

# Private Health Insurance

Code of Conduct:

Self-Audit Certification Form

October 2025: Version 11

Commercial-in-Confidence

# Private Health Insurance Code of Conduct

## Self-Audit Certification Form

Code of Conduct Compliance Committee  
Private Healthcare Australia

October 2023: Version 10

Please direct any inquiries regarding the  
Private Health Insurance Code of Conduct to:  
Code of Conduct Compliance Committee  
c/o Private Healthcare Australia  
Phone: (02) 6202 1000  
Email: [code@pha.org.au](mailto:code@pha.org.au)  
Web: [privatehealth.com.au/codeofconduct](https://privatehealth.com.au/codeofconduct)

Completed Self-Audit Certification forms should be  
submitted via the portal:  
<https://www.privatehealthcareaustralia.org.au/sacp/>

# Contents

|  |           |
|--|-----------|
| <b>Process and Health Fund Certification</b>                                 | <b>5</b>  |
| <b>1. Code Compliance</b>  | <b>5</b>  |
| 1.1 Certification  | 5         |
| 1.2 Parts A, B, C, D, E and F  | 6         |
| 1.3 Requirements for Compliance  | 6         |
| 1.4 Health Fund Details for Self-Audit                                       | 7         |
| 1.5 Self-Audit Certification   | 8         |
| 1.6 Triennial Cycle Certification  | 9         |
| <br>   |           |
| <b>Part A – Introduction</b>   | <b>10</b> |
| <b>1. Employees</b>  | <b>10</b> |
| <br>   |           |
| <b>Part B – Consumer Information</b>   | <b>16</b> |
| <b>1. Clear and Complete Policy Documentation</b>                            | <b>16</b> |
| <b>2. Privacy Policies</b>   | <b>18</b> |
| <b>3. Data Storage</b>   | <b>18</b> |
| <br>   |           |
| <b>Part C – Code Compliance</b>  | <b>19</b> |
| <br>   |           |
| <b>Part D – Changes To Policies</b>  | <b>21</b> |
| <b>1. General Changes to Hospital or General Treatment (Extras) Policies</b> | <b>23</b> |
| <b>2. General Changes to Hospital or General Treatment (Extras) Benefits</b> | <b>24</b> |

# Contents

|  |           |
|--|-----------|
| <b>Part E – Dispute Resolution</b>                                 | <b>26</b> |
| <b>Part F – Intermediaries</b>                                     | <b>28</b> |
| <b>1. Responsibilities in Respect of Intermediaries</b>            | <b>28</b> |
| <b>2. Training</b>   | <b>31</b> |
| <b>Part G – Definitions</b>  | <b>32</b> |
| <b>1. Link to Defined Words</b>                                    | <b>32</b> |
| <b>Supporting Documents Summary</b>                                | <b>33</b> |
| <b>Private Health Insurance Code of Conduct</b>                    | <b>57</b> |
| <b>Private Health Insurance Code of Conduct: Compliance Policy</b> | <b>67</b> |

# Process and Health Fund Certification

## 1. Compliance Process

From time to time, the Committee may request health funds submit a full self-audit in order to confirm that the health funds are compliant with an updated Code of Conduct.

*Any reference to “we” or “our” is a reference to the signatory health funds to the Code of Conduct.*

The Private Health Insurance Code of Conduct (**the Code**) is a self-regulatory code to promote informed relationships between health funds (**health fund** or **organisation**), consumers and intermediaries.

The Code sets out the information that a health fund will provide to consumers regarding its policies, its complaints handling process and what happens if a health fund needs to change a customer’s policy.

A health fund that is seeking to adopt the Code must complete a detailed self-audit and be approved to participate in the audit processes by the Code of Conduct Compliance Committee (**the Committee**).

A signatory health fund that has satisfied the Committee that the health fund continues to be compliant with the Code is able, once authorised by the Committee, to certify compliance using a triennial cycle of:

- a. Annual certification for years one and two, in which the health fund certifies that, subject to any changes identified in the certification, the policies and processes identified in the self-audit continue to be followed. Where changes to policies or processes, or changes to the Code, have been implemented since the last certification, the health fund will also certify that those changes are compliant;
- b. A detailed self-audit in year three, as outlined in this Self-Audit Certification Form.

A health fund that has not satisfied the Committee that it is compliant with the Code must continue to submit a detailed self-audit annually. A health fund may indicate that it has achieved partial compliance, with a timeline for achieving full compliance.

The design of the self-audit is aimed at eliminating, wherever possible, the need for additional documentation to be provided by a health fund to certify compliance. Instead, the process calls for the health funds to identify individuals in their organisations responsible for the development, implementation and monitoring of various processes. These individuals must then check, and where appropriate sign off on compliance, respond to questions and also sight, identify and verify documentation and processes.

From time to time, the Committee may request health funds submit a full self-audit in order to confirm that the health funds are compliant with an updated Code of Conduct.

### 1.1 Certification

The Chief Executive Officer (**CEO**) and the Board Chair of a health fund are to certify that the Board of the health fund has made a resolution concerning the accuracy of the responses in the self-audit application form.

There are two options for completing the Certification section:

- a. **Self-Audit:** The health fund must complete Section 1.5 Certification following full completion of Parts A, B, C, D, E and F of the Self-Audit Certification Form. This is the default position; or
- b. **Triennial Cycle:** This option is available to those health funds that have been authorised by the Committee. In years one and two of the cycle, Section 1.6 must be submitted. In year three, the health fund must complete Section 1.5 Certification following full completion of Parts A, B, C, D, E and F of the Self-Audit Certification Form.

## 1.2 Parts A, B, C, D, E and F

In the absence of written authority from the Committee to participate in the triennial cycle, each year health funds are required to identify those in their organisation responsible for:

- The development of standards and processes;
- Implementing the standards and processes; and,
- Monitoring those standards and processes.

It is a requirement that within each major section of the Self-Audit Certification Form the individual/s responsible for monitoring those standards must be different to and either senior to or independent from the person/s responsible for implementing those standards. It will be necessary for these different individuals to provide certification on the detail contained within each section of the Certification Form, in addition to the formal certification required by the CEO and the Board Chair in Part A.

Health funds that are authorised by the Committee to participate in the triennial cycle must complete and submit responses to questions in Parts A, B, C, D, E and F every third year.

## 1.3 Requirements for Compliance

Compliance with the Code requires a response to all questions unless the Committee agrees the question does not apply to the health fund. If a health fund considers a positive response not applicable to its organisation, it should provide reasons.

Compliance also requires a health fund to identify the documents it is relying on to support its compliance with the Code requirements. Please insert a policy identifier such as a policy number or code that your health fund uses to identify documents, together with a suitable description or document heading.

If in the preparation of the self-audit you believe your health fund will be compliant in a particular area at a future date AND your health fund has a plan in place to become fully compliant within the next 12 months please answer 'No' to that question and provide your plans for compliance as part of the document description. If your health fund is partially compliant you should answer 'Pending' to that question and provide your plans for full compliance with the document description.

Once the initial self-audit has been completed and the Committee is satisfied that a health fund is able to fulfil its obligations under the Code, a Deed of Adoption can be entered into. Following authorisation by the Committee, health funds can display the Code of Conduct logo. For ongoing compliance, each year a new self-audit will be required for consideration of ongoing compliance unless authorised by the Committee to participate in the triennial cycle.

In addition to the self-audit process, health funds may be subject to desk audits or on-site visits to verify their compliance with the Code. The results of the self-audit, desk audits, on-site visits and any complaints or pending compliance requirements will be used to assess a health fund's ability to participate in the triennial cycle set out below.

#### 1.4 Health Fund Details for Self-Audit

Registered name of health fund:

Is this health fund under the subsidiary of a parent company or associated entity of a Parent Company?

Yes                      No

If yes, please list the name of the Parent Company:

Address of health fund listed at question 1.4:

Mailing address (if different from above):

Self-audit contact person  
Name:

Position:

Phone:

Mobile:

Email:

Date submission lodged:

**Please complete this certification if you are submitting a full self-audit this year.**

### **1.5 Self-Audit Certification**

Health funds that have not been authorised by the Code of Conduct Compliance Committee to participate in the Certification on a triennial cycle, or are due to complete a full self-audit this year, should complete this section and Parts A, B, C, D,E, F of this Self-Audit Certification Form.

