Frequently asked questions (FAQs)

Gold/Silver/Bronze/Basic product tiers

When do the new product tier requirements apply?

Insurers can now start implementing the new product tiers and standard clinical categories, as the *Private Health Insurance (Reforms) Amendment Rules 2018* were made on 11 October 2018. All insurers will be required to adopt the tiers for all products by 1 April 2020.

The Rules include transitional provisions dealing with a number of matters including the naming of policies as 'Gold', 'Silver', 'Bronze' and 'Basic' during the 'transition period' 1 April 2019 to 31 March 2020 (see question below on limitations on naming of products).

Can an insurer cover part of a clinical category under a policy?

No. From 1 April 2020, which is the end of the transition period, if a policy provides cover for a specific clinical category, the policy must cover all of the hospital treatments that fall within the scope of cover of that clinical category.

If an insurer chooses to include cover for hospital treatments that are not minimum coverage requirements for the relevant product tier, then the policy must provide cover for all treatments that fall within the scope of cover of the relevant clinical category.

Is it necessary to cover all hospital treatments within a clinical category for a product to obtain the plus (+) designation?

Yes. From 1 April 2020, which is the end of the transitional period, only complete clinical categories can be covered under a policy. If a policy covers a clinical category that is not a minimum coverage requirement for the relevant product tier, then an insurer may use the word 'plus' (or symbol '+') in the policy name.

Accident cover, ambulance cover, and travel and accommodation benefits are not recognised as clinical categories. As such, the inclusion of cover for such items under a policy does not qualify the policy to use the word 'plus' (or symbol '+') as part of the policy name.

Why have General Treatment (extras) products not been categorised as Gold, Silver, Bronze?

Consumer testing and comprehensive stakeholder feedback has indicated that consumers have a better understanding of general treatment (extras) polices, and are familiar with their level of cover and policy features.

Implementation of Gold, Silver, Bronze product tiers for general treatment products can be considered as part of future reviews of the current reforms.

What are the limitations on naming of products (e.g. use of metals, gemstones and plus(+))?

The Government has established naming requirements for products to enable consumers to easily understand the level of cover provided by a particular policy, and to compare different policies on a 'like for like' basis. The *Private Health Insurance*

(Complying Product) Rules 2015 place limitations on naming a policy as a metal, a gemstone or a semi-precious stone, or including the word 'plus' (or symbol '+') within the policy's name. These product naming requirements come into effect from 1 April 2019. There are separate naming requirements for policies covering hospital treatment (including combined products) and those policies which cover general treatment only.

Naming conventions for policies covering hospital treatment (including combined hospital and general treatment policies)

From 1 April 2019, insurers will not be permitted to include the words 'Gold', 'Silver', 'Bronze' or 'Basic' in the name of a policy, unless the policy meets the minimum coverage requirements specified for that particular product tier. In addition, from 1 April 2019, product names must not include any other metals (e.g. platinum) or gemstones (e.g. diamond) or semi-precious stones (e.g. amber).

From 1 April 2020, all policies covering hospital treatment must include a name that contains the policy's product tier (i.e. Gold, Silver, Bronze or Basic).

A number of products presently include the word 'plus' (or symbol '+') as part of the policy name (e.g. a combined policy named Budget Hospital + Excellent Extras; or a hospital only product called Budget Hospital Plus). For the duration of the transitional period (1 April 2019 to 31 March 2020) there will be no limitation placed upon the use of 'plus' (or '+') within a policy name. However, from 1 April 2020, the word 'plus' (or symbol '+') may only be included in a policy name if that policy covers hospital treatments that are not minimum coverage requirements for the relevant product tier.

Naming of General treatment only products

From 1 April 2019, insurers will not be permitted to include the name of any metal, gemstone or semi-precious stone in the name of general treatment only products. This requirement is to avoid any confusion for consumers between general treatment products and the Gold, Silver, Bronze and Basic tiers of hospital cover. In addition, from 1 April 2020, insurers will not be permitted to use the word 'plus' (or symbol '+') in the name of policy that covers general treatment only.

Can insurers offer accident cover for clinical categories not otherwise covered under a product?

Yes. Insurers will be able to continue to offer 'accident cover'.

The Rules allow an insurer to offer cover which is conditional on a patient requiring hospital treatment for an injury sustained in an accident, even where the policy does not otherwise cover that clinical category.

Accident cover is not recognised as a clinical category. As such, the inclusion of accident cover would not qualify as cover that would enable a policy to include the plus (+) designation as part of the policy name.

How will ambulance cover be treated in the product tiers?

Health insurers will continue to be able to offer ambulance cover. Where ambulance cover is combined with a hospital treatment policy, insurers can include ambulance cover on the Standard Information Statement or Private Health Information Statement.

Ambulance cover is not recognised as a clinical category. As such, the inclusion of ambulance cover would not qualify as cover that would enable a policy to include the plus (+) designation as part of the policy name.

What is meant by restricted and unrestricted cover?

A policy provides restricted cover for particular hospital treatments if the benefit paid toward the hospital's charge for that treatment is always at a restricted level, even if the service is provided at a hospital contracted to the insurer.

Where a policy provides a restricted benefit for particular services, the benefit for the hospital component is generally restricted to the amount required under the *Private Health Insurance (Benefit Requirements) Rules*.

If a policy fully covers the hospital charge for the particular hospital treatment when the treatment is provided at a contracted hospital it is not restricted cover. This is the case even if the policy only pays benefits equal to the amounts required in the *Private Health Insurance (Benefit Requirements) Rules* for that treatment at non-contracted hospitals.

Do the new product tier coverage requirements and clinical categories impact insurer preferred hospital provider arrangements?

No. Insurers will continue to be able to enter into negotiated agreements with preferred hospitals.

Nothing in the new product tier requirements extend to regulating the commercial terms of a negotiated agreement between a private health insurer and hospital. When treatment is provided at a hospital that does not have a negotiated agreement with the insurer, and the treatment in question is covered by the patient's policy, then the *Private Health Insurance (Benefit Requirements) Rules* will continue to apply.

Some hospital treatment services provided by podiatric surgeons are included in coverage requirements for Silver and Gold product tiers. What benefits will insurers be required to pay?

While insurers are required to include cover for podiatric surgery performed by registered podiatric surgeons in line with the minimum product tier requirements, nothing in these requirements extend to regulating the commercial terms of negotiated agreements between private health insurers and hospitals.

