Private Health Insurance Act 2007

No. 31, 2007

Compilation No. 42

Compilation date: 19 September 2026

Includes amendments: Act No. 90, 2026

Prepared by the Office of Parliamentary Counsel, Canberra

Authorised Version C2026C00412 registered 28/09/2026

About this compilation

This compilation

This is a compilation of the *Private Health Insurance Act 2007* that shows the text of the law as amended and in force on 19 September 2026 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au).

Application, saving and transitional provisions

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Presentational changes

The *Legislation Act 2003* provides for First Parliamentary Counsel to make presentational changes to a compilation. Presentational changes are applied to give a more consistent look and feel to legislation published on the Register, and enable the user to more easily navigate those documents.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. Any modifications affecting the law are accessible on the Register.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

Contents

Chapter 1—Introduction 1

Part 1-1—Introduction 1

Division 1—Preliminary 1

1-1 Short title 1
1-5 Commencement....1
1-10 Identifying defined terms 1
1-15 Extension to Norfolk Island 2

Division 3—Overview of this Act 3

3-1 What this Act is about 3
3-5 Incentives (Chapter 2) 3
3-10 Complying health insurance products (Chapter 3)....3
3-15 Health insurance business, health benefits funds and miscellaneous obligations of private health insurers (Chapter 4) 4
3-20 Enforcement (Chapter 5)....4
3-25 Administration (Chapter 6) 4
3-30 Dictionary (Schedule 1)....4

Division 5—Constitutional matters 5

5-1 Meaning of *insurance*....5
5-5 Act not to apply to State insurance within that State 5
5-10 Compensation for acquisition of property....5

Chapter 2—Incentives 6

Part 2-1—Introduction 6

Division 15—Introduction 6

15-1 What this Chapter is about 6

Part 2-2—Premiums reduction scheme 7

Division 20—Introduction 7

20-1 What this Part is about....7
20-5 Private Health Insurance (Incentives) Rules 7

Authorised Version C2026C00412 registered 28/09/2026

Division 22—PHIIB, PHII benefit and related concepts 8

Subdivision 22-A—PHIIB, PHII benefit and related concepts 8

22-1 Application of Subdivision....8
22-5 Meaning of *PHIIB*....8
22-10 Meaning of *PHII benefit*....9
22-15 Meaning of *share of the PHII benefit*—single PHIIB....9
22-20 Meaning of *share of the PHII benefit*—multiple PHIIBs....12
22-25 Application of subsection 22-15(1) after a person 65 years or over ceases to be covered by policy....12

Subdivision 22-B—Private health insurance tiers 13

22-30 Private health insurance tiers....13
22-35 Private health insurance singles thresholds....15
22-40 Private health insurance family thresholds....16
22-45 Indexation....16

Division 23—Premiums reduction scheme 19

Subdivision 23-A—Amount of reduction 19

23-1 Reduction in premiums....19

Subdivision 23-B—Participation in the premiums reduction scheme 19

23-15 Application to register as a participant in the premiums reduction scheme....19
23-16 Registration of participants....20
23-20 Refusal to register....21
23-30 Participants who want to withdraw from scheme....21
23-35 Revocation of registration....22
23-40 Variation of registration....23
23-45 Retention of applications by private health insurers....23

Part 2-3—Lifetime health cover 24

Division 31—Introduction 24

31-1 What this Part is about....24
31-5 Private Health Insurance (Lifetime Health Cover) Rules....24

Division 34—General rules about lifetime health cover 25

34-1 Increased premiums for person who is late in taking out hospital cover....25

Authorised Version C2026C00412 registered 28/09/2026

34-5 Increased premiums for person who ceases to have hospital cover after his or her lifetime health cover base day 25
34-10 Increased premiums stop after 10 years' continuous cover....26
34-15 Meaning of *hospital cover*....27
34-20 Meaning of *permitted days without hospital cover*....28
34-25 Meaning of *lifetime health cover base day* 28
34-30 When a person is overseas or enters Australia....30

Division 37—Exceptions to the general rules about lifetime health cover 31
37-1 People born on or before 1 July 1934....31
37-5 People over 31 and overseas on 1 July 2000....31
37-7 Person yet to turn 31....31
37-10 Hardship cases....32
37-15 Increases cannot exceed 70% of base rates....32
37-20 Joint hospital cover....32

Division 40—Administrative matters relating to lifetime health cover 33
40-1 Notification to insured people etc. 33
40-5 Evidence of having had hospital cover, or of a person's age....34

Part 2-4—Excess levels for medicare levy and medicare levy surcharge purposes 35

Division 42—Introduction 35
42-1 What this Part is about....35

Division 45—Excess levels for medicare levy and medicare levy surcharge purposes 36
45-1 Excess level amounts....36

Chapter 3—Complying health insurance products 37

Part 3-1—Introduction 37

Division 50—Introduction 37
50-1 What this Chapter is about 37
50-5 Private Health Insurance Rules relevant to this Chapter 37

Authorised Version C2026C00412 registered 28/09/2026

Part 3-2—Community rating 38

Division 55—Principle of community rating 38

55-1 What this Part is about....38
55-5 Principle of community rating....38
55-10 Closed products, and terminated products and product subgroups....40
55-15 Pilot projects....41

Part 3-3—Requirements for complying health insurance products 42

Division 60—Introduction 42

60-1 What this Part is about....42

Division 63—Basic rules about complying health insurance products 43

63-1 Obligation to ensure products are complying products....43
63-5 Meaning of *complying health insurance product*....43
63-10 Meaning of *complying health insurance policy*....44

Division 66—Community rating requirements 45

66-1 Community rating requirements....45
66-5 Premium requirement....45
66-6 Meaning of approved application period....47
66-7 Meaning of *designated change*....47
66-8 Minister's approval of premiums charged under new product subgroups....48
66-10 Minister's approval if certain changes are made to premiums or products....51
66-11 Further information about applications under sections 66-8 and 66-10....54
66-12 When Minister must invite resubmission etc. of applications under sections 66-8 and 66-10....55
66-13 Annual report....56
66-15 Entitlement to benefits for general treatment....57
66-20 Different amount of benefits depending on where people live....57
66-25 Different amounts of benefits for travel or accommodation....58

Division 69—Coverage requirements 59

69-1 Coverage requirements....59

Authorised Version C2026C00412 registered 28/09/2026

69-5 Meaning of *cover* 59
69-10 Meaning of *hospital-substitute treatment* 60

Division 72—Benefit requirements for policies that cover hospital treatment 61

72-1 Benefit requirements 61
72-5 Rules requirement in relation to provision of benefits 64
72-10 Minimum benefits for medical devices and human tissue products 65
72-11 Meaning of *medical device* 67
72-12 Meaning of *human tissue product* 68
72-15 Fees for certain activities 69
72-20 Delisting because of unpaid fees or levy 69
72-25 Minister may direct that activities not be carried out 70
72-27 Matters to have regard to before exercising certain powers 70
72-30 When cost-recovery fee must be paid 71
72-35 Payment of cost-recovery fee 71
72-40 Recovery of fee 71
72-45 Other matters 71

Division 75—Waiting period requirements 72

75-1 Waiting period requirements 72
75-5 Meaning of *waiting period* 72
75-10 Meaning of *transfers* 73
75-15 Meaning of *pre-existing condition* 73

Division 78—Portability requirements 75

78-1 Portability requirements 75

Division 81—Quality assurance requirements 78

81-1 Quality assurance requirements 78

Division 84—Enforcement of this Part 79

84-1 Offence: advertising, offering or insuring under non-complying policies 79
84-5 Offence: directors and chief executive officers liable if systems not in place to prevent breaches 79
84-10 Injunction in relation to non-complying policies 80
84-15 Remedies for people affected by non-complying policies 81

Authorised Version C2026C00412 registered 28/09/2026

Part 3-4—Obligations relating to complying health insurance products 83

Division 90—Introduction 83

90-1 What this Part is about....83

Division 93—Giving information to consumers 84

93-1 Maintaining up to date private health information statements....84

93-5 Meaning of *private health information statement*....85

93-10 Making private health information statements available....85

93-15 Giving information to newly insured people....85

93-20 Keeping insured people up to date....86

93-25 Giving advance notice of detrimental changes to rules....87

93-30 Failure to give information to consumers....88

Division 96—Giving information to the Department and the Private Health Insurance Ombudsman 89

96-1 Giving private health information statements on request....89

96-5 Giving private health information statements for new products....89

96-10 Giving updated private health information statements....89

96-15 Giving additional information on request....90

96-20 Failure to give information to Department or Private Health Insurance Ombudsman....90

96-25 Giving information required by the Private Health Insurance (Complying Product) Rules....91

Division 99—Transfer certificates 92

99-1 Transfer certificates....92

Division 102—Private health insurers to offer cover for hospital treatment 94

102-1 Private health insurers to offer cover for hospital treatment....94

Authorised Version C2026C00412 registered 28/09/2026

Chapter 4—Health insurance business, health benefits funds and miscellaneous obligations of private health insurers 95

Part 4-1—Introduction 95

Division 110—Introduction 95

110-1 What this Chapter is about 95

Part 4-2—Health insurance business 96

Division 115—Introduction 96

115-1 What this Part is about....96
115-5 Private Health Insurance (Health Insurance Business) Rules 96
115-10 Whether a business etc. is health insurance business 96

Division 121—What is health insurance business? 98

121-1 Meaning of *health insurance business* 98
121-5 Meaning of *hospital treatment* 99
121-7 Conditions on declarations of hospitals....101
121-8 Application for inclusion of hospital in a class 102
121-8A Minister to decide application 102
121-8B Period of inclusion of hospital in a class 103
121-8C Revocation of inclusion of hospital in a class 103
121-8D Private Health Insurance (Health Insurance Business) Rules 103
121-10 Meaning of *general treatment* 104
121-15 Extension to *employee health benefits schemes* 104
121-20 Exception: accident and sickness insurance business 106
121-25 Exception: liability insurance business 106
121-30 Exception: insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules 107

Part 4-4—Health benefits funds 108

Division 131—Health benefits funds 108

131-1 What this Part is about....108
131-5 Private Health Insurance (Health Benefits Fund Policy) Rules 108

Authorised Version C2026C00412 registered 28/09/2026

131-10 Meaning of *health benefits fund* 109
131-15 Meaning of *health-related business* 109
131-20 Risk equalisation jurisdictions 110
131-25 Operation of health-related businesses through health benefits funds 110

Part 4-5—Miscellaneous obligations of private health insurers 111

Division 157—Introduction 111
157-1 What this Part is about 111
157-5 Private Health Insurance (Data Provision) Rules 111

Division 169—Notification obligations 112
169-10 Private health insurers to notify any changes to rules 112

Division 172—Other obligations 113
172-5 Agreements with medical practitioners 113
172-10 Private health insurers to give information to Secretary 113
172-15 Restrictions on payment of pecuniary penalties etc. 114

Chapter 5—Enforcement 115

Part 5-1—Introduction 115

Division 180—Introduction 115
180-1 What this Chapter is about 115

Part 5-2—General enforcement methods 116

Division 185—What this Part is about 116
185-1 Introduction 116
185-5 Meaning of *enforceable obligation* 116

Division 188—Performance indicators 118
188-1 Performance indicators 118

Division 191—Explanation of private health insurer's operations 119
191-1 Minister may seek an explanation from a private health insurer 119
191-5 Minister must respond to insurer's explanation 119

Division 194—Investigation of private health insurer's operations 121
194-1A Purposes for which powers may be exercised etc. 121

Authorised Version C2026C00412 registered 28/09/2026

194-1 Minister may investigate a private health insurer 121
194-5 Notice to give information 121
194-10 Notice to produce documents 122
194-15 Notice to give evidence 123
194-20 Offences in relation to investigation notices 123
194-25 Authorisation to examine books and records etc.....124
194-35 Minister must notify outcome of investigation 124

Division 197—Enforceable undertakings 125

197-1 Minister may accept written undertakings given by a private health insurer 125
197-5 Enforcement of undertakings 125

Division 200—Ministerial directions 126

200-1 Minister may give directions 126
200-5 Direction requirements 127

Division 203—Remedies in the Federal Court 128

203-1 Minister may apply to the Federal Court.....128
203-5 Declarations of contravention 128
203-10 Pecuniary penalty order.....129
203-15 Compensation order 129
203-20 Adverse publicity order 129
203-25 Other order 130
203-30 Time limit for declarations and orders 130
203-35 Civil evidence and procedure rules for declarations and orders 130
203-40 Civil proceedings after criminal proceedings.....130
203-45 Criminal proceedings during civil proceedings.....131
203-50 Criminal proceedings after civil proceedings.....131
203-55 Evidence given in proceedings for penalty not admissible in criminal proceedings 131
203-60 Minister may require person to assist.....132
203-65 Relief from liability for contravening an enforceable obligation 134
203-70 Powers of Federal Court.....135

Division 206—Revoking entitlement to offer rebate as a premium reduction 136

206-1 Revocation of status of participating insurer.....136

Authorised Version C2026C00412 registered 28/09/2026

Chapter 6—Administration 137

Part 6-1—Introduction 137

Division 230—Introduction 137

230-1 What this Chapter is about 137

Part 6-4—Administration of premiums reduction scheme 138

Division 276—Introduction 138

276-1 What this Part is about....138

Division 279—Reimbursement of participating insurers and powers of Chief Executive Medicare 139

Subdivision 279-A—Reimbursement of private health insurers for premiums reduced under scheme 139

279-1 Who can make reimbursement claims....139

279-5 Participating insurers....139

279-10 Requirements relating to reimbursement claims 140

279-11 Determination of claim....141

279-15 Amounts payable to the private health insurer....142

279-45 Reconsideration of decisions....143

Subdivision 279-B—Powers of Chief Executive Medicare in relation to participating insurers 144

279-50 Audits by Chief Executive Medicare 144

279-55 Chief Executive Medicare may require production of applications 145

Division 282—Recovery of amounts and other matters 146

Subdivision 282-A—When and how payments can be recovered 146

282-1 Recovery of payments....146

282-5 Interest on amounts recoverable....148

282-10 Chief Executive Medicare may set off debts against amounts payable....149

282-15 Reconsideration of certain decisions under this Division 150

Subdivision 282-AA—Recovery of certain amounts by Commissioner of Taxation 151

282-16 Administration of this Subdivision by Commissioner of Taxation 151

282-17 Subdivision operates in addition to Subdivision 282-A....151

Authorised Version C2026C00412 registered 28/09/2026

282-18 Liability for excess private health insurance premium reduction or refund....152
282-19 When general interest charge payable....154
Subdivision 282-B—Miscellaneous 155
282-20 Notification requirements—private health insurers....155
282-25 Use etc. of information relating to another person....155
282-30 Information to be provided to the Commissioner of Taxation....156
282-35 Delegation....156
282-40 Appropriation....156
Part 6-6—Private health insurance levies 157
Division 304—Introduction 157
304-1 What this Part is about....157
304-5 Private Health Insurance (Levy Administration) Rules....157
304-10 Meaning of *private health insurance levy*....157
Division 307—Collection and recovery of private health insurance levies 159
307-1 When private health insurance levy must be paid....159
307-5 Late payment penalty....159
307-10 Payment of levy and late payment penalty....160
307-15 Recovery of levy and late payment penalty....160
307-20 Waiver of late payment penalty....161
307-30 Other matters....161
Division 310—Returns, requesting information and keeping records: private health insurers 162
310-1 Returns relating to complaints levy....162
310-5 Insurer must keep records....162
310-10 Power to request information from insurer....163
Division 313—Power to enter premises and search for documents related to complaints levy 165
313-1 Authorised officer may enter premises with consent....165
313-5 Authorised officer may enter premises under warrant....165
313-10 Announcement before entry....166
313-15 Executing a warrant to enter premises....167
313-20 Identity cards....168

Authorised Version C2026C00412 registered 28/09/2026

Part 6-7—Private Health Insurance Risk Equalisation Special Account 169

Division 318—Private Health Insurance Risk Equalisation Special Account 169

318-1 Private Health Insurance Risk Equalisation Special Account 169
318-5 Credits to the Risk Equalisation Special Account....169
318-10 Purpose of the Risk Equalisation Special Account 170
318-15 Record keeping....171

Part 6-8—Disclosure of information 172

Division 323—Disclosure of information 172

323-1 Prohibition on disclosure of protected information....172
323-5 Authorised disclosure: official duties....173
323-10 Authorised disclosure: sharing information about insurers among agencies....174
323-15 Authorised disclosure: sharing information about insurers other than among agencies....175
323-20 Authorised disclosure: public interest 176
323-23 Terms and conditions on subsequent use or disclosure following an authorised disclosure under section 323-15 or 323-20....177
323-30 Authorised disclosure: court proceedings 177
323-33 Authorised disclosure: other permitted disclosures....177
323-35 Authorised use: use of information for authorised disclosure....178
323-40 Offence: disclosure of information obtained by certain authorised disclosures....178
323-45 Offence: soliciting disclosure of protected information 178
323-50 Offence: use etc. of protected information after unauthorised disclosure 179
323-55 Offence: offering to supply protected information....179

Division 324—Publication of information about treatments covered by health insurance policies etc. 181

324-1 Objects of this Division....181
324-5 Publication of information about treatments covered by complying health insurance policies....181
324-7 Review of decision to publish information 185
324-10 Use and disclosure of information....185

Authorised Version C2026C00412 registered 28/09/2026

324-15 Protection from civil proceedings 187
324-20 Annual report....187

Part 6-9—Review of decisions 189

Division 328—Review of decisions 189

328-1 What this Part is about....189
328-5 ART review of decisions....189

Part 6-10—Miscellaneous 191

Division 333—Miscellaneous 191

333-1 Delegation by Minister....191
333-5 Delegation by Secretary 192
333-10 Approved forms....192
333-15 Signing approved forms 193
333-16 Approved electronic system 193
333-17 Automation of administrative action....193
333-18 Oversight and safeguards for automation of administrative action 196
333-20 Private Health Insurance Rules made by the Minister 198
333-25 Private Health Insurance Rules made by APRA 199
333-30 Regulations....200

Schedule 1—Dictionary 201

1 Dictionary....201

Endnotes 212

Endnote 1—About the endnotes 212

Endnote 2—Abbreviation key 214

Endnote 3—Legislation history 215

Endnote 4—Amendment history 222

Endnote 5—Editorial changes 242

Authorised Version C2026C00412 registered 28/09/2026

Authorised Version C2026C00412 registered 28/09/2026

An Act to regulate private health insurance, and for related purposes

Chapter 1—Introduction

Part 1-1—Introduction

Division 1—Preliminary

1-1 Short title

This Act may be cited as the *Private Health Insurance Act 2007*.