**Name of health fund (the health fund):**

We hereby certify that the Board of

has an effective and adequate system of controls in place to “comply”, i.e. has an effective and adequate system of controls in place to comply with our obligations under the Code and has resolved that this self-audit has been completed with due diligence by those identified in this document and represents a true and accurate response to the questions raised.

**Signed (CEO):**

**Date:**

**Name:**

**Signed (Board Chair):**

**Date:**

**Name:**

**Date of Board Meeting approving Certification:**

## 1.6 Triennial Cycle Certification

Please complete this section if you have received a written authorisation from the Committee that you may participate in the certification on a triennial cycle and you are not required to complete a full self-audit this year.

**Name of health fund (the health fund):**

**Date of last self-audit submission:**

We hereby certify that the Board of the health fund has an effective and adequate system of controls in place to ensure compliance with our obligations under the Code of Conduct and that we have implemented any requirements identified from previous self-audits, audits or directions of the Code of Conduct Compliance Committee that were required to satisfy our obligations under the Code of Conduct.

AND

We further certify that there have been no material changes to our practices or procedures since our last self-audit that have affected our compliance with our obligations under the Code of Conduct.

OR

We further certify that there have been material changes to our practices or procedures that are covered by the Code of Conduct since our last self-audit and that those changes are compliant with our obligations under the Code of Conduct.

**(Please cross out whichever is not applicable to your health fund)**

**Signed (CEO):**

**Date:**

**Name:**

**Signed (Board Chair):**

**Date:**

**Name:**

**Date of Board Meeting approving Certification:**

## Part A: Employees

In this Part it will be necessary to identify those groups of people in your organisation involved in all aspects of arranging private health insurance (PHI) or providing PHI services directly to members (sales, operations, etc.) as well as other employees, such as marketing, and identify their needs in relation to the Code. Consider the necessary training for existing employees and ensure such training is provided to all new employees (including those transferred from other areas in your organisation either as a permanent or temporary transfer) on an ongoing basis.

Consider the process for identifying training needs of various employees and roles responsible for and authorised to arrange private health insurance. Following on from this, explain the process of ensuring and documenting that appropriate and adequate training is not only undertaken, but also monitored by individual employee performance with corrective measures undertaken to address issues uncovered.

Please note that you will need to have regard to different responsibilities for different roles.

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <b>Identification of the Need For Training</b>   |     |                           |    |
| <b>A1.</b> Does the health fund have a systematic way of identifying and documenting specific responsibilities of individuals and groups within your organisation?                 |     |                           |    |
| <b>A2.</b> Does the health fund's process for identifying specific responsibilities of individuals and groups include those who have responsibilities in each of the following:    |     |                           |    |
| A2-1. Providing private health insurance services directly to consumers, including claims processing;  |     |                           |    |
| A2-2. Arranging private health insurance;  |     |                           |    |
| A2-3. Developing policy documentation or product sales material;   |     |                           |    |
| A2-4. Developing marketing services;   |     |                           |    |
| A2-5. Dispute resolution.  |     |                           |    |
| <b>A3.</b> Has the health fund identified the training needs and requirements of all appropriate individuals and groups within the health fund in regard to each of the following: |     |                           |    |
| A3-1. The Private Health Insurance Code of Conduct; and  |     |                           |    |
| A3-2. The health fund's Privacy Policy.  |     |                           |    |
| <b>Training Programs</b>   |     |                           |    |
| <b>A4.</b> Does the health fund have a written, up-to-date training material or packages for all individuals and groups within the health fund described above?                    |     |                           |    |
| <b>A5.</b> Does the health fund have a documented system to ensure changes to health insurance products are built into training programs prior to these changes taking effect?     |     |                           |    |
| <b>A6.</b> Does the health fund have a documented system for ensuring people described in A2 and A2-1 to A2-5 have received training adequate to their responsibilities?           |     |                           |    |

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <p><b>A7.</b> Has the health fund complied with its responsibility to incorporate necessary information into all training packages for appropriate people in the organisation in regard to each of the following:</p>  |     |                           |    |
| <p>A7-1. The Private Health Insurance Code of Conduct; and</p>   |     |                           |    |
| <p>A7-2. Dispute resolution; and</p>   |     |                           |    |
| <p>A7-3. The health fund's Privacy Policy; and</p>   |     |                           |    |
| <p>A7-4. Private health insurance product information; and</p>   |     |                           |    |
| <p>A7-5. Best Practice Guidelines for Assessment of Pre-existing Conditions?</p>   |     |                           |    |
| <p><b>A8.</b> Has the health fund incorporated necessary information (to comply with its responsibilities) into the induction training for new employees in regard to each of the following:</p>   |     |                           |    |
| <p>A8-1. The Private Health Insurance Code of Conduct; and</p>   |     |                           |    |
| <p>A8-2. Dispute resolution; and</p>   |     |                           |    |
| <p>A8-3. Privacy Policy; and</p>   |     |                           |    |
| <p>A8-4. Privatehealth.gov.au?</p>   |     |                           |    |
| <p><b>A9.</b> Do induction and training programs for employees in the organisation who are involved in arranging private health insurance or provide PHI services to members provide specific instructions on the need to keep appropriate records of their advice to consumers?</p> |     |                           |    |
| <p><b>A10.</b> Do training programs for employees in the organisation who are involved in arranging private health insurance to consumers include specific instructions on the need to provide, in addition to policy documentation, the following:</p>                              |     |                           |    |
| <p>A10-1. A clear explanation of a consumer's options; and</p>   |     |                           |    |
| <p>A10-2. Information the consumer requires to make an informed choice as to their health insurance purchase?</p>  |     |                           |    |

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <p><b>A11.</b> Do induction and training programs for appropriate staff who are not involved in arranging private health insurance, providing PHI services or dispute resolution and have not received adequate and up to date product training, provide specific instructions:</p> |     |                           |    |
| <p>A11-1. Not to give information on PHI products to consumers; and</p>   |     |                           |    |
| <p>A11-2. How a consumer may receive information on PHI products?</p>   |     |                           |    |
| <b>Training</b>   |     |                           |    |
| <p><b>A12.</b> Have all individuals in the organisation completed sufficient training such that they are familiar with the provisions of the Code of Conduct relevant to their duties and involved in each of the following responsibilities:</p>                                   |     |                           |    |
| <p>A12-1. Arranging private health insurance; and</p>   |     |                           |    |
| <p>A12-2. Providing private health insurance services directly to consumers, including claims processing; and</p>   |     |                           |    |
| <p>A12-3. Developing policy documentation or product sales material; and</p>  |     |                           |    |
| <p>A12-4. Developing marketing services; and</p>  |     |                           |    |
| <p>A12-5. Dispute resolution?</p>   |     |                           |    |
| <p><b>A13.</b> Is the organisation satisfied that all employees who have the following responsibilities, possess the necessary skills appropriate to their responsibilities:</p>  |     |                           |    |
| <p>A13-1. Arranging private health insurance; and</p>   |     |                           |    |
| <p>A13-2. Providing private health insurance services directly to consumers, including claims processing;</p>   |     |                           |    |
| <p>A13-3. Developing policy documentation or product sales material;</p>  |     |                           |    |
| <p>A13-4. Developing marketing services;</p>  |     |                           |    |
| <p>A13-5. Dispute resolution?</p>   |     |                           |    |