If treatment by a registered podiatric surgeon is provided at a hospital that does not have a negotiated agreement with the insurer for the service provided, the benefit paid will continue to be at least the amount required under the *Private Health Insurance (Benefit Requirements) Rules* and the *Private Health Insurance (Prostheses) Rules*.

Insurers and hospitals will continue to be able to enter into negotiated agreements which cover the hospital's charge for particular treatments, including treatment by podiatric surgeons. Insurers can also enter commercial agreements which provide benefits towards the fees of the podiatric surgeon and anaesthetist.

What happens for people who have a pre-existing condition and want to upgrade their policy under the new product tiers?

Existing provisions in the *Private Health Insurance (Complying Product) Rules 2015* allow for a maximum twelve month waiting period to be applied to pre-existing

conditions for new and upgrading members. These provisions remain the same under these reforms.

Clinical categories for hospital treatment

Amendment Rules put in place the new clinical categories

The *Private Health Insurance (Reforms) Amendment Rules 2018* are referred to in this section of the FAQs as 'the Amendment Rules'.

The Amendment Rules amend the *Private Health Insurance (Complying Product) Rules 2015* (the Complying Product Rules) to introduce new gold, silver, bronze and basic product tiers and related clinical categories with effect from 1 April 2019.

The Complying Product Rules published on the Federal Register of Legislation will be updated to include product tiers and clinical categories after commencement of these reform amendments on 1 April 2019. In the meantime, refer to the Amendment Rules, which are available on the Federal Register of Legislation and and search for "Private Health Insurance (Reforms) Amendment Rules 2018".

What treatments must be covered for a clinical category?

Insurers are required to provide cover for all hospital treatments within the 'scope of cover' of a clinical category, as described in the table of clinical categories at Schedule 5 of the Complying Product Rules. This includes but is not limited to the Medicare Benefits Scheme (MBS) items mentioned against a clinical category. More information about how MBS item coverage works is provided below.

The Schedule 5 table of clinical categories is available on the Private Health Insurance (Reforms) Amendment Rules 2018 webpage.

Are MBS items covered only for the clinical category they are listed against?

No. Treatment using an MBS item is required to be covered under a policy where the treatment is within the scope of cover for a clinical category included in the policy.

Where an MBS item is included against a clinical category in the table at Schedule 5 of the Complying Product Rules, it is covered in that category. However, the list of MBS Items against each category is not exhaustive. This is because, in response to feedback from insurers about their systems and processes, MBS items have been allocated against only one clinical category, or in the Common or Support treatment lists. An explanation of the Common and Support treatment lists is provided below.

How have MBS items been allocated to clinical categories and Common and Support treatment lists? How are MBS items covered across different categories?

A significant amount of advice and feedback contributed to the final placement of MBS items against categories and lists, including through the Private Health Ministerial Advisory Committee and its clinical categories working group, broader consultation with interested groups, independent advice from Professor Nick Talley in April and May 2019, public consultation in July to August 2019, and ongoing feedback from clinician and consumer advocacy groups and insurers.

In order to accommodate insurers' administrative systems, while ensuring coverage for treatments in the scope of a clinical category, MBS items have been dealt with in the Complying Product Rules in four different ways.

1. MBS items specific to a clinical Category

MBS items that are likely to be relevant to the scope of cover for only one clinical category have been placed against that category in the table at Schedule 5 of the Complying Product Rules.

Where an MBS item is not likely to be a reason for admission for hospital treatment it has not been placed into a specific category. These items have generally been placed in the Support treatments list (see below) even if they are specific to a single body system.

2. MBS items that may be relevant for two clinical categories

MBS items that may be relevant to the scope of cover for two clinical categories have been placed against the clinical category that is in the lowest product tier for which the MBS item is likely to apply. These MBS items are in the table at Schedule 5 of the Complying Product Rules against the 'lower tier' clinical category. If the item is relevant to two categories in the same product tier, it has generally been placed against a category that insurers may be more likely to include in a lower tier policy.

This approach supports insurers who may wish to have a general administrative practice of covering all MBS items listed against a clinical category for all policies that have the same or a higher tier of cover.

For example, an MBS item may be relevant for both Heart and vascular system and Lung and chest clinical categories, both of which are in a silver policy. The MBS item is listed against Lung and chest. An insurer's administrative system may provide for the MBS item to automatically also be available for Heart and vascular system treatments for silver policies as both Lung and chest and Heart and vascular system are in the same product tier.

In a slight variant to this example, if the insurer places the Lung and chest clinical category into a bronze plus policy, the insurer's administrative systems may also provide for the MBS item listed against Lung and chest to automatically be available for Heart and vascular system treatments for silver policies (i.e. treatment under the higher level policy would be covered because all the lower tier clinical category treatments are automatically included).

However, the MBS item is required to be covered if the item is for treatment within the scope of cover of any clinical category covered by an insured person's policy, regardless of which category the MBS item is listed against. For example, MBS items for arthroscopy are listed under the Bone, Joint and Muscle category. These procedures are also relevant to the Joint reconstructions category. Both clinical categories are minimum requirements for bronze policies. If an insurer includes the Joint reconstruction clinical category in a basic-plus policy, they will still need to provide cover for arthroscopies under that policy.

3. MBS items that may be relevant for more than two clinical categories – Common treatments list

The Common treatments list in Schedule 6 of the Complying Product Rules consists of MBS items that are commonly used across multiple clinical categories. For

example, professional attendances by a medical practitioner are on the Common treatments list.

MBS items on the Common treatments list will generally be for treatments that may be the primary reason for an admission. In some cases they may also be associated with or support another treatment that is the reason for admission.

Insurers are required to cover MBS items in the Common treatments list where the treatment falls within the scope of cover for the clinical categories included in an insurance policy.

For administrative ease, insurers may have a general practice of covering all items on the Common treatments list under all policies above a certain tier (e.g. bronze and above). Insurers could supplement this arrangement for items they consider require special consideration, to ensure they are only covered where the treatment is related to a clinical category for which an insured person has cover.

The Complying Product Rules only require cover where the treatment falls in the scope of cover for a clinical category included in a policy.

4. ***MBS items that generally support other primary treatments – Support treatments list***

The Support treatments list in Schedule 7 of the Complying Product Rules consists of MBS items for treatments that are generally used to support the provision of a primary treatment (e.g. support treatment using an MBS item listed against one of the clinical categories or in the Common treatments list). For example, the Support treatments list includes MBS items for pathology, diagnostic imaging and anaesthetic management.

