees or charges incurred in respect of that hospital treatment less the amount of the patient contribution in relation to the patient for each day on which the patient is a nursing-home type patient at the hospital.

(3) In this rule:

nursing-home type patient has the same meaning as in the *Private Health Insurance (Benefit Requirements) Rules,* made under section 333-20 of the Act, as in force from time to time.

patient contribution, for each day on which the patient is a nursing-home type patient at the hospital, means:

(a) in relation to a nursing-home type patient at a public hospital, the following amount for the State or Territory in which the hospital is located:

(i) Australian Capital Territory—$38.20;

(ii) New South Wales—$39.05;

(iii) Northern Territory—$39.05;

(iv) Queensland—$39.70;

(v) South Australia—$39.70;

(vi) Tasmania—$39.70;

(vii) Victoria—$39.70;

(viii) Western Australia—$39.05;

(b) in relation to a nursing-home type patient at a private hospital, $39.70.

9. Waiting periods—former gold card holders

(1) The waiting period requirements in subsection 75-1 (1) of the Act are modified in relation to insured persons referred to in subrule (2) by specifying the conditions set out in that subrule.

(2) A policy that covers a person who:

(a) held a gold card, or was entitled to treatment under a gold card, before applying for the insurance; and

(b) applies for the insurance no longer than 2 months after the person ceased to hold, or be entitled under, the gold card,

must not apply to the person any waiting period or benefit limitation period for any hospital treatment or general treatment covered by the policy.

(3) In this rule:

gold card has the same meaning as in section 34-15 of the Act.

benefit limitation period, in respect of the person's insurance policy, means a period:

(a) starting at the time the person becomes insured under the policy referred to in this rule; and

(b) ending at the time specified in the policy,

during which the amount of benefit in relation to any period is less than the amount for which the person would be eligible during any other period.

10. Transfer certificates

For section 99-1 of the Act, the following periods are set out:

(a) for subsection 99-1 (1), certificate for the insured person—14 days;

(b) for subsection 99-1 (2), certificate for the new insurer—14 days;

(c) for subsection 99-1 (3), old insurer to provide a certificate to the new insurer on request—14 days.

11. Performance indicators

For subsection 188-1 (1) of the Act, the following performance indicators are set out:

(a) the number and kind of complaints made to the Private Health Insurance Ombudsman about private health insurers;

(b) changes in the number of insured persons in particular age groups;

(c) changes in the number of episodes of hospital treatment and hospital-substitute treatment, and the average number of episodes of each, for particular age groups;

(d) changes in the nature of the episodes of hospital treatment and hospital-substitute treatment, for which benefits are paid in particular age groups;

(e) changes in the average amount of benefits paid for an insured person, or an episode of hospital treatment or hospital substitute treatment, in particular age groups.

Part 3 Standard information statements

12. Definitions

In this Part:

complying product means a complying health insurance product.

permitted content means the words in italics in the column headed 'Permitted content' in the tables in Schedule 4, and the words set out in the forms in Schedules 1, 2 and 3.

13. Information and form

(1) For subsection 93-5 (1) of the Act, this Part and Schedules 1, 2, 3 and 4 set out the form of, and the permitted content to be contained in, a statement about a product subgroup of a complying product.

(2) The form of the statements in Schedules 1, 2 and 3, and the permitted content for those forms, must not be added to, deleted, rearranged or modified in any way except:

(a) as specified in the relevant Schedules;

(b) to omit, when inapplicable, the grey text, or to omit text for which the grey text is the appropriate alternative;

(c) to place a barcode or product code in the margin; and

(d) until 1 April 2008 - to omit the 'Medicare Levy Surcharge' field.

(3) A statement must not exceed one A4 page, except as permitted by rule 16.

14. Policies covering hospital treatment only

For a product subgroup of a complying product made up of policies which cover hospital treatment only:

(a) the statement must be in the form of the statement set out in Schedule 1; and

(b) the fields of that form must contain the permitted content specified in Parts 1 and 2 of Schedule 4 as is relevant to the particular product.

15. Policies covering general treatment only

For a product subgroup of a complying product made up of policies which cover general treatment only:

(a) the statement must be in the form of the statement set out in Schedule 2; and

(b) the fields of that form must contain the permitted content specified in Parts 1 and 3 of Schedule 4 as is relevant to the particular product.