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <b>A14.</b> Does the organisation keep a record of the training undertaken by each individual employee involved in each of the following responsibilities:   |     |                           |    |
| A14-1. Arranging private health insurance;   |     |                           |    |
| A14-2. Providing private health insurance services directly to consumers, including claims processing;   |     |                           |    |
| A14-3. Developing policy documentation or product sales material;  |     |                           |    |
| A14-4. Developing marketing services;  |     |                           |    |
| A14-5. Dispute resolution?   |     |                           |    |
| <b>A15.</b> Has the organisation instructed their employees, who are not detailed in A13, A13-1 and A13-4 and who have not received adequate and up-to-date product training:                              |     |                           |    |
| A15-1. Not to give information on private health insurance products to consumers; and  |     |                           |    |
| A15-2. On how a consumer may receive information on private health insurance products?   |     |                           |    |
| <b>A16.</b> Is the organisation satisfied that all employees who are not detailed in A13, A13-1 and A13-4 and have not received adequate and up to date product training have been instructed:             |     |                           |    |
| A16-1. Not to give information on private health insurance products to consumers; and  |     |                           |    |
| A16-2. On how a consumer may receive information on private health insurance products?   |     |                           |    |
| <b>Effectiveness of Training</b>   |     |                           |    |
| <b>A17.</b> Does the organisation have in place a system to monitor the performance of individual employees against the training provided to them relative to their obligations under the Code of Conduct? |     |                           |    |

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>A18.</b> Does the organisation have in place a process of additional or remedial training for employees identified during the monitoring of performance as requiring additional or remedial training to address any deficiencies identified? |     |                           |    |
| <b>A19.</b> Is the organisation satisfied that the performance of all employees is monitored against the training provided to them and receive appropriate follow-up training when required?  |     |                           |    |

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>Records on Advice Given to Consumers</b>   |     |                           |    |
| <b>A20.</b> Does the organisation have in place a system to enable employees to keep appropriate records of their advice to consumers?  |     |                           |    |
| <b>A21.</b> Do employees who are involved in arranging private health insurance or providing private health insurance services to consumers, keep appropriate records of their advice to consumers? |     |                           |    |
| <b>A22.</b> Are records easily accessible when required?  |     |                           |    |

We, the persons responsible for development of the process, implementation and monitoring of Part A: Employees, certify that documentation referred to above has been sighted and the information provided is correct.

| Function              | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|-----------------------|-----------------------------------|---------------------------------|-------------|
| <b>Development</b>    |                                   |                                 |             |
| <b>Implementation</b> |                                   |                                 |             |
| <b>Monitoring*</b>    |                                   |                                 |             |

\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.

# Part B: Consumer Information

## 1. Policy Documentation

Where appropriate, please identify all relevant documentation to support your statement.

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <p><b>B1.</b> Does the health fund have a policy of providing information to consumers in plain language and in presenting private health insurance policy documentation with the aim of assisting comprehension by consumers?</p>   |     |                           |    |
| <p><b>B2.</b> Does the health fund have a formal process of review of information provided to consumers?</p>   |     |                           |    |
| <p><b>B3.</b> Does the health fund have a process for feedback to those in the organisation who are responsible for producing policy documentation regarding complaints by consumers about unclear information or language?</p>  |     |                           |    |
| <p><b>B4.</b> Does the health fund provide consumers with policy documentation, information or advice outlining:</p> <ul style="list-style-type: none"> <li>• the consumer’s entitlement to benefits, including any waiting periods and pre-existing conditions,</li> <li>• exclusions;</li> <li>• restrictions;</li> <li>• co-payments and/or excesses and limits;</li> </ul> <p>prior to them joining or changing cover?</p> |     |                           |    |

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <p><b>B5.</b> Following joining or upgrading cover, does the health fund provide members with information outlining the consumer's entitlement to:</p> <ul style="list-style-type: none"> <li>• Benefits, including any waiting periods and pre-existing conditions;</li> <li>• Exclusions;</li> <li>• Restrictions;</li> <li>• Co-payments and/or excesses and limits?</li> </ul> |     |                           |    |
| <p><b>B6.</b> Upon confirmation of the consumer's acceptance into the health fund's policy, does the health fund provide the consumer with further information regarding the specific entitlements and exclusions relevant to their policy?</p>  |     |                           |    |

## 2. Privacy Policies

Where appropriate, please identify all relevant documentation to support your statement.

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <b>B7.</b> Has the health fund published its own Privacy Policy? |     |                           |    |

## 3. Data Storage

Where appropriate, please identify all relevant documentation to support your statement.

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>B8.</b> Has the health fund adequate protocols for data storage? |     |                           |    |

We, the persons responsible for development of the process, implementation and monitoring of Part B: Consumer Information, certify that the documentation referred to above has been sighted and the information provided is correct.

| Function              | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|-----------------------|-----------------------------------|---------------------------------|-------------|
| <b>Development</b>    |                                   |                                 |             |
| <b>Implementation</b> |                                   |                                 |             |
| <b>Monitoring*</b>    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part C: Code Compliance

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>C1.</b> Has the health fund previously submitted all relevant submissions on time?   |     |                           |    |
| <b>C2.</b> Has the health fund been investigated for suspected or alleged breaches by a regulatory body since the last audit submission? If yes, please provide further information at the end of the submission. |     |                           |    |
| <b>C3.</b> Has the health fund been deemed non-compliant by a regulatory body since the last audit submission? If yes, please provide further information at the end of the submission.                           |     |                           |    |
| <b>C4.</b> Has the Code of Conduct Compliance Committee determined that the health fund has been non-compliant with the Code? If yes, please provide the following:   |     |                           |    |
| C4-1. Date;   |     |                           |    |
| C4-2. Details of the non-compliance;  |     |                           |    |
| C4-3. Has the non-compliance issue been resolved?   |     |                           |    |
| <b>C5.</b> Has the health fund had any sanctions applied against it? If yes, please provide the following:  |     |                           |    |
| C5-1. Date,   |     |                           |    |
| C5-2. Details of the sanction   |     |                           |    |
| C5-3. Is the sanction still applicable?   |     |                           |    |

We, the persons responsible for development of the process, implementation and monitoring of Part C: Code Compliance, certify that documentation referred to above has been sighted and the information provided is correct.

| <b>Function</b>       | <b>Position of Responsible Officer/s</b> | <b>Name/s of Responsible Officer/s</b> | <b>Signature/s</b> |
|-----------------------|--|--|--------------------|
| <b>Development</b>    |  |  |                    |
| <b>Implementation</b> |  |  |                    |
| <b>Monitoring*</b>    |  |  |                    |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

# Part D: Changes to Policies

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <b>D1.</b> Does the health fund’s policy documentation contain accurate information on each of the following:                        |     |                           |    |
| D1-1. Waiting periods for treatments and pre-existing conditions which might be excluded from benefits;                              |     |                           |    |
| D1-2. Which procedures and treatments are excluded from policy and the impact on the policy holder;                                  |     |                           |    |
| D1-3. Restriction on benefits in the policy and what this could mean for the policy holder;  |     |                           |    |
| D1-4. Co-payments and/or excesses;   |     |                           |    |
| D1-5. Annual limits;   |     |                           |    |
| D1-6. An explanation of pre-existing conditions;   |     |                           |    |
| D1-7. How to find details of hospitals the health fund has treatment agreements with;  |     |                           |    |
| D1-8. How to find no gap or known gap doctors for the health fund;   |     |                           |    |
| D1-9. How to find out if an extras or general treatment provider is either a preferred provider or is recognised by the health fund; |     |                           |    |
| D1-10. How to find out about the health fund’s Privacy Policy;   |     |                           |    |
| D1-11. How to access the complaints handling procedures;   |     |                           |    |
| D1-12. Information about the existence of the Code of Conduct, including the Code logo;  |     |                           |    |
| D1-13. Advice that the documentation should be read carefully and retained;  |     |                           |    |
| D1-14. Where to find any additional rules, product disclosure statements or Private Health Information Statements.                   |     |                           |    |

*Note: If a health fund does not provide one or more of the above features, for example exclusion products, you may write “N/A” in the “No” column beside the product and provide a reason.*