1-5 Commencement

This Act commences on 1 April 2007.

1-10 Identifying defined terms

(1) Many of the terms in this Act are defined in the Dictionary in Schedule 1.

(2) Most of the terms that are defined in the Dictionary are identified by an asterisk appearing at the start of the term: as in "*health benefits fund". The footnote with the asterisk contains a signpost to the Dictionary.

(3) An asterisk usually identifies the first occurrence of a term in a section (if not divided into subsections), subsection, definition, table item or diagram. Later occurrences of the term in the same provision are not usually asterisked.

(4) Terms are not asterisked in headings, notes, examples or guides.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(5) If a term is not identified by an asterisk, disregard that fact in deciding whether or not to apply to that term a definition or other interpretation provision.

(6) The following basic terms used throughout the Act are not identified with an asterisk:

Terms that are not identified with an asterisk

Item	This term ...	is defined in ...
2	Federal Court	the Dictionary in Schedule 1
3	insurance	section 5-1
4	Chief Executive Medicare	the Dictionary in Schedule 1
5	Private Health Insurance Ombudsman	the Dictionary in Schedule 1
6	private health insurer	the Dictionary in Schedule 1

1-15 Extension to Norfolk Island

This Act extends to Norfolk Island.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 3—Overview of this Act

3-1 What this Act is about

This Act is about private health insurance. It:

(a) provides incentives to encourage people to have private health insurance; and

(b) sets out rules governing private health insurance *products.

Note: The *Private Health Insurance (Prudential Supervision) Act 2015* sets out the registration process for private health insurers, imposes requirements about how private health insurers conduct health insurance business and deals with other matters in relation to the prudential supervision of private health insurers.

3-5 Incentives (Chapter 2)

Chapter 2 provides the following incentives:

(a) reductions in premiums for *complying health insurance policies;

(c) a lifetime health cover scheme, under which premiums may rise for people who do not maintain private health insurance from an early age.

3-10 Complying health insurance products (Chapter 3)

Chapter 3 requires insurers who make private health insurance available to people to do so in a non-discriminatory way, to offer *products that comply with this Act, and to meet certain other obligations imposed by this Act in relation to those products.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

3-15 Health insurance business, health benefits funds and miscellaneous obligations of private health insurers (Chapter 4)

Chapter 4 defines the key concepts of *health insurance business and *health benefits funds. It also deals with some related matters and imposes miscellaneous obligations on private health insurers.

3-20 Enforcement (Chapter 5)

Chapter 5 provides for a range of enforcement mechanisms aimed at monitoring and ensuring compliance with this Act and protecting the interests of *policy holders.

3-25 Administration (Chapter 6)

Chapter 6 contains administrative and machinery provisions relating to the operation of this Act.

3-30 Dictionary (Schedule 1)

The Dictionary in Schedule 1 contains definitions of terms used throughout this Act.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 5—Constitutional matters

5-1 Meaning of *insurance*

In this Act:

insurance means insurance to which paragraph 51(xiv) of the Constitution applies.

5-5 Act not to apply to State insurance within that State

This Act does not apply with respect to State insurance that does not extend beyond the limits of the State concerned.

5-10 Compensation for acquisition of property

(1) If the operation of this Act would result in an acquisition of property from a person otherwise than on just terms, the Commonwealth is liable to pay a reasonable amount of compensation to the person.

(2) If the Commonwealth and the person do not agree on the amount of the compensation, the person may institute proceedings in the Federal Court for the recovery from the Commonwealth of such reasonable amount of compensation as the court determines.

(3) In this section:

acquisition of property has the same meaning as in paragraph 51(xxxi) of the Constitution.

just terms has the same meaning as in paragraph 51(xxxi) of the Constitution.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Chapter 2—Incentives

Part 2-1—Introduction

Division 15—Introduction

15-1 What this Chapter is about

This Chapter contains the following incentives to encourage people to have private health insurance:

(a) reductions in premiums (see Division 23);

(c) lifetime health cover (see Part 2-3).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 2-2—Premiums reduction scheme

Division 20—Introduction

20-1 What this Part is about

To encourage people to take out, and continue to hold, private health insurance, this Part provides that people may reduce the premiums payable for their complying health insurance policies by participating in the premiums reduction scheme in Division 23.

Note: The premiums reduction scheme is complemented by the private health insurance offset provided for by Subdivision 61-G of the *Income Tax Assessment Act 1997*.

20-5 Private Health Insurance (Incentives) Rules

Matters relating to the *premiums reduction scheme are also dealt with in the Private Health Insurance (Incentives) Rules. The provisions of this Part indicate when a particular matter is or might be dealt with in these Rules.

Note: The Private Health Insurance (Incentives) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 22—PHIIB, PHII benefit and related concepts

Subdivision 22-A—PHIIB, PHII benefit and related concepts

22-1 Application of Subdivision

This Subdivision applies if a premium, or an amount in respect of a premium, was paid, or is payable, during a financial year under a *complying health insurance policy in respect of a period (the ***premium period***).

22-5 Meaning of *PHIIB*

Adults insured under policy

(1) Each *adult insured under the *complying health insurance policy throughout the premium period is a ***PHIIB***, in respect of the premium or amount.

Note: ***PHIIB*** is short for ***private health insurance incentive beneficiary***.

Dependent person-only policies

(2) Subsections (3) and (4) apply if the only persons insured under the *complying health insurance policy throughout the premium period are one or more *dependent persons.

(3) Each person who is a parent (within the meaning of Part 2.11 of the *Social Security Act 1991*) in relation to one or more of those *dependent persons on the last day of the financial year mentioned in section 22-1 is a ***PHIIB***, in respect of the premium or amount.

(4) However, the person who pays the premium or amount is the only ***PHIIB***, in respect of the premium or amount, if:

(a) disregarding this subsection, more than one person would be a *PHIIB in respect of the premium or amount because of subsection (3); and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) those persons are not married to each other (within the meaning of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*) at the end of the financial year; and

(c) the person who pays the premium or amount is not a *dependent person.

22-10 Meaning of *PHII benefit*

The amount of the ***PHII benefit***, in respect of the premium or amount, is:

(a) if there is only one *PHIIB in respect of the premium or amount—the PHIIB's *share of the PHII benefit in respect of the premium or amount; or

(b) if there is more than one PHIIB in respect of the premium or amount—the sum of each of those PHIIB's share of the PHII benefit in respect of the premium or amount.

Note: ***PHII benefit*** is short for ***private health insurance incentive benefit***.

22-15 Meaning of *share of the PHII benefit*—single PHIIB

(1) If there is only one *PHIIB in respect of the premium or amount, the amount of the *PHIIB's ***share of the PHII benefit***, in respect of the premium or amount, is the sum of:

(a) 30% of the amount of the premium, or of the amount in respect of a premium, paid or payable in respect of days in the premium period on which no person insured under the policy was aged 65 years or over; and

(b) 35% of the amount of the premium, or of the amount in respect of a premium, paid or payable in respect of days in the premium period on which:

(i) at least one person insured under the policy was aged 65 years or over; and

(ii) no person insured under the policy was aged 70 years or over; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(c) 40% of the amount of the premium, or of the amount in respect of a premium, paid or payable in respect of days in the premium period on which at least one person insured under the policy was aged 70 years or over.

Private health insurance tiers

(2) Reduce the amount of each percentage specified in subsection (1) (as affected by subsection (5A)) by 10 percentage points if the *PHIIB is a *tier 1 earner for the financial year mentioned in section 22-1.

(3) Reduce the amount of each percentage specified in subsection (1) (as affected by subsection (5A)) by 20 percentage points if the *PHIIB is a *tier 2 earner for the financial year mentioned in section 22-1.

(4) Reduce the amount of each percentage specified in subsection (1) (as affected by subsection (5A)) to nil if the *PHIIB is a *tier 3 earner for the financial year mentioned in section 22-1.

(5) For the purposes of applying subsections (2), (3) and (4) in relation to the premium or amount, treat the table in subsection 22-30(1) as applying to the *PHIIB for the financial year if he or she is a PHIIB in respect of the premium or amount because of subsection 22-5(3) or (4).

Note 1: The table in subsection 22-30(1) sets out the private health insurance tiers for families.

Note 2: Subsections 22-5(3) and (4) apply if the only persons insured under the policy are dependent persons.

Annual adjustment of percentages

(5A) For each adjustment year, each percentage specified in subsection (1), (2) or (3) is replaced by the percentage worked out as follows:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) for the adjustment year starting on 1 April 2014—multiply the specified percentage by the adjustment factor for the adjustment year;

(b) for a later adjustment year—multiply the specified percentage, as worked out under this subsection for the preceding adjustment year, by the adjustment factor for the later adjustment year.

(5B) Percentages are to be worked out under subsection (5A) to 3 decimal places (rounding up if the fourth decimal place is 5 or more).

(5C) The percentages worked out under subsection (5A) for an adjustment year apply in relation to premiums, or amounts in respect of premiums, that were paid, or that are payable, at any time in the adjustment year.

(5D) Each of the following is an ***adjustment year***:

(a) the period of 12 months starting on 1 April 2014;

(b) the period of 12 months starting on each later 1 April.

(5E) The ***adjustment factor*** for an adjustment year is to be determined in accordance with the Private Health Insurance (Incentives) Rules. However, if the factor so determined for an adjustment year is more than 1, the ***adjustment factor*** for that year is instead taken to be 1.

Lifetime health cover loading

(6) For the purposes of applying paragraphs (1)(a), (b) and (c), reduce the amount of the premium, or the amount in respect of a premium, by any part of that amount that is attributable to an increase in the premium in accordance with Division 34.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

22-20 Meaning of *share of the PHII benefit*—multiple PHIIBs

If there is more than one *PHIIB in respect of the premium or amount, work out in accordance with section 22-15 the amount of each of those PHIIB's ***share of the PHII benefit***, in respect of the premium or amount, on the following assumptions:

(a) assume that the PHIIB is the only person who is a PHIIB in respect of the premium or amount;

(b) assume that the premium or amount is the amount of the premium (or the amount in respect of the premium) divided by the number of persons who are PHIIBs in respect of the premium or amount.

22-25 Application of subsection 22-15(1) after a person 65 years or over ceases to be covered by policy

(1) If:

(a) the *PHIIB mentioned in subsection 22-15(1) was insured under a *complying health insurance policy (the ***original policy***) (whether or not the policy mentioned in section 22-1) at a time before the start of the premium period mentioned in that section; and

(b) the PHIIB was not a *dependent person at that time; and

(c) at that time, another person (the ***entitling person***) was:

(i) insured under the original policy; and

(ii) aged 65 years or over; and

(d) the entitling person subsequently ceased to be insured under the original policy;

subsection 22-15(1) applies in relation to the complying health insurance policy mentioned in section 22-1 as if:

(e) the entitling person were also insured under that policy; and

(f) the entitling person were the same age as the age at which he or she ceased to be insured under the original policy.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2) Subsection (1) ceases to apply if a person (other than a *dependent person) who was not insured under the original policy at the time the entitling person ceased to be insured under it becomes insured under the *complying health insurance policy mentioned in section 22-1.

(3) Subsection (1) does not apply if its application would result in the *PHIIB's *share of the PHII benefit being less than it would otherwise have been.

Subdivision 22-B—Private health insurance tiers

22-30 Private health insurance tiers

Families

(1) The following table applies to a person (the ***first person***) for a financial year if:

(a) on the last day of the financial year, the person is married (within the meaning of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*); or

(b) on any day in the financial year, the person contributes in a substantial way to the maintenance of a *dependent person who is:

(i) the person's child (within the meaning of the *Income Tax Assessment Act 1997*); or

(ii) the person's sibling (including the person's half-brother, half-sister, adoptive brother, adoptive sister, step-brother, step-sister, foster-brother or foster-sister) who is dependent on the person for economic support:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Private health insurance tiers—families			
Item	**Column 1** **For the financial year, the person is a ...**	**Column 2** **if his or her income for surcharge purposes for the financial year exceeds the following for the financial year …**	**Column 3** **but does not exceed the following (if applicable) for the financial year …**
1	***tier 1 earner***	his or her *family tier 1 threshold	his or her *family tier 2 threshold.
2	***tier 2 earner***	his or her *family tier 2 threshold	his or her *family tier 3 threshold.
3	***tier 3 earner***	his or her *family tier 3 threshold	not applicable.

(2) For the purposes of subsection (1), if paragraph (1)(a) applies, treat the *income for surcharge purposes for the financial year of the person to whom the first person is married (as mentioned in that paragraph) as included in the first person's income for surcharge purposes for the financial year.

(3) Subdivision 960-J of the *Income Tax Assessment Act 1997* (Family relationships) applies to subparagraphs (1)(b)(i) and (ii) of this section in the same way as it applies to that Act.

Singles

(4) The following table applies to a person for a financial year if the table in subsection (1) does not apply to the person for the financial year:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Private health insurance tiers—singles			
Item	**Column 1** **For the financial year, the person is a ...**	**Column 2** **if his or her income for surcharge purposes for the financial year exceeds the following for the financial year …**	**Column 3** **but does not exceed the following (if applicable) for the financial year …**
1	***tier 1 earner***	his or her *singles tier 1 threshold	his or her *singles tier 2 threshold.
2	***tier 2 earner***	his or her *singles tier 2 threshold	his or her *singles tier 3 threshold.
3	***tier 3 earner***	his or her *singles tier 3 threshold	not applicable.

22-35 Private health insurance singles thresholds

(1) A person's ***singles tier 1 threshold*** for the 2021-22 and 2022-23 financial year is $90,000. This amount is indexed for later financial years under section 22-45.

(2) A person's ***singles tier 2 threshold*** for the 2021-22 and 2022-23 financial year is $105,000. This amount is indexed for later financial years under section 22-45.

(3) A person's ***singles tier 3 threshold*** for the 2021-22 and 2022-23 financial year is $140,000. This amount is indexed for later financial years under section 22-45.

Note: A person may be a tier 1 earner, tier 2 earner or tier 3 earner if the person's income for surcharge purposes exceeds the applicable threshold for that tier: see section 22-30.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

22-40 Private health insurance family thresholds

(1) A person's ***family tier 1 threshold*** for a financial year is an amount equal to double his or her *singles tier 1 threshold for the financial year.

(2) A person's ***family tier 2 threshold*** for a financial year is an amount equal to double his or her *singles tier 2 threshold for the financial year.

(3) A person's ***family tier 3 threshold*** for a financial year is an amount equal to double his or her *singles tier 3 threshold for the financial year.

(4) However, if the person has 2 or more dependants (within the meaning of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*) who are children, increase his or her ***family tier 1 threshold***, ***family tier 2 threshold*** and ***family tier 3 threshold*** for the financial year by the result of the following formula:

$$\$1{,}500 \times \left(\text{Number of those dependants who are children} - 1 \right)$$

Example: If the person has 3 such dependants who are children, the person's family tier 2 threshold for the 2021-22 and 2022-23 financial year is:

$$\$210{,}000 + (\$1{,}500 \times 2) = \$213{,}000$$

Note: A person may be a tier 1 earner, tier 2 earner or tier 3 earner if his or her income for surcharge purposes exceeds the applicable threshold for that tier: see section 22-30.

22-45 Indexation

(1) An amount mentioned in section 22-35 is indexed for the 2023-24 financial year, and later financial years, in accordance with this section.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Indexing amounts

(2) Index the amount by:

(a) firstly, multiplying the amount by the *indexation factor for the financial year under subsection (4); and

(b) next, rounding the result in paragraph (a) down to the nearest multiple of $1,000.

Example 1: If the amount to be indexed is $105,000 and the indexation factor increases this to an indexed amount of $107,500, the indexed amount is rounded back down to $107,000.

Example 2: If the amount to be indexed is $140,000 and the indexation factor increases this to an indexed amount of $142,500, the indexed amount is rounded down to $142,000.

(3) However, do not index the amount for a financial year if the amount worked out under subsection (2) for the financial year is less than the amount applicable under section 22-35 or this section for the previous financial year.

(3A) If the amount is not indexed for a financial year because of subsection (3), the amount for the financial year is the same as the amount for the previous financial year.

(4) For the purposes of this section, the ***indexation factor*** for a financial year is:

$$\frac{\text{*Index number mentioned in subsection (7) for the *quarter ending on 31 December just before the start of the relevant financial year}}{\text{*Index number mentioned in subsection (7) for the *quarter ending on 31 December 2021}}$$

(6) Work out the *indexation factor to 3 decimal places (rounding up if the fourth decimal place is 5 or more).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Index number

(7) For calculating the amounts, the ***index number*** for a *quarter is the estimate of full-time adult average weekly ordinary time earnings for the middle month of the quarter first published by the Australian Statistician in respect of that month.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 23—Premiums reduction scheme

Subdivision 23-A—Amount of reduction

23-1 Reduction in premiums

(1) The amount of premiums payable under a *complying health insurance policy in respect of a period is reduced in accordance with this section if a person is a *participant in the *premiums reduction scheme in respect of the policy.

(2) The amount of the reduction for each premium is the *PHII benefit in respect of the premium.

Subdivision 23-B—Participation in the premiums reduction scheme

23-15 Application to register as a participant in the premiums reduction scheme

(1) A person may apply to a private health insurer, in the *approved form, to become a *participant in the *premiums reduction scheme in respect of a *complying health insurance policy issued by the insurer if:

(a) the insurer is a *participating insurer; and

(b) the person is a *PHIIB in respect of a premium paid or payable under the policy; and

(c) the person meets any requirements specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph.

(2) A private health insurer that receives an application under subsection (1) must notify the Chief Executive Medicare of the application no more than 7 business days (or any other period

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

determined by the Chief Executive Medicare under subsection (4)) after receiving the application.

(3) A notice under subsection (2) must:
  (a) be given electronically in accordance with the electronic system approved by the Chief Executive Medicare under section 333-16 for the purposes of this paragraph; and
  (b) include the information required by that system to be included in the notice; and
  (c) be accompanied by any documents required by that system to accompany the notice.