16. Policies covering hospital and general treatment

For a product subgroup of a complying product made up of policies which cover both hospital treatment and general treatment:

(a) the statement must be in the form of the statement set out in Schedule 3;

(b) the fields of that form must contain the permitted content specified in Parts 1, 2 and 3 of Schedule 4 as is relevant to the particular product; and

(c) the statement must not exceed two A4 pages.

17. Transitional period

Until 7 December 2007, the Schedules in the *Private Health Insurance (Complying Products) Rules 2007 (No.2)* have effect in place of the Schedules in these Rules.

Schedule 1—Standard information statements: hospital treatment

Form of statement

Note: The next page of these rules is page 14. It appears without page number, header or footer. This is to allow the form to be shown in its actual size as an A4 page.

Private Health Insurance Standard Information Statement – Hospital Policy

This Statement provides basic information for the purposes of comparison only. **For full explanation of this hospital policy please contact the health insurer** on <phone number> or visit <website URL>.

HEALTH INSURER: <Health Insurer name>
(This insurer has membership restrictions)

PRODUCT NAME: <Product name>

AVAILABLE FOR: Residents of <State/Territory>
Employees/Members of <Company/Organisation name>
Closed to new members

WHO IS COVERED: <Type of cover>

MONTHLY PREMIUM: $<xx.yy> (indicative only)
(must be purchased with certain general treatment policies)

MEDICARE LEVY SURCHARGE: <NOT> Exempt

AVAILABLE FROM: <dd mmm yyyy>

The price shown is monthly premium with the 30% Rebate deducted. It does not include any Lifetime Health Cover loading or factor in any discounts that may be available or higher level of Rebate that may apply.

WHAT'S COVERED IF I HAVE TO GO TO HOSPITAL?	✓ <Insert appropriate text>
WHAT MEDICAL SERVICES ARE NOT COVERED AT ALL? (Exclusions)	× <Insert list of exclusions> OR No exclusions
WHAT MEDICAL SERVICES ARE ONLY COVERED TO A LIMITED EXTENT? (Restrictions, Benefit Limitation Periods)	You are not fully covered for: OR No restrictions • <Insert list of restrictions> You are not fully covered for the time period listed after the services for: OR No benefit limitation periods • <Insert list of BLP items + limitation periods>
HOW LONG WILL I HAVE TO WAIT BEFORE I CAN CLAIM? (Waiting Periods)	• <Insert list of waiting periods>
WILL I HAVE TO PAY ANYTHING IF I GO TO HOSPITAL? (Excesses, Co-payments, Medical/Hospital gaps)	EXCESS: <insert appropriate phrase> EXTRA COSTS PER DAY (CO-PAYMENTS): <Insert appropriate phrase(s)> OR No co-payments DOCTORS' AND HOSPITAL BILLS: <X> out of 10 medical services paid for by this health insurer in <State/Territory> have no out-of-pocket expenses. plus (optionally) This insurer also has arrangements that may mean lower out-of-pocket expenses on doctors' bills. OR Gap cover benefits are not available under this policy. You may have to pay additional costs depending on the doctors chosen, the treatment you are having and the hospital you go to. 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.
WHAT OTHER FEATURES DOES THIS POLICY HAVE?	

Schedule 2—Standard information statements: general treatment

Form of statement

Note: The next page of these rules is page 16. It appears without page number, header or footer. This is to allow the form to be shown in its actual size as an A4 page.

Private Health Insurance Standard Information Statement – General Treatment Policy

This Statement provides basic information for the purposes of comparison only. **For full explanation of this general treatment policy please contact the health insurer** on <phone number> or visit <website URL>.

HEALTH INSURER: <Health Insurer name>
(This insurer has membership restrictions)

PRODUCT NAME: <Product name>

AVAILABLE FOR: Residents of <State/Territory>
Employees/Members of <Company/Organisation name>
Closed to new members

WHO IS COVERED: <Type of cover>

MONTHLY PREMIUM: $<xx.yy> (indicative only)
(must be purchased with certain hospital policies)

MEDICARE LEVY SURCHARGE: NOT Exempt

AVAILABLE FROM: <dd mmm yyyy>

The price shown is monthly premium with the 30% Rebate deducted. It does not include any Lifetime Health Cover loading or factor in any discounts that may be available or higher level of Rebate that may apply.