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>D2.</b> Does the product sales material accurately reflect the cover offered or described in that material?  |     |                           |    |
| <b>D3.</b> Does the health fund have a policy and a defined process of providing, at the request of an existing consumer:   |     |                           |    |
| D3-1. Details of the entitlement to benefits; and   |     |                           |    |
| D3-2. Specific information on benefits payable prior to treatment being undertaken?   |     |                           |    |
| <b>D4.</b> Does the health fund provide specific details of changes to policy terms:  |     |                           |    |
| D4-1. In a timely manner;   |     |                           |    |
| D4-2. To all existing consumers; and  |     |                           |    |
| D4-3. Within a format aimed to assist comprehension by consumers?   |     |                           |    |
| <b>D5.</b> Have all staff, responsible for communication of changes to policy terms, been instructed to use plain language and to use a format aimed at assisting comprehension by consumers? |     |                           |    |
| <b>D6.</b> Do those staff referred to above receive feedback in relation to complaints by consumers about unclear information or language or lack of comprehension in the communication?      |     |                           |    |
| <b>D7.</b> Does the health fund have a documented system of providing Transfer Certificates on behalf of a member or former member to that member's new health fund within 14 days?           |     |                           |    |
| <b>D8.</b> Does the health fund monitor the Transfer Certificates to ensure these have been issued within 14 days of the request?   |     |                           |    |
| <b>D9.</b> Does the health fund have a formal process of identifying and addressing any issues if the Transfer Certificates have not been issued within 14 days of request?                   |     |                           |    |

## General Changes to Hospital or General Treatment (Extras) Policies

| Question   | Yes | Document/s Identification | No |
|--|-----|---------------------------|----|
| <p><b>D10.</b> Does the health fund have a documented policy that a significant detrimental changes to hospital policies must result in the following action being taken:</p>      |     |                           |    |
| <p>D10-1. Provide the affected consumer with details of the change giving at least 60 days' written notice; and</p>  |     |                           |    |
| <p>D10-2. For all other changes, provide the affected consumers with detail of the change giving at least 30 days' written notice; and</p>   |     |                           |    |
| <p>D10-3. Not apply the changes to planned hospital admissions prior to the notification date; and</p>   |     |                           |    |
| <p>D10-4. Put in place transitional measures for patients already in a course of treatment for a reasonable time period, for example, up to six months?</p>                        |     |                           |    |
| <p><b>D11.</b> Is the documented policy on changes to hospital policy benefits communicated in writing to and implemented by those people in your health fund responsible for:</p> |     |                           |    |
| <p>D11-1. Developing product and pricing; and</p>  |     |                           |    |
| <p>D11-2. Providing private health insurance advice or services to consumers; and</p>  |     |                           |    |
| <p>D11-3. Communicating with hospitals and relevant medical providers; and</p>   |     |                           |    |
| <p>D11-4. Dispute resolution?</p>  |     |                           |    |

## Changes to General Treatment (Extras) Policy Benefits

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <p><b>D12.</b> Does the health fund have a documented policy that significant detrimental changes to general treatment (extras) policy benefits must result in the following action being taken:</p>              |     |                           |    |
| <p>D12-1. Provide the affected consumer with at least 60 days' written notice;</p>  |     |                           |    |
| <p>D12-2. For all other changes, provide the affected consumers with detail of the change giving at least 30 days' written notice.</p>  |     |                           |    |
| <p>D12-3. A transitional period for unused benefits in the previous year may be provided for up to 6 months (where a health fund provides benefits such as an accumulative roll over).</p>                        |     |                           |    |
| <p>D12-4. Provide a transitional period for policy holders undertaking a course of treatment, for example, orthodontic or endodontic services, for up to 6 months?</p>  |     |                           |    |
| <p><b>D13.</b> Is the health fund's documented policy on changes to general treatment (extras) policy benefits communicated in writing to and implemented by those people in the health fund responsible for:</p> |     |                           |    |
| <p>D13-1. Developing product and pricing;</p>   |     |                           |    |
| <p>D13-2. Providing private health insurance advice or services to consumers;</p>   |     |                           |    |
| <p>D13-3. Communicating with general treatment (extras) service providers;</p>  |     |                           |    |
| <p>D13-4. Dispute resolution?</p>   |     |                           |    |

We, the persons responsible for development of the process, implementation and monitoring of Part D: Changes to Policies, certify that documentation referred to above has been sighted and the information provided is correct.

| Function              | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|-----------------------|-----------------------------------|---------------------------------|-------------|
| <b>Development</b>    |                                   |                                 |             |
| <b>Implementation</b> |                                   |                                 |             |
| <b>Monitoring*</b>    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

# Part E: Dispute Resolution

Please think about the Internal Dispute Resolution process, how this is communicated to relevant staff (both existing and new) as well as consumers and the process of resolving and monitoring resolution.

Where appropriate, please identify all relevant documentation to support your statement.

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <p><b>E1.</b> Does the health fund have a written internal dispute resolution procedure that includes information outlining a consumer’s rights to deal directly with an external body in the event of an unsatisfactory outcome of a dispute?</p>  |     |                           |    |
| <p><b>E2.</b> Does the health fund have a written internal dispute resolution procedure that conforms to the <i>International Standard (ISO10002:2018 Quality Management – Customer Satisfaction – Guidelines for Complaints Handling in Organizations)</i> and/or the <i>Australian Standard (AS/NZS 10002:2014 Guidelines for complaint management in organizations)</i>?</p> |     |                           |    |
| <p><b>E3.</b> Is information regarding the internal dispute resolution process freely available wherever a consumer might be expected to find it?</p>   |     |                           |    |

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>E4.</b> Does the health fund have a policy of prompt reply, including written reply where requested, to all requests of response to a dispute by a consumer? |     |                           |    |
| <b>E5.</b> Does the health fund have a process to monitor compliance with the timeliness requirements?  |     |                           |    |
| <b>E6.</b> Where a dispute is not resolved to the satisfaction of a consumer, does the health fund have a policy of giving:                                     |     |                           |    |
| E6-1. Where appropriate, general reasons for the outcome; and   |     |                           |    |
| E6-2. Information on the further action the consumer can take via an external dispute resolution processes, including access to the Commonwealth Ombudsman?     |     |                           |    |
| <b>E7.</b> Does the health fund have a process of monitoring disputes within the organisation?  |     |                           |    |
| <b>E8.</b> Does the health fund have a process for feedback on outcomes of disputes to applicable personnel?  |     |                           |    |

We, the persons responsible for the development of the process, implementation and monitoring of Part E: Dispute Resolution, certify that documentation referred to above has been sighted and the information provided is correct.

| FUNCTION              | POSITION OF RESPONSIBLE OFFICER/S | NAME/S OF RESPONSIBLE OFFICER/S | SIGNATURE/S |
|-----------------------|-----------------------------------|---------------------------------|-------------|
| <b>Development</b>    |                                   |                                 |             |
| <b>Implementation</b> |                                   |                                 |             |
| <b>Monitoring*</b>    |                                   |                                 |             |

\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.

# Part F: Intermediaries

## 1. Responsibilities in Respect of Intermediaries

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <p><b>F1.</b> Does the health fund have any agreement with any third party (including a related body corporate) who has a responsibility to perform, whether on a continuous, intermittent or ad hoc basis (for a specified limited period or an ongoing period of time) a business activity that is part of the health fund's health insurance business or could be, undertaken by the health fund itself?</p> |     |                           |    |
| <p><b>F2.</b> Name all intermediaries/third parties the health fund has an agreement with.</p>  |     |                           |    |
| <p><b>F3.</b> Are the intermediaries/third parties signatories to the Private Health Insurance Intermediaries Association Code of Conduct: yes/no.</p>  |     |                           |    |
| <p><b>F4.</b> If no, what action has the health fund taken to ensure it is compliant with the Private Health Insurance Intermediaries Association Code of Conduct?</p>  |     |                           |    |
| <p><b>F5.</b> Were all of the agreements that the health fund has with intermediaries, entered into or renewed before 1 July 2012?<br/>If 'No' please answer the following questions in regard to those intermediaries whose agreements were entered into or renewed any time after 1 July 2012.</p>  |     |                           |    |

Where appropriate, please identify all relevant documentation to support your statement.

