Private Health Insurance Code of Conduct™

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PART A: GENERAL

1. INTRODUCTION

1.1 Introduction

The Private Health Insurance Code of Conduct (**"Code"**) is a self-regulatory code to promote informed relationships between Private Health Insurers, consumers, and intermediaries.

The PHI industry's objective is that the Code will maintain and enhance regulatory compliance and service standards of PHI policies across the private health insurance industry.

For this purpose the Code is to be a "living Code" which will be progressively reviewed from time to time. The PHI industry, through Private Healthcare Australia (**"PHA"**), welcomes the input of consumers into the Code and its operation. The PHI industry may also seek the input of consumers from time to time, including through consulting with the Private Health Insurance Ombudsman (**"PHIO"**).

1.2 Compliance

Code Compliance Committee

The PHA has formed an independent Code Compliance Committee (**Committee**). The Committee has the responsibility to ensure the Code is fully complied with by Health Funds and does this by: admitting Funds to participate in the Code; monitoring and enforcing compliance by participants by conducting random and other 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.

Responsibilities of Health Funds

Health Funds who are signatories to the Code must, in addition to complying with the Code, ensure they: implement appropriate systems and document procedures to comply with the Code; report to the Committee on the operation and compliance with the Code in accordance with the requirements of the Code and any guidelines issued by the Committee; cooperate with any compliance audits by or on behalf of the Committee and comply with any sanctions or requests made or imposed by the Committee. Health Funds must further satisfy the Code Compliance Committee that they continue to comply with all requirements of this Code by certifying their compliance with the Code in accordance with any guidelines or requests made by the Committee.

Full details of the process of compliance with the Code of Conduct are contained in the document *Private Health Insurance Practice Codes*.

2. OUR COMMITMENT UNDER THE CODE

As a signatory under the Code, as a private health insurer, we will:

(a) continuously work towards improving the standards of practice and service in the private health insurance industry;

(b) provide information to consumers in plain language;

(c) promote better informed decisions about our private health insurance products and services:

(i) by ensuring that our Policy documentation is full and complete;

(ii) when asked by a consumer, by providing an effective verbal explanation of the contents of the Policy documentation;

(iii) by ensuring that our staff and other persons providing information on our behalf are appropriately trained;

(d) provide information to consumers on their rights and obligations under their relationship with their Private Health Insurer, including information on this Code;

(e) provide consumers with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner; and

(f) where internal dispute resolution procedures do not reach a satisfactory outcome for the consumer, or if a consumer wishes to deal directly with an external body, advise the consumer of the right to take the issue to an external body, such as the PHIO;

but apart from the provisions for enforcement and sanctions in the Private Health Insurance Codes of Practice, a breach of the Code shall not give rise to any legal right or liability.

3. PRIVATE HEALTH INSURANCE ENVIRONMENT

In meeting our commitments, we will have regard to:

(a) the provisions of the *Private Health Insurance Act 2007* which govern private health insurance policies and arrangements between consumers, Private Health Insurers and government, including the requirement to meet prudential standards;

(b) our requirement to comply with the provisions of the *Competition and Consumer Act 2010*;

(c) the need for effective competition and cost efficiency being promoted in the private health insurance industry, and the need for ensuring flexibility in the development and enhancement of products and services for consumers.

PART B: DISPUTE RESOLUTION PROCEDURES IN RELATION TO THE CODE

1. INTERNAL DISPUTE RESOLUTION

1.1 INTERNAL DISPUTE RESOLUTION

We have a fully documented internal process for resolving a dispute between the consumer and us.

This process shall be readily accessible by consumers, without charge.

The internal process shall comply with the appropriate Australian Standard or equivalent and provide a fair and timely method of handling disputes, together with procedures for monitoring the efficient resolution of disputes.

1.2 RESOLUTION REQUESTS

Where we receive from a consumer a request, whether written or oral, for the resolution of a dispute or a request for a response in writing in relation to the dispute, we will promptly reply to the consumer. If the dispute is not resolved in a manner acceptable to the consumer, we will provide:

(a) where appropriate, the general reasons for that outcome; and

(b) information on the further action that the consumer can take such as the process for resolution of disputes referred to in Section 2 below.