For administrative ease, insurers may have a general practice of covering all items on the Support treatments list where an insured person is admitted for a primary treatment that is covered in the scope of a clinical category included under their policy. Insurers may have a general administrative practice of not using MBS items on the Support treatments list to consider eligibility against an insured person's policy. However, insurers would need to supplement this arrangement for items requiring special consideration if an unusual situation arises where an MBS item on the Support treatments list was the reason for admission. This is because the Complying Product Rules *require* cover where the treatment falls in the scope of cover for a clinical category included in a policy.

Why do some clinical categories have no MBS item listed?

A clinical category may have no items listed as the relevant items may be in the Common or Support treatments lists, or perhaps listed under another clinical category.

For some clinical categories, for example Rehabilitation, most of the relevant MBS Items are likely to be attendances by a health professional. MBS Items for attendances are placed in the Common treatments list as they are not necessarily only for rehabilitation. For example, MBS Item 880 is for an attendance related to either geriatric or rehabilitation medicine, not just rehabilitation. For other clinical categories, for example, Podiatric surgery, there may be no relevant MBS Item.

Why are some MBS Items not listed against any of the clinical categories or in the Common treatments or Support treatments lists?

MBS items for which the treatment is not permitted to be provided in hospital are not intended to be listed in the clinical categories, Common treatment or Support treatment lists. For example, Child Dental Benefits Scheme treatments have an Item code for ease of administration, but they are not hospital treatments on the MBS. Some other MBS items state specifically that they cannot be provided in hospital, or are only for treatments in, for example, a residential aged care facility. The MBS items allocated under the Complying Product Rules will be continuously reviewed – some MBS Items that are allocated at this time may be removed later because they cannot be hospital treatments.

Does the fact an MBS Item is listed mean it is expected that the treatment will be provided during a hospital admission?

No. Many treatments covered by MBS items will usually be provided out of hospital (e.g. consultations with specialists, or diagnostic scans), but can also be provided as an admitted treatment.

'Type C' procedures under the *Private Health Insurance (Benefit Requirements) Rules 2011* are listed in the clinical categories or the Common or Support treatments list. These are services that do not normally require hospital treatment, but may be provided as hospital treatments with the appropriate certification.

Inclusion of an MBS item against a clinical category or in the Common or Support treatments lists has no bearing on whether that service requires a hospital admission and should not be interpreted as implying that these services necessarily require admission.

Are complications that are otherwise not covered by a policy required to be covered?

Insurers are required to provide cover that is otherwise outside an insured person's policy for complications that arise during an episode of hospital treatment where the episode was for treatment within the scope of cover of the policy.

However, treatment for the complication that is otherwise outside the insured person's policy is only required to be covered within the same episode of care as the primary treatment.

For example, if a person has surgery for a digestive illness and they develop acute arrhythmia during the episode of hospital treatment, attendance by a cardiologist and cardioversion would be covered even if the person's policy did not otherwise cover the *Heart and vascular system* clinical category.

When is unplanned treatment that is not otherwise covered by an insured persons policy required to be covered?

Insurers are required to provide cover for treatment that is otherwise outside an insured person's policy when:

- it is provided during a planned surgery that is within the scope of cover of the patient's policy and
- is, in the view of the medical practitioner providing the unplanned treatment, medically necessary and urgent.

If an insurer is concerned that a surgery that is outside an insured person's cover has been planned and then provided and claimed as though it were unplanned, this can be raised with the relevant medical practitioner and if necessary referred to the relevant review board.

Insurers may also raise any ongoing concerns about clinical categories and the coverage required for hospital treatments during the planned review of the clinical categories, scheduled to be conducted in 2020.

Is an entire episode of care covered if it consists of two or more elective procedures and one of those procedures is excluded from the patient's policy?

Insurers are required to cover elective procedures that are covered by the patients' policy, and all associated services or complications arising from that procedure. An insurer does not have to cover any planned elective procedures not covered by the patients' policy, even if it is provided in the same admission.

For example, a patient with a bronze policy has elective surgery for the removal of their tonsils and also elects to have dental surgery in the same admission; their policy only covers the tonsillectomy and not the dental surgery. Therefore, the insurer is only required to cover the tonsillectomy and associated services such as post-operative care for the tonsillectomy.

Is rehabilitation related to a condition that is not otherwise treated in hospital covered by the Rehabilitation category? Are patients who receive rehabilitation services for a condition not covered by their policy still covered for rehabilitation services?

Yes, the *Rehabilitation* category covers all physical rehabilitation hospital treatment. This includes rehabilitation from an illness not otherwise treated in hospital and a condition not otherwise covered by a clinical category under the patient's policy.

Do waiting periods for obstetric services extend to all items in the Pregnancy and birth category? What about newborn / neonates?

The *Private Health Insurance Act 2007* allows for a maximum twelve month waiting period for obstetric services. These provisions are unchanged. A 12-month waiting period may be applied to all services covered under the *Pregnancy and birth* category.

Current arrangements for neonatal care are unchanged. As is currently the case, dependents are covered under their parent's policy (either under a single parent or family policy). Treatments provided to an unadmitted newborn would be covered by the admission of the mother.

Treatments for an admitted newborn are covered by the clinical category relevant to the condition being treated. Insurers have arrangements for waiting periods for newborns. In general, a new born is considered to have served a waiting period already served by the insured parent.

Is the entire course of breast cancer treatment included in bronze products, including sentinel node biopsies and all breast reconstruction surgery?

Chemotherapy, radiotherapy and immunotherapy for all cancers are covered in the *Chemotherapy, radiotherapy and immunotherapy for cancer* category.

Hospital treatment for the investigation and treatment of breast conditions and associated lymph nodes, including sentinel node biopsies and breast reconstruction and/or reduction following breast surgery or a preventative mastectomy are included in the *Breast surgery* category.

Both these clinical categories are minimum requirements for bronze products.

Does the Blood category cover treatment for cancers of the blood?

Blood cancer treatment is covered in the *Chemotherapy, radiotherapy and immunotherapy for cancer* category. Blood cancers do not require the removal of a tumour. They are treated with chemotherapy, radiotherapy or immunotherapy such as stem cell transplantation, or a combination thereof.

The *Chemotherapy, radiotherapy and immunotherapy for cancer* category is a minimum requirement for bronze products. As such, a consumer who has a bronze policy will be covered for their treatment for a blood cancer. However, they will not be covered for other blood disorders, which are covered by the *Blood* category – a minimum requirement for silver products - unless they upgrade their policy or it becomes a bronze 'plus' that includes the *Blood* category.

Does the cancer clinical category mean all treatment for cancer is covered under bronze?