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <p><b>F6.</b> Does the health fund have agreements in place with all intermediaries who arrange private health insurance or provide private health insurance services to consumers on the health fund's behalf?</p>                     |     |                           |    |
| <p><b>F7.</b> Do the health fund's agreements with intermediaries include provisions that require the intermediary or its employees to:</p>   |     |                           |    |
| <p>F7-1. Discharge their responsibilities and duties competently, with integrity and honesty and in compliance with the law;</p>  |     |                           |    |
| <p>F7-2. Exercise reasonable care and skill in the discharge of their duties;</p>   |     |                           |    |
| <p>F7-3. Comply with the provisions of the <i>Private Health Insurance Act 2007</i>, the <i>Competition and Consumer Act 2010</i> and any other relevant laws;</p>  |     |                           |    |
| <p>F7-4. Maintain records required by law and comply with legal requirements for production of, access to, or copying of such records and provide such information as may be legally required by any regulatory or other authority;</p> |     |                           |    |
| <p>F7-5. Maintain confidentiality regarding any confidential information in relation to consumers or health fund's business, and comply with relevant privacy laws;</p>   |     |                           |    |
| <p>F7-6. Have the necessary skills to represent health insurance business and its products;</p>   |     |                           |    |
| <p>F7-7. Not provide advice, make representations or otherwise act outside the areas of activity or private health insurance products authorised under agreement, arrangement or understanding;</p>                                     |     |                           |    |
| <p>F7-8. Make clear disclosure to all consumers who deal with the intermediary in relation to health insurance business, as well as the nature of their relationship with the health insurance business;</p>                            |     |                           |    |

Where appropriate, please identify all relevant documentation to support your statement.

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| F7-9. Make clear disclosure to all consumers who deal with the intermediary advising if the intermediary is paid any fees, commissions or other benefits for health insurance services;                         |     |                           |    |
| F7-10. Have an effective dispute resolution procedure for resolving a dispute between a consumer and the intermediary;  |     |                           |    |
| <b>F8.</b> Does the health fund have agreements with intermediaries who are authorised or required to provide information about health insurance products to consumers?   |     |                           |    |
| <b>F9.</b> Do these agreements include provisions that will require the intermediary or its employees to:   |     |                           |    |
| F9-1. Only provide consumer with copies of product sales material or Policy documentation that complies with the requirements of the Code of Conduct; and   |     |                           |    |
| F9-2. Explain the consumer’s options clearly, using plain language and provide such information as the consumer requires to make an informed choice regarding their private health insurance purchase; and      |     |                           |    |
| F9-3. Keep appropriate records of advice to consumers.  |     |                           |    |
| <b>F10.</b> Does the health fund’s agreements with any intermediaries authorise those intermediaries to produce product sales material or policy documentation? If ‘Yes’ please answer the following questions: |     |                           |    |
| F10-1. Does the health fund have a process of review and approval of any product sales material or policy documentation provided to consumers by intermediaries?  |     |                           |    |
| F10-2. Is the health fund satisfied that any product sales material or policy documentation provided to consumers by intermediaries is compliant with the Code of Conduct?                                      |     |                           |    |

## 2. Training

| Question  | Yes | Document/s Identification | No |
|---|-----|---------------------------|----|
| <b>F11.</b> Do the health fund's agreements with intermediaries require the intermediaries to receive adequate training or instruction to enable them to competently provide the services to consumers that they are authorised to provide, during the term of the agreement? |     |                           |    |
| <b>F12.</b> Do the health fund's agreements with intermediaries require the intermediaries to document and maintain records (for a reasonable period)?  |     |                           |    |
| <b>F13.</b> Is the health fund satisfied that adequate ongoing training is being undertaken by your the health fund's intermediaries?   |     |                           |    |

We, the persons responsible the development of the process, implementation and monitoring of Part F: Intermediaries, certify that documentation referred to above has been sighted and the information provided is correct.

| Function              | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|-----------------------|-----------------------------------|---------------------------------|-------------|
| <b>Development</b>    |                                   |                                 |             |
| <b>Implementation</b> |                                   |                                 |             |
| <b>Monitoring*</b>    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

# Part G: Definitions

## 1. Link to Defined Words

# Supporting Document Summary

**Health Fund Name:**

Additional information can be completed in the below text box. List each question number that requires additional information.

## **Part A: Employees**





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part B: Consumer Information





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part C: Code Compliance





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part D: Change to Policies





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part E: Dispute Resolution





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

## Part F: Intermediaries





| Function       | Position of Responsible Officer/s | Name/s of Responsible Officer/s | Signature/s |
|----------------|-----------------------------------|---------------------------------|-------------|
| Development    |                                   |                                 |             |
| Implementation |                                   |                                 |             |
| Monitoring*    |                                   |                                 |             |

*\*Note: Monitoring Officers must be different to and either senior to or independent of Implementation Officers.*

# Private Health Insurance Code of Conduct

October 2025: Version 8



# Contents

|                      |    |
|----------------------|----|
| Introduction         | 2  |
| Consumer Information | 4  |
| Changes to Policies  | 6  |
| Dispute Resolution   | 8  |
| Intermediaries       | 9  |
| Code Compliance      | 11 |
| Definitions          | 13 |

# Introduction

## What is the Private Health Insurance Code of Conduct?

Any reference to “we” or “our” is a reference to the signatory health funds to the Code.

The Private Health Insurance Code of Conduct (**the Code**) has been developed by [Private Healthcare Australia \(PHA\)](#) and the [Members Health Fund Alliance \(MHFA\)](#) as the bodies which represent private health funds, in consultation with private health funds themselves.

Private health insurance is an important and cost-effective way to protect you and your family against unexpected health issues, giving you more control over your health care, choice of services, choice of doctor and where you receive elective surgery. Private hospitals usually have shorter wait times for planned elective surgery than public hospitals.

As an industry, private health insurance funds are committed to helping you choose the best private health insurance for your needs.

The Code explains how this will be achieved and is a commitment by individual health funds to provide you with a standard of customer service, accountability and transparency. It only applies to health funds that are signatories to the Code and does not apply to the industry generally or its peak bodies, Private Healthcare Australia and the Members Health Fund Alliance.

At the end of this document, you will find a list of key terms and their definitions, which will assist you in reading and understanding the Code.

The Code sets out the information that your health fund will provide to you regarding its policies; the complaints handling process and what happens if your health fund needs to change your policy.

Under the Code health funds commit to:

- Providing you with clear, concise and relevant information about data storage and privacy policies;
- Helping you better understand the role of private health insurance in Australia’s healthcare system;
- Helping you understand the coverage provided in your policy;
- Assisting you to navigate the healthcare system and

to use your private health insurance to claim for healthcare;

- Only offering you insurance based on your own personal needs;
- Providing you with clear, concise and relevant information about policies and benefits;
- Ensuring health fund employees are trained to clearly explain your health insurance options and to provide you with the information you need to make an informed choice about your private health insurance policy;
- Recording the advice given to you and maintaining those records;
- Resolving any complaints you might have with your health fund in a timely, efficient and transparent manner;
- Maintaining a fully-documented dispute resolution process for resolving any dispute between you and your health fund; and
- Working with the [Federal Government’s Private Health Insurance Ombudsman](#) to understand the sorts of complaints that are made against health funds and to use this information to improve our policies and procedures.

### Commitment to compliance with key legislative and regulatory requirements

Private health insurance funds are required to comply with relevant legislation, including:

- *Private Health Insurance Act 2007*;
- *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007*;
- *Competition and Consumer Act 2010*;
- *Private Health Insurance (Prudential Supervision) Act 2015*;
- *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional*

- Provisions) Act 2015LJ*
- *The Privacy Act 1988;*
  - *Corporations Act 2001;*
  - *Private Health Insurance (Complaints Levy) Act 1995;*
  - *Private Health Insurance (Risk Equalisation Levy) Act 2003;*
  - *Private Health Insurance Supervisory Levy Imposition Act 2015;*
  - *Private Health Insurance (Collapsed Insurer Levy) Act 2003;*
  - *Private Health Insurance (National Joint Replacement; Register Levy) Act 2009;*
  - *Private Health Insurance (Prostheses Application and Listing Fees) Act 2007;*
  - *Private Health Insurance (Health Insurance Business) Rules 2018;*
  - *Financial Planning Association of Australia Code of Professional Practice;*
  - *Unclaimed Money Act 1995;*
  - *The Spam Act 2003 (Cth);*
  - *Do Not Call Register Act 2006 (Cth);*
  - *Private Health Insurance (Benefit Requirements) Rules 2011;*
  - *Private Health Insurance (Complying Product) Rules 2015.*

# Consumer Information

Health funds aim to make all their communication with you clear and easy to read, to help you understand what your health insurance policy covers and how to make the best use of it.