PREFERRED SERVICE PROVIDER ARRANGEMENTS: By using this health insurer's "preferred providers" you will have lower out-of-pocket costs on <list of services>and have access to more "no gap" services. A list of preferred providers is available from the health insurer. OR Insurer's own wording

SERVICES	COVER	WAITING PERIOD (MAX MONTHS)	BENEFIT LIMITS (PER 12 MONTHS)	EXAMPLES OF MAXIMUM BENEFITS
DENTAL • General dental				Periodic oral examination – $<xx.yy> OR <xx>% of charge Scale & clean – $ OR % as above Fluoride treatment – $ OR %
• Major dental				Tooth extraction – $ OR % Full crown veneered – $ OR % Provisional bridge – $ OR %
• Endodontic				Root canal therapy (one canal including preparation & filling) – $ OR % Removal of old root canal filling – $ OR % Emergency root canal – $ OR %
• Orthodontic				Braces for upper & lower teeth, including removal plus fitting of retainer – $ OR %
OPTICAL (eg prescribed spectacles/ contact lenses)				Single vision lenses & frames – $ OR % Multi-focal lenses & frames – $ OR %
PHYSIOTHERAPY				Initial visit – $ OR % Subsequent visit – $ OR %
CHIROPRACTIC				Initial visit – $ OR % Subsequent visit – $ OR %
PODIATRY				Initial visit – $ OR % Subsequent visit – $ OR %
PSYCHOLOGY				Initial visit – $ OR % Subsequent visit – $ OR %
NON PBS PHARMACEUTICALS				Per prescription - $ OR %
ACUPUNCTURE				Initial visit – $ OR % Subsequent visit – $ OR %
NATUROPATHY				Initial visit – $ OR % Subsequent visit – $ OR %
REMEDIAL MASSAGE				Initial visit – $ OR % Subsequent visit – $ OR %
HEARING AIDS				Per hearing aid – $ OR %
BLOOD GLUCOSE MONITORS				Per monitor – $ OR %
AMBULANCE				<Insert appropriate phrase>

HEALTH CARE PROGRAMS AND OTHER FEATURES:

Schedule 3—Standard information statements: combined products

Form of statement

Note: The next two pages of these rules are pages 18 and 19. They appear without page numbers, headers or footers. This is to allow the form to be shown in its actual size as two A4 pages.

Private Health Insurance Standard Information Statement – Combined Policy

This Statement provides basic information for the purposes of comparison only. **For full explanation of this combined hospital and general treatment policy please contact the health insurer** on <phone number> or visit <website URL>.

HEALTH INSURER: <Health Insurer name>
(This insurer has membership restrictions)

PRODUCT NAME: <Product name>

AVAILABLE FOR: Residents of <State/Territory>
Employees/Members of <Company/Organisation name>
Closed to new members

WHO IS COVERED: <Type of cover>

MONTHLY PREMIUM: $<xx.yy> (indicative only)

MEDICARE LEVY SURCHARGE: <NOT> Exempt

AVAILABLE FROM: <dd mmm yyyy>

The price shown is monthly premium with the 30% Rebate deducted. It does not include any Lifetime Health Cover loading or factor in any discounts that may be available or higher level of Rebate that may apply.

Hospital Component

The following applies to the hospital component for the <Product name> policy from <Health Insurer name>.

WHAT'S COVERED IF I HAVE TO GO TO HOSPITAL?	✓ <Insert appropriate text>
WHAT MEDICAL SERVICES ARE NOT COVERED AT ALL? (Exclusions)	✗ <Insert list of exclusions> OR No exclusions
WHAT MEDICAL SERVICES ARE ONLY COVERED TO A LIMITED EXTENT? (Restrictions, Benefit Limitation Periods)	You are not fully covered for: OR No restrictions • <Insert list of restrictions> You are not fully covered for the time period listed after the services for: OR No benefit limitation periods • <Insert list of BLP items + limitation periods>
HOW LONG WILL I HAVE TO WAIT BEFORE I CAN CLAIM? (Waiting Periods)	• <Insert list of waiting periods>
WILL I HAVE TO PAY ANYTHING IF I GO TO HOSPITAL? (Excesses, Co-payments, Medical/Hospital gaps)	EXCESS: <insert appropriate phrase> OR No excess EXTRA COSTS PER DAY (CO-PAYMENTS): <Insert appropriate phrase(s)> OR No co-payments DOCTORS' AND HOSPITAL BILLS: <X> out of 10 medical services paid for by this health insurer in <State/Territory> have no out-of-pocket expenses. plus (optionally) This insurer also has arrangements that may mean lower out-of-pocket expenses on doctors' bills. OR Gap cover benefits are not available under this policy. You may have to pay additional costs depending on • the doctors chosen • the treatment you are having and • the hospital you go to. 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.
WHAT OTHER FEATURES DOES THIS HOSPITAL POLICY HAVE?	