No. All chemotherapy, radiotherapy and immunotherapy for cancer and benign tumours is covered in that category. Other investigations, surgery or treatment, for example removal of tumours, is covered by the clinical category for the affected or suspected body system being investigated or treated.

Where do organ transplants fit into the clinical categories?

Organ transplants are covered by the clinical category relevant to the organ that is being transplanted. For example, a renal transplant is covered under the *Kidney and bladder* category.

Age-based discounts

How will insurers advise consumers that they offer age-based discounts on a product? Will this information be included on the Private Health Information Statement?

Insurers can choose their own method for advising consumers about age-based discounts. Information about age-based discounts is not part of the minimum mandatory information for a Private Health Information Statement. Insurers may provide additional information about age-based discounts along with the Private Health Information Statement. See the **Information Provision** FAQs below for more details about providing additional information.

Do insurers have flexibility about what discount they offer?

If an insurer chooses to offer a product with age-based discounts, which it is free to do for anyone it chooses between the ages of 18-29, the discount percentage offered must be the rate allowed for that age as shown in the table below. Insurers don't have to offer discounts for everyone between these ages. It's a choice for the insurer.

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

What is the difference between an 'age-based discount policy' and a 'retained age-based discount policy'?

If an insurer chooses to offer a policy with an age-based discount, it can also choose to make it a 'retained age-based discount policy'. That means that, if someone transfers into that policy, either from a different insurer or from a different policy with the same insurer, any existing age-based discount will be maintained.

For example, if a 29 year-old purchased an age-based discounted policy when they were 25 (and therefore has a 10% age-based discount) and then transfers to a new 'retained age-based discount policy' that also offers discounts to 25 year olds, the new policy would honour the person's existing 10% discount.

If the same person chose to transfer to an age-based discounted policy that was not a 'retained age-based policy' they would only be eligible for a 2% discount based on their age at the time of transfer.

Whether or not an age-based discounted product maintains a person's existing age-based discount, all individual policies under the product must be available on the same basis for all consumers.

The Rules require health insurers to state whether the age-based discounted policy is a 'retained age-based discount policy'. How/where are insurers required to make this statement?

If an insurer offers age-based discounts, details about the discounts provided would need to be included in the insurer's Fund Rules. Likewise, if the age-based discounted product will retain a person's existing age-based discount for new policy holders, the insurer would need to state in their Fund Rules that the policy is a 'retained age-based discount policy'

Does a 'retained age-based discount policy' have to honour a person's existing age-based discount percentage if they transfer to the policy from another insurer?

If the new policy is defined as a 'retained age-based discount policy', any existing discount (including from another insurer) will be retained, provided the new policy offers age-based discounts relevant to the person's existing discount.

For example, if a 29 year old who purchased an age-based discounted policy when they were 25 (and has a 10% age-based discount) transfers to a new 'retained age-based discount policy' that offers discounts to 25 year olds, the new policy would honour the person's existing 10% discount.

If an insurer offers a "retained age-based discount policy", how will the insurer know what discount percentage a person who transfers to the policy is entitled to?

Before age-based discounts commence on 1 April 2019, the Department will update the approved form for Transfer Certificates to include the age-based discount percentage that a person was receiving under their old policy.

How will an age-based discount apply on discounted couple policies?

For joint age-based discount policies, the total age-based discount is equal to the average of the discounts to which each eligible person who is insured under the policy is entitled.

To calculate each person's applicable discount, that person's discount percentage will be applied to his or her proportion of the policy's base rate for hospital cover.

For example, on a couple policy where one adult is eligible for a 10% age-based discount and the other adult is eligible for a 6% age-based discount the total discount applied to the policy would be the average discount, or 8% (applied only to the hospital cover component of the policy).

This is the same principle as when a policy covers two people but only one has a Lifetime Health Cover (LHC) loading, or they have different LHC loadings.

Clause 11C of the *Private Health Insurance (Complying Product) Rules* provides the calculation of the applicable discount and the definition of base rate for hospital cover.

How will the age-based discount apply for discounted couple (or family) policies where one adult insured under the policy is eligible for a discount and the other has a Lifetime Health Cover (LHC) loading?

In these cases, each discount or loading component will be applied to the relevant person's proportion of the policy's base rate for hospital cover. In this example, the discount (at the allowed percentage) would apply to half the base rate for hospital cover and the LHC loading would apply to half the base rate for hospital cover.

This is the same principle as when a policy covers two people but only one has an LHC loading, or they have different LHC loadings.

For the discount-eligible person, the applicable discount will be calculated in accordance with Clause 11C of the *Private Health Insurance (Complying Product) Rules*. For the person who has a LHC loading the amount of the increase would be worked out in accordance with the LHC provisions in Part 2-3 of the *Private Health Insurance Act 2007* (Clause 37-20 provides for joint hospital cover).

The combined effect of both calculations will provide the total increase, or decrease, to apply to the policy's premium. For example, if the hospital cover component of a couple's policy is $2,000 per year and 1 person is entitled to a 10% discount and the other has a 6% LHC loading, a 10% discount would be applied to half the hospital cover base rate and the 6% loading to the other half:

$1,000 with a 10% discount = $900

$1,000 with a 6% loading = $1,060

Total payable for the hospital cover component = $1,960

Can an insurer choose to remove age-based discounts from a product?

Yes. The provision of age-based discounted products by insurers will be voluntary. It will be a matter of commercial judgement about whether insurers choose to offer products with age-based discounts or not.

Likewise, the removal of age-based discounts from a product is a matter for the insurer. However, the discount must be removed on the same basis for all holders of that product, including new and existing policy holders.

If an insurer removes an age-based discount from a product, how will consumers be informed of this change?

If an insurer chooses to remove discounts from a product, the *Private Health Insurance (Complying Product) Rules* requires the insurer to inform policy holders within a reasonable time before the change:

- that the policy will no longer provide an age-based discount; and
- of the new premium that will be payable for the policy.

This will allow those affected time to consider transferring to a retained age-based discount policy. A policy defined as a 'retained aged-based discount policy' is one which will maintain an existing discount for new policy holders, whether that existing discount is with the same or another insurer.

If an insurer removes an age-based discount from a product, can they reintroduce the discount to the product at a later date?

Yes. The provision of age-based discounted products by insurers will be voluntary. It will be a matter of commercial judgement about whether insurers choose to offer, and maintain, products with age-based discounts or not.

If an insurer has removed an age-based discount from a product, and subsequently chooses to reintroduce a discount on that product, the discount assessment date will be recalculated. In other words, a discounted status held when the product was previously offering discounts is not preserved over the period in which the product did not offer age-based discounts.