Health funds will also provide information to you in plain language.

## Helping you choose the right private health insurance policy

Health funds are committed to ensuring you have access to comprehensive up-to-date information so you can navigate the health system and make informed choices when purchasing or switching between private health insurance policies.

This includes ensuring that you have access to the following information:

- How the Australian health system works, including the healthcare options available through the public system (Medicare);
- How private health insurance works and the benefits it offers compared to the public system;
- Factors you should consider when choosing a private health insurance policy based on circumstances such as age, family situation and health needs; and
- The different health funds and policy options available to choose from.

Health funds will either provide you with the information listed above or provide internet links so you can access the relevant information.

On the health fund's website, you will have access to the comprehensive, independent information set out on the Department of Health and Commonwealth Ombudsman websites, as well as any relevant internet links. These sites contain detailed explanations of how the Australian

healthcare system and private health insurance operate. A health fund's website will also outline how you can find and compare different private health insurance policies.

When you are choosing a private health insurance policy, health funds will make sure all of its sales material accurately reflects the cover offered.

## When you join a health fund

Health funds will ensure that, prior to joining, you will be provided with information about your entitlement to benefits, including any waiting periods and pre-existing conditions, exclusions, restrictions, co-payments and/or excesses.

Upon confirmation of your acceptance into the health fund's policy, you will be provided with further information regarding the specific entitlements and exclusions relevant to your policy.

If you are an existing customer, you will be provided with advance notice of any changes that are made to your policy benefits.

Some funds may undertake a periodic review of your cover and suggest alternative policy options that might better suit you as your circumstances change over time. You should contact your health fund if you think your circumstances will change to discuss the options available to you.

If you want to transfer to another private health fund, your new private health fund will be provided with a Transfer Certificate that will help you change funds.

Your previous health fund will provide this within 14 days after you have told your fund that you want to transfer and your new fund has made the request.

## Policy documentation

Policy documentation is the information regarding what is covered by your policy and what is excluded, as well as any restrictions on what you can claim for and limits on how much you can claim.

Health funds will:

- (a) express all consumer information as clearly and simply as possible, using plain language and readily accessible formats
- (b) ensure that health funds' Policy documentation and product sales material accurately reflects the cover offered, and—as appropriate to a particular document's intended purpose—contains accurate information about:
  - (1) waiting periods and pre-existing conditions;
  - (2) what sorts of procedures and treatments are excluded from your policy and what that could mean

(3) the restriction on benefits in your policy and what this could mean for you;

(4) co-payments and/or excesses;

(5) annual limits;

(6) an explanation of pre-existing conditions;

(7) how to find details of hospitals which the health fund have treatment agreements with;

(8) 'no gap' or 'known' gap doctors;

(9) how to find out if an extras or general treatment provider is either a preferred provider or is recognised by the health fund;

(10) how to find out about the health fund's privacy policy;

(11) how to access the health fund's complaints handling procedures;

(12) information about the existence of this Code, including the Code logo;

(13) advice that the documentation should be read carefully and retained; and

(14) where to find any additional rules or product disclosure statements.

## Cooling off period

You can cancel your policy and receive a full refund of any premiums you have paid within 30 days of your policy starting, as long as you haven't yet made a claim.

## Additional information from your health fund

At your request, your health fund will provide you with details of your entitlement to benefits.

You will also be provided with specific information on any changes to your policy. This information should be provided in a timely manner and will be in a clear and consumer friendly format.

# Changes to Policies

From time to time, changes might need to be made to your policy.

These changes may be general membership updates to your policy or may extend to either hospital or general treatment (extras) cover benefits.

## General principle in relation to detrimental changes to policies and benefits

Health funds adopt the approach that any detrimental change (that is not significant) requires a minimum of 30 days' notice.

Health funds are committed to being transparent with you regarding changes to insurance policies and benefits (the amount a health fund will pay towards a service).

This transparency is supplemented with the Private Health Information Statement (PHIS) for Hospital, General Treatment ("Extras"), and Combined cover and also the comprehensive information available on the [PrivateHealth.gov.au](http://PrivateHealth.gov.au) website. Health funds must engage with you regarding changes to insurance policies and benefits particularly where a policy may be closing or a change is considered that will impact the price of your policy or the treatments covered by your policy.

To protect consumers with health insurance, health funds (who are regulated by the Australian Prudential Regulation Authority (APRA)), review health insurance products to ensure they continue to meet the evolving needs of customers, provide value for money and ensures the health funds remain sustainable over time.

Products may be closed from time to time for a range of reasons—including to protect existing policyholders from substantial premium increases. Sometimes sharp increases in the cost of treatments covered means insurance products have to be repriced at a higher level or withdrawn from the market. A number of factors are considered in each scenario. For example, a product that is priced beyond what is reasonable in the market may be withdrawn and replaced if the fund believes it is no longer sustainable. Health funds will provide you with notice and further information such as a detailed description of the treatments covered so you can decide whether it is still the right product for you.

The health insurance sector, which includes 29 health funds, provides choice and options. Health funds want you to have an insurance policy that suits your needs.

When choosing a health insurance product or reviewing a product, always talk to the health fund to check your eligibility and cover requirements are being met. Private Health Insurance is unlike other insurance products. It is designed to be portable and adjustable to your needs. You have the right to change your policy with your health fund or transfer to another health fund to ensure you are receiving the cover you want. Portability means you can switch your cover from one health fund to another or even between policies with the same health fund without the need to re-serve waiting periods already served for benefits under your current cover. Waiting periods apply to new services and benefits.

## General changes to hospital or general treatment (extras) policies

General changes to a hospital or general treatment policy include:

- A change of policy name; or
- A change to payment frequency or method.

*These changes require a minimum of 30 days' notice to members.*

A detrimental general change to hospital or general treatment (extras) policy include:

- Where a change to a payment frequency or method results in a payment frequency or method no longer being available, the health fund will provide a minimum of 60 days' notice.
- Where closing a product has a significant detrimental effect to a policy holder, or group of policy holders (for example, when policy holders are required to move to an alternative product) the health fund will provide a minimum of 60 days' notice.

## Changes to hospital policy benefits

A detrimental change to hospital policy benefits includes:

- The removal of a clinical category;
- An increase to a policy holder's excess or co-payment; or

- A change in which an excess or co-payment may apply.

*These changes require a minimum 60 days' notice to members.*

Where the above changes to hospital benefits occur, health funds will:

- Not apply the changes to pre-booked hospital admissions prior to the notification date; and
- Put in place transitional measures for patients already in a course of treatment for a reasonable time period, for example, up to 6 months.

## **Changes to general treatment (extras) policy benefits**

A detrimental change to general treatment (extras) benefits includes:

- The reduction of a limit;
- A change to entitlement under such limit;
- Removal of a service or modality covered under a general treatment (extras) policy.

*These changes require a minimum 60 days' notice to members.*

Where the above changes to general treatment (extras) benefits occur, health funds will:

- Provide a transitional period for policy holders undertaking a course of treatment, for example, orthodontic or endodontic services, for up to 6 months.

Where a health fund provides benefits such as an accumulative roll over, a transitional period for unused benefits in the previous year may be provided for up to 6 months.

# Dispute Resolution

Your health fund believes it is important to comply with a rigorous and credible standard of complaints handling.

It is also important the standard is independent of the private health insurance sector and adheres to global best practice in dispute resolution.

To that end, your health fund will:

- At a minimum, comply with the global benchmark in complaints handling, as set out in the *International Standard, ISO10002:2018 Quality Management – Customer Satisfaction – Guidelines for Complaints Handling in Organizations* and/or the *Australian Standard AS/NZS 10002:2014 Guidelines for Complaint Management in Organizations*.
- Make information on the complaints-handling process available, including:
  - How complaints can be made;
  - Information that should be provided when making a complaint;
  - The process for handling complaints;
  - Time periods associated with various stages in the process;

- How your privacy and personal information is handled in accordance with the health fund's Privacy Policy;
- Advice on how to engage with the Commonwealth Ombudsman's complaint handling service if you are not satisfied with the outcome of the health fund's dispute resolution process; and
- How you can obtain information on the status of your complaint.