(4) The Chief Executive Medicare may, by legislative instrument, determine a different period for the purposes of subsection (2).

23-16 Registration of participants

(1) If a private health insurer notifies the Chief Executive Medicare of an application made under subsection 23-15(1) in respect of a *complying health insurance policy issued by the insurer, the Chief Executive Medicare must register the applicant as a *participant in respect of the policy if:
  (a) the notice complies with subsection 23-15(3); and
  (b) the criteria (if any) specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph are met in relation to the application.

Note: A decision under this subsection is able to be automated by a computer program: see section 333-17.

Notification of proposed refusal

(2) If the Chief Executive Medicare proposes to refuse to register the applicant as a *participant in respect of the policy, the Chief Executive Medicare must:
  (a) notify the private health insurer of the proposed refusal and the reasons for the proposed refusal; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) give the private health insurer an opportunity to amend and resubmit the notice given to the Chief Executive Medicare in relation to the application before the end of the period that applies in relation to section 23-20.

Notification of registration

(3) If the Chief Executive Medicare registers the applicant as a *participant in the *premiums reduction scheme in respect of the policy, the Chief Executive Medicare must notify the private health insurer of the decision.

23-20 Refusal to register

The Chief Executive Medicare is taken to have refused to register an applicant as a *participant in the *premiums reduction scheme in respect of a *complying health insurance policy if the Chief Executive Medicare has not registered the applicant as a participant within:

(a) the period of 30 days commencing on the day the Chief Executive Medicare is notified of the application under subsection 23-15(2); or

(b) if another period is specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph—that specified period.

23-30 Participants who want to withdraw from scheme

(1) A *participant must notify (the ***withdrawal notice***) the private health insurer that issued the policy in respect of which a person is a participant if the person no longer wishes to be registered in respect of the policy.

(2) A private health insurer must notify the Chief Executive Medicare of each withdrawal notice that the insurer receives under subsection (1).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2A) A notice given by the private health insurer under subsection (2) must:

(a) be given no more than 7 business days (or any other period determined by the Chief Executive Medicare under subsection (4)) after the withdrawal notice is received by the private health insurer; and

(b) be given electronically in accordance with the electronic system approved by the Chief Executive Medicare under section 333-16 for the purposes of this paragraph; and

(c) include the information required by that system to be included in the notice; and

(d) be accompanied by any documents required by that system to accompany the notice.

(3) If notified under subsection (2), the Chief Executive Medicare must revoke the person's registration in respect of the policy.

Note: A revocation under this subsection is able to be automated by a computer program: see section 333-17.

(4) The Chief Executive Medicare may, by legislative instrument, determine a different period for the purposes of paragraph (2A)(a).

23-35 Revocation of registration

(1) The Chief Executive Medicare must revoke a person's registration in respect of a *complying health insurance policy if the Chief Executive Medicare is satisfied that the person is not eligible to participate in the *premiums reduction scheme in respect of the policy.

Note: Revocations of registration are reviewable under section Part 6-9.

(2) Revocation of registration under subsection (1) does not affect a person's right to make another application for registration under section 23-15.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) The Chief Executive Medicare must give notice of the revocation of a person's registration in respect of a *complying health insurance policy to the person, and to the private health insurer that issued the policy, within 28 days after the day on which the revocation occurs.

23-40 Variation of registration

(1) A private health insurer must notify the Chief Executive Medicare if the treatments *covered by a *complying health insurance policy, issued by the private health insurer and in respect of which a person is a *participant, are varied.

(2) On receiving such a notice, the Chief Executive Medicare must vary the details of the registration accordingly and give notice of the variation to the private health insurer.

Note: A variation under this subsection is able to be automated by a computer program: see section 333-17.

23-45 Retention of applications by private health insurers

(1) A private health insurer must retain an application made to it under subsection 23-15(1) for the period of 5 years beginning on the day on which the application was made.

(2) The private health insurer may retain the application in any form approved in writing by the Chief Executive Medicare.

(3) An application retained in such a form must be received in all courts or tribunals as evidence as if it were the original.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 2-3—Lifetime health cover

Division 31—Introduction

31-1 What this Part is about

People are encouraged to take out hospital cover by the time they turn 30. A person who is older than 30 when he or she takes out hospital cover for the first time, or who drops hospital cover for a period after having turned 30, may have to pay higher premiums for hospital cover. This scheme is known as lifetime health cover.

31-5 Private Health Insurance (Lifetime Health Cover) Rules

Matters relating to lifetime health cover are also dealt with in the Private Health Insurance (Lifetime Health Cover) Rules. The provisions of this Part indicate when a particular matter is or might be dealt with in these Rules.

Note: The Private Health Insurance (Lifetime Health Cover) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 34—General rules about lifetime health cover

34-1 Increased premiums for person who is late in taking out hospital cover

(1) A private health insurer must increase the amount of premiums payable for *hospital cover in respect of an *adult if the adult did not have hospital cover on his or her *lifetime health cover base day.

(2) The amount of the increase is worked out as follows:

$$\left(\text{Lifetime health cover age} - 30\right) \times 2\% \times \text{*Base rate}$$

where:

base rate, for *hospital cover, is the amount of premiums that would be payable for the cover if:

(a) the premiums were not increased under this Part; and

(b) there was no discount of the kind allowed under subsection 66-5(2).

lifetime health cover age, in relation to an *adult who takes out *hospital cover after his or her *lifetime health cover base day, means the adult's age on the 1 July before the day on which the adult took out the hospital cover.

34-5 Increased premiums for person who ceases to have hospital cover after his or her lifetime health cover base day

(1) A private health insurer must increase the amount of premiums payable for *hospital cover in respect of an *adult if, after the adult's *lifetime health cover base day, the adult ceases to have hospital cover.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2) The amount of the increase is worked out as follows:

Years without hospital cover × 2% × *Base rate

where:

base rate is the *base rate for the *hospital cover.

years without hospital cover is the number obtained by:

(a) dividing by 365 the number of days (other than *permitted days without hospital cover), after the first day on which subsection (1) applied to the *adult, on which he or she did not have *hospital cover; and

(b) rounding up the result to the nearest whole number.

(3) Any increase under this section in the amount of premiums payable for *hospital cover is in addition to any increase under section 34-1 in the amount of premiums payable for that hospital cover.

34-10 Increased premiums stop after 10 years' continuous cover

(1) A private health insurer must stop increasing the amount of premiums payable for *hospital cover in respect of an *adult under this Part if the adult has had hospital cover (including under an *applicable benefits arrangement), the premiums for which have been increased under this Part or *old Schedule 2:

(a) for a continuous period of 10 years; or

(b) for a period of 10 years that has been interrupted only by *permitted days without hospital cover or periods during which the adult was taken to have had hospital cover otherwise than because of paragraph 34-15(2)(a) (none of which count towards the 10 years).

(2) The amount must stop being increased on the day after the last day of the 10 year period.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) The amount of premiums payable for *hospital cover in respect of the *adult must start to be increased under this Part again if:

(a) after the end of the 10 year period, the adult ceases to have hospital cover; and

(b) the adult later takes out hospital cover again; and

(c) the days in the period between ceasing to have the cover and taking it out again are not all *permitted days without hospital cover in respect of the adult.

(4) Subsection (3) does not prevent this section applying again in respect of any later 10 year period.

(5) In subsection (1):

old Schedule 2 means Schedule 2 to the *National Health Act 1953* as in force before 1 April 2007.

34-15 Meaning of *hospital cover*

(1) ***Hospital cover*** is so much of a *complying health insurance policy as *covers *hospital treatment. An *adult has hospital cover if he or she is insured under a complying health insurance policy that covers hospital treatment.

(2) An *adult is taken to have *hospital cover:

(a) at any time during which the adult was covered by an *applicable benefits arrangement; or

(b) at any time during which the adult holds a *gold card; or

(c) at any time during which the adult is in a class of adults specified in the Private Health Insurance (Lifetime Health Cover) Rules for the purposes of this paragraph.

(3) In this section:

gold card means a card that evidences a person's entitlement to be provided with treatment:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) in accordance with the Treatment Principles prepared under section 90 of the *Veterans' Entitlements Act 1986*; or

(b) in accordance with a determination made under section 286 of the *Military Rehabilitation and Compensation Act 2004* in respect of the provision of treatment.

34-20 Meaning of *permitted days without hospital cover*

(1) Any of the following days that occur after an *adult ceases, for the first time after his or her *lifetime health cover base day, to have *hospital cover are ***permitted days without hospital cover*** in respect of that adult:

(a) days on which the cover was suspended by the private health insurer in accordance with the rules for suspensions set out in the Private Health Insurance (Lifetime Health Cover) Rules;

(b) days (not counting days covered by paragraph (a)) on which the adult is *overseas that form part of a continuous period overseas of more than one year;

(c) the first 1,094 days (not counting days covered by paragraph (a) or (b)) on which the adult did not have hospital cover.

(2) The Private Health Insurance (Lifetime Health Cover) Rules may specify days that, despite subsection (1), are taken not to be *permitted days without hospital cover.

34-25 Meaning of *lifetime health cover base day*

General rule: 1 July after person turns 31

(1) Subject to subsections (2), (3), (4) and (4A), a person's ***lifetime health cover base day*** is the 1 July after the person turns 31.

Note: See also section 37-5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Person who had lifetime health cover base day on or before 30 June 2010

(2) If a person had a lifetime health cover base day on or before 30 June 2010, that lifetime health cover base day remains the person's ***lifetime health cover base day***.

Person who is not an Australian citizen and is not covered by subsection (2)

(3) Subject to subsection (4), the ***lifetime health cover base day*** of a person who is not an Australian citizen on the person's *medicare eligibility day and is not covered by subsection (2) is the later of:

(a) the 1 July after the person turns 31; and

(b) the first anniversary of the person's medicare eligibility day.

Note: See also section 37-5.

Person overseas on day worked out under subsection (1) or (3)

(4) However, if the person is *overseas on the day worked out under subsection (1) or (3), the person's ***lifetime health cover base day*** is the first anniversary of:

(a) the person's first return to Australia from overseas; or

(b) the person's first entry to Australia;

after the day worked out under subsection (1) or (3), whichever is applicable.

Person living on Norfolk Island at the final transition time

(4A) If:

(a) a person was living on Norfolk Island at the final transition time (within the meaning of the *Norfolk Island Act 1979*); and

(b) the person had turned 31 before that time;

the person's lifetime health cover base day is the first day after the end of the 12-month period that began at that time.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4B) If:

(a) a person is living on Norfolk Island at the final transition time (within the meaning of the *Norfolk Island Act 1979*); and

(b) the person turns 31 at or after that time;

the person's lifetime health cover base day is whichever is the later of the following:

(c) the 1 July after the person turns 31;

(d) the first day after the 12-month period that began at that time.

Medicare eligibility day

(5) A person's ***medicare eligibility day*** is the day on which the person is registered by the Chief Executive Medicare as an eligible person within the meaning of section 3 of the *Health Insurance Act 1973*.

34-30 When a person is overseas or enters Australia

(1) Without limiting when a person is taken to be *overseas for the purposes of this Part:

(a) a person who lived on Norfolk Island before the final transition time (within the meaning of the *Norfolk Island Act 1979*) is taken, while the person was living on Norfolk Island before that time, to have been overseas; and

(b) any period in which a person returns to Australia for less than 90 days counts as part of a continuous period overseas.

(2) For the purposes of this Part, a person is taken not to have returned to Australia from *overseas, or entered Australia, if the person returns to Australia, or enters Australia, but remains in Australia for a period of less than 90 days.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 37—Exceptions to the general rules about lifetime health cover

37-1 People born on or before 1 July 1934

(1) The amount of premiums payable for *hospital cover in respect of an *adult does not increase under this Part if the adult was born on or before 1 July 1934.

(2) However, this section does not prevent section 37-20 applying to the *hospital cover in respect of any *adults who were born after 1 July 1934.

37-5 People over 31 and overseas on 1 July 2000

A person:

(a) who turned 31 on or before 1 July 2000; and

(aa) who:

(i) was an Australian citizen on 1 July 2000; or

(ii) was an Australian resident (within the meaning of section 3 of the *Health Insurance Act 1973*) on 1 July 2000; or

(iii) had a lifetime health cover base day on or before 30 June 2010; and

(b) who was *overseas on 1 July 2000;

is taken, for the purposes of section 34-1, to have had *hospital cover on the person's *lifetime health cover base day.

37-7 Person yet to turn 31

If the 1 July after a person turns 31 has not arrived, lifetime health cover does not yet apply to the person.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

37-10 Hardship cases

A person is treated for the purposes of this Part as if he or she had *hospital cover on 1 July 2000 if a determination under clause 10 of Schedule 2 to the *National Health Act 1953* (as in force immediately before 1 April 2007) had effect in relation to the person immediately before 1 April 2007.

37-15 Increases cannot exceed 70% of base rates

The maximum amount of any increase under this Part in the amount of premiums payable for *hospital cover in respect of an *adult is an amount equal to 70% of the *base rate for the hospital cover.

37-20 Joint hospital cover

(1) If:

(a) more than one *adult is covered under the same *hospital cover; and

(b) the amount of premiums payable for the cover in respect of at least one of those adults is increased under this Part;

the amount of the premiums payable for the cover in respect of all of the adults is increased.

(2) The amount of the increase in the premiums payable for the cover is worked out by:

(a) dividing the *base rate for the cover by the number of *adults it covers; and

(b) using that rate to work out for each adult what the amount of the increase for that adult (if any) would be; and

(c) adding together the results of paragraph (b).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 40—Administrative matters relating to lifetime health cover

40-1 Notification to insured people etc.

(1) A private health insurer must comply with any requirements specified in the Private Health Insurance (Lifetime Health Cover) Rules relating to providing information to:

(a) *adults in respect of *hospital cover with the private health insurer; and

(b) other adults who apply for, or inquire about, that hospital cover;

about increases under this Part in the amounts of premiums payable for hospital cover in respect of those adults.

(2) A private health insurer must comply with any requirements specified in the Private Health Insurance (Lifetime Health Cover) Rules relating to providing information to other private health insurers about increases under this Part in the amounts of premiums payable for *hospital cover with the private health insurer.

(3) The Private Health Insurance (Lifetime Health Cover) Rules may require or permit a private health insurer to provide information of a kind referred to in this section in the form of an age notionally attributed, to an *adult or other person, as the age from which the adult or other person will be treated as having had continuous *hospital cover.

(4) A private health insurer must keep separate records in relation to each *adult who has *hospital cover.

(5) When an *adult ceases to be *covered by *hospital cover under which more than one adult was covered, the private health insurer

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

must notify each other adult that the adult has ceased to be covered by the cover.

40-5 Evidence of having had hospital cover, or of a person's age

A private health insurer must comply with any requirements specified in the Private Health Insurance (Lifetime Health Cover) Rules relating to whether, and in what circumstances, particular kinds of evidence are to be accepted, for the purposes of this Part, as conclusive evidence of:

(a) whether a person had *hospital cover at a particular time, or during a particular period; or

(b) a person's age.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 2-4—Excess levels for medicare levy and medicare levy surcharge purposes

Division 42—Introduction

42-1 What this Part is about

This Part sets out the excess levels for complying health insurance products that relate to whether a person is liable to pay medicare levy or medicare levy surcharge.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 45—Excess levels for medicare levy and medicare levy surcharge purposes

45-1 Excess level amounts

For the purposes of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and the *Medicare Levy Act 1986*, any excess payable in respect of benefits under a *complying health insurance policy that provides *hospital cover must not be more than:

(a) $750 in any 12 month period, in relation to a policy under which only one person is insured; and

(b) $1,500 in any 12 month period, in relation to any other policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Chapter 3—Complying health insurance products

Part 3-1—Introduction

Division 50—Introduction

50-1 What this Chapter is about

Broadly, health insurance that is made available to the public must meet the requirements in this Chapter. This means that:

(a) the insurance must be community-rated (that is, made available in a way that does not discriminate between people) (see Part 3-2); and

(b) the insurance must be in the form of a complying health insurance product (see Part 3-3); and

(c) the private health insurers who make the products available must meet certain obligations to people insured or seeking to be insured under the products (see Part 3-4).

50-5 Private Health Insurance Rules relevant to this Chapter

Matters relating to *complying health insurance products are also dealt with in the Private Health Insurance (Complying Product) Rules, the Private Health Insurance (Benefit Requirements) Rules, the Private Health Insurance (Medical Devices and Human Tissue Products) Rules and the Private Health Insurance (Accreditation) Rules. The provisions of this Chapter indicate when a particular matter is or may be dealt with in these Rules.

Note: These Rules are all made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 3-2—Community rating

Division 55—Principle of community rating

55-1 What this Part is about

To ensure that everybody who chooses has access to health insurance, the principle of community rating prevents private health insurers from discriminating between people on the basis of their health or for any other reason described in this Part.

55-5 Principle of community rating

(1) A private health insurer must not:

(a) take or fail to take any action; or

(b) in making a decision, have regard or fail to have regard to any matter;

that would result in the insurer *improperly discriminating between people who are or wish to be insured under a *complying health insurance policy of the insurer.

(2) ***Improper discrimination*** is discrimination that relates to:

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

(b) the gender, race, sexual orientation or religious belief of a person; or

(c) the age of a person, except to the extent allowed under:

(i) Part 2-3 (lifetime health cover); or

(ii) subsection 63-5(4); or

(iii) section 66-5, because of the reason mentioned in paragraph 66-5(3)(ea); or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(d) where a person lives, except to the extent allowed under subsection 66-8(3) or 66-10(3) or section 66-20 or 66-25; or

(e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for *hospital treatment or *general treatment; or

(f) the frequency with which a person needs hospital treatment or general treatment; or

(g) the amount or extent of the benefits to which a person becomes entitled during a period under a *complying health insurance policy, except to the extent allowed under section 66-15; or

(h) any matter set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

(3) Despite subsection (2), discrimination by a *restricted access insurer is not improper discrimination to the extent to which the insurer:

(a) takes or fails to take an action; or

(b) in making a decision, has regard or fails to have regard to a matter;

only to ensure that its *complying health insurance products are not made available to persons to whom its constitution or *rules prohibits it from making the products available.