2. EXTERNAL DISPUTE RESOLUTION

2.1 EXTERNAL DISPUTE RESOLUTION

In the event that a dispute is considered by the consumer to be unresolved internally, we will advise the consumer of the available external dispute resolution procedures in which we participate.

This includes providing information regarding the Private Health Insurance Ombudsman.

PART C: EMPLOYEES

1. TRAINING OF EMPLOYEES

We will ensure that:

(a) employees involved in:

- arranging PHI,
- providing PHI services directly to consumers, including claims processing,
- developing Policy documentation or product sales material,
- developing marketing services, or
- dispute resolution,

are familiar with the provisions of this Code, and that they possess the necessary skills, appropriate to their responsibilities;

(b) we provide adequate on-going training in relation to PHI and Code requirements to employees having regard to the employee's role and responsibility and the PHI contracts for and the insurance services to consumers that the employee is authorised to arrange or provide;

(c) we measure the effectiveness of this training by monitoring the performance of individual employees in relation to their obligations under the Code;

(d) we require employees to undergo any necessary additional or remedial training to address any identified deficiencies identified by our monitoring; and

(e) we keep appropriate records of the training provided to individual employees.

2. IMPLEMENTATION FOR EMPLOYEES

In implementing these requirements, we will have regard to whether the employee would ordinarily make representations on PHI products to consumers and, if this is not the case, we will provide such employees with information as to how consumers may be able to obtain product information.

We will instruct and remind our employees not to make representations in relation to any PHI product in respect of which they have not been trained to provide information.

We will instruct our employees to explain the consumer's options clearly and provide, in addition to the Policy documentation, the information that the consumer requires to make an informed choice as to their private health insurance purchase. We will ensure the necessary systems and procedures are in place for the appropriate recording of advice given to consumers and we will instruct employees to keep appropriate records of their advice to consumers.

PART D: INTERMEDIARIES

1. RESPONSIBILITIES IN RESPECT OF INTERMEDIARIES

We acknowledge that there are many different types of arrangements we may enter into with intermediaries to provide a range of services or act on our behalf in dealing with consumers. We also acknowledge that some intermediaries have obligations under their own industry self-regulatory code of conduct, namely the Private Health Insurance Intermediaries Code of Conduct ("Intermediary Code"). We will satisfy our obligations under this code in relation to intermediaries if the intermediary is a signatory to the Intermediary Code. However, if the intermediary is not a signatory to the Intermediary Code we will comply with the following principles.

We 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.

We will ensure that any agreement that we have with an intermediary to provide PHI services on our behalf and who is not a signatory to the Intermediary Code that is entered into or renewed any time after the implementation of version 4 of this Code will include provisions that will require the intermediary or its employees to:

(a) discharge their responsibilities and duties competently and with integrity and honesty and in compliance with the law;

(b) exercise reasonable care and skill in the discharge of their duties;

(c) comply with the provisions of the *Private Health Insurance Act 2007*, the *Competition and Consumer Act 2010*, and any other relevant laws;

(d) maintain records required by law and comply with legal requirements for production of, access to, or copying of, such records;

(e) provide such information as may be legally required by any regulatory or other authority;

(f) maintain confidentiality of any confidential information in relation to consumers or our business, and comply with relevant privacy laws;

(g) have the necessary skills to represent our health insurance business, and its products, having regard to the nature of representation required and the areas of activity undertaken or required to be undertaken by the intermediary;

(h) not provide advice, make representations or otherwise act outside the areas of activity or private health insurance products authorised under our agreement, arrangement or understanding;

(i) make clear disclosure to all consumers who deal with the intermediary in relation to our health insurance business the nature of their relationship with our health insurance business;

(j) make clear disclosure to all consumers who deal with the intermediary in relation to our health insurance business whether any fees, commissions or other benefits are paid or payable by us to the intermediary in respect of any health insurance business entered into by the consumer through or as a result of the services of the intermediary;

(k) have an effective alternative dispute resolution procedure for resolving a dispute between a consumer and the intermediary;

(l) comply with any applicable industry Code where relevant,

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

(m) only provide to the consumer copies of product sales material and Policy documentation that complies with the requirements of this Code; and

(n) explain the consumer's options clearly using plain language and provide such information as the consumer requires to make an informed choice as to their private health insurance purchase; and

(o) keep appropriate records of their advice to consumers.

