Attachment A

Insurance benefits at least equivalent to:

Public hospital – For admitted patient treatment, a benefit equal to the State and Territory health authority gazetted rates for ineligible patients for:

- overnight and day only hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs),
- emergency department fees that lead to an admission,
- admitted patient care and post-operative services that are a continuation of care associated with an early discharge from hospital.

Note: for the purpose of clarity this includes all admitted treatments covered by the Medicare Benefit Schedule.

Surgically implanted prostheses – For no gap prostheses and gap permitted prostheses as listed in the Private Health Insurance (Prostheses) Rules 2007, a benefit at least equal to 100% of minimum benefit amount listed.

Pharmacy – all PBS listed drugs that are prescribed according to the PBS approved indications, that are administered during and form part of an admitted episode of care, a benefit equal to the PBS listed price in excess of the patient contribution.

Note: for the purpose of clarity, this includes the cost of PBS-listed drugs administered post-discharge if they form part of the admitted episode of care.

Medical services – admitted medical services with an MBS item number, 100% of the Medicare Benefits Schedule fee, or less if the patient is charged less.

Ambulance services – 100% of the charge, that is not otherwise covered by third party arrangements for transport by ambulance provided by, or under an arrangement with, a government-approved ambulance service when medically necessary for admission to hospital, emergency treatment on-site, or inter-hospital transfer for emergency treatment.

Note: for the purposes of clarity, this includes inter-hospital transfers that are necessary because the original admitting hospital does not have the required clinical facilities. It does not extend to transfers due to patient preferences.

Other minimum health insurance policy features:

Informed Financial Consent
Insurers will make available membership eligibility checking to hospitals to enable the provision of Informed Financial Consent to members when they are admitted to hospital for medical treatment.

Informed Financial consent means that as a patient, you are given a clear explanation of the costs involved in your hospital treatment, including any out-of-pocket expenses, so you can understand and agree to them prior to proceeding.

Waiting periods
To comply with the minimum level of health insurance, the only waiting periods that maybe imposed are:

- 12 months for pregnancy and birth related treatments (obstetrics);
- 12 months for pre-existing conditions;
- Two months for psychiatric, rehabilitation or palliative care, even for a pre-existing condition;
- Two months in all other circumstances.

Excluded treatments

To comply with the minimum level of health insurance, the only admitted patient treatments that may be excluded are:

- Assisted reproductive treatments;
- Elective cosmetic treatments;
- Stem cells, bone marrow and organ transplants;

Insurance policies may also exclude the following:

- Treatment rendered outside of Australia including treatment necessary en route to or from Australia,
- Treatment arranged in advance of the insured's arrival in Australia,
- Services and treatment which are covered by compensation and damages provisions of any kind.

Note: insurers are not required to exclude these treatments. A decision to cover them is at the discretion of the insurer.

Global annual benefit limits

To comply with the minimum level of health insurance, the per person per annum benefit must not be less than AUD $1,000,000.

Out-of-hospital cover

For out-of-hospital treatments where an MBS item number and benefit is payable, cover should include benefits up to the benefit listed in the MBS.

Except where otherwise stated, an Australian registered private health insurer can determine whether it provides cover for out-of-hospital treatments and, as such, consumers may choose to purchase additional cover to meet their individual health care needs while in Australia.

Excess, co-payment or patient contribution

Any excess, co-payment or patient contribution is at the discretion of the insurer. If an excess, co-payment or patient contribution is charged, it can be on an annual or per - separation basis.

Portability

To comply with the minimum level of health insurance, when determining waiting periods, insurers must recognise previous length of membership on a policy held with another Australian insurer that meets the minimum standards. That is:

- When transferring between Australian-based insurers where the customer has been a member of the previous fund for more than 12 months, waiting periods of no longer than 12 months will apply to the higher level of benefits.
- When transferring between Australian-based insurers where the customer has been a member of the previous fund for less than 12 months, any unserved waiting periods must be completed with the new fund. If increasing the level of cover or benefits, additional waiting periods of no longer than 12 months will apply to the higher level of benefits. These waiting periods are served concurrently.

To comply with the minimum level of health insurance an insurer must agree to:

- Grant a member who seeks a transfer between Australian-based insurers continuity of cover for up to 30 days from the date they leave the previous insurer; and
- Provide members who terminate their policy with a clearance certificate, approved by the Department of Home Affairs, within 14 days of the date of termination or the date of notification of the termination, whichever is later.

Buy-out clauses

To comply with the minimum level of health insurance, a policy must not contain a buy-out clause that has the effect of terminating the insurers liabilities in exchange for a pre-determined lump sum payment.

Arrears

To comply with the minimum level of health insurance, an insurer will allow for acceptance of premiums for 60 days from the last financial date of membership without terminating the membership. Insurers are not obligated to pay for treatments received during any arrears period until and unless the arrears are paid for the relevant period.