(4) Despite subsection (2), discrimination by a private health insurer is not improper discrimination to the extent to which:

(a) the insurer:

(i) takes or fails to take an action; or

(ii) in making a decision, has regard or fails to have regard to a matter; and

(b) taking or failing to take the action, or having regard or failing to have regard to that matter, has the effect of the premiums

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

payable under an insurance policy that covers a person who is:

(i) employed by a particular person or body; or

(ii) under contract to provide services to a particular person or body;

being the subject of a discount or discounts (whether or not the policy also covers one or more persons who are not so employed and are not under such a contract); and

(c) the premiums meet the premium requirement in section 66-5.

(5) To avoid doubt, subsection (4) does not apply if taking or failing to take the action, or having regard or failing to have regard to that matter, has the effect of an insurance policy being cancelled because a person ceases to be an employee of, or ceases to be under contract to provide services to, a particular employer.

55-10 Closed products, and terminated products and product subgroups

The principle of community rating in section 55-5 does not:

(a) prevent a private health insurer from closing a *complying health insurance product, such that the *product will not be available to anyone except those persons, who at the time of closing, are insured under a policy forming part of the product; or

(b) prevent a private health insurer from terminating a complying health insurance product or a *product subgroup of a complying health insurance product, such that:

(i) in the case of a product—the product will not be available to any person insured under a policy forming part of the product; and

(ii) in the case of a product subgroup—the product subgroup will not be available to any person insured under a policy that belongs to the product subgroup.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

55-15 Pilot projects

(1) The principle of community rating in section 55-5 does not prevent a private health insurer from:

(a) taking or failing to take any action; or

(b) in making a decision, having regard or failing to have regard to any matter;

for the purposes of conducting a pilot project in accordance with the Private Health Insurance (Complying Product) Rules.

(2) The Private Health Insurance (Complying Product) Rules may permit pilot projects of a kind specified in the Rules to be conducted by private health insurers in accordance with requirements specified in the Rules.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 3-3—Requirements for complying health insurance products

Division 60—Introduction

60-1 What this Part is about

Complying health insurance products (which are made up of complying health insurance policies) are the only kind of insurance that private health insurers are allowed to make available as part of their health insurance business (see section 63-1 and Division 84). This Part sets out the requirements that an insurance policy must meet in order to be a complying health insurance policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 63—Basic rules about complying health insurance products

63-1 Obligation to ensure products are complying products

(1) A private health insurer must ensure that the only kind of insurance that it makes available as part of its *health insurance business is insurance in the form of *complying health insurance products.

(2) However, subsection (1) does not apply in relation to *health insurance business of a kind that the Private Health Insurance (Complying Product) Rules specify is excluded from subsection (1).

63-5 Meaning of *complying health insurance product*

(1) A ***complying health insurance product*** is a *product made up of *complying health insurance policies.

(2) A ***product*** is all the insurance policies issued by a private health insurer:
  (a) that *cover the same treatments; and
  (b) that provide benefits that are worked out in the same way; and
  (c) whose other terms and conditions are the same as each other.

(2A) A ***product subgroup***, of a *product, is all the insurance policies in the product:
  (a) under which the addresses of the people insured, as known to the private health insurer, are located in the same *risk equalisation jurisdiction; and
  (b) under which the same kind of insured group (within the meaning of the Private Health Insurance (Complying Product) Rules) is insured.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2B) The Private Health Insurance (Complying Product) Rules may specify insured groups for the purposes of paragraph (2A)(b). An insured group may be specified by reference to any or all of the number of people in the group, the kind of people in the group, or any other matter. A group may consist of only one person.

(3) Different premiums may be payable under policies in the same *product.

(4) A premium payable for a policy that covers an insured group of 2 or more people that includes a *dependent non-student or *dependent person with a disability may be higher than a premium payable for a policy in the same *product that covers an insured group of 2 or more people that includes one or more *dependent children or *dependent students but no dependent non-student or dependent person with a disability.

63-10 Meaning of *complying health insurance policy*

A ***complying health insurance policy*** is an insurance policy that meets:

(a) the community rating requirements in Division 66; and
(b) the coverage requirements in Division 69; and
(c) if the policy *covers *hospital treatment—the benefit requirements in Division 72; and
(d) the waiting period requirements in Division 75; and
(e) the portability requirements in Division 78; and
(f) the quality assurance requirements in Division 81; and
(g) any requirements set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 66—Community rating requirements

66-1 Community rating requirements

An insurance policy meets the community rating requirements in this Division if:

(a) the policy prohibits the private health insurer that issued the policy from breaching the principle of community rating in section 55-5 in relation to a person insured under the policy; and

(b) the policy has no terms or conditions that would allow the insurer to *improperly discriminate against a person insured under the policy; and

(c) the only discounts (if any) available under the policy are discounts allowed under subsection 66-5(2); and

(d) the premiums payable under the policy meet the premium requirement in section 66-5.

66-5 Premium requirement

(1) For the purposes of paragraph 66-1(d), the premiums payable under an insurance policy for a period meet the premium requirement in this section if there is an approval in effect under section 66-8 or 66-10 for the *product subgroup of the *product to which the policy belongs, and the amount of premiums payable under the policy for the period:

(a) is the amount specified in the approval for the product subgroup to which the policy belongs; or

(b) is the proportion, for the period, of that amount; or

(c) would be the amount mentioned in paragraph (a) or (b) except that a different amount is payable:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(i) because of the application of Part 2-3 (lifetime health cover); or

(ii) because of a discount or discounts allowed under subsection (2), if the total percentage discount (not counting discounts available for the reason in paragraph (3)(f)) does not exceed the percentage specified in the Private Health Insurance (Complying Product) Rules as the maximum percentage discount allowed; or

(iii) because of a combination of subparagraphs (i) and (ii).

(2) A discount is allowed if:

(a) it is for a reason in subsection (3); and

(b) the discount is also available for that reason under every policy in the *product; and

(c) if there are different percentage discounts available for that reason—the same percentage discount is available on the same basis under every policy in the product; and

(d) any other conditions set out in the Private Health Insurance (Complying Product) Rules are met.

(3) A discount may be for any of these reasons:

(a) because premiums are paid at least 3 months in advance;

(b) because premiums are paid by payroll deduction;

(c) because premiums are paid by pre-arranged automatic transfer from an account at a bank or other financial institution;

(d) because the persons insured under the policy have agreed to communicate with the private health insurer, and make claims under the policy, by electronic means;

(e) because a person insured under the policy is, under the *rules of the private health insurer, treated as belonging to a contribution group;

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(ea) because a person insured under the policy is entitled to an age-based discount in the circumstances set out in the Private Health Insurance (Complying Product) Rules;

(f) because the insurer is not required to pay a levy in relation to the policy under a law of a State or Territory;

(g) for a reason set out in the Private Health Insurance (Complying Product) Rules.

66-6 Meaning of approved application period

(1) The ***approved application period*** for an application under section 66-8 or 66-10 is:

(a) if the Minister has not determined a period for a year under subsection (2)—the period of 55 days beginning on the third Friday in September of that year; or

(b) if the Minister has determined one or more periods for a year under subsection (2)—that period or those periods.

(2) For the purposes of paragraph (1)(b), the Minister may, by legislative instrument, determine a period that is an approved application period.

(2A) Without limiting subsection 33(3A) of the *Acts Interpretation Act 1901*, a determination under subsection (2) of this section may be expressed to apply in relation to a specified class of application. Such a determination does not affect the operation of paragraph (1)(a) of this section in relation to other classes of application.

(3) Section 42 (disallowance) of the *Legislation Act 2003* does not apply to a legislative instrument made under subsection (2).

66-7 Meaning of *designated change*

(1) A ***designated change*** to a *complying health insurance product is any of the following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) subject to subsection (2), a change that results in a reduction in, or removal of, a treatment covered by the product;

(b) a change:

(i) that results, or might result, in a benefit under the product being reduced; and

(ii) that is of a kind specified in the Private Health Insurance (Product Premium) Rules for the purposes of this subparagraph;

(c) a change:

(i) to any other term or condition of the product that results, or might result, in the value to persons insured under a policy that belongs to the product being reduced; and

(ii) that is of a kind specified in the Private Health Insurance (Product Premium) Rules for the purposes of this subparagraph.

(2) The Private Health Insurance (Product Premium) Rules may provide that paragraph (1)(a) does not apply in relation to a change of a kind specified in those Rules for the purposes of this subsection.

66-8 Minister's approval of premiums charged under new product subgroups

Application for approval of premiums charged under new product subgroups

(1) A private health insurer that proposes to make one or more *product subgroups of a *product available must, before the insurer first begins to make the product subgroups available, apply to the Minister for approval of the proposed premiums to be charged under the product subgroups.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Requirements for application

(2) The application must:
  (a) be in the *approved form; and
  (b) be accompanied by the fee (if any) specified in the Private Health Insurance (Product Premium) Rules.

Note: The Private Health Insurance (Product Premium) Rules are made by the Minister under section 333-20.

(3) The application may propose different premiums for policies in a *product, but the proposed premiums must be the same for each policy in the product that belongs to the same *product subgroup.

Minister must make decision on application

(4) The Minister must, by written notice to the insurer, either approve or refuse to approve the proposed premiums.

Minister's decision—applications made within approved application period

(5) If the application is made within an *approved application period, the Minister must approve the proposed premiums, unless the Minister is satisfied that approving the proposed premiums would be contrary to the public interest.

Minister's decision—applications made outside approved application period

(6) If the application is not made within an *approved application period, the Minister must:
  (a) approve the proposed premiums if, and only if, the Minister is satisfied that approving the proposed premiums is in the public interest; or
  (b) otherwise, refuse to approve the proposed premiums.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Matters relating to the approval of premiums

(7) If the Minister approves the proposed premiums, the approval has effect, in relation to a *product subgroup to which the application relates, from the day specified in the approval until the earlier of the following:

(a) the day when an approval for the *product subgroup under section 66-10 takes effect;

(b) if the insurer makes a *designated change to the product without an approval under section 66-10 being in effect in relation to the change—the time when the insurer makes the designated change.

(8) The day specified in the approval as the day from which the approval has effect must be a day that is after the day on which the Minister approves the proposed premiums.

Tabling of reasons for refusal to approve premiums

(9) If the Minister refuses to approve the proposed premiums, the Minister must table the Minister's reasons for refusal in each House of the Parliament no later than 15 sitting days of that House after the refusal.

Other matters

(10) A notice under subsection (4) is not a legislative instrument.

(11) A fee specified for the purposes of paragraph (2)(b):

(a) must not amount to taxation; and

(b) must not exceed the amount the Minister estimates to be the reasonable costs of processing an application made under subsection (1).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Delegation

(12) If the Minister delegates the Minister's powers under this section to a delegate:

(a) the delegate may approve the proposed premiums in accordance with this section; or

(b) if the delegate considers that the proposed premiums should not be approved, the delegate:

(i) must not make a final decision refusing to approve the proposed premiums; and

(ii) must refer the application to the Minister for the Minister's consideration.

Note: For delegation by the Minister, see subsection 333-1(1).

66-10 Minister's approval if certain changes are made to premiums or products

Application for approval of changes

(1) A private health insurer must apply to the Minister for approval of:

(a) the premiums to be charged under one or more *product subgroups of a *complying health insurance product, if the insurer proposes to change the premiums to be charged under the product subgroups; or

(b) the premiums to be charged under each product subgroup of a complying health insurance product, if the insurer proposes to make a *designated change to the *product (whether or not the insurer proposes to change the premiums when the designated change is made).

Requirements for application

(2) The application must:

(a) be in the *approved form; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) be accompanied by the fee (if any) specified in the Private Health Insurance (Product Premium) Rules.

Note: The Private Health Insurance (Product Premium) Rules are made by the Minister under section 333-20.

(3) The application may propose different premiums for policies in a *product, but the proposed premiums must be the same for each policy in the product that belongs to the same *product subgroup.

Minister must make decision on application

(4) The Minister must, by written notice to the insurer, either approve or refuse to approve the proposed premiums.

Minister's decision—applications made within approved application period

(5) If the application is made within an *approved application period, the Minister must approve the proposed premiums, unless:

(a) the insurer proposes to increase the premiums to be charged under one or more *product subgroups, or proposes to make a *designated change to the *product, or both; and

(b) the Minister is satisfied that approving the proposed premiums would be contrary to the public interest.

Minister's decision—applications made outside approved application period

(6) If the application is not made within an *approved application period, the Minister must:

(a) approve the proposed premiums if, and only if, either:

(i) the insurer does not propose to increase the premiums to be charged under any *product subgroups, and does not propose to make a *designated change to the *product; or

(ii) the insurer proposes to increase the premiums to be charged under one or more product subgroups, or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

proposes to make a *designated change to the *product, or both, and the Minister is satisfied that approving the proposed premiums is in the public interest; or

(b) otherwise, refuse to approve the proposed premiums.

Matters relating to the approval of proposed premiums

(7) If the Minister approves the proposed premiums, the approval has effect, in relation to a *product subgroup to which the application relates, from the day specified in the approval until the earlier of the following:

(a) the day when another approval for the product subgroup under this section takes effect;

(b) if the insurer makes a *designated change to the *product without an approval under this section being in effect in relation to the change—the time when the insurer makes the designated change.

(8) The day specified in the approval as the day from which the approval has effect must be a day that is after the day on which the Minister approves the proposed premiums.

Tabling of reasons for refusal to approve premiums

(9) If the Minister refuses to approve the proposed premiums, the Minister must table the Minister's reasons for refusal in each House of the Parliament no later than 15 sitting days of that House after the refusal.

Other matters

(10) A notice under subsection (4) is not a legislative instrument.

(11) A fee specified for the purposes of paragraph (2)(b):

(a) must not amount to taxation; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) must not exceed the amount the Minister estimates to be the reasonable costs of processing an application made under subsection (1).

Delegation

(12) If the Minister delegates the Minister's powers under this section to a delegate:

(a) the delegate may approve the proposed premiums in accordance with this section; or

(b) if the delegate considers that the proposed premiums should not be approved, the delegate:

(i) must not make a final decision refusing to approve the proposed premiums; and

(ii) must refer the application to the Minister for the Minister's consideration.

Note: For delegation by the Minister, see subsection 333-1(1).

66-11 Further information about applications under sections 66-8 and 66-10

(1) The Minister may, by written notice, request a private health insurer to give the Minister, within the period specified in the notice, specified information about an application made by the insurer under section 66-8 or 66-10.

(2) The Minister may refuse to consider the application until the earlier of the following times:

(a) the time when the insurer gives the Minister the specified information;

(b) the end of the period specified in the notice.

(3) The Minister must have regard to any information provided by an insurer, in accordance with a notice under subsection (1), in deciding whether to approve or refuse to approve the application.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4) If the insurer does not give the specified information within the period specified in the notice, the Minister may deal with the application on the basis of the information contained in the application.

(5) The Minister may give more than one notice under subsection (1) to an insurer in relation to an application made by the insurer.

66-12 When Minister must invite resubmission etc. of applications under sections 66-8 and 66-10

(1) If the Minister proposes to refuse to approve an application made by a private health insurer under section 66-8 or 66-10, the Minister must give the insurer a written notice that the Minister is proposing to refuse the application.

(2) The notice must:
  (a) invite the insurer to do either or both of the following:
    (i) amend the application and resubmit the application;
    (ii) give the Minister a submission, in writing, setting out the reasons why the insurer should not be required to resubmit the application; and
  (b) specify a period within which the insurer must do either or both of the things mentioned in paragraph (a); and
  (c) set out the effects of subsections (3) and (4).

(3) The Minister may refuse to consider the application until the earlier of the following times:
  (a) the time when the insurer resubmits the application in accordance with the notice;
  (b) the time when the insurer gives the Minister a submission in accordance with the notice.

(4) If the insurer does not do one of the things mentioned in paragraph (2)(a) within the period specified in the notice, the

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Minister may deal with the application on the basis of the information contained in the application.

(5) Before deciding whether to approve or refuse to approve the application, the Minister must consider:
  (a) any application resubmitted in accordance with the notice; and
  (b) any submission given in accordance with the notice.

(6) If a private health insurer receives a notice under this section in relation to an application (the ***original application***), and the insurer resubmits the application in accordance with the notice, the resubmitted application is taken, for the purposes of section 66-8 or 66-10 (as the case may be), to have been submitted on the same day as the original application.

(7) The Minister may give more than one notice under subsection (1) to an insurer in relation to an application made by the insurer.

66-13 Annual report

(1) The Minister must, as soon as practicable after the end of each financial year that starts after the commencement of this section, cause a review to be conducted of any changes during that year to *products and premiums payable under policies in products.

(2) Without limiting subsection (1), the review must consider:
  (a) applications made during that year under section 66-8 (about new product subgroups); and
  (b) applications made during that year under section 66-10 (about changes to premiums and products); and
  (c) any *designated changes to *complying health insurance products made during that year; and
  (d) whether, and to what extent, insurers engaged in any product phoenixing during that year.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) The person or persons conducting the review must give the Minister a written report of the review no later than 3 months after the end of that year.

(4) The Minister must cause a copy of the report to be tabled in each House of the Parliament within 15 sitting days of that House after the Minister receives the report.

(5) If the report includes any recommendations, the Minister must:
  (a) prepare a written statement setting out the Commonwealth Government's response to each recommendation; and
  (b) cause a copy of the statement to be tabled in each House of the Parliament within 6 months after receiving the report.

66-15 Entitlement to benefits for general treatment

Neither:
  (a) the community rating principle in section 55-5; nor
  (b) the community rating requirement in paragraph 66-1(b);

prevents a private health insurer from determining a person's entitlement under a *complying health insurance policy to a benefit for *general treatment (other than *hospital-substitute treatment) in respect of a period by having regard to the amount of benefits for that kind of treatment already claimed for the person in respect of the period.

66-20 Different amount of benefits depending on where people live

Neither:
  (a) the community rating principle in section 55-5; nor
  (b) the community rating requirements in section 66-1;

prevents the amount of a benefit for a treatment under a *complying health insurance policy from being different from the amount of a benefit for the same treatment under another policy that is in the same *product, if the difference is only because the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

persons insured under the policies live in different *risk equalisation jurisdictions.