Federal Register of Legislative Instruments F2008L00940

General Treatment Component

The following applies to the general treatment component for the <Product name> policy from <Health Insurer name>.

PREFERRED SERVICE PROVIDER ARRANGEMENTS: By using this health insurer's "preferred providers" you will have lower out of pocket costs on <list of services> and have access to more "no gap" services. A list of preferred providers is available from the health insurer. OR Insurer's own wording

SERVICES	COVER	WAITING PERIOD (MAX MONTHS)	BENEFIT LIMITS (PER 12 MONTHS)	EXAMPLES OF MAXIMUM BENEFITS
DENTAL • General dental				Periodic oral examination – $<xx.yy> OR xx% of charge Scale & clean – $ OR % as above Fluoride treatment – $ OR %
• Major dental				Tooth extraction – $ OR % Full crown veneered – $ OR % Provisional bridge – $ OR %
• Endodontic				Root canal therapy (one canal including preparation & filling) – $ OR % Removal of old root canal filling – $ OR % Emergency root canal – $ OR %
• Orthodontic				Braces for upper & lower teeth, including removal plus fitting of retainer – $ OR %
OPTICAL (eg prescribed spectacles/ contact lenses)				Single vision lenses & frames – $ OR % Multi-focal lenses & frames – $ OR %
PHYSIOTHERAPY				Initial visit – $ OR % Subsequent visit – $ OR %
CHIROPRACTIC				Initial visit – $ OR % Subsequent visit – $ OR %
PODIATRY				Initial visit – $ OR % Subsequent visit – $ OR %
PSYCHOLOGY				Initial visit – $ OR % Subsequent visit – $ OR %
NON PBS PHARMACEUTICALS				Per prescription – $ OR %
ACUPUNCTURE				Initial visit – $ OR % Subsequent visit – $ OR %
NATUROPATHY				Initial visit – $ OR % Subsequent visit – $ OR %
REMEDIAL MASSAGE				Initial visit – $ OR % Subsequent visit – $ OR %
HEARING AIDS				Per hearing aid – $ OR %
BLOOD GLUCOSE MONITORS				Per monitor – $ OR %
AMBULANCE				<Insert appropriate phrase>

HEALTH CARE PROGRAMS AND OTHER FEATURES:

Schedule 4—Standard information statements: permitted content

Part 1—all statements

Field	Description	Permitted content
Date of Issue:	Date on which the content of the SIS is updated.	*dd [month in words] yyyy*
Health Insurer:	**Trading Name or Brand Name** of the health insurer in the State the product is being sold.	*[Health insurer trading name]*
Restricted Membership insurers:	Disclaimer to be printed directly below the health insurer name if the product is offered by a restricted membership insurer.	*(This insurer has membership restrictions)*
Available for:	Name of the State/Territory in which the product subgroup is available for sale. *All States* can only be used where every feature of the product subgroups are identical, **including the premium.**	One of: • *NSW & ACT*; OR • *Northern Territory*; OR • *Queensland*; OR • *South Australia*; OR • *Tasmania*; OR • *Victoria*; OR • *Western Australia* OR • *All States*
Corporate products:	One of the following statements to be printed directly below the State name if the product is a corporate product. One of "employees" or "members" may be deleted or both can be used.	*Employees/Members of* ***[Company/Organisation name]*** OR *Employees/Members of organisations with arrangements with this health insurer*
Closed Products:	Statement to be printed directly below the State name (or below the corporate product statement if applicable) if the product is not currently available for purchase.	***Closed*** *to new members*
Product Name:	Marketing name of the product.	*[product name]*

