Private Health Insurance

Code of Conduct

December 2021: Version 5

Contents

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:

- 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 private health insurers 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 2015*;
- *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 our 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 for you;

(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.

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' written 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' written 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' written 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:

- 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 call centre 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 Office of 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 private health insurer. If a policy covers a certain clinical category, then it must cover everything listed in it—not only some things. Further information on clinical categories is available at: https://www.privatehealth.gov.au/health_insurance/ howitworks/clinical_categories.htm

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

More information can be found here: https://www.ombudsman.gov.au/How-we-can-help/private-health-insurance

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; prostheses items 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 at: https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/informed-financial-consent

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 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 private health insurers 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 insurer, existed at any time during the six months prior to taking out hospital cover or upgrading to a higher level of cover.

Health insurers 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 insurer 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, 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.