66-25 Different amounts of benefits for travel or accommodation

Neither:

(a) the community rating principle in section 55-5; nor

(b) the community rating requirements in section 66-1;

prevents a private health insurer from determining a person's entitlement under a *complying health insurance policy to a benefit for travel or accommodation in respect of *hospital treatment or *general treatment based on the distance between the person's principal place of residence and the facility where treatment is provided.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 69—Coverage requirements

69-1 Coverage requirements

(1) An insurance policy meets the coverage requirements in this Division if:

(a) the only treatments the policy *covers are:

(i) specified treatments that are *hospital treatment; or

(ii) specified treatments that are hospital treatment and specified treatments that are *general treatment; or

(iii) specified treatments that are general treatment but none that are hospital-substitute treatment; and

(b) if the policy provides a benefit for anything else—the provision of the benefit is authorised by the Private Health Insurance (Complying Product) Rules.

(2) Despite paragraph (1)(a), the policy must also *cover any treatment that a policy of its kind is required by the Private Health Insurance (Complying Product) Rules to cover.

(3) Despite paragraph (1)(a), the policy must not *cover any treatment that a policy of its kind is not allowed under the Private Health Insurance (Complying Product) Rules to cover.

69-5 Meaning of *cover*

(1) An insurance policy ***covers*** a treatment if, under the policy, the insurer undertakes liability in respect of some or all loss arising out of a liability to pay fees or charges relating to the provision of goods or a service that is or includes that treatment.

(2) An insurance policy also ***covers*** a treatment if the insurer provides an insured person, or arranges for an insured person to be provided with, goods or a service that is or includes that treatment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) If an insurance policy *covers a treatment in the way described in subsection (2), this Part applies as if the provision of the goods or service were a benefit provided under the policy.

69-10 Meaning of *hospital-substitute treatment*

Hospital-substitute treatment means *general treatment that:

(a) substitutes for an episode of *hospital treatment; and

(b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and

(c) is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 72—Benefit requirements for policies that cover hospital treatment

72-1 Benefit requirements

(1) An insurance policy that *covers *hospital treatment meets the benefit requirements in this Division if:

(a) the policy meets the requirements in the table in subsection (2); and

(b) the policy meets any requirements specified in the Private Health Insurance (Complying Product) Rules to be benefit requirements; and

(c) the policy does not provide benefits for:

(i) the cost of funded aged care services (within the meaning of the *Aged Care Act 2024*); or

(ii) a charge for a pharmaceutical benefit supplied under Part VII of the *National Health Act 1953*, unless the circumstances of the charge are covered by section 92B of that Act; or

(iii) any other treatment specified in the Private Health Insurance (Complying Product) Rules as a treatment for which benefits must not be provided; and

(d) the *rules of the private health insurer that issues the policy meet the rules requirement in section 72-5.

(2) These are the requirements that a policy must meet for the purposes of paragraph (1)(a):

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 72-1

Requirements that a policy that *covers *hospital treatment must meet		
Item	**There must be a benefit for ...**	**The amount of the benefit must be ...**
1	any part of *hospital treatment that is one or more of the following: (a) psychiatric care; (b) rehabilitation; (c) palliative care; if the treatment is provided in a *hospital and no *medicare benefit is payable for that part of the treatment.	at least the amount set out, or worked out using the method set out, in the Private Health Insurance (Benefit Requirements) Rules as the minimum benefit, or method for working out the minimum benefit, for that treatment.
2	*hospital treatment *covered under the policy for which a *medicare benefit is payable.	(a) if the charge for the treatment is less than the *schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) otherwise—at least 25% of the schedule fee for the treatment.
3	if the policy *covers *hospital-substitute treatment—hospital-substitute treatment covered under the policy for which a *medicare benefit is payable.	(a) if the charge for the treatment is less than the *schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) otherwise—at least 25% of the schedule fee for the treatment; but the benefit must not be provided if a medicare benefit of an amount that is at least 85% of the schedule fee is claimed for the treatment (or could be claimed for the treatment but for section 19AD of the *Health Insurance Act 1973*).
4	(a) *hospital treatment *covered under the policy; and (b) if the policy covers	(a) at least the amount set out, or worked out using the method set out, in the Private Health Insurance (Medical

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Requirements that a policy that *covers *hospital treatment must meet		
Item	**There must be a benefit for ...**	**The amount of the benefit must be ...**
	*hospital-substitute treatment—hospital-substitute treatment covered under the policy; that is the provision of a *medical device or *human tissue product, of a kind listed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, as described in either of the following paragraphs: (c) the medical device or human tissue product is provided in circumstances in which a *medicare benefit is payable, and, if those Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those conditions are satisfied; (d) the medical device or human tissue product is provided in other circumstances set out in those Rules, and, if those Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those	Devices and Human Tissue Products) Rules as the minimum benefit, or method for working out the minimum benefit, for the medical device or human tissue product; and (b) if the Private Health Insurance (Medical Devices and Human Tissue Products) Rules set out an amount, or a method for working out an amount, as the maximum benefit, or method for working out the maximum benefit, for the medical device or human tissue product—no more than that amount or the amount worked out using that method.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Requirements that a policy that *covers *hospital treatment must meet		
Item	**There must be a benefit for ...**	**The amount of the benefit must be ...**
	conditions are satisfied.	
5	any treatment for which the Private Health Insurance (Benefit Requirements) Rules specify there must be a benefit.	at least the amount set out, or worked out using the method set out, in the Private Health Insurance (Benefit Requirements) Rules as the minimum benefit, or method for working out the minimum benefit, for that treatment.

Note: If a private health insurer provides an insured person with, or arranges for an insured person to be provided with, treatment, it is treated as a benefit for the purposes of this Division (see subsection 69-5(3)).

(3) For the purposes of this section, disregard section 19AD of the *Health Insurance Act 1973* when determining whether medicare benefit is payable.

(4) If an amount of a benefit payable under an insurance policy does not meet the requirements in the table in subsection (2) merely because of the operation of subsection 10(4) of the *Health Insurance Act 1973* (which rounds the calculation of a *medicare benefit), the amount of the benefit payable is taken to meet the requirements in the table in subsection (2).

72-5 Rules requirement in relation to provision of benefits

(1) For the purposes of paragraph 72-1(1)(d), the *rules of the private health insurer that issues the policy meet the rules requirement in this section if the rules have the effect required by subsection (2).

(2) The effect required is that if, under an agreement or arrangement with a private health insurer, a particular *health care provider (other than a *medical practitioner) provides particular *hospital treatment or *hospital-substitute treatment to people insured under the same *complying health insurance product of the insurer, any charge for the treatment:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) that is payable by an insured person; and

(b) which is not recoverable by a benefit under the product;

must be the same for all of the people insured under the product, irrespective of:

(c) the frequency with which that provider provides that particular treatment to people insured under that product; or

(d) any other matter.

(3) The Private Health Insurance (Complying Product) Rules may modify the effect required by subsection (2) in relation to all or particular kinds of *complying health insurance products, benefits, treatments or *health care providers. To the extent the Rules do so, the rules requirement is taken to be met if the conditions in the Rules are met.

72-10 Minimum benefits for medical devices and human tissue products

(1) Private Health Insurance (Medical Devices and Human Tissue Products) Rules made for the purposes of item 4 of the table in subsection 72-1(2) must only list a kind of *medical device or *human tissue product if:

(a) an application has been made under subsection (2) in relation to that kind of medical device or human tissue product; and

(b) the Minister has granted the application.

(2) A person may apply to the Minister to have the Private Health Insurance (Medical Devices and Human Tissue Products) Rules list a *medical device or *human tissue product of the kind to which the application relates.

(3) The application must be:

(a) in the *approved form; and

(b) accompanied by any *cost-recovery fee that the applicant is liable to pay at the time the application is made.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4) The Minister must inform the applicant in writing of the Minister's decision whether or not to grant the application. If the Minister decides not to grant the application, the Minister must also inform the applicant of the reason for that decision.

(5) If:

(a) the Minister grants the application; and

(b) the applicant pays to the Commonwealth any *cost-recovery fee that the applicant is liable to pay in connection with the initial listing of the kind of *medical device or *human tissue product to which the application relates;

the Minister must, on the next occasion when the Minister makes or varies the Private Health Insurance (Medical Devices and Human Tissue Products) Rules:

(c) list the kind of *medical device or *human tissue product to which the application relates in those Rules; and

(d) set out in those Rules a minimum benefit for the medical device or human tissue product; and

(e) if the Minister considers it appropriate—set out in those Rules a maximum benefit for the medical device or human tissue product.

Note: Despite this subsection, the Minister may, under section 72-25, refuse to perform a function under this subsection if the applicant fails to pay a cost-recovery fee or medical devices and human tissue products levy that is due and payable.

(6) The Private Health Insurance (Medical Devices and Human Tissue Products) Rules may set out criteria (***listing criteria***) to be satisfied in order for an application (a ***listing application***) made under subsection (2) to be granted. The Rules may provide for different listing criteria to apply in different circumstances.

(7) The Minister must not grant a listing application if any applicable listing criteria are not satisfied in relation to the application.

Note: The Minister may refuse to grant a listing application even if the applicable listing criteria are satisfied.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

72-11 Meaning of *medical device*

(1) A ***medical device*** is:

(a) any instrument, apparatus, appliance, software, implant, reagent, material or other article (whether used alone or in combination, and including the software necessary for its proper application) intended, by the person under whose name it is or is to be supplied, to be used for human beings for the purpose of one or more of the following:

(i) prevention, monitoring, prediction, prognosis, treatment or alleviation of disease;

(ii) monitoring, treatment, alleviation of or compensation for an injury or disability;

(iii) investigation, replacement or modification of the anatomy or of a physiological or pathological process or state;

(iv) control or support of conception;

(v) in vitro examination of a specimen derived from the human body for a specific medical purpose;

and that does not achieve its principal intended action in or on the human body by pharmacological, immunological or metabolic means, but that may be assisted in its function by such means; or

(b) any instrument, apparatus, appliance, software, implant, reagent, material or other article specified in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules; or

(c) an *accessory to an instrument, apparatus, appliance, software, implant, reagent, material or other article covered by paragraph (a) or (b).

(2) For the purposes of paragraph (1)(a), the purpose for which an instrument, apparatus, appliance, software, implant, reagent, material or other article (the ***main equipment***) is to be used is to be ascertained from the information supplied, by the person under

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

whose name the main equipment is or is to be supplied, on or in any one or more of the following:

(a) the labelling on the main equipment;

(b) the instructions for using the main equipment;

(c) any advertising material relating to the main equipment;

(d) any technical documentation describing the mechanism of action of the main equipment.

(3) In relation to a *medical device covered by paragraph (1)(a) or (b), an ***accessory*** is a thing that the manufacturer of the thing specifically intended to be used together with the device to enable or assist the device to be used as the manufacturer of the device intended.

72-12 Meaning of *human tissue product*

A ***human tissue product*** is a thing that:

(a) either:

(i) comprises, contains or is derived from human cells or human tissues; or

(ii) is specified in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for the purposes of this subparagraph; and

(b) is represented in any way to be, or is, whether because of the way in which it is presented or for any other reason, likely to be taken to be:

(i) for use in the treatment or prevention of a disease, ailment, defect or injury affecting persons; or

(ii) for use in influencing, inhibiting or modifying a physiological process in persons; or

(iii) for use in the replacement or modification of parts of the anatomy in persons; and

(c) is not specified in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules as a thing that is not a human tissue product for the purposes of this Act.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

72-15 Fees for certain activities

(1) The Private Health Insurance (Medical Devices and Human Tissue Products) Rules may specify fees (***cost-recovery fees***) that may be charged in relation to activities carried out by, or on behalf of, the Commonwealth in connection with the performance of functions, or the exercise of powers, conferred by or under this Act in relation to the list of kinds of *medical devices and *human tissue products in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules.

(2) Without limiting subsection (1), the Private Health Insurance (Medical Devices and Human Tissue Products) Rules may do any of the following:

(a) specify 2 or more *cost-recovery fees for the same matter;

(b) specify a method for working out a cost-recovery fee;

(c) specify the circumstances in which a specified cost-recovery fee is payable, including by providing that the fee is payable if the Minister is satisfied of specified matters;

(d) specify the circumstances in which a person is exempt from paying a specified cost-recovery fee;

(e) specify the circumstances in which the Minister may waive a cost-recovery fee.

(3) A *cost-recovery fee specified under this section must not be such as to amount to taxation.

72-20 Delisting because of unpaid fees or levy

(1) The Minister may remove a kind of *medical device or *human tissue product from the list in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules if:

(a) a person is liable to pay a *cost-recovery fee in connection with the kind of medical device or human tissue product; and

(b) the person fails to pay that fee in accordance with those Rules.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Note: Matters relating to payment of cost-recovery fees, such as the time for payment, may be specified in Private Health Insurance (Medical Devices and Human Tissue Products) Rules (see sections 72-30 and 72-45).

(2) The Minister may remove a kind of *medical device or *human tissue product from the list in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules if:

(a) a person is liable to pay *medical devices and human tissue products levy in respect of the ongoing listing of the kind of medical device or human tissue product; and

(b) the person fails to pay the levy in accordance with the Private Health Insurance (Levy Administration) Rules.

Note: Matters relating to payment of the levy, such as the time for payment, may be specified in Private Health Insurance (Levy Administration) Rules (see sections 307-1 and 307-30).

72-25 Minister may direct that activities not be carried out

(1) This section applies if:

(a) a person (the ***debtor***) is liable to pay a *cost-recovery fee or *medical devices and human tissue products levy; and

(b) the fee or levy is due and payable.

(2) Despite any other provision of this Act, the Minister may refuse to carry out, or direct a person not to carry out, specified activities or kinds of activities in relation to the debtor under this Division until the fee or levy has been paid.

72-27 Matters to have regard to before exercising certain powers

In deciding whether to exercise a power under section 72-20 or 72-25, the Minister must have regard to the following:

(a) whether the exercise of the power would be detrimental to the interests of insured persons;

(b) whether the exercise of the power would significantly limit medical practitioners' professional freedom, within the scope

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

of accepted clinical practice, to identify and provide appropriate treatments.

72-30 When cost-recovery fee must be paid

A *cost-recovery fee becomes due and payable at the time specified in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules.

72-35 Payment of cost-recovery fee

A *cost-recovery fee must be paid to the Commonwealth.

72-40 Recovery of fee

A *cost-recovery fee that is due and payable:

(a) is a debt due to the Commonwealth; and

(b) may be recovered as a debt by action in a court of competent jurisdiction by the Commonwealth.

72-45 Other matters

The Private Health Insurance (Medical Devices and Human Tissue Products) Rules may, in relation to *cost-recovery fees, specify, or provide for matters relating to, any or all of the following:

(a) the person who is liable to pay;

(b) methods for payment;

(c) extending the time for payment;

(d) refunding, in whole or in part, an amount paid;

(e) applying overpayments;

(f) rules relating to fees to be paid in relation to specified activities.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 75—Waiting period requirements

75-1 Waiting period requirements

(1) An insurance policy meets the waiting period requirements in this Division if the *waiting period that applies to a person who did not *transfer to the policy is no longer than:

(a) for a benefit for *hospital treatment or *hospital-substitute treatment that is obstetric treatment or treatment for a *pre-existing condition (other than treatment covered by paragraph (b))—12 months; and

(b) for a benefit for hospital treatment or hospital-substitute treatment that is psychiatric care, rehabilitation or palliative care (whether or not for a pre-existing condition)—2 months; and

(c) for any other benefit for hospital treatment or hospital-substitute treatment—2 months.

(2) The Private Health Insurance (Complying Product) Rules may modify the requirements in subsection (1) in relation to all or particular kinds of private health insurers, benefits or insured persons. To the extent the Rules do so, the waiting period requirements in this Division are taken to be met if the conditions in the Rules are met.

Note: If a private health insurer provides an insured person with, or arranges for an insured person to be provided with, treatment, it is treated as a benefit for the purposes of this Division (see subsection 69-5(3)).

75-5 Meaning of *waiting period*

The ***waiting period*** that applies to a person for a benefit under an insurance policy is the period:

(a) starting at the time the person becomes insured under the policy; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) ending at the time specified in the policy;

during which the person is not entitled to the benefit.

75-10 Meaning of *transfers*

A person ***transfers*** to a policy (the ***new policy***) from another policy (the ***old policy***) if:

(a) either:

(i) the person is insured under the old policy at the time the person becomes insured under the new policy; or

(ii) the person ceased to be insured under the old policy no more than 7 days, or a longer number of days allowed by the new policy's insurer for this purpose, before becoming insured under the new policy; and

(b) the old policy is a *complying health insurance policy; and

(c) the person's premium payments under the old policy were up to date at the time the person became insured under the new policy.

Note: See section 99-1 about transfer certificates.

75-15 Meaning of *pre-existing condition*

(1) A person insured under an insurance policy has a ***pre-existing condition*** if:

(a) the person has an ailment, illness or condition; and

(b) in the opinion of a *medical practitioner appointed by the insurer that issued the policy, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy.

(2) In forming an opinion for the purposes of paragraph (1)(b), the *medical practitioner must have regard to any information in relation to the ailment, illness or condition that the medical

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

practitioner who treated the ailment, illness or condition gives him or her.

(3) If:

(a) a private health insurer replaces a *complying health insurance product with another complying health insurance product; and

(b) a person who was insured under a policy that was in the replaced *product is *transferred by the insurer to a policy that is in the replacement product;

the reference in paragraph (1)(b) to the day on which the person became insured under the policy is taken to be a reference to the day on which the person became insured under the replaced policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 78—Portability requirements

78-1 Portability requirements

(1) An insurance policy meets the portability requirements in this Division if the policy meets the requirements in subsections (2), (3), (4) and (5A).

(2) An insurance policy meets the requirement in this subsection if the *waiting period that applies to a person who *transferred to the policy (the ***new policy***) from another policy (the ***old policy***) is no longer than:

(a) for a benefit for *hospital treatment or *hospital-substitute treatment that was not *covered under the old policy—the period allowed under section 75-1; and

(b) for a benefit for hospital treatment or hospital-substitute treatment that was covered under the old policy—the balance of any unexpired waiting period for that benefit that applied to the person under the old policy.

(3) An insurance policy meets the requirement in this subsection if the policy does not impose on a person who *transferred to the policy any period (other than a *waiting period allowed under subsection (2)) during which the amount of a benefit in relation to any particular *hospital treatment or *hospital-substitute treatment is less than the amount the person would be eligible for during any other period.