2. TRAINING

We will require our intermediaries to possess the necessary skills appropriate to the private health insurance products they are promoting or selling or activities they are undertaking.

To this end, we will require our intermediaries to receive adequate on-going and documented training or instruction to competently provide the services to consumers that they are authorised to provide. The obligation to provide training or instruction is ongoing during the term of the agreement.

PART E: POLICY DOCUMENTATION

1. CLEAR AND COMPLETE POLICY DOCUMENTATION

We will:

(a) provide information to consumers in plain language;

(b) express Policy documentation in plain language and design and present Policy documentation, with the aim of assisting comprehension by consumers;

(c) ensure each new consumer to our fund is advised of or has presented to them prior to joining Policy documentation, information or advice detailing the consumer's entitlement to benefits, including any waiting periods and pre-existing conditions, exclusions, restrictions, benefit limitation periods and co-payments and/or excesses, and we will confirm this cover following acceptance by our fund;

(d) ensure all forms of Policy documentation accurately reflect the cover offered, will highlight information at (i) to (vi) below and contain accurate information at a minimum on:

(i) waiting periods and pre-existing conditions;

(ii) an explanation of the scope and implications of exclusions;

(iii) an explanation of the scope and implications of restriction on benefits;

(iv) an explanation of the scope and implications of benefit limitation periods;

(v) co-payments and/or excesses;

(vi) annual limits (individual and membership);

(vii) an explanation of pre-existing conditions;

(viii) how to find agreement hospital details;

(ix) how to find no gap or known gap doctors for our fund;

(x) how to find out if an ancillary provider is recognised by our fund;

(xi) how to find out about our fund's privacy policy;

(xii) how to access our fund's complaints handling procedures;

(xiii) information about the existence of the Code including the Code logo; and

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

(e) ensure all forms of product sales material including in any digital or electronic media, will accurately reflect the cover offered.

(f) at the request of any existing consumer, provide the consumer with the details of the consumer's entitlements to benefits;

(g) provide in a timely manner to consumers information on any changes to their policy, being made in plain language and in a format aimed to assist comprehension by consumers;

(h) on a State-by-State basis (where applicable), produce and maintain, in both written and electronic format, material detailing all tables of benefits or products that are available to consumers and ensure that the material:

(i) is freely available to any person; and

(ii) includes advice as to the existence of, and contact details for, the PHIO; and

(iii) indicates the date at which it is correct; and

(iv) is available in its written format at all of our organisation's offices; and

(v) can be accessed reasonably in its electronic format; and

(i) at the request of another Private Health Insurer holding an authority (whether written, electronic or as a sound recording) from a transferring member, provide direct to that Private Health Insurer in a timely manner, but within 14 days, a Transfer Certificate on behalf of a member or former member of our fund.

2. DETRIMENTAL CHANGES TO POLICIES

2.1 DETRIMENTAL CHANGES TO HOSPITAL POLICY BENEFITS

A significant detrimental change to hospital policy benefits includes:

(a) removal of material benefits or restriction to default benefits for any identified condition;

(b) addition of material excesses/co-payments; or

(c) increases in excesses/co-payments greater than 50%.

Where there is a detrimental change to hospital benefits we will:

(a) or significant detrimental changes provide the affected consumer with details of the change giving at least 60 days' written notice;

(b) for all other detrimental changes provide the affected consumer with details of the change giving at least 30 days' written notice; and

(c) not apply the changes to pre-booked admissions; and

(d) put in place transitional measures for patients in a course of treatment for a reasonable time period, for example, up to six months.

2.2 SIGNIFICANT DETRIMENTAL CHANGES TO ANCILLARY BENEFITS

A significant detrimental change to ancillary policy benefits includes:

(a) introduction of a new limit or sub-limit; or

(b) a greater than 50% reduction in any limit.