Field	Description	Permitted content
Who is covered:	Who is covered under this policy.	One of the following: • *One adult*; OR • *Two adults*; OR • *Dependants only*; OR • *One adult & dependant(s)*; OR • *Two adults & dependant(s)*; OR • *Two adults & any dependant(s);* OR • *At least 3 adults & any dependants;*
Monthly Premium:	Monthly premium, less the 30% Rebate. Other discounts are not to be included here.	*$[xx.yy amount of premium]*
Available from:	Date from which the product becomes available for purchase. Field only to appear/be completed if the statement is provided before the product is available. The field is to be placed beneath the monthly premium field.	*dd [month in words] yyyy*
Medicare Levy Surcharge:	Indicates whether or not the policy will exempt the holder from the Medicare Levy Surcharge. The field is to be placed beneath the monthly premium field.	*Exempt* OR *NOT exempt*
<product code>	A unique identifying code for the standard information statement	A product code generated by the PrivateHealth.gov.au system.

Part 2—hospital treatment

Field	Description	Permitted content
[If available with general treatment policy only]:	The statement is to be placed below the premium on the hospital SIS if the policy cannot be purchased on its own. Not required for a combined policy.	*(must be purchased with a general treatment policy)* (where the hospital policy can be purchased with any general treatment policy offered by the insurer) OR *(must be purchased with certain general treatment policies)* (where there is a set range of general treatment policies the hospital policy can be combined with)
What's covered if I have to go to hospital?	Outline of treatment, accommodation and services covered. Order of content cannot be changed. Comprehensive cover can only be used to describe ambulance cover where the product covers at least 100% medically necessary ambulance transport.	One of the following: ✓ *Hospital treatment, including accommodation as a private patient in a private or public hospital* OR ✓ *Hospital treatment, including accommodation as a private patient in a public hospital only* OR ✓ *Hospital treatment, including accommodation as a private patient in a shared room in a private or public hospital* OR ✓ *Hospital treatment, including accommodation as a private patient in a shared room in a public hospital only* OR ✓ *Hospital treatment, including accommodation as a private patient in a public hospital and shared room accommodation only in a private hospital* AND (the following can be added directly in front of the hospital statement if applicable) *[number]% of charge for hospital…* (where the product covers a set percentage of hospital bills. Maximum allowed percentage is 90%) AND *limited to [number] days per year* (added to any of the above options if required); ✓ *Doctors' bills in hospital (see below)* AND one of (if applicable): ✓ *Comprehensive cover for ambulance (see insurer for details)* OR ✓*Partial cover for ambulance (see insurer for details)* OR *(Ambulance covered by State government)*

<table>
<tr><th>Field</th><th>Description</th><th colspan="2">Permitted content</th></tr>
<tr><td></td><td></td><td colspan="2">AND (the following can be added directly after the ambulance statement if applicable)
– [number] day waiting period OR
– [number] month waiting period</td></tr>
<tr><td>What medical services are not covered at all?</td><td>A list of excluded services.
Order of content cannot be changed.
Only one joint replacement item can be used.
If additional services are excluded, use other services.</td><td colspan="2">No exclusions OR
Any of the following:
× Cardiac and cardiac related services
× Cataract and eye lens procedures
× Pregnancy and birth related services
× Assisted reproductive services
× Joint replacements i.e. shoulder, knee, hip and elbow including revisions
× Hip and knee replacements
× Hip replacements
× Dialysis for chronic renal failure
× Surgery by podiatrists
× Sterilisation
× Non-cosmetic plastic surgery
× Hospital treatment for which Medicare pays no benefit eg most cosmetic surgery
× Other services (see insurer for details)</td></tr>
<tr><td rowspan="5">What medical services are only covered to a limited extent?</td><td rowspan="5">A list of restrictions and benefit limitation periods.
Restrictions are to be listed before benefit limitation periods.
Order of content cannot be changed.
For benefit limitation periods, after each service listed insert the number of months.
Only one joint replacement item can be used.
Only one of the two surgery by podiatrists items can be used.
Surgery by podiatrists – partly covered (see fund for details) is to be used where benefits are payable to a limited extent on the hospital accommodation but not on the podiatrist's fee. Surgery by podiatrists</td><td>No restrictions or benefit limitation periods. OR</td><td>No restrictions/benefit limitation periods</td></tr>
<tr><td>No restrictions OR</td><td>If the policy has no restrictions but has benefit limitation periods</td></tr>
<tr><td>No benefit limitation periods OR</td><td>If the policy has no benefit limitation periods but has restrictions</td></tr>
<tr><td>You are not fully covered for:
AND/OR</td><td>Restrictions</td></tr>
<tr><td>You are not fully covered for the time period listed after the services for:</td><td>benefit limitation periods</td></tr>
<tr><td colspan="2">List any of the following for restrictions:
• Cardiac and cardiac related services
• Cataract and eye lens procedures
• Pregnancy and birth related services
• Assisted reproductive services
• Joint replacements i.e. shoulder, knee, hip and elbow including revisions</td></tr>
</table>