(4) An insurance policy meets the requirement in this subsection if, in relation to a benefit for *hospital treatment or *hospital-substitute treatment:

(a) that was *covered under the old policy; and

(b) in respect of which a higher excess or higher co-payment applied under the old policy than is the case under the new policy;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

any period during which the higher excess or higher co-payment continues to apply under the new policy to a person who *transferred to the policy is no longer than the *waiting period allowed under section 75-1 for a benefit for that treatment.

(5) In working out:

(a) for the purposes of subsection (2) or (4), whether a treatment was *covered under an old policy; or

(b) for the purposes of subsection (3), whether the amount of a benefit under a new policy during a period is less than the amount it would be during another period;

disregard the existence or otherwise of contracts between the insurer in relation to either of the policies and particular *health care providers or groups of health care providers.

(5A) An insurance policy meets the requirement in this subsection if:

(a) the policy forms part of a *complying health insurance product or belongs to a *product subgroup of a complying health insurance product; and

(b) the *product or product subgroup is being terminated by the private health insurer, and as a consequence, an *adult insured under the policy is to be transferred to a new policy; and

(c) the insurer informs the adult insured under the policy, in writing, of the matters set out in the Private Health Insurance (Complying Product) Rules; and

(d) the adult insured under the policy is informed of those matters a reasonable time before the transfer to the new policy is to take effect.

Note: See also section 55-10.

(6) The Private Health Insurance (Complying Product) Rules may modify the requirements in this section in relation to all or particular kinds of private health insurers, benefits or insured persons. To the extent the Rules do so, the portability requirements

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

in this Division are taken to be met if the conditions in the Rules are met.

Note: If a private health insurer provides an insured person with, or arranges for an insured person to be provided with, treatment, it is treated as a benefit for the purposes of this Division (see subsection 69-5(3)).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 81—Quality assurance requirements

81-1 Quality assurance requirements

An insurance policy meets the quality assurance requirements in this Division if the policy prohibits the payment of benefits for a treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.

Note: The Private Health Insurance (Accreditation) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 84—Enforcement of this Part

84-1 Offence: advertising, offering or insuring under non-complying policies

(1) A person commits an offence if:

(a) the person:

(i) advertises a *product; or

(ii) offers a person insurance under a policy; or

(iii) insures a person under a policy; or

(iv) arranges for another person to do a thing mentioned in subparagraph (i), (ii) or (iii); and

(b) the insurance under the policy, or under a policy in the product, is *health insurance business; and

(c) the policy is not a *complying health insurance policy; and

(d) the *health insurance business is not business of a kind specified in the Private Health Insurance (Complying Product) Rules as excluded from subsection 63-1(1).

Penalty: 1,000 penalty units or imprisonment for 5 years, or both.

(2) In imposing a penalty on a private health insurer for an offence under subsection (1), the court:

(a) must have regard to the possible impact of a penalty on the insurer's capital adequacy, solvency and the level of premiums for its *complying health insurance products; and

(b) must not impose a penalty if satisfied that doing so would adversely affect the insurer's capital adequacy or solvency, or be likely to lead to an increase in premiums for its products.

84-5 Offence: directors and chief executive officers liable if systems not in place to prevent breaches

A person commits an offence if:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) the person is a *director or *chief executive officer of a private health insurer; and
(b) the insurer commits an offence under section 84-1; and
(c) the person failed to exercise due diligence to ensure that adequate systems were in place to prevent the insurer from committing the offence.

Penalty: 1,000 penalty units or imprisonment for 5 years, or both.

84-10 Injunction in relation to non-complying policies

(1) If a private health insurer has engaged, is engaging, or is proposing to engage, in conduct:
(a) that contravenes or would contravene section 63-1; or
(b) that is or that would be an offence against section 84-1;
the Federal Court may, on application by a person mentioned in subsection (3), grant an injunction restraining the insurer from engaging in the conduct.

(2) If:
(a) a private health insurer has refused or failed, is refusing or failing, or is proposing to refuse or fail, to do a thing; and
(b) the refusal or failure:
(i) contravenes or would contravene section 63-1; or
(ii) is or would be an offence against section 84-1;
the Federal Court may, on application by a person mentioned in subsection (3), grant an injunction requiring the insurer to do the thing.

(3) For the purposes of subsections (1) and (2), an application may be made by:
(a) the Minister; or
(c) any other person.

(4) The court may grant an interim injunction pending the determination of an application under subsection (1) or (2).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(5) The court must not require an applicant for an injunction to give an undertaking as to damages as a condition of granting an interim injunction.

(6) The court may discharge or vary an injunction granted under this section.

(7) The power of the court to grant an injunction restraining a private health insurer from engaging in conduct may be exercised:
  (a) whether or not it appears to the court that the insurer intends to engage again, or to continue to engage, in conduct of that kind; and
  (b) whether or not the insurer has previously engaged in conduct of that kind.

(8) The power of the court to grant an injunction requiring a private health insurer to do a thing may be exercised:
  (a) whether or not it appears to the court that the insurer intends to refuse or fail again, or to continue to refuse or fail, to do that thing; and
  (b) whether or not the insurer has previously refused or failed to do that thing.

84-15 Remedies for people affected by non-complying policies

On application by the Minister, if the Federal Court is satisfied that:
  (a) a private health insurer has engaged in conduct that contravenes section 63-1 or is an offence against section 84-1; or
  (b) both:
    (i) a private health insurer has refused or failed to do a thing; and
    (ii) that refusal or failure contravenes section 63-1 or is an offence against section 84-1;

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

the court may order the insurer to do either or both of the following:

(c) take specified action to ensure that an insurance policy becomes a *complying health insurance policy;

(d) take specified action to ensure that a person insured under an insurance policy is put in the position the person would have been in, had the policy always been a complying health insurance policy.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 3-4—Obligations relating to complying health insurance products

Division 90—Introduction

90-1 What this Part is about

Private health insurers have obligations to people insured under their complying health insurance products and people seeking to become insured under those products. Private health insurers also have to keep the Department and the Private Health Insurance Ombudsman informed about their health insurance business.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 93—Giving information to consumers

93-1 Maintaining up to date private health information statements

(1) A private health insurer must ensure that it maintains at all times an *up to date *private health information statement:

(a) for each *product subgroup of each *complying health insurance product that it makes available; and

(b) for each product subgroup of each complying health insurance product under which it insures people.

(1A) A single *private health information statement may be the private health information statement for more than one *product subgroup of a *complying health insurance product if the premiums payable under policies in the subgroups the statement covers are the same.

(2) The *private health information statement for a *product subgroup of a *complying health insurance product is ***up to date*** at a particular time, if, at that time, the information in the statement is accurate.

(3) A private health insurer commits an offence if there is no *private health information statement for a *product subgroup of a *complying health insurance product of the insurer.

Penalty: 60 penalty units.

(4) A private health insurer commits an offence if:

(a) there is a *private health information statement for a *product subgroup of a *complying health insurance product of the insurer; and

(b) the private health information statement is not *up to date.

Penalty: 60 penalty units.

(5) Strict liability applies to subsections (3) and (4).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

93-5 Meaning of *private health information statement*

(1) A ***private health information statement*** for a *product subgroup of a *complying health insurance product is a statement about the product subgroup that contains the information, and is in the form, set out in the Private Health Insurance (Complying Product) Rules.

(2) The Private Health Insurance (Complying Product) Rules may set out methods by which *private health information statements are to be made available to people who ask for information about *complying health insurance products.

93-10 Making private health information statements available

A private health insurer must ensure that, if a person asks an *officer, employee or agent of the insurer for information about a *complying health insurance product of the insurer:

(a) the person is told about the *private health information statement for the *product subgroup that is likely to apply to the person and how to obtain a copy of the statement; and

(b) if the person asks for a copy—the person is given an *up to date copy of the statement for that subgroup.

93-15 Giving information to newly insured people

(1) A private health insurer must ensure that, when an *adult first becomes insured under a *complying health insurance policy of the insurer, the adult is given:

(a) an *up to date copy of the *private health information statement for the *product subgroup that the policy belongs to, by a method (if any) set out in the Private Health Insurance (Complying Product) Rules; and

(b) details about what the policy *covers and how benefits provided under it are worked out; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(c) a statement identifying the *health benefits fund to which the policy is referable.

(2) If more than one *adult becomes insured under a single *complying health insurance policy of a private health insurer, the insurer is taken to comply with subsection (1) if the insurer complies with that subsection in relation to only one of those adults.

93-20 Keeping insured people up to date

(1) A private health insurer must ensure that an *adult insured under a *complying health insurance policy issued by the insurer is given the *private health information statement for the *product subgroup that the policy belongs to, at least once every 12 months.

(2) A private health insurer must ensure that, if a proposed change to the insurer's *rules:

(a) is or might be detrimental to the interests of an insured person; and

(b) will require an update to the *private health information statements for a *complying health insurance product of the insurer;

an *adult insured under each *complying health insurance policy in the product:

(c) is informed about the proposed change a reasonable time before the change takes effect; and

(d) is given the updated private health information statement for the *product subgroup that the policy belongs to as soon as practicable after the statement is updated.

(3) A private health insurer must ensure that, if an *adult who is insured under a *complying health insurance policy of the insurer asks an *officer, employee or agent of the insurer for information about what the policy covers or the benefits the policy provides, the adult is given the information as soon as practicable.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4) If a private health insurer changes the *health benefits fund to which a *complying health insurance policy of the insurer is *referable, the insurer must ensure that:

(a) before the change takes effect, an *adult insured under the policy is given a statement identifying the health benefits fund to which the policy will be referable as a result of the change; or

(b) within 2 weeks after the change takes effect, an adult insured under the policy is given a statement identifying the health benefits fund to which the policy is referable as a result of the change.

Note: The health benefits fund to which a policy is referable may change in accordance with Division 4 of Part 3 of the *Private Health Insurance (Prudential Supervision) Act 2015*.

(5) If more than one *adult is insured under a single *complying health insurance policy of a private health insurer, the insurer is taken to comply with subsection (1), (2) or (4) if the insurer complies with the subsection in relation to only one of those adults.

93-25 Giving advance notice of detrimental changes to rules

(1) A private health insurer must ensure an *adult insured under a *complying health insurance policy issued by the insurer is informed about any proposed change to the insurer's *rules (other than a change to which subsection 93-20(2) applies), a reasonable time before the change takes effect, if the proposed change is or might be detrimental to the interests of an insured person.

(2) If more than one *adult is insured under a single *complying health insurance policy of a private health insurer, the insurer is taken to comply with subsection (1) if the insurer complies with that subsection in relation to only one of those adults.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

93-30 Failure to give information to consumers

(1) A private health insurer commits an offence if:

(a) the insurer is required under section 93-10, 93-15, 93-20 or 93-25 to ensure that a particular thing happens in relation to a particular person; and

(b) the thing does not happen in relation to the person.

Penalty: 60 penalty units.

(2) Strict liability applies to subsection (1).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 96—Giving information to the Department and the Private Health Insurance Ombudsman

96-1 Giving private health information statements on request

A private health insurer must ensure that, if:

(a) the Secretary of the Department; or

(c) the Private Health Insurance Ombudsman;

requests the private health insurer for the *private health information statements for a *complying health insurance product of the insurer, the insurer gives the person who made the request *up to date copies of the statements, as soon as practicable after being asked and by the method (if any) specified by the person.

96-5 Giving private health information statements for new products

A private health insurer must ensure that copies of the *private health information statements for a *complying health insurance product of the insurer are given to:

(a) the Secretary of the Department; and

(c) the Private Health Insurance Ombudsman;

no later than the first day on which the insurer first begins to make the *product available.

96-10 Giving updated private health information statements

A private health insurer must ensure that, if the *private health information statements for a *complying health insurance product of the insurer are updated, copies of the updated statements are given to:

(a) the Secretary of the Department; and

(c) the Private Health Insurance Ombudsman;

as soon as practicable after the statement is updated.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

96-15 Giving additional information on request

(1) Any of the following:
  (a) the Secretary of the Department;
  (c) the Private Health Insurance Ombudsman;

may request a private health insurer for specified information about, or in relation to, a *complying health insurance product or products, or a *complying health insurance policy, of the insurer.

(2) The request must:
  (a) be in writing; and
  (b) specify the time by which the information requested is to be given.

(3) The request may specify the manner and form in which the information requested is to be given.

(4) A private health insurer must ensure that the request is complied with, by the time specified in the request or any longer time allowed by the person who made the request.

96-20 Failure to give information to Department or Private Health Insurance Ombudsman

(1) A private health insurer commits an offence if:
  (a) the insurer is required under section 96-1, 96-5, 96-10 or 96-15 to ensure that a particular thing is given to a particular person; and
  (b) the thing is not given to the person.

Penalty: 60 penalty units.

(2) Strict liability applies to subsection (1).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

96-25 Giving information required by the Private Health Insurance (Complying Product) Rules

The Private Health Insurance (Complying Product) Rules may set out any or all of the following:

(a) information in relation to *complying health insurance products;

(b) persons to whom the information is to be given (who may include, but need not be limited to, the Secretary of the Department or the Private Health Insurance Ombudsman);

(c) the time within which, or the intervals at which, the information is to be given to a person;

(d) the manner and form in which the information is to be given to a person.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 99—Transfer certificates

99-1 Transfer certificates

Certificate for the insured person

(1) A private health insurer (the ***old insurer***) must, if a person ceases to be insured under a *complying health insurance policy of the insurer and does not become insured under another policy of the insurer, give the person a certificate under this subsection:
  (a) in the *approved form; and
  (b) within the period set out in the Private Health Insurance (Complying Product) Rules.

Certificate for the new insurer

(2) A private health insurer (the ***new insurer***) must request a certificate from an old insurer if:
  (a) a person who is or has been insured under a *complying health insurance policy of the old insurer *transfers to a complying health insurance policy of the new insurer; and
  (b) the person does not give the new insurer the certificate the old insurer gave the person under subsection (1) within 7 days of becoming insured by the new insurer.

The request must be made:
  (c) in the *approved form; and
  (d) within the period set out in the Private Health Insurance (Complying Product) Rules.

(2A) A private health insurer must not request a certificate except in the circumstances set out in subsection (2).

(3) If a certificate is requested by the new insurer (whether or not the request is in the *approved form or made within the period

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

mentioned in paragraph (2)(d)), the old insurer must give the new insurer a certificate:

(a) in the approved form; and

(b) within the period set out in the Private Health Insurance (Complying Product) Rules.

Offence

(4) A private health insurer commits an offence if:

(a) the insurer is required to do a thing under subsection (1), (2) or (3); and

(b) the insurer does not do the thing.

Penalty: 60 penalty units.

(5) Strict liability applies to subsection (4).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 102—Private health insurers to offer cover for hospital treatment

102-1 Private health insurers to offer cover for hospital treatment

At any time when a private health insurer makes available a *complying health insurance product that *covers *general treatment, the insurer must also make available a complying health insurance product that covers *hospital treatment.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Chapter 4—Health insurance business, health benefits funds and miscellaneous obligations of private health insurers

Part 4-1—Introduction

Division 110—Introduction

110-1 What this Chapter is about

This Chapter defines the key concepts of health insurance business and health benefits funds. It also deals with some related matters and imposes miscellaneous obligations on private health insurers.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 4-2—Health insurance business

Division 115—Introduction

115-1 What this Part is about

This Part defines the key concept of health insurance business.

Note: Entities are only permitted to carry on health insurance business if they are registered under Division 3 of Part 2 of the *Private Health Insurance (Prudential Supervision) Act 2015*.

115-5 Private Health Insurance (Health Insurance Business) Rules

(1) The Private Health Insurance (Health Insurance Business) Rules also deal with matters relating to *health insurance business. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

Note: The Private Health Insurance (Health Insurance Business) Rules are made by the Minister under section 333-20.

(2) Before making Private Health Insurance (Health Insurance Business) Rules, the Minister must consult *APRA. However, a failure to consult APRA does not affect the validity of those Rules.

Note: This consultation requirement also applies to any repeal or amendment of such Rules: see subsection 33(3) of the *Acts Interpretation Act 1901*.

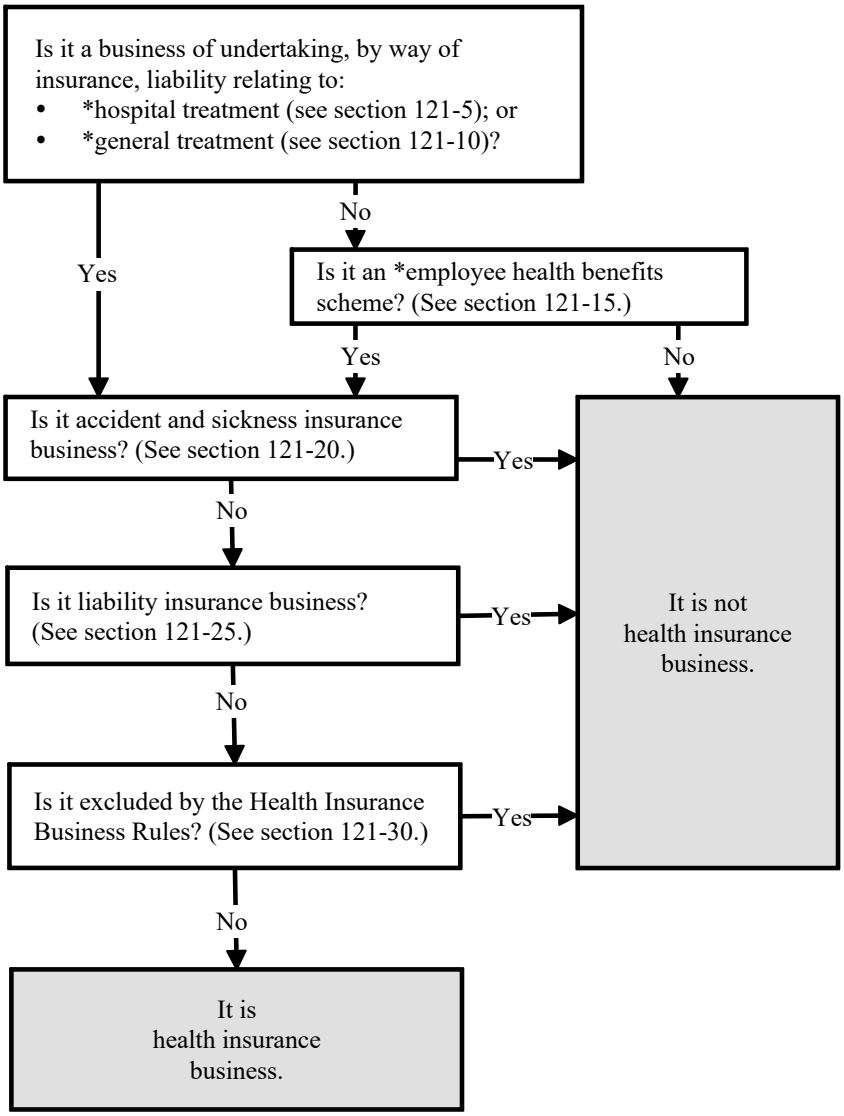
115-10 Whether a business etc. is health insurance business

The following diagram shows how to work out whether a business or arrangement is *health insurance business:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Working out whether a business or arrangement is health insurance business



*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 121—What is health insurance business?