While health funds do everything possible to resolve a dispute, in some cases it is not always possible to reach a resolution.

If you and your health fund are unable to resolve the dispute you have the option of taking your complaint to the [Commonwealth Ombudsman](#).

To improve the effectiveness of the complaints handling process and to see what improvements can be made, health funds will periodically review their complaints handling process.

# Intermediaries

As an industry, health funds are committed to helping you choose the best private health insurance for your needs.

Organisations other than your health fund may advise you about private health insurance or sell you private health insurance on a health fund's behalf. These organisations are known as intermediaries and can include insurance brokers, consultants and comparison websites.

There are many different types of arrangements health funds may enter into with intermediaries to provide services or act on their behalf in dealing with consumers. On occasions, health funds might also pay the intermediaries a fee or a commission when they sell insurance policies. Disclosure obligations require intermediaries to disclose if they have commission or referral arrangements. This means that intermediaries must take reasonable steps to make consumers aware of any commission or referral arrangements where the business receives a financial incentive from another supplier. Intermediaries do not need to disclose the nature or value of the financial incentive.

Some intermediaries have obligations under their own industry self-regulatory code of conduct titled the [Private Health Insurance Intermediaries Code of Conduct](#). Health funds will abide by the obligations under this Code in relation to intermediaries if the intermediary is a signatory to the Code.

If the intermediary is not a signatory of the Private Health Insurance Intermediaries Code of Conduct, it is the health fund's responsibility to demonstrate that the intermediary is meeting the compliance requirements equivalent to the Private Health Insurance Intermediaries Code of Conduct.

## What is required of health funds who work with intermediaries

Health funds will ensure that all arrangements with any intermediary clearly and unambiguously set out the obligations of each party and are able to be verified, if required, by an audit.

Health funds require the intermediary and its employees to do the following:

- Discharge their responsibilities and duties competently, with integrity and honesty, in compliance with the law and to exercise reasonable care and skill;
- Make clear disclosures to all consumers who deal with

the intermediary advising if the intermediary is paid any fees, commissions or other benefits for health insurance services;

- Make clear disclosures to all consumers who deal with the intermediary in relation to health insurance business, as well as the nature of their relationship with the health insurance business;
- Not provide advice, make representations or otherwise act outside the areas of activity or private health insurance products authorised under any agreement, arrangement or understanding;
- Have the necessary skills to represent a health fund and its products; and
- Have an effective alternative dispute resolution procedure for resolving a dispute between a consumer and the intermediary.

If an intermediary is required or authorised under an agreement to provide information about private health insurance products to consumers, health funds will ensure that the agreement requires the intermediary to:

- Only provide to the consumer copies of product sales material and policy documentation that comply with the requirements of this Code;
- Explain the consumer's options clearly, using plain language and provide the information a consumer requires to make an informed choice regarding their private health insurance purchase; and
- Keep appropriate records of advice given to consumers.

Intermediaries are also required to:

- Maintain confidentiality regarding any confidential information in relation to consumers or health fund's business and comply with relevant privacy laws;
- Maintain records required by law and comply with legal requirements for production of, access to, or copying of such records, and provide such information as may be legally required by any regulatory or other authority;
- Comply with the provisions of the *Private Health Insurance Act 2007*, the *Competition and Consumer Act 2010*, and any other relevant laws; and
- Comply with any applicable industry code where relevant.

## Training

Health funds will require intermediaries (including call centre workers) to possess the necessary skills appropriate to the private health insurance products they are promoting or selling and the activities they are undertaking. This will ensure that intermediary employees can provide appropriate advice taking into account a consumer's individual circumstances.

To achieve this, health funds must provide appropriate ongoing and documented training to intermediaries.

# Code Compliance

To ensure the Code is adhered to by participating health funds and is as effective as possible, Private Healthcare Australia has established a Code of Conduct Compliance Committee (**the Committee**), comprising independent consumer and industry representatives.

The Committee has the responsibility to ensure the Code is fully complied with by health funds and does this by:

- Admitting health funds to participate in the audit process;
- Monitoring and enforcing compliance by participants by conducting audits, as well as requiring the health funds to conduct full self-audits and triennial audits;
- Receiving complaints about any alleged breach of the Code;
- Imposing sanctions for breaches of the Code; and
- Publicising an annual report on compliance and operation of the Code.

## Monitoring compliance

Health funds are required to submit an annual self-audit of their compliance to the Code, to the Code's independent auditors using the form prescribed by the Committee.

At other times, the Committee can also verify a health fund's ongoing compliance with the Code through full-compliance audits and spot audits of the health fund either in full or in part. These audits are undertaken by independent auditors.

## Annual report

The Committee will publish an annual report on the operation of the Code, including a summary of compliance. This report will be published on the websites of PHA and the MHFA.

## Complaints handling

The Committee will accept complaints about alleged breaches of the Code from other health funds or relevant bodies. It will respond to complainants within 21 business days, provided all necessary information is available to the Committee and any required investigation has been completed. It will keep complainants informed of the progress of the response to the complaint, any decision and

information on how a response can be reviewed.

As part of its annual reporting process, the Committee will from time to time receive and analyse data on consumer complaints from the Commonwealth Ombudsman to identify any systematic issues and areas where the Code can be improved.

## Non-compliance with the Code

The Committee may investigate suspected or alleged breaches of the Code and make findings in relation to the suspected or alleged non-compliance. Such investigations will involve consultation with the health fund, which is required to cooperate with the Committee and provide information about the subject of the investigation.

Any findings will be provided in writing to the health fund, which must take all reasonable steps to ensure that procedures are established to prevent any breach identified by the Committee from reoccurring.

If the Committee has determined that a health fund has not cooperated with the Committee, has not materially complied with the Code or has not put in place procedures to prevent the reoccurrence of the breach, it may apply sanctions.

## Sanctions imposed by the Committee

The Committee imposes and reviews sanctions in accordance with a defined/documented procedure.

The Committee may give notice to the health fund in accordance with a documented procedure, stating that it proposes to impose sanctions on the health fund for non-compliance with the Code according to documented policy.

Sanctions can be applied if the health fund:

- Refuses or fails to cooperate with a request of the Committee in response to an alleged or suspected breach of the Code.
- Fails or refuses to comply with any recommendation by the Committee.
- Fails to adopt or comply with amendments to the Code within the timeframe required, and without an extension of time being granted by the Committee.

- Fails to implement procedures to prevent a reoccurrence of breaches identified by the Committee.

## Failure to comply

If a health fund fails to comply with a sanction, the Committee may do one or more of the following:

- Take action to enforce compliance with the Code or sanction.
- Disqualify and immediately ban the health fund from using the Code of Conduct tick logo.
- Name the health fund in the annual Code of Conduct report as having not complied with the Code and/or having not complied with a sanction.
- Report the breach on the PHA and Members Health Fund Alliance websites.

- Request that the health fund report the breach on their own website.
- Request that any issued sanctions be published on the non-compliant health fund's website.
- In cases where the Committee considers the breach of the Code may constitute a breach of any regulatory or legislative obligation, report the health fund to the appropriate government agency.
- Request the health fund publish corrective advertising within one month of the request.

# Definitions

**Agreement Private Hospitals** – These are hospitals, including day hospitals, where a health fund has negotiated agreed charges for treatment within those hospitals. In most cases, where the treatment is included under the customer's cover, the only out-of-pocket expenses will be those applied to a level of cover, for example, excesses and co-payments. All agreement hospitals are obliged to provide an estimated out-of-pocket cost, if any, prior to admission.

- *Public Hospitals* – Public hospitals do not negotiate agreed charges with private health funds, rather, they have their charges set by State Governments. In most cases, a health fund will pay the set public hospital charges, less any excess or co-payment applied to a level of cover.

**Annual Limit** – A maximum benefit payable for a particular service, or group of services with a 12-month period. Annual limits can be calculated based on a calendar year, or financial year, or for every 12-month period from the anniversary of the membership commencement date.