Field	Description	Permitted content
	is to be used where benefits are payable to a limited extent on both the hospital accommodation and the podiatrist's fee. If additional services are restricted or have benefit limitation periods, use *other services*.	• *Hip and knee replacements* • *Hip replacements* • *Dialysis for chronic renal failure* • *Surgery by podiatrists* • *Surgery by podiatrists – partly covered (see insurer for details)* • *Sterilisation* • *Non-cosmetic plastic surgery* • *Rehabilitation* • *Psychiatric services* • *Palliative care* • *Hospital treatment for which Medicare pays no benefit eg most cosmetic surgery* • *Other services (see insurer for details)*
		List any of the following for benefit limitation periods: • *Cardiac and cardiac related services – [number] months* • *Cataract and eye lens procedures – [number] months* • *Pregnancy and birth related services – [number] months* • *Assisted reproductive services – [number] months* • *Joint replacements i.e. shoulder, knee, hip and elbow including revisions – [number] months* • *Hip and knee replacements – [number] months* • *Hip replacements – [number] months* • *Dialysis for chronic renal failure – [number] months* • *Surgery by podiatrists – [number] months* • *Surgery by podiatrists – partly covered (see insurer for details) – [number] months* • *Sterilisation– [number] months* • *Non-cosmetic plastic surgery – [number] months* • *Rehabilitation – [number] months* • *Psychiatric services – [number] months* • *Palliative care – [number] months* • *Hospital treatment for which Medicare*

Field	Description	Permitted content
		pays no benefit eg most cosmetic surgery – [number] months • *Other services (see insurer for details) – [number] months*
How long will I have to wait before I can claim?	Waiting periods that apply before a member can claim. Must be provided in the order listed. The waiting period for obstetrics must be deleted if the product does not cover obstetrics.	• *[number* (maximum 2)*] months for palliative care, rehabilitation and psychiatric treatments* • *[number* (maximum 12)*] months for treatments relating to other pre-existing ailments* • *[number* (maximum 12)*] months for obstetric treatments* • *[number* (maximum 2)*] months for all other treatments*
Will I have to pay anything if I go to hospital?	This box covers excesses, co-payments and medical/hospital gaps. Each of these appear in separate sub-boxes	
Excess:	Choose appropriate statement and insert dollar figures. The dollar amount for excess per admission is the excess for an overnight admission (if different from the excess for day surgery).	If no excess: • *No excess* If there is an excess: *You will have to pay an excess of $[number] per admission.* OR *You will have to pay an excess of $[number] per admission. This is limited to a maximum of $[number] per year.* OR *You will have to pay an excess on admission. This is limited to a maximum of $[number] per year.* OR *You will have to pay an excess of $[number] per admission. This is limited to a maximum of $[number] per person per year.* OR *You will have to pay an excess on admission. This is limited to a maximum of $[number] per person per year.* OR *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.* *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.* AND (if required)

Field	Description	Permitted content
		• *Excess payments do not apply to hospital admissions for accidents, child dependents or day surgery* (delete any that do not apply but do not change the order)
Extra Cost per day (co-payments):	Insert dollar amounts for the appropriate co-payment amount.	If no co-payment • *No co-payments* If there is a co-payment: *Every time you go to hospital you will have to pay:* • *$[number] per day for overnight admissions* OR • *$[number] per day for a shared room* AND • *$[number] per day for a private room* (must be deleted if the policy does not cover accommodation in a private room) AND • *$[number] for day surgery (no overnight stay)* OR • *No co-payment for day surgery (no overnight stay)* AND (The following can be added directly after the shared and private room co-payment descriptions if applicable) *– up to $[number] per hospital stay* AND (If applicable) *The maximum co-payment is $[number] per year*.