121-1 Meaning of *health insurance business*

(1) ***Health insurance business*** is:

(a) the business of undertaking liability, by way of insurance; or

(b) an *employee health benefits scheme;

that relates, in a way referred to in subsection (2), to *hospital treatment or *general treatment.

Note: The following kinds of insurance business are not health insurance business:

(a) accident and sickness insurance business (see section 121-20);

(b) liability insurance business (see section 121-25);

(c) insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules (see section 121-30).

(2) The liability by way of insurance, or the arrangement to make payments under the *employee health benefits scheme, must relate to:

(a) loss arising out of a liability to pay fees or charges relating to provision in Australia of such treatment; or

(b) provision in Australia of such treatment; or

(c) the happening of an occurrence connected with the provision in Australia of such treatment; or

(d) the happening of an occurrence in Australia that ordinarily requires the provision of such treatment.

(3) It does not matter for the purposes of paragraph (2)(d) whether payment of benefits to the insured is dependent upon one or more of the following:

(a) such treatment or benefit being provided to the insured;

(b) the insured requiring such treatment or benefit;

(c) fees or charges being payable by the insured in relation to the provision of such treatment or benefit.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

121-5 Meaning of *hospital treatment*

(1) ***Hospital treatment*** is treatment (including the provision of goods and services) that:

(a) is intended to manage a disease, injury or condition; and

(b) is provided to a person:

(i) by a person who is authorised by a *hospital to provide the treatment; or

(ii) under the management or control of such a person; and

(c) either:

(i) is provided at a hospital; or

(ii) is provided, or arranged, with the direct involvement of a hospital.

(2) Without limiting subsection (1), ***hospital treatment*** includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

(2A) Without limiting subsection (1) or (2), ***hospital treatment*** also includes benefits for travel or accommodation relating to treatment covered by subsection (1) or (2).

(3) Without limiting subsection (1) or (2), the reference to treatment in those subsections includes a reference to any of, or any combination of, accommodation, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.

(4) Despite subsections (1), (2) and (2A), treatment is not *hospital treatment if it is specified in, or is included in a class of treatments specified in, the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 121-5

(5) A ***hospital*** is a facility for which a declaration under subsection (6) is in force.

(6) The Minister may, in writing:
  (a) declare that a facility is a *hospital; or
  (b) revoke such a declaration.

Note: Refusals to make declarations, and revocations of declarations are reviewable under Part 6-9.

(7) In deciding whether to declare that a facility is a *hospital, or to revoke such a declaration, the Minister must have regard to:
  (a) the nature of the facility; and
  (b) the range and scope of the services provided, or proposed to be provided, under the management or control of the facility and at or on behalf of the facility; and
  (c) whether the necessary approvals by a State or Territory, or by an authority of a State or Territory, have been obtained in relation to the facility; and
  (d) whether the accreditation requirements of an appropriate accrediting body have been met; and
  (e) whether undertakings have been made, or have been complied with, relating to providing to private health insurers information, of the kind specified in the Private Health Insurance (Health Insurance Business) Rules, relating to treatment of persons insured under *complying health insurance products that are *referable to *health benefits funds; and
  (ea) if the Minister is deciding whether to revoke such a declaration—any contravention of conditions to which the declaration is subject; and
  (f) any other matters specified in the Private Health Insurance (Health Insurance Business) Rules.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(8) A declaration under subsection (6) that a facility is a *hospital must include either a statement that the hospital is a public hospital or a statement that the hospital is a private hospital.

121-7 Conditions on declarations of hospitals

(1) A declaration under paragraph 121-5(6)(a) that a facility is a hospital is subject to:

(a) any conditions specified under subsection (2); and

(b) any conditions that the Minister specifies under subsection (3) in relation to the facility.

Note: Decisions by the Minister to specify conditions in relation to particular facilities are reviewable under Part 6-9.

(2) The Private Health Insurance (Health Insurance Business) Rules may specify conditions to which declarations under paragraph 121-5(6)(a) are subject. Any conditions so specified apply to all such declarations, whether or not the declarations were made before the conditions were so specified.

(3) The Minister may specify:

(a) in a declaration under paragraph 121-5(6)(a) relating to a facility; or

(b) in a written notice given to a facility for which such a declaration is already in force;

conditions, or additional conditions, to which the declaration is subject.

(4) A contravention of a condition to which a declaration under paragraph 121-5(6)(a) is subject does not cause the declaration to cease to have effect.

Note: Contraventions are taken into consideration in deciding whether to revoke a declaration.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 121-8

121-8 Application for inclusion of hospital in a class

(1) A person may apply to the Minister for a *hospital to be included in a class set out in the Private Health Insurance (Health Insurance Business) Rules.

(2) The application must be:
  (a) in the *approved form; and
  (b) accompanied by any application fee imposed under the Private Health Insurance (Health Insurance Business) Rules.

121-8A Minister to decide application

(1) The Minister must consider whether a *hospital to which an application relates satisfies the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules.

(2) If the *hospital satisfies the assessment criteria, the Minister must, within 60 days after the day the application is made:
  (a) include the hospital in a class set out in the Private Health Insurance (Health Insurance Business) Rules; and
  (b) notify the person, in writing, of:
    (i) the hospital's inclusion in a class set out in the Rules; and
    (ii) the day that the hospital is included in that class and the day that the hospital's inclusion in that class ends.

(3) If the *hospital does not satisfy the assessment criteria, the Minister must, within 60 days after the day the application is made:
  (a) notify the person, in writing, of that fact; and
  (b) provide reasons for the decision.

Note: A decision that a hospital does not satisfy the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules is reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

121-8B Period of inclusion of hospital in a class

The inclusion of a *hospital in a class set out in the Private Health Insurance (Health Insurance Business) Rules:

(a) comes into force on the day specified in the notice referred to in subparagraph 121-8A(2)(b)(ii); and

(b) expires on the day specified in that notice, unless it is revoked earlier.

121-8C Revocation of inclusion of hospital in a class

The Minister may revoke the inclusion of a *hospital in a class set out in the Private Health Insurance (Health Insurance Business) Rules if the Minister considers that the hospital ceases to satisfy the assessment criteria set out in the Rules.

Note: A decision to revoke the inclusion of a hospital in a class set out in the Private Health Insurance (Health Insurance Business) Rules is reviewable under Part 6-9.

121-8D Private Health Insurance (Health Insurance Business) Rules

The Private Health Insurance (Health Insurance Business) Rules may provide for all or any of the following:

(a) for the purposes of this Part and Division 72—set out one or more classes of *hospital;

(b) impose an application fee for the purposes of section 121-8;

(c) set out assessment criteria for including a hospital in a particular class;

(d) set out matters of a transitional nature relating to the current arrangements for hospitals and the new application process provided for by section 121-8.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 121-10

121-10 Meaning of *general treatment*

(1) ***General treatment*** is treatment (including the provision of goods and services) that:
  (a) is intended to manage or prevent a disease, injury or condition; and
  (b) is not *hospital treatment.

(2) Without limiting subsection (1), ***general treatment*** includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

(2A) Despite paragraph (1)(b), ***general treatment*** also includes benefits for travel or accommodation relating to hospital treatment.

(3) Despite subsections (1), (2) and (2A), neither of the following is *general treatment:
  (a) the rendering in Australia of a service for which *medicare benefit is payable (or would be payable if section 19AD of the *Health Insurance Act 1973* were disregarded), unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise;
  (b) any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this paragraph.

121-15 Extension to *employee health benefits schemes*

(1) An arrangement is an ***employee health benefits scheme*** if:
  (a) the arrangement provides for a person (an ***employer***) to arrange payment in respect of the whole or part of the fees and charges that an employee of, or a person providing services to, the employer incurred in relation to *hospital treatment or *general treatment; and
  (b) one or more of the following applies:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(i) the employer is a *constitutional corporation;
(ii) the employer is a body corporate incorporated in a Territory;
(iii) the employer carries on business in a Territory.

(2) It does not matter for the purposes of this section whether the arrangement:
(a) constitutes a business of undertaking liability by way of insurance; or
(b) is a minor or incidental part of the employer's business; or
(c) does not require the employee, or person providing services, to pay any contributions; or
(d) does not require the employee, or person providing services, to pay contributions that reflect the value of the benefits that the employer is providing under the arrangement; or
(e) provides for the employer to make payments in relation to *hospital treatment, or *general treatment, provided to a person other than the employee or person providing services; or
(f) confers on the employer or another person a discretion whether to make payments.

(3) However, an arrangement:
(a) is not an *employee health benefits scheme merely because, under the arrangement, the employer will pay, or will reimburse employees, or persons providing services, for payment of, one or both of the following:
(i) the premiums payable by them for *complying health insurance policies;
(ii) the difference between benefits payable to them under policies, and amounts that they are liable to pay, for health services provided to them or members of their families; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) is not an employee health benefits scheme if the Private Health Insurance (Health Insurance Business) Rules provide that:
  (i) it is not an employee health benefits scheme; or
  (ii) arrangements of a class in which it is included are not employee health benefits schemes; and
(c) is not an employee health benefits scheme to the extent (if any) that the arrangement constitutes State insurance within the meaning of paragraph 51(xiv) of the Constitution.

121-20 Exception: accident and sickness insurance business

(1) Despite section 121-1, *health insurance business does not include the business of undertaking liability, by way of insurance, to pay a lump sum, or to make periodic payments, on the happening of a personal accident, disease or sickness.

(2) However, this section does not apply to:
  (a) business where liability is undertaken with respect to loss arising out of a liability to pay fees or charges in relation to the provision in Australia of *hospital treatment or *general treatment; or
  (b) business of a kind specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this paragraph.

121-25 Exception: liability insurance business

Despite section 121-1, *health insurance business does not include the business of undertaking liability, by way of insurance, with respect to any loss arising out of a liability to pay compensation or damages, including:
(a) a liability to pay compensation or damages because of the use of a motor vehicle; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) a liability to pay compensation or damages to an employee because of an event occurring in connection with the employee's employment.

121-30 Exception: insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules

Despite section 121-1, *health insurance business does not include a business of a kind that the Private Health Insurance (Health Insurance Business) Rules state not to be a health insurance business.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 4-4—Health benefits funds

Division 131—Health benefits funds

131-1 What this Part is about

This Part defines the key concept of a health benefits fund.

This Part also defines the concepts of health-related business and risk equalisation jurisdictions, and deals with some related matters (including the operation of health-related businesses through health benefits funds).

Note: The *Private Health Insurance (Prudential Supervision) Act 2015* requires private health insurers to have health benefits funds. Health benefits funds must be operated in accordance with the requirements of that Act.

131-5 Private Health Insurance (Health Benefits Fund Policy) Rules

(1) *Health benefits funds (and some related matters) are also dealt with in the Private Health Insurance (Health Benefits Fund Policy) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

Note: The Private Health Insurance (Health Benefits Fund Policy) Rules are made by the Minister under section 333-20.

(2) Before making Private Health Insurance (Health Benefits Fund Policy) Rules for the purposes of section 131-15, the Minister must consult *APRA. However, a failure to consult APRA does not affect the validity of those Rules.

Note: This consultation requirement also applies to any repeal or amendment of such Rules: see subsection 33(3) of the *Acts Interpretation Act 1901*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

131-10 Meaning of *health benefits fund*

A ***health benefits fund*** is a fund that:

(a) is established in the records of a private health insurer; and

(b) relates solely to:

(i) its *health insurance business, or a particular part of that business; or

(ii) its health insurance business, or a particular part of that business, and some or all of its *health-related businesses, or particular parts of those businesses.

131-15 Meaning of *health-related business*

(1) ***Health-related business*** is business that is any one or more of the following:

(a) a business of providing goods or services (or both) in order to manage or prevent diseases, injuries or conditions;

(b) a business of undertaking liability, by way of insurance, to indemnify people who are *ineligible for Medicare for costs associated with providing treatment, goods or services that:

(i) are provided to those people in Australia; and

(ii) are provided to manage or prevent diseases, injuries or conditions;

(c) a business of providing a financial service to assist people insured under *complying health insurance products to meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions;

(d) any other business, or business included in a class of businesses, specified in the Private Health Insurance (Health Benefits Fund Policy) Rules for the purposes of this paragraph.

(2) Despite subsection (1), neither of the following is ***health-related business***:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) business that is *health insurance business; or

(b) any other business, or business included in a class of businesses, specified in the Private Health Insurance (Health Benefits Fund Policy) Rules for the purposes of this paragraph.

131-20 Risk equalisation jurisdictions

(1) An area is a ***risk equalisation jurisdiction*** if the Private Health Insurance (Health Benefits Fund Policy) Rules so provide.

(2) The Private Health Insurance (Health Benefits Fund Policy) Rules may specify circumstances in which a private health insurer may (despite subsection 23(2) of the *Private Health Insurance (Prudential Supervision) Act 2015*) have more than one *health benefits fund in respect of a particular *risk equalisation jurisdiction.

131-25 Operation of health-related businesses through health benefits funds

If a private health insurer has a *health benefits fund in respect of its *health insurance business and some or all of its *health-related businesses, the insurer must comply with any requirements specified in the Private Health Insurance (Health Benefits Fund Policy) Rules relating to how the health-related businesses are to be conducted.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 4-5—Miscellaneous obligations of private health insurers

Division 157—Introduction

157-1 What this Part is about

This Part imposes miscellaneous notification and other obligations on private health insurers.

157-5 Private Health Insurance (Data Provision) Rules

Obligations of private health insurers are also dealt with in the Private Health Insurance (Data Provision) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

Note: The Private Health Insurance (Data Provision) Rules are made by the Minister under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 169—Notification obligations

169-10 Private health insurers to notify any changes to rules

(1) A private health insurer that proposes to change its *rules (other than a change to which section 66-10 applies) must notify the Secretary of the Department of the proposed change:

(a) in the *approved form; and

(b) before the day on which the insurer proposes the change to take effect.

Note: See section 93-25 for a private health insurer's obligation to notify insured persons of changes to its rules.

(2) The Minister may, in writing, direct the insurer not to make the change if the Minister is satisfied that the change might or would result in a breach of the Act.

Note: Directions are reviewable under Part 6-9.

(3) The Minister must give the Secretary and *APRA a copy of a direction under subsection (2).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 172—Other obligations

172-5 Agreements with medical practitioners

Medical purchaser-provider agreements

(1) If a private health insurer enters into an agreement with a *medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

Practitioner agreements

(2) If a hospital or day hospital facility enters into an agreement with a *medical practitioner, under which treatment is provided to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

Note: Medical practitioners may, in dealings with private health insurers, be able to take advantage of the collective bargaining provisions of Subdivision B of Division 2 of Part VII of the *Competition and Consumer Act 2010*.

172-10 Private health insurers to give information to Secretary

(1) The Private Health Insurance (Data Provision) Rules may specify kinds of information, relating to treatment of persons insured under *complying health insurance products that are *referable to *health benefits funds, that private health insurers are to give to the Secretary of the Department.

(2) A private health insurer must, in accordance with the Private Health Insurance (Data Provision) Rules, give to the Secretary of

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

the Department any information of that kind that the insurer receives from a *hospital.

172-15 Restrictions on payment of pecuniary penalties etc.

A private health insurer must not:

(a) use its money, or permit the use of its money, for:

(i) the payment of a pecuniary penalty imposed on a *director or *officer of the insurer because of an offence under this Act; or

(ii) the payment of an amount that a director or officer of the insurer, or a person who has been such a director or officer, is liable to pay under Division 203; or

(b) reimburse:

(i) a director or officer of the insurer in respect of a pecuniary penalty imposed on the director or officer because of an offence under this Act; or

(ii) a director or officer of the insurer, or a person who has been such a director or officer, in respect of a liability imposed on the director under Division 203.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Chapter 5—Enforcement

Part 5-1—Introduction

Division 180—Introduction

180-1 What this Chapter is about

Private health insurers who do not comply with this Act may have action taken against them under this Chapter.

Note: The methods set out in this Chapter are not the only enforcement methods available (see for example Division 84).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 5-2—General enforcement methods

Division 185—What this Part is about

185-1 Introduction

This Part gives the Minister powers to enable him or her to find out whether a private health insurer is complying with its enforceable obligations and to encourage or compel an insurer to comply with those obligations.

The Minister can:

(a) set performance indicators for insurers; or
(b) seek explanations from insurers; or
(c) investigate insurers; or
(d) obtain enforceable undertakings from insurers; or
(e) direct insurers to do particular things; or
(f) seek remedies in the Federal Court; or
(g) revoke an insurer's entitlement to offer tax rebates as premium reductions.

185-5 Meaning of *enforceable obligation*

All of the following provisions are ***enforceable obligations***:

(a) a provision of this Act;
(b) a provision of any Private Health Insurance Rules made under section 333-20;
(c) a provision of the regulations;
(d) a direction given to a private health insurer under this Act;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(e) if the insurer is a *restricted access insurer—a provision included in the insurer's constitution or *rules in order to comply with subsection 15(3) of the *Private Health Insurance (Prudential Supervision) Act 2015*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 188—Performance indicators

188-1 Performance indicators

(1) The Private Health Insurance (Complying Product) Rules may set out performance indicators to be used by the Minister in monitoring private health insurers' compliance with the principle of community rating in section 55-5 and the community rating requirements in Division 66.