## Benefit

- *General Treatment benefit (also known as extras or ancillary)* – A benefit refund where the service is provided by a registered provider with the health fund, not covered by Medicare, or in some circumstances is not covered within a hospital agreement. Some examples of services commonly covered under general treatment are dental, physiotherapy, optical and ambulance (depending on the level of cover).
- *Default benefit* – The minimum amount of money that a health fund is permitted to pay to a hospital for inpatient treatment under your policy.
- *Hospital Cover benefit* – This is the benefit that a health fund pays to a hospital for a policy holder under the membership. It is paid according to the level of cover and includes hospital services like bed accommodation, theatre charges, medical treatment and in most cases extends to ambulance cover.

**Clinical Categories** (also known as product tiers) – What is, and is not, covered in the Gold, Silver, Bronze and Basic Hospital Tiers is based on clinical categories. Each standard clinical category—for example, 'bone, joint and muscle' category or 'heart and vascular system' category—sets out the hospital treatments that must be covered by your health fund. If a policy covers a certain clinical category, then it must cover everything listed in it—not only some things. Further information about clinical categories is

is available from the Commonwealth Ombudsman.

**Commonwealth Ombudsman** – The Commonwealth Ombudsman protects the interests of private health insurance consumers.

More information can be found here:

<https://www.ombudsman.gov.au/about/how-we-can-help-you>

**Community Rating** – Private health insurance is community rated. Community rating means that every person is entitled to buy the same health insurance products or renew the same products for the same price as any other person (except where State-based pricing, Lifetime Health Cover loading or aged based discount applies). A health fund cannot charge one person more – or refuse to cover them – based on what health conditions they have or how often they have claimed on their health insurance in the past.

There are some exemptions to this, for example, where a person has a Lifetime Health Cover penalty, or a person has an aged-based discount applied to their premium.

**Consumer** – A person who has purchased or is considering the purchase of a private health insurance policy.

**Course of Treatment** – A plan made up of several cycles of treatment. This can include visits rather than medication. I.e. an agreed documented plan between a consumer and a provider for more than one treatment.

**Co-payment** (also known as a daily excess or overnight excess, referred to as **excess** in this document)

- *Hospital co-payment* – Is an agreed, upfront contribution amount under the level of cover that a policy holder agrees to, in exchange for a lower premium. This may be an agreed reduced daily contribution or an agreed upfront larger monetary amount, or both. For example, \$50 per night for 5 nights, or the first \$250 co-payment on an overnight stay, or both excess and co-payment combined. Usually, the higher the excess and/or additional co-payment, the lower the premium.
- *General Treatment co-payment (also known as extras or ancillary)* – Some general treatment products require a policy holder to pay a contribution amount before benefits are claimable. This is commonly known as a co-payment and is more likely when purchasing items such as CPAP machines (breathing apparatus) or weight loss memberships, for example, a benefit of \$300 after a co-

payment of the first \$50 by the policy holder. A general treatment co-payment is less likely on services such as dental, physiotherapy and optical. Policy holders are advised to always check with their health fund prior to any claim for services.

**Detrimental Changes** – These are changes made to a level of cover by the health fund or may be imposed across all health funds on an industry basis outside of a health fund’s reasonable control.

Health funds adopt the approach that any detrimental change, that is not significant, requires a minimum of 30 days’ notice. Where the rule is imposed outside of the health fund’s control, there is flexibility to deal with special or unusual circumstances on a case-by-case basis.

Where a health fund removes or reduces benefits that are deemed a significant detrimental change, the fund must provide the policy holders on that cover with a minimum of 60 days’ notice and in some cases provide additional flexibility to those directly affected. For example, a reduction or removal in benefit for a clinical category where a patient is undertaking a course of treatment.

**Dispute** – This is where a policy holder and health fund disagree with the outcome of services such as payment of benefits, premiums, a change in benefits or information provided and/or any other matter. Policy holders should obtain a copy of the health fund’s dispute resolution policy and submit a complaint to the health fund following that process.

Where a policy holder believes the outcome is unsatisfactory following all actions taken with the health fund, they can escalate the complaint to the Commonwealth Ombudsman, who acts as an independent adjudicator through their own dispute resolution service.

**Excess** (also known as **co-payment** in this document) – An agreed upfront contribution amount, under the level of cover that a policy holder agrees to, in exchange for a lower premium. An excess may apply to a day hospital procedure or overnight stay in hospital, usually with a maximum per person, or overall policy limit.

**Gap Payment** (also known as out-of-pocket expenses or gap cover) – In most cases, referred to as the amount a policy holder has to pay above the Medicare and health fund benefit for medical treatment while in hospital.

This may also extend to additional hospital services like medical devices or human tissue products or pharmacy services where the charge is above the agreed fund benefit. In all gap cover charges, the doctor, hospital or service provider is obliged to provide the policy holder with informed financial consent, prior to treatment.

**Hospital Cover** – A product that provides services and benefits for inpatient medical treatment in a hospital setting. There are four tiers of hospital cover: Gold, Silver, Bronze and Basic.

**Informed Financial Consent** – An agreement between health funds and their contracted service providers that all patients will be provided with informed financial consent and a quote for out-of-pocket costs, prior to the agreement for services.

Further information on informed financial consent and consumer rights as a patient is available from the Commonwealth Ombudsman.

**Intermediary** (also known as insurance brokers, consultants or comparator websites) – A third- party organisation or business that offers advice or compares health insurance products on behalf of a health fund. In most cases these organisations may be paid a fee or commission.

**Lifetime Health Cover** (also known as LHC) – A government initiative for private hospital insurance introduced on 1 July 2000, to encourage participants to take out and maintain private health insurance before the 1 July following their 31st birthday.

A person who delays taking out a hospital policy will pay a 2% loading on top of their premium for each year they are aged over 30, to a maximum loading of 70%. This loading is removed after 10 years’ continuous hospital cover.

The Lifetime Health Cover loading does not apply to general treatment cover.

**Policy Documentation** (also known as health fund brochure, product disclosure statement or Private Health Information Statements (PHIS)) – This documentation provides a full description of all the terms and conditions, benefits, restrictions and/or exclusions under the cover. This documentation is part of the legal requirement that forms part of your insurance contract.

A health fund is also required to provide its policy holders with an annual PHIS. To provide consumers with a simple comparison tool, all health funds are required to provide details of their products online at: <https://www.privatehealth.gov.au/>.

**Pre-Existing Condition** – A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the six months prior to taking out hospital cover or upgrading to a higher level of cover.

Health funds are able to impose a maximum 12 month waiting period for hospital treatment for ailments, illnesses or conditions that are considered to be pre-existing.

For hospital psychiatric services, rehabilitation and palliative care, the maximum waiting period is two months, even if the condition is pre-existing. If you are going to hospital during your waiting period, it is important to check with your health fund prior to the admission as to whether you will be covered or if the condition will be deemed pre-existing.

**Private Health Insurance** – There are generally three categories of private health insurance policies: hospital, general treatment and combined policies.

Hospital cover provides benefits for hospital and medical services when you are admitted to hospital.

General treatment/extras cover primarily provides benefits for services such as dental, physiotherapy, optical and some therapies.

Combined policies are combined hospital and general treatment covers that allow consumers to “mix and

match” their insurance. However, some health funds only provide set packaged products. Most health funds provide some coverage for ambulance services, while others offer an additional ambulance policy.

**Private Healthcare Australia Limited (PHA)** – A body that represents Australia’s private health insurance industry for the benefit of its members.

**Transfer Certificate** (also known as a clearance certificate) – This document is generated when a person ceases cover with a health fund. It provides level of cover information and Lifetime Health Cover entitlements and ensures that this information is considered when transferring or rejoining private health insurance and where applicable, information regarding if those waiting periods are exempt.

**Waiting Periods** – How long you will need to be a member before you are eligible for benefits.

The Government has set maximum waiting periods for benefits for hospital services, but insurers can set their own waiting periods for general treatment benefits. The PHIS lists waiting periods in months for standard services.



Private Healthcare Australia

ABN 35 008 621 994

Copyright © 2025

TM – the Private Health Insurance Code of Conduct logo is a trade mark of Private Healthcare Australia