Australian Government

Private Health Insurance Reforms

Gold, Silver, Bronze, Basic product tiers

The Australian Government has introduced reforms that will make private health insurance simpler and will help people choose the cover that best suits their needs.

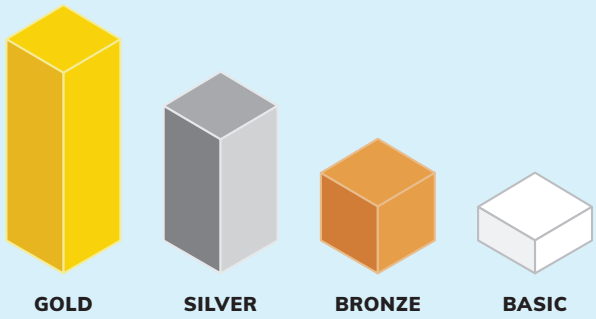
For the first time, private health insurers will be required to classify their private hospital cover into four easy to understand tiers: Gold, Silver, Bronze or Basic.

What is, and is not covered in these tiers will be based on new minimum standard clinical categories.

Clinical categories are simply types of hospital treatments described in a standard way.

If a policy covers a certain clinical category, then it must cover everything described as part of the category – not only some things. For example, 'bone, joint and muscle' category, or 'heart and vascular system' category. This makes policies easier to compare.

Private health insurers will place all policies into one of these tiers – Gold, Silver, Bronze or Basic, and will tell people where their policy has been placed. People can then check if the cover is right for their needs.



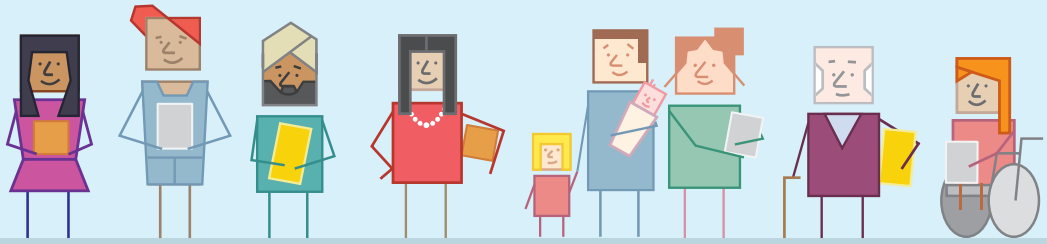
The tiers are intended to mandate minimum service coverage requirements generally reflecting the existing range of health insurance policies.

Insurers will continue to be able to offer additional coverage above the minimum requirements in Basic Plus (+), Bronze Plus (+) and Silver Plus (+) product tiers.

Health insurers have until 1 April 2020 to introduce the tiers and clinical categories.

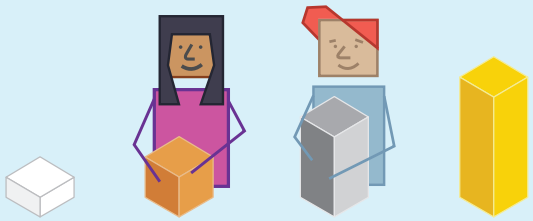
Who will benefit?

The new product tiers and clinical categories will give people greater certainty about the services covered by each type of private hospital cover. The changes will make it easier to shop around and compare different hospital policies to find one that meets a person's or a family's needs.



For more information visit **health.gov.au/private-health-reforms**

Hospital Treatment Product Tiers – Gold, Silver, Bronze and Basic



HOSPITAL TREATMENTS BY CLINICAL CATEGORY	BASIC	BRONZE	SILVER	GOLD
Rehabilitation	✓(R)	✓(R)	✓(R)	✓
Hospital psychiatric services	✓(R)	✓(R)	✓(R)	✓
Palliative care	✓(R)	✓(R)	✓(R)	✓
Brain and nervous system	O (R)	✓	✓	✓
Eye (not cataracts)	O (R)	✓	✓	✓
Ear, nose and throat	O (R)	✓	✓	✓
Tonsils, adenoids and grommets	O (R)	✓	✓	✓
Bone, joint and muscle	O (R)	✓	✓	✓
Joint reconstructions	O (R)	✓	✓	✓
Kidney and bladder	O (R)	✓	✓	✓
Male reproductive system	O (R)	✓	✓	✓
Digestive system	O (R)	✓	✓	✓
Hernia and appendix	O (R)	✓	✓	✓
Gastrointestinal endoscopy	O (R)	✓	✓	✓
Gynaecology	O (R)	✓	✓	✓
Miscarriage and termination of pregnancy	O (R)	✓	✓	✓
Chemotherapy, radiotherapy & immunotherapy for cancer	O (R)	✓	✓	✓
Pain management	O (R)	✓	✓	✓
Skin	O (R)	✓	✓	✓
Breast surgery (medically necessary)	O (R)	✓	✓	✓
Diabetes management (excluding insulin pumps)	O (R)	✓	✓	✓
Heart and vascular system	O (R)	O	✓	✓
Lung and chest	O (R)	O	✓	✓
Blood	O (R)	O	✓	✓
Back, neck and spine	O (R)	O	✓	✓
Plastic and reconstructive surgery (medically necessary)	O (R)	O	✓	✓
Dental surgery	O (R)	O	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	O (R)	O	✓	✓
Implantation of hearing devices	O (R)	O	✓	✓
Cataracts	O (R)	O	O	✓
Joint replacements	O (R)	O	O	✓
Dialysis for chronic kidney failure	O (R)	O	O	✓
Pregnancy and birth	O (R)	O	O	✓
Assisted reproductive services	O (R)	O	O	✓
Weight loss surgery	O (R)	O	O	✓
Insulin pumps	O (R)	O	O	✓
Pain management with device	O (R)	O	O	✓
Sleep studies	O (R)	O	O	✓

✓ Minimum requirement of the product tier

(R) Insurers are allowed to offer cover for this clinical category on a restricted basis/with limited benefits

O Optional for insurer to include – not a minimum requirement of the product tier

Clinical categories can be either 'restricted (R)' or 'unrestricted'. This refers to the level of benefits paid for hospital costs (e.g. hospital accommodation, operating theatre fees, prosthesis costs), which are separate to doctors' fees.

For clinical categories listed as 'restricted (R)'

Insurers pay only a limited amount for private hospital costs, which means people are likely to face substantial out of pocket expenses.

For unrestricted categories

Insurers and most hospitals have agreements meaning people don't pay out of pocket hospital costs, other than any excess or fixed copayment amount.

Out of pocket costs for doctors' fees may also be payable if a doctor charges more than the Medicare Benefits Schedule fee and the insurer covers only part of the remaining payment.

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