If a person stops their private health insurance hospital cover, and at a later date purchases another hospital policy, what discount can be offered?

If a person stops their private health insurance and at a later date purchases another hospital policy the insurer can only offer them a discount based on their age when they re-join hospital cover.

An exception is when a person transfers from an age-based discounted policy to a retained age-based discounted policy. In these cases, transfer has the same meaning as Clause 75-10 of the *Private Health Insurance Act 2007*, that is:

> A person ***transfers*** to a policy (the ***new policy***) from another policy (the ***old policy***) if:
>
> (a) either:
>
> (i) the person is insured under the old policy at the time the person becomes insured under the new policy; or

(ii) the person ceased to be insured under the old policy no more than 7 days, or a longer number of days allowed by the new policy's insurer for this purpose, before becoming insured under the new policy; and

(b) the old policy is a complying health insurance policy; and

(c) the person's premium payments under the old policy were up to date at the time the person became insured under the new policy.

When age-based discounts are phased out from a person's 41st birthday, how is the discount calculated when the person's age changes during their premium period?

When the person's discount percentage changes because they turn 41 (and each subsequent year up to age 45) , the applicable discount for that premium period is calculated pro rata based on the portion of the period before and after the change.

For example, if a person holds a 10% age-based discount, pays their premiums monthly and turns 41 on the 10th day of their monthly premium period their discount would be calculated as:

- 10% age-based discount for the first 9 days of the premium period, and
- 8% age-based discount for the remainder of that premium period.

This is a similar principle as removing Lifetime Health Cover loadings after 10 continuous years. (Clause 34-10 of the *Private Health Insurance Act 2007* requires that the Lifetime Health Cover loading must cease on the day after the last day of the required 10-year loading period. Where the last day of the 10 year period falls with a premium period, a pro rata calculation is required.)

How is an age-based discount calculated for people who rate-protect by purchasing insurance for 12 months in advance?

Purchasing insurance 12 months in advance in order to rate-protect would not affect the calculation of the discount, unless the age-based discount eligible person turns 41 (to 45) during the 12 month period. In this case the applicable discount would be calculated on a pro rata basis by reference to the portion of the period before and after the change.

For example, if a 40 year old person with an existing 8% discount pays 12 months premiums in advance, turns 41 100 days into the 12 month period they would be eligible for:

- 8% age-based discount for the first 99 days of the 12 month period; and
- 6% age-based discount for the remainder of the 12 month period.

This is a similar principle as removing Lifetime Health Cover loadings after 10 continuous years. (Clause 34-10 of the *Private Health Insurance Act 2007* requires that the Lifetime Health Cover loading must cease on the day after the last day of the required 10-year loading period. Where the last day of the 10 year period falls with a premium period, a pro rata calculation is required.)

Can gift cards, frequent flyer points or any other incentives be used in replacement of a direct premium discount?

No, the age-based discount must be a monetary discount applied to the base rate for hospital cover.

Will providing age-based discounts on a policy reduce that policy's Single Equivalent Unit (SEU) count for the purposes of risk equalisation?

No, offering an age-based discount on a policy will not affect how that policy is counted for risk equalisation.

Like other allowable discounts, the provision of age-based discounted products by insurers will be voluntary. There are no risk equalisation adjustments made for other discounts that insurers choose to offer.

Will insurers be required to provide data for age-based discounted policies to the Australian Prudential Regulation Authority (APRA)?

APRA and the Department will work together with Private Health Insurers to formalise the data collection processes using existing APRA submission channels for all relevant data for the PHI reform measures announced in October 2017.

In the case of a Dependent Student over 18 is there any requirement that age-based discounts be applied, or is it only in relation to Adults on a policy?

The age-based discount policy is designed to encourage young independent people to purchase and retain private health insurance. Most family policy holders do not pay additional premiums for the dependents covered under their policy.

The Rules only allow insurers to offer an age-based discount to a person who is aged between 18 and 29 (inclusive) and is specified in the policy as eligible for the discount, but is not a dependent child under the policy.

The *Private Health Insurance Act 2007* defines a dependent child to mean a person:

(a) who is:
  (i) aged under 18; or

  (ii) a dependent child under the *rules of the private health insurer that insures the person; and

(b) who is not aged 25 or over; and

(c) who does not have a partner.

Information Provision

Amendment Rules put in place the new Information provisions

The *Private Health Insurance (Reforms) Amendment Rules 2018* are referred to in this section of the FAQs as 'the Amendment Rules'.

The Amendment Rules amend product information requirements in the *Private Health Insurance (Complying Product) Rules 2015*:

from 1 January 2019 to

- change from the old Standard Information Statement (which specifies the precise format and information that can be given) to a minimum set of mandatory information, and otherwise allowing flexibility in presentation and giving additional information;

- make transitional provisions, to allow an old Standard Information Statement to be used up until 31 March 2020. However, from 1 April 2019 an old Statement Information Statement cannot be provided if the product uses gold, silver, bronze or basic in its name (i.e. uses new product design);
- require insurers to provide premium change information to the Private Health Insurance Ombudsman.

from 1 April 2019 to

- require some personalised information to be provided to insured persons along with the Private Health Information Statement at least once per year (name of insured persons and lifetime health cover information);
- allow flexibility in the method for delivering the information statement and other information sent at the same time to insured persons;
- cater for changes to language used in the information statement due to introduction of product tiers and clinical categories;
- provide that the transition arrangement that allows use of the old Standard Information Statement does not apply from 1 April 2019 onward if the product uses gold, silver, bronze or basic in its name (i.e. uses new product design);
- remove the requirement for annual rebate tax statement and lifetime health cover statement (and instead require them to be provided on request);
- change references to Standard Information Statement to Private Health Information Statement.

An updated version of the *Private Health Insurance (Complying Product) Rules 2015 (*Complying Product Rules) incorporating amended product information requirements will be available on the Federal Register of Legislation after each of the 1 January and 1 April 2019 commencement dates. In the meantime, refer to the Amendment Rules, which are available on the Federal Register of Legislation and search for "Private Health Insurance (Reforms) Amendment Rules 2018".