Field	Description	Permitted content
Doctors' and Hospital Bills	This provides information on the proportion of no gap medical services for the insurer. The percentage of medical services with no gap is the figure for the state in which the product is available. The information related to the percentage of medical services with no gap is the information submitted to the Private Health Insurance Administration Council (PHIAC) for the year ending 30 June for "Total Services with No Gap" divided by "Total All Services". The information required is that released by PHIAC for the most recent year ending 30 June (i.e. when the June quarter figures are released by PHIAC).If the product is an "All States" product, the national average of medical services with no gap is to be used. Health insurers who participate in the Australian Health Services Alliance's gap cover arrangements may use the percentage of services with no gap (by state) for the Alliance as a whole.	As per the form. The percentage of medical services with no gap is to be expressed as per the example below: • greater than or equal to 69% and less than or equal to 71% – *7 out of 10* • greater than 71% but less than 75% – *More than 7 out of 10* • greater than or equal to 75% but less than 79% – *Almost 8 out of 10* [State] is to be the same as "available to" field
	If insurer has known gap arrangements, then insert the following after the first sentence:	*This insurer also has arrangements that may mean lower out-of-pocket expenses on doctors' bills.*
	If gap cover benefits are not available with this policy, then substitute first two sentences with:	*Gap cover benefits are not available under this policy.*

Field	Description	Permitted content
	A new health insurer that does not have available figures for gap cover benefits must use the following (if the new insurer participates in the Australian Health Services Alliance's gap cover arrangements, they may use the Alliance's figure):	*Gap cover benefit figures are not yet available.*
What other features does this policy have?	The total text in this box must not exceed 4 lines. If the hospital policy pays full benefits for 10 or fewer specific services, those services MUST be listed in this box. This box may also be used to describe (for example): • disease management programs and other programs that support healthy lifestyles • discounts for direct debit, paying in advance etc • loyalty bonus/incentive schemes • waiver(s) of co-payments • any other significant product features	Free text up to 4 lines INCLUDING (if applicable) *This policy only provides full benefits for [list services].*

Part 3—general treatment

Field	Description	Permitted content	
[If available with hospital policy only]:	The statement is to be placed below the premium on the general treatment SIS if the policy cannot be purchased on its own. Not required for a combined policy.	*(must be purchased with a hospital policy)* (where the general treatment policy can be purchased with any hospital policy offered by the insurer) OR *(must be purchased with certain hospital policies)* (where there is a set range of hospital policies the general policy can be combined with)	
Preferred Service Provider Arrange-ments: (box)	Describes special arrangements with particular providers. Text in this box must not exceed 3 lines, including the line with the heading.	Free text up to 3 lines (including the line with the heading) OR *By using this health insurer's "preferred providers" you will 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.*	
	Insurers that do not have preferred provider arrangements must use this phrase.	*This health insurer does not operate a preferred provider scheme.*	
'Services' column:	A list of a number of services covered by general treatment.	As provided in form. Additions, deletions, modifications or rearrangements not permitted	
'Covered' column:	Indicates if the service is covered or not. A service is considered to be covered if a benefit is paid for at least one of the examples in the "examples of maximum benefits" columns. Ambulance is considered to be covered if the description in the "examples of maximum benefits" column indicates it has comprehensive cover or partial cover.	✓ (service is covered) × (service is not covered) *n/a* (for ambulance where it is covered by the state government)	
'Waiting	The maximum period of time	Choose one of…:	When…