(2) The performance indicators are to be framed:

(a) to assist the Minister in detecting breaches of the principle of community rating in section 55-5 or the community rating requirements in Division 66; and

(b) to alert the Minister to any practices of a private health insurer in relation to community rating that may require investigation; and

(c) to alert the Minister to any practices of one or more private health insurers in relation to community rating that may be contrary to government health policy and may require a regulatory response.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 191—Explanation of private health insurer's operations

191-1 Minister may seek an explanation from a private health insurer

(1) If, having regard to information available to the Minister or to any performance indicators under the Private Health Insurance (Complying Product) Rules, the Minister believes that a private health insurer may have contravened an *enforceable obligation, the Minister may write to the private health insurer:

(a) explaining the Minister's concerns; and

(b) asking the insurer to explain its operations in relation to those concerns; and

(c) specifying the period within which the Minister requires the insurer's response.

(2) The private health insurer must respond within the specified period, or any longer period that the Minister, in writing before the end of the specified period, allows.

(3) If the Minister refuses a request by the private health insurer for a longer period to respond, the Minister must state the Minister's reasons for refusing.

Note: Refusals of requests for longer periods to respond are reviewable under Part 6-9.

191-5 Minister must respond to insurer's explanation

The Minister must, after receiving an explanation from a private health insurer in response, inform the insurer in writing:

(a) whether the Minister is or is not satisfied with the explanation; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) if the Minister is not satisfied with the explanation—what steps the Minister intends to take.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 194—Investigation of private health insurer's operations

194-1A Purposes for which powers may be exercised etc.

(1) The powers in this Division may only be exercised for the purposes of this Act.

(2) The powers in this Division cannot be exercised for the purposes of this Act, as it applies in relation to:

(a) levy imposed under the *Private Health Insurance (Risk Equalisation Levy) Act 2003*; or

(b) the Risk Equalisation Special Account.

194-1 Minister may investigate a private health insurer

The Minister may, at any time and for any reason, begin an investigation of the operations of a private health insurer by doing either or both of the following:

(a) giving a notice under any one or more sections of this Division;

(b) authorising a person under section 194-25.

194-5 Notice to give information

(1) The Minister may give a written notice to a person who is or who has been an *officer, employee or agent of:

(a) a private health insurer; or

(b) an entity that was a private health insurer at any time in the year ending on the day on which the notice is given;

requiring the person to give the Minister or the person specified in the notice, within the period specified in the notice, information about the area of the insurer's operations specified in the notice.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2) The Minister may require the person to give the information orally or in writing.

(3) The Minister may require the person to give the information on oath or affirmation. For that purpose, the Minister or the person specified in the notice may administer an oath or affirmation.

(4) The person is not excused from giving information on the ground that giving the information might tend to incriminate the person or make the person liable to a penalty. However, the information, or anything obtained as a direct or indirect consequence of the information, is not admissible in evidence against the person in any proceedings, other than proceedings for an offence against section 137.1 or 137.2 of the *Criminal Code*.

194-10 Notice to produce documents

(1) The Minister may give a written notice to a person who is or who has been an *officer, employee or agent of:

(a) a private health insurer; or

(b) an entity that was a private health insurer at any time in the year ending on the day on which the notice is given;

requiring the person to produce, at the time and place specified in the notice, records, books, accounts and other documents of the insurer that are in the person's custody or under the person's control and that relate to the area of the insurer's operations specified in the notice.

(2) The person is not excused from producing a document on the ground that the production of the document might tend to incriminate the person or make the person liable to a penalty. However, the production of the document, or anything obtained as a direct or indirect consequence of the production, is not admissible in evidence against the person in any proceedings, other than proceedings for an offence against section 137.1 or 137.2 of the *Criminal Code*.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

194-15 Notice to give evidence

(1) The Minister may give a written notice to a person who is or who has been an *officer, employee or agent of:

(a) a private health insurer; or

(b) an entity that was a private health insurer at any time in the year ending on the day on which the notice is given;

requiring the person to attend, at the time and place specified in the notice, before the Minister or the person specified in the notice and give evidence relating to an area of the insurer's operations specified in the notice.

(2) The Minister may require the person to give the evidence orally or in writing.

(3) The Minister may require the person to give the evidence on oath or affirmation. For that purpose, the Minister or the person specified in the notice may administer an oath or affirmation.

(4) The person is not excused from answering a question on the ground that the answer to the question might tend to incriminate the person or make the person liable to a penalty. However, the answer, or anything obtained as a direct or indirect consequence of the answer, is not admissible in evidence against the person in any proceedings, other than proceedings for an offence against section 137.1 or 137.2 of the *Criminal Code*.

194-20 Offences in relation to investigation notices

(1) A person must not fail to comply with a requirement contained in a notice given to the person:

(a) under section 194-5 (notice to give information); or

(b) under section 194-10 (notice to produce documents); or

(c) under section 194-15 (notice to give evidence).

Penalty: 10 penalty units.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2) A person must not fail to be sworn or to make an affirmation when required to do so:
  (a) under section 194-5 (notice to give information); or
  (b) under section 194-15 (notice to give evidence).

  Penalty: 10 penalty units.

(3) An offence under subsection (1) or (2) is an offence of strict liability.

  Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

194-25 Authorisation to examine books and records etc.

(1) The Minister may, in writing, authorise a person to examine and report on the records, books, accounts and other documents of:
  (a) a private health insurer; or
  (b) an entity that was a private health insurer at any time in the year ending on the day on which the authorisation is given.

(2) A person authorised under subsection (1) must, at all reasonable times, have full and free access to any *premises at which the records, books, accounts and other documents are kept and may take extracts from, or copies of, the records, books, accounts and other documents.

194-35 Minister must notify outcome of investigation

After completing an investigation under this Division of a private health insurer or former private health insurer, the Minister must inform the insurer in writing:
  (a) whether the Minister is or is not satisfied with the performance of the insurer; and
  (b) if the Minister is not satisfied with the performance of the insurer—what steps the Minister intends to take.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 197—Enforceable undertakings

197-1 Minister may accept written undertakings given by a private health insurer

(1) The Minister may accept a written undertaking, given by a private health insurer at the Minister's request, if the Minister considers that compliance with the undertaking will:

(a) be likely to improve the performance of the insurer in relation to one or more matters of a kind regulated by this Act; or

(b) if the Minister is satisfied that the insurer has contravened an *enforceable obligation—be likely to ensure that the insurer will cease to be in contravention of the enforceable obligation.

(3) The private health insurer may withdraw or vary the undertaking at any time with the consent of the acceptor of the undertaking.

197-5 Enforcement of undertakings

(1) If the Minister considers that a private health insurer that gave an undertaking under this Division has contravened any of its terms, the Minister may apply to the Federal Court for an order under subsection (2).

(2) If the Federal Court is satisfied that the private health insurer has contravened a term of the undertaking, the court may make one or more of the following orders:

(a) an order directing the insurer to comply with the terms of the undertaking;

(b) if there is a contravention of an *enforceable obligation—any other order of a kind set out in Division 203 that the court considers appropriate.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 200—Ministerial directions

200-1 Minister may give directions

(1) If, at any time and for any reason, the Minister considers that it will assist in the prevention of *improper discrimination to do so, the Minister may give a direction to a private health insurer requiring it:

(a) to modify its day-to-day operations in a particular respect; or

(b) to modify its *rules in a particular respect; or

(c) if the insurer is a *restricted access insurer—to modify the provisions included in its constitution or *rules in order to comply with subsection 15(3) of the *Private Health Insurance (Prudential Supervision) Act 2015* in a particular respect.

Note: A decision to give a direction is reviewable under Part 6-9.

(2) If, at any time and for any reason, the Minister considers that there appears to be a contravention of an *enforceable obligation involving *improper discrimination by a private health insurer, the Minister may give a direction to the insurer requiring it to address the contravention by:

(a) modifying its day-to-day operations; or

(b) modifying its *rules; or

(c) if the insurer is a *restricted access insurer—modifying the provisions included in its constitution or *rules in order to comply with subsection 15(3) of the *Private Health Insurance (Prudential Supervision) Act 2015*.

Note: A decision to give a direction is reviewable under Part 6-9.

(3) A direction mentioned in subsection (1) or (2) may, if the Minister considers it proper to do so, include requirements with respect to the reconsideration by the private health insurer of an application

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

or claim made to the insurer and dealt with by it before the direction takes effect.

(4) A private health insurer must, in reconsidering an application or claim in accordance with subsection (3), deal with the application or claim as if the direction had been in force at the time when the application or claim was first considered.

(5) A direction given under this section must be published on the Department's website not later than 5 working days after the direction is given.

200-5 Direction requirements

A direction given under this Division to a private health insurer:

(a) must be in writing; and

(b) must be signed by the Minister; and

(c) may be served on the insurer by serving a copy on the insurer's *chief executive officer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 203—Remedies in the Federal Court

203-1 Minister may apply to the Federal Court

If the Minister is satisfied that a private health insurer has contravened an *enforceable obligation, the Minister may apply to the Federal Court for:

(a) a *declaration of contravention; and

(b) any one or more of the following orders:

(i) a pecuniary penalty order under section 203-10;

(ii) a compensation order under section 203-15;

(iii) an adverse publicity order under section 203-20;

(iv) any other order that the Minister considers to be appropriate to redress the contravention.

203-5 Declarations of contravention

(1) If the Federal Court is satisfied that a private health insurer has contravened an *enforceable obligation, it must make a declaration of contravention.

(2) The declaration must specify:

(a) the *enforceable obligation that was contravened; and

(b) the private health insurer that contravened the provision; and

(c) the conduct that constituted the contravention; and

(d) if the court is satisfied that an *officer of the private health insurer failed to take reasonable steps to prevent the insurer contravening the enforceable obligation—the officer.

(3) A *declaration of contravention is conclusive evidence of the matters mentioned in subsection (2).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

203-10 Pecuniary penalty order

(1) If the Federal Court has made a *declaration of contravention that specifies an *officer of a private health insurer (see paragraph 203-5(2)(d)), the court may order the officer to pay the Commonwealth a pecuniary penalty of up to 1,000 penalty units.

(2) The court must not make an order under subsection (1) if it is satisfied that a court has ordered the *officer to pay damages in the nature of punitive damages in respect of:

(a) the contravention of the *enforceable obligation; or

(b) the officer's failure to take reasonable steps to prevent the insurer contravening the enforceable obligation.

(3) The penalty is a civil debt payable to the Commonwealth. The Commonwealth may enforce the order as if it were an order made in civil proceedings against the *officer to recover a debt due by the officer. The debt arising from the order is taken to be a judgment debt.

203-15 Compensation order

(1) If the Federal Court has made a *declaration of contravention, the court may order the private health insurer specified in the declaration to compensate an individual for any injury or loss suffered by the individual as a result of the contravention.

(2) The order must specify the amount of compensation.

(3) The order may be enforced as if it were a judgment of the court.

203-20 Adverse publicity order

(1) If the Federal Court has made a *declaration of contravention, the court may make an order requiring the private health insurer specified in the declaration to do either or both of the following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) *disclose in a way, and to the person or persons, specified in the order, the information specified in the notice to correct or counter the effect of the contravention;

(b) publish, in the way specified in the order, an advertisement to correct or counter the effect of the contravention in the terms specified in, or determined in accordance with, the order.

(2) The order may be enforced as if it were a judgment of the court.

203-25 Other order

(1) If the Federal Court has made a *declaration of contravention, the court may make any order that the applicant applies for.

(2) The order may be enforced as if it were a judgment of the court.

203-30 Time limit for declarations and orders

Proceedings under this Division may be started no later than 6 years after the contravention.

203-35 Civil evidence and procedure rules for declarations and orders

The Federal Court must apply the rules of evidence and procedure for civil matters in proceedings under this Division.

Note: The standard of proof in civil proceedings is the balance of probabilities (see section 140 of the *Evidence Act 1995*).

203-40 Civil proceedings after criminal proceedings

The Federal Court must not make a pecuniary penalty order against an *officer of a private health insurer under section 203-10 if the officer has been convicted of an offence constituted by conduct that is substantially the same as the conduct to which the court had regard in satisfying itself that the officer failed to take reasonable

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

steps to prevent the insurer contravening the *enforceable obligation.

203-45 Criminal proceedings during civil proceedings

(1) Proceedings for a pecuniary penalty order against an *officer of a private health insurer are stayed if:

(a) criminal proceedings are started or have already been started against the officer for an offence; and

(b) the offence is constituted by conduct that is substantially the same as the conduct to which the court had regard in satisfying itself that the officer failed to take reasonable steps to prevent the insurer contravening the *enforceable obligation.

(2) The proceedings for the order may be resumed if the *officer is not convicted of the offence. Otherwise, the proceedings for the order are dismissed.

203-50 Criminal proceedings after civil proceedings

Criminal proceedings may be started against a person for conduct that is substantially the same as conduct constituting a contravention of an *enforceable obligation regardless of whether:

(a) a *declaration of contravention has been made that specifies the person; or

(b) an order has been made against the person under this Division.

203-55 Evidence given in proceedings for penalty not admissible in criminal proceedings

Evidence of information given or evidence of production of documents by an *officer of a private health insurer is not admissible in criminal proceedings against the officer if:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) the officer previously gave the evidence or produced the documents in proceedings for a pecuniary penalty order against the officer under section 203-10 (whether or not the order was made); and

(b) the conduct alleged to constitute the offence is substantially the same as the conduct to which the court had regard in satisfying itself that the officer failed to take reasonable steps to prevent the insurer contravening the *enforceable obligation.

However, this does not apply to a criminal proceeding in respect of the falsity of the evidence given by the officer in the proceedings for the pecuniary penalty order.

203-60 Minister may require person to assist

(1) The Minister may, in writing, require a person to give all reasonable assistance in connection with:

(a) an application:

(i) for a *declaration of contravention in relation to a private health insurer; or

(ii) for a declaration of contravention that specifies an *officer of a private health insurer; or

(iii) for a pecuniary penalty order under section 203-10 in relation to an officer of a private health insurer; or

(b) criminal proceedings against a private health insurer, or an officer of a private health insurer, for an offence against this Act.

The person must comply with the request.

Penalty: 5 penalty units.

(3) The Minister must not require the person to assist in connection with an application for a declaration or order unless:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) it appears to the Minister that someone other than the person required to assist may have contravened an *enforceable obligation; and

(b) the Minister suspects or believes that the person required to assist can give information relevant to the application.

(4) The Minister must not require the person to assist in connection with criminal proceedings unless:

(a) it appears to the Minister that the person required to assist is unlikely to be a defendant in the proceedings; and

(b) the person required to assist is an employee or agent (including a banker or auditor) of the private health insurer concerned.

(5) The Minister may require the person to assist regardless of whether:

(a) an application for the declaration or order has actually been made; or

(b) criminal proceedings for the offence have actually begun.

(6) The person cannot be required to assist if the person is or has been a lawyer for:

(a) in an application for a declaration or order—the person suspected of the contravention; or

(b) in criminal proceedings—a defendant or likely defendant in the proceedings.

(7) The Federal Court may order the person to comply with the requirement in a specified way. Only the Minister may apply to the court for an order under this subsection.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

203-65 Relief from liability for contravening an enforceable obligation

(1) If, in proceedings brought against a person under this Division, it appears to the Federal Court that:

(a) the person has, or may have:

(i) contravened an *enforceable obligation; or

(ii) if the person is an *officer of a private health insurer—failed to take reasonable steps to prevent the insurer from contravening an enforceable obligation; but

(b) the person has acted honestly and, having regard to all the circumstances of the case, the person ought fairly to be excused for the contravention;

the court may relieve the person either wholly or partly from a liability to which the person would otherwise be subject, or that might otherwise be imposed on the person, because of the contravention.

(2) A person who thinks that proceedings will or may be begun against the person under this Division may apply to the Federal Court for relief.

(3) On an application under subsection (2), the court may grant relief under subsection (1) as if the proceedings had been begun in the court.

(4) For the purposes of subsection (1) as applying for the purposes of a case tried by a judge with a jury:

(a) a reference in that subsection to the court is a reference to the judge; and

(b) the relief that may be granted includes withdrawing the case in whole or in part from the jury and directing judgment to be entered for the defendant on such terms as to costs as the judge thinks appropriate.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

203-70 Powers of Federal Court

A provision of this Act conferring a power on the Federal Court does not affect any other power of the court conferred by this Act or otherwise.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 206—Revoking entitlement to offer rebate as a premium reduction

206-1 Revocation of status of participating insurer

(1) If a *participating insurer:

(b) has failed to comply with a condition specified in the Private Health Insurance (Incentives) Rules as a condition of participation in the *premiums reduction scheme; or

(c) refuses or fails to comply with:

(i) a direction given by the Minister under section 200-1; or

(ii) the principle of community rating in section 55-5;

the Minister may, by notice given to the insurer, revoke the insurer's status as a participating insurer.

(2) Upon the giving of the notice, the insurer ceases to be a *participating insurer.

Note: Decisions to revoke an insurer's status as a participating insurer are reviewable under Part 6-9.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Chapter 6—Administration

Part 6-1—Introduction

Division 230—Introduction

230-1 What this Chapter is about

This Chapter:

(c) deals with some general administrative matters relating to the premiums reduction scheme in Part 2-2;

(e) deals with administration and collection of private health insurance levies;

(f) provides for the Private Health Insurance Risk Equalisation Special Account;

(g) protects information obtained for the purposes of this Act and sets out the circumstances in which such information may be used;

(h) provides for review by the Administrative Review Tribunal of certain decisions made under this Act;

(i) provides for miscellaneous other matters such as delegations, the approval of forms and the making of Private Health Insurance Rules and regulations.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-4—Administration of premiums reduction scheme

Division 276—Introduction

276-1 What this Part is about

Part 2-2 provides for a premiums reduction scheme. This Part provides:

(a) for private health insurers to be reimbursed for premiums that were reduced under the premiums reduction scheme in Division 23; and

(b) for the Chief Executive Medicare to supervise that reimbursement and related matters; and

(c) for recovery of amounts paid in error; and

(d) for various other related administrative matters in relation to the scheme.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 279—Reimbursement of participating insurers and powers of Chief