Below is a table summarising the arrangements for Information Statements during the transition periods:

Date	**Type of Information Statement that can be used**
11 October 2018 to 31 December 2018	All products use: • Old Standard Information Statement
1 January 2018 to 31 March 2019	Can use: • Old Standard Information Statement OR • New Standard Information Statement
1 April 2019 to 31 March 2020	For a product that DOES NOT use gold, silver, bronze or basic in its name – can use: • Old Standard Information Statement OR • New Private Health Information Statement (old type product)
	For a product that DOES use gold, silver, bronze or basic in its name – must use: • New Private Health Information Statement (new type product)

Date	Type of Information Statement that can be used
1 April 2020 onward	All products – must use: • New Private Health Information Statement (new type product)

'**Old Standard Information Statement**' means the information statement under the Complying Product Rules in force before 1 January 2019 (i.e. old SIS template).

'**New Standard Information Statement**' means a statement that includes the new minimum mandatory information under the Complying Product Rules in force from 1 January 2019. This allows insurers to use the new minimum mandatory information approach to information statements before 1 April 2019.
'**New Private Health Information Statement (old type product)**' means a statement that includes the new minimum mandatory information under the Complying Product Rules in force from 1 January 2019.
'**New Private Health Information Statement (new type product)**' – means a statement that includes the new minimum mandatory information under the Complying Product Rules from 1 January 2019, with minor language modifications from 1 April 2019 due to mandatory application of product tiers and clinical categories when gold, silver, bronze or basic is used in the name.

Is the Private Health Information Statement different from the Private Health Insurance Statement?

Yes. There are two documents that are similarly named but with different information and serving different purposes:

1. Private Health Information Statement (replacing the Standard Information Statement from 1 April 2019, with transitional arrangements applying until 1 April 2020). This document contains minimum mandatory information about a private health insurance policy.
2. Private Health Insurance Statement ('tax statement'). This document contains information relevant to the private health insurance rebate to help insured persons complete their tax return.

Do insurers have to provide the Private Health Information Statement?

Yes, a Private Health Information Statement replaces the Standard Information Statement from 1 April 2019 (with transitional arrangements, mentioned above). Insurers are required to provide an Information Statement:

- to newly insured people;
- annually to currently insured persons;
- upon request;
- when a change is made that might be detrimental to an insured person.

When do insurers have to provide a Private Health Insurance Statement?

The requirement for insurers to provide a separate annual Private Health Insurance Statement (tax statement) has been removed from the Complying Product Rules, with effect from 1 April 2019. This is because provision of the tax statement has become largely unnecessary, as insurers provide the relevant data to the Australian Taxation Office (ATO) automatically. However, insurers are required to provide to policy

holders information stating the premium paid and reduction received under the premiums reduction scheme when requested (within 14 days).

The information required covers a previous financial year – ie, regardless of when the request is made, the information to be provided will cover a previous period from 1 July to 30 June.

The relevant changes have been made to the Complying Product Rules, with effect from 1 April 2019. Related tax laws have also been amended. The ATO will issue updated guidance for insurers about submission of tax rebate information. The ATO will still require health funds to issue an amended Private Health Insurance Statement where applicable. Under the ATO's Private Health Insurance Statement Specification health funds are required to issue amended statements when there has been a change to the original values that result in a financial impact value of $10 or more. Please contact the ATO if you need further information about their requirements.

What are the obligations to provide a lifetime health cover statement?

The Amendment Rules provide for information relevant to lifetime health cover to be given to insured persons under both the Complying Product Rules and the *Private Health Insurance (Lifetime Health Cover Rules) 2017* as follows:

Lifetime Health Cover (LHC) Rules - from 1 April 2019
Insurers are required to send out information **on request**, within 14 days, re:

- amount premiums are increased by LHC rules; and
- days policy holder has not had hospital cover since the LHC base day.

The LHC Rules no longer require insurers to send this information in an annual statement, but insurers could do so if they wish. This is intended to provide flexibility sought by insurers.

Complying Product Rules - from 1 April 2019
Insurers are required to send out information with the Private Health Information Statement, for each adult covered on the policy re:

- LHC loading %; and
- the period remaining until a person has reached 10 continuous years of cover and the loading is removed.

However, insurers are not required to inform a person of this information more than once in any 12 month period. Where this information is being sent out with the initial PHIS for a newly insured person, but the LHC loading is not known because a transfer certificate has not been received, this could be advised to the insured person. The information would be updated on receipt of the transfer certificate. Business approaches vary and each insurer can work out the best way to comply, under their own processes and systems, with the requirement to give the information at least once in each 12 month period.

It is up to insurers whether they include information stating that the LHC loading percentage is "not applicable' for a person who is named on the policy and has no loading. This is not required by the Rules. The insurer could also choose to provide information about the impact on the policy premium of a

LHC loading applying to only one joint policy holder, or different loadings for each joint policy holder.

The Amendment Rules provide that the period of time remaining until the loading is removed is expressed in years, months, days as appropriate. Insurers may also wish to indicate that the information will be correct only if premium payments remain up to date and there is no change in the days with no hospital cover.

Under both of the Rules mentioned above, the Department considers that where lifetime health cover information is being provided at the same time as a premium increase letter, it would be reasonable for the information to be provided 'as at' 1 April, and make this clear. That is, it would be prospective information to co-incide with the premium change. If the lifetime health cover information is sent at other times, it should be current at the time it is provided.

Do insurers need to include the policy holder's name with the Private Health Information Statement?

Yes, at least once per year.

From 1 April 2019, when providing an insured person with a Private Health Information Statement an insurer must, at least once a year, also provide the name of each person covered by the policy. This information can be included in the same document as the Private Health Information Statement, or in a separate document.

Can insurers and consumers still generate a Private Health Information Statement from the privatehealth.gov.au website?

Yes. Insurers are still required to provide the Ombudsman with product information and will be able to generate a Private Health Information Statement from their portal. This will be prepared in a generic format and include the required mandatory information.

The mandatory information for a Private Health Information Statement will be published and downloadable by consumers on privatehealth.gov.au. This will be in a generic format. The format for the generic Private Health Information Statement is being considered by the Ombudsman and Consumer Website Reference Group, which includes insurer and consumer representation.

Do insurers need to provide two sets of information, one to the Ombudsman for the website and one to consumers?

There is no change to the requirement that information statements about policies be provided to:

- the Private Health Insurance Ombudsman, which is used to generate a downloadable Private Health Information Statement on privatehealth.gov.au; and
- consumers and insured persons as set out in the *Private Health Insurance Act 2007* and the Complying Product Rules.

Insurers will still be able to use the Private Health Information Statement generated from their Private Health Insurance Ombudsman website portal to provide to consumers and insured persons if they wish. Insurers may also modify that document to provide more information if they wish.

Insurers are required to provide mandated personalised information to insured persons along with the Private Health Information Statement at least once each year (name of insured persons and lifetime health cover information). See more information above.