<table>
<tr><th>Field</th><th>Description</th><th colspan="2">Permitted content</th></tr>
<tr><td rowspan="4">Period (max Months)' column:</td><td rowspan="4">before a member can claim benefits.
Waiting periods for ambulance can be expressed in days or months.</td><td>-</td><td>the service is not covered</td></tr>
<tr><td>[number]</td><td>waiting period in months</td></tr>
<tr><td>None</td><td>no waiting period</td></tr>
<tr><td>[x days]</td><td>short term waiting period for ambulance cover</td></tr>
<tr><td>'Benefit Limits (per 12 months)' column:</td><td>Limits on benefits.
If there is a limit on general dental, but not on preventative dental, the "(no limit on preventative dental)" words should be used.
If services with combined limits are in adjacent rows in the table, lines between the boxes can be deleted and the limit and list of combined services only written once.
If a sub limit applies on any of these services, use "Sub-limits apply".
Combined limits for services in non-adjacent boxes must be written in this field in the first occurrence; thereafter "(Combined limit – see [service])", inserting the name of the service where the list first occurs.
If benefit limits increase over time for any services, only the lowest payable benefit is to be used.</td><td colspan="2">Any combination of:
• $[number] per person</i>
• <i>$[number] per service
• $[number] per policy
If more than one of the above phrases is used, they are to be linked by the words "up to" eg $X per person up to $Y per service up to $Z per policy.
The following may also be used:
• <i>$[number] lifetime limit AND/OR
• ([number] appliance(s)/service(s) [delete one] every [number] years (if there is a limit on claims every X years) AND/OR
• (combined limit for [list services]) OR
• (combined limit – see [service]) AND/OR
• Sub-limits apply AND/OR
• (no limit on preventative dental) OR
• No annual limit OR
• - (service is not covered)
For combined limits, choose from services:
• general dental
• major dental
• endodontic
• orthodontic
• optical
• physiotherapy
• chiropractic
• podiatry</td></tr>
</table>

<table>
<tr><th>Field</th><th>Description</th><th colspan="2">Permitted content</th></tr>
<tr><td></td><td></td><td colspan="2">• psychology
• non PBS pharmaceuticals
• acupuncture
• naturopathy
• remedial massage
• hearing aids
• blood glucose monitors
• ambulance
• other services</td></tr>
<tr><td rowspan="5">‘Examples of Maximum Benefits’ column:</td><td rowspan="5">Examples of the maximum benefit paid for the listed treatments when an insured person visits a practitioner who is not a ‘preferred service provider’.
Only the examples listed may be used.
A percentage figure can only be used where the insurer does not have a maximum limit on the particular item, other than an annual limit. If an insurer pays a benefit that is a percentage of the charge up to a specified dollar limit (i.e. a limit for that item, separately specified from the annual limit), then the specified dollar limit must be used.
General dental, major dental and endodontic examples must be listed even if the service is not covered.
Other examples should be deleted if not covered.
The maximum benefit paid on the following dental item numbers are to be used for the listed examples:
Periodic oral examination – 012
Scale & clean – 114
Fluoride treatment – 121
Tooth extraction – 322
Full crown veneered – 615
Provisional bridge – 632
Root canal therapy (one canal including preparation & filling)</td><td>$[xx.yy number]</td><td>amount of maximum benefit</td></tr>
<tr><td>[number]% of charge</td><td>where there is no maximum benefit limit on the particular item, other than an annual limit.</td></tr>
<tr><td>n/a</td><td>For general dental, major dental and endodontic if not covered</td></tr>
<tr><td>-</td><td>Other services if not covered – delete example(s)</td></tr>
<tr><td colspan="2">Ambulance – one of:
• Comprehensive cover (see insurer for details) OR
• Partly covered (see insurer for details) OR
• See hospital policy information (if part of a combined product in states those where ambulance is covered by the State government) OR
• Covered by State government OR
• - (not covered)</td></tr>
</table>

Field	Description	Permitted content
	– 417 Removal of old root canal filling – 421 Emergency root canal – 438 Braces for upper & lower teeth, including removal plus fitting of retainer – 881 If tooth extraction is covered under general dental instead of major dental, this example can be moved to the general dental box. Orthodontics – if different benefits are offered for treatments provided for orthodontists and general dentists, the maximum benefit for an orthodontist should be used. Optical – if benefits for frames and lenses are paid separately, add together the maximum benefit for each component. Initial/subsequent visit examples are for individual sessions. If there is no maximum benefit for the examples listed, the annual benefit limit figure should be used. Comprehensive cover can only be used to describe ambulance cover where the product at least covers 100% medically necessary ambulance transport. Otherwise, 'partly covered' should be used.	
Health Care Programs and Other Features: (box)	OPTIONAL – this box may be used to describe (for example): • services covered that are not listed in the first column of the main table • discounts for direct debit, paying in advance etc • preventative health/health management programs • loyalty bonus/incentive	Free text up to 4 lines, including the line with the heading.

Field	Description	Permitted content
	schemes • other significant product features	

Note

1. All legislative instruments and compilations are registered on the Federal Register of Legislative Instruments kept under the *Legislative Instruments Act 2003*. See www.frli.gov.au