For significant detrimental changes to ancillary benefits we will:

(a) provide the affected consumer with at least 30 days' written notice; and

(b) put in place transitional measures for rollover type benefits accumulated in a previous year.

2.3 GENERAL PRINCIPLE IN RELATION TO DETRIMENTAL CHANGES TO BENEFITS

We acknowledge and agree that although the above principles should be adhered to in the majority of cases, there is the flexibility to deal with special or unusual circumstances on a case-by-case basis. For example, the rules would not apply to changes imposed outside our reasonable control.

3. CHANGES TO HOSPITAL CONTRACTING ARRANGEMENTS

We recognise that while not constituting a change to hospital benefits for the purpose of Section 2 above, changes to hospital contracting arrangements between a fund and a hospital can affect a consumer. We understand that requirements for notification of consumers of such changes and transition arrangements are included in the relevant agreements and the Code of Conduct for Health Fund and Hospital Negotiations. We acknowledge that additional guidance can be found in DoHA circulars and in PHIO's Transition and Communication Protocols.

4. GUIDELINES FOR PRE-EXISTING CONDITIONS

We recognise that while not part of hospital contracting arrangements referred to in Section 3 above, we will ensure that the 'Best Practice Guidelines for Pre-existing Ailments' or any subsequent review are implemented as appropriate throughout our fund, including in the specific areas of:

- our medical practitioner; and
- in our dealings with hospitals including emergency admissions and other medical providers if appropriate and if applying to them.

5. "COOLING OFF" PERIOD

We will allow any consumer who has not yet made a claim, to cancel their private health insurance policy and receive a full refund of any premiums paid within a period of 30 days from the commencement date of their policy.

PART F: PRIVACY

AUSTRALIAN PRIVACY PRINCIPLES

We will:

(a) embrace the Australian Privacy Principles under the *Privacy Act 1988* as amended and the provisions of relevant State privacy legislation or requirements; and

(b) formulate and publish our own Privacy Policy, by which we will abide.

PART G: DEFINITIONS

1. DEFINED WORDS

In this Code, the following terms mean:

"consumer" means an individual, where that individual, whether alone or jointly with another individual, enters or proposes to enter into a PHI contract;

"DoHA" means the Australian Government Department of Health and Ageing, or such other name given to such body from time to time;

"dispute" means an unresolved complaint about a product or service of a Private Health Insurer and for this purpose a complaint is an expression of dissatisfaction conveyed to a Private Health Insurer together with a request that the complaint be remedied by the Private Health Insurer;

"health insurance business" is as defined in Division 121 of the *Private Health Insurance Act 2007*;

"HIRMAA" means the Health Insurance Restricted & Regional Membership Association of Australia, an industry body that Private Health Insurers may join if they wish;

"intermediary" means a third party (including a related body corporate) who, pursuant to an agreement with a Private Health Insurer or another person, has responsibility to perform, whether on a continuous, intermittent or ad hoc basis and whether for a specified limited period or an ongoing period of time, a business activity that is part of the Private Health Insurer's health insurance business, or could be, undertaken by the Private Health Insurer itself.

"Minister" means the Federal Minister or his or her delegate with the powers vested in the Minister under the *Private Health Insurance Act 2007*;

"PHA" means Private Healthcare Australia (formerly the Australian Health Insurance Association), the national PHI industry organisation, which Private Health Insurers may join if they wish;

"PHI" means private health insurance;

"PHI contract" or **"PHI policy"** means each PHI contract arising out of or in connection with health insurance business between a Private Health Insurer and a consumer;

"PHIO" means the Private Health Insurance Ombudsman as appointed by the Minister from time to time;

"Policy documentation" means private health insurance product policy wording, fund rules or similar PHI policy information in any printed or electronic form;

"product sales material" means material that markets or promotes a PHI fund, PHI policy or PHI product of a Private Health Insurer that is not Policy documentation, whether in printed or electronic form;

"Private Health Insurance" means health insurance business;

"Private Health Insurer" means a private health insurer registered under the *Private Health Insurance Act 2007*;

"Transfer Certificate" means a certificate issued pursuant to section 99 of the *Private Health Insurance Act 2007*.

NOTES

Private Healthcare Australia

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