Do insurers have to use specific phrases/words in the Private Health Information Statement?

Yes, but information statement requirements are less restrictive, and allow additional information to be provided (see answers below about providing additional information). This answer is relevant to policies using the new information statement provisions that apply from1 January 2019 and 1 April 2019 rather than the old Standard Information Statement in force immediately before 1 January 2019.

The Complying Product Rules set out the minimum mandatory information for:

- 'All policies' information – Schedule 1 of the Rules;
- Hospital treatment policy – Schedule 2 of the Rules;
- General treatment policy – Schedule 3 of the Rules.

If the policy is a combined policy, the minimum information requirements in all three Schedules apply (except if ambulance cover is the only general treatment, when only Schedules 1 and 2 apply).

The wording in quotation marks in Schedules 1, 2 and 3 must be used in new information statements. However, the new information statements are much more flexible than the old Standard Information Statement. Additional information can be provided, and outside of the specified phrases/words, the statements can be prepared by insurers using their own words.

Can insurers provide additional information along with the Private Health Information Statement?

Yes. Insurers can provide consumers with information in addition to the mandated information. Additional information provided along with a Private Health Information Statement can be:

- general statements intended for provision to a consumer on request (ie, non-personalised). This could include branding or other information relevant to the policy in addition to the minimum mandatory information;
- personalised information specific to policy holders – such as details about whether waiting periods have been served, or the amount of benefits claimed against certain treatments. Insurers are required to provide certain personalised information to insured persons along with the Private Health Information Statement at least once each year (name of insured persons and lifetime health cover information). See more information above.

Additional information can be included in the same document as the Private Health Information Statement, or in a separate document. If it is included in the same document it must not obscure or contradict the mandatory information. There is no other restriction on the nature of the additional information that can be provided.

Additional information can only be included in a new style information statement (i.e. one that is fully compliant with the new standard information / private health information statement under the amended Complying Product Rules). Additional

information cannot be provided if the insurer is still using the old standard information statement template, which is permitted until 31 March 2020 for any product that does not include gold, silver, bronze or basic in its name.

Additional information will, in general, not be published on privatehealth.gov.au. However, the Private Health Insurance Ombudsman may seek and publish some information separate to the mandatory Private Health Information Statement, for example about age-based discounts.

Can insurers include information with the Private Health Information Statement about age-based discounts?

Yes, but information on age-based discounts is not part of the mandatory information required to be provided in a Private Health Information Statement. Insurers are free to provide additional information not specified in the Complying Product Rules.

Can insurers include their own branding on the Private Health Information Statement?

Yes. Insurers can include their branding on the Private Health Information Statement that they send to consumers.

Allowing insurers to include branding on Private Health Information Statements available on the Private Health Insurance Ombudsman's website is being considered by the Ombudsman and Consumer Website Reference Group.

Does the Private Health Information Statement sent to insured persons need to include the information in the order listed in the Complying Product Rules?

No. The order of the items and exact presentation of the mandatory information is not specified, so long as the mandatory information is included and is not obscured or contradicted. For example, the order in which treatments in the general treatment Private Health Information Statement are listed can be changed.

Does an insurer have to provide details about the premium payable after any rebate, loading or discount is applied on the Private Health Information Statement?

An insurer must provide the total monthly premium payable before any rebate, loading or discount is applied. It is optional for insurers to provide an insured person with information on their specific premium (e.g. premium amount taking into account applicable rebates, loading or discounts).

Can insurers include information on ambulance cover in both the hospital and general treatment Private Health Information Statements?

Insurers are required to provide information about ambulance cover in the 'all policies' part of the Private Health Information Statement (Schedule 1 to the Complying Product Rules). This information is provided along with hospital, general and combined policies.

If ambulance is the only general treatment covered, insurers are not required to provide the mandatory information under the separate Schedule 3 to the Complying Product Rules for general treatments. That is because information about the

ambulance cover will already be provided as part of the 'all policies' statements required under Schedule 1 to the Complying Product Rules.

For general treatment policies, can insurers provide information on additional general treatments to those listed in Schedule 3 to the Complying Product Rules?

Yes. Insurers are able to add additional items and change the order in which the general treatments appear. The services listed in Item 3 of Schedule 3 to the Complying Product Rules are not exhaustive, and insurers may cover additional services – for example, exercise physiology and occupational therapy.

For general treatment policies, can insurers change the treatment names as they appear in Schedule 3, items 3 and 4 in the Complying Product Rules?

No. Insurers cannot amend the treatment names listed (for example, 'psychology' must be used instead of 'mental health services'). There is no requirement for items to be listed in any specific order, but all the listed treatments in item 3 must be covered in either item 3 or item 4 of Schedule 3 to the Complying Product Rules.

What type of information can insurers provide in 'Other features' as part of the Private Health Information Statement?

Insurers can include whatever other information they wish. This might be about:

- disease management programs and other programs that support healthy lifestyles
- age-based discounts
- discounts for direct debit, paying in advance etc.
- loyalty bonus/incentive schemes
- waiver(s) of co-payments
- travel and accommodation benefits
- other significant product features.

There is a 100 word cap on the additional information that can be provided as part of the Private Health Information Statement (mandatory information) so that this information can be provided to Private Health Insurance Ombudsman and consumers. There is a separate 100 word cap for hospital and general treatment.

Insurers can provide other additional information to consumers and insured persons. This is discussed in more detail above.

Why are both the terms 'policy' and 'product subgroup' used in the Schedules to the Complying Product Rules relating to the Private Health Information Statement?

An interpretative provision for Schedules 1, 2 and 3 of the Complying Product Rules makes it clear that a reference to a policy in those Schedules is a reference to a policy that forms part of the relevant product subgroup.

The word 'policy' is used to ensure that statements that will be provided to consumers refer to 'policy', as this is more relevant to them than 'product sub-group'.

Product subgroup still has the same meaning as the Act (see section 63.5(2A)).

Can insurers provide Private Health Information Statements, Private Health Insurance Statements and Lifetime Health Cover information by any method they choose? Are they required to provide it on their website?

From 1 April 2019 the default method for giving Private Health Information Statements, Private Health Insurance Statements and Lifetime Health Cover information is by post. However, if the person has asked for it to be provided in another manner, then it must be provided in that manner as long as it is reasonably practicable. This will allow insurers to provide information by methods such as email or text, or via a webpage, as long as the person seeking the information has agreed to receive information by that particular method.

Insurers can put in place a method for consumers to request that this information be provided via their website (public or members portal or a mix, to deal appropriately with active and closed products), or by email or other means.

If a consumer requests that the Information Statement be provided in a particular way, and it is reasonably practicable to do so, that is the required method for delivery.

Do insurers have to provide premium change information to the Private Health Insurance Ombudsman?

Yes. From 1 January 2019 the Complying Product Rules provide that insurers are required to inform the Ombudsman of new premiums once they have been approved by the Minister. Insurers are required to provide the Ombudsman with this information within 14 days of the date of the Minister's approval for the change, or 1 April of the year in which the Minister approved the change (whichever of the two is earlier).

How do insurers upload their Private Health Information Statement and premium information to the Private Health Insurance Ombudsman website?

Insurers will continue to supply information to the Ombudsman in the way they currently do. That is, insurers upload product information via a software interface. The processes for uploading information on premium benefit details will be discussed with insurers by the Ombudsman.

Are SIS codes still relevant or is there an alternative that needs to be created/applied?

SIS codes are administrative codes used by insurers and Government agencies to identify individual private health insurance products. A PHIS code will replace the SIS code for new products. Existing products that are 'updated' to satisfy the requirements of the new rules will retain their current code.

How does the 'who is covered' wording in a Private Health Information Statement cater for differentiation between student and non-student dependants?

The requirement to state who is covered by the policy refers to the same insured groups as are set out in Rule 5 of the Complying Product Rules. Rule 5 contemplates that an insured group may include student and non-student dependents. However, the *insured group names* do not discriminate between cases where people insured under

the policy are student or non-student dependents. The Private Health Information Statement simply requires that the insured group type be identified – it does not set up the requirements for insured groups. This occurs under Rule 5. Therefore, insurers can have different product sub-groups that accommodate for student or non-student dependents. If insurers wish to provide information about the type of people in the insured group they may provide this 'additional information' along with the Private Health Information Statement.

Second-tier

Has the note under Schedule 4, amendment [2], clause 1A(2) in the Amendment Rules been included because insurers will not be required to recalculate second-tier rates until 1 August 2019?

Insurers will not be required to recalculate second-tier default benefits until 1 August 2019. Insurers will continue to use the second-tier rates that were calculated in August 2018 until 1 September 2019, when the new rates calculated using the department's categorisation of hospitals will come into effect.

Schedule 4, amendment [8], rule 3 in the Amendment Rules defines the word 'accredited'. How will hospitals with interim accreditation be treated?

The Australian Commission on Safety and Quality in Health Care has released Advisory A13/02, which states that, 'Interim accreditation for a new health service organisation, as described in this document, satisfies the requirement to be accredited to the NSQHS Standards for the purpose of achieving second-tier default benefits eligibility under the *Private Health Insurance (Benefit Requirements) Rules 2011'*.

Why don't the Amendment Rules include indexation of second-tier default benefits?

This issue will be considered in the near future. The department intends to establish a working group to consider an appropriate inflation factor to index second-tier default benefits on a three year cycle.

Will the department assess applications for second-tier default benefits eligibility on an ad-hoc basis or at set times of year?

From 1 January 2019, the department will accept and assess applications for second-tier default benefits eligibility on an ad-hoc basis.

Will second-tier default benefits eligibility expire 12 months from the date of approval when the department commences administration of second-tier default benefits eligibility?

No. From 1 January 2019, the Minister or delegate will advise the end date for new second-tier eligibility, which is intended to be 60 calendar days after the hospital's accreditation expiry date. Therefore, the length of second-tier eligibility for a new eligible period could be up to three years plus 60 days.

For hospitals that were already second tier eligible on 1 January 2019, there are two possibilities. If accreditation expiry falls within 12 months of the second tier expiry

date, the second tier expiry is automatically extended to 60 calendar days after accreditation expiry. If accreditation expiry falls more than 12 months after the second tier expiry date, second-tier eligibility ends on the eligibility expiry date. A new application would result in a new second tier expiry date that is 60 days after the accreditation expiry.

Natural therapies

Which natural therapies are excluded from complying health insurance products?

From 1 April 2019, the following natural therapies are excluded: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homoeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi and yoga.

Can services for excluded natural therapies be covered by complying health insurance products where they are provided by health professional whose core business is not the provision of those services? For example, Pilates services provided by a physiotherapist or kinesiology services provided by a chiropractor.

See PHI Circular 69/2018, on the Department of Health website, which provides:

> From 1 April 2019 the Private Health Insurance (Health Insurance Business) Rules (the Rules) will provide that general treatment does not include a range of natural therapies ("the excluded natural therapies"). This means that insurers cannot pay benefits for these therapies under a complying health insurance policy.
>
> A number of insurers and other groups have asked how the Rules apply to professionals providing natural therapies as an element of other treatment. The most often identified scenario is a physiotherapist providing Pilates services.
>
> The Department considers that an insurer may lawfully pay benefits if a physiotherapist, providing services to a patient within the accepted scope of clinical practice, uses exercises or techniques drawn from Pilates as part of that patient's treatment as long as the exercises or techniques are within the accepted scope of clinical practice.
>
> However, if a physiotherapist (or any other health professional) conducts a Pilates session – either advertised or promoted as such, or a session where the only service provided is Pilates exercises – then benefits cannot lawfully be paid.
>
> The same principle applies to any other excluded natural therapy.

What type of herbalism is excluded from complying health insurance products?

There are three main types of herbalism: Chinese, Ayervedic and Western. Only Western herbalism is excluded. Chinese herbalism, including Traditional Chinese Medicine, and Ayerveda were outside the scope of the 'Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance' and are not excluded from 1 April 2019. For more information on Western Herbalism see the Review on the Department's website.

Can health insurers continue to use the term 'natural therapies'?

Yes, only the excluded natural therapies cannot be covered by complying health insurance products from 1 April 2019. Others may be covered and still referred to as natural therapies.

Can insurers offer incentives/rewards/inducements to their customers which include excluded natural therapies?

Health insurers can offer a range of incentives for excluded natural therapies, for example vouchers or other eligibility for free or discounted natural therapy services. Note that any discounts offered must meet the requirements set out at subsections 66-5 (2) and (3) of the *Private Health Insurance Act 2007* and section 6 of the *Private Health Insurance (Complying Product) Rules 2015*.

Can health insurers cover natural therapies outside of private health insurance?

Yes. Health insurers can, outside of their health insurance business, cover the excluded natural therapies under general insurance policies provided they do not breach any of the prudential requirements and meet the relevant regulatory requirements for general insurance. This is a commercial matter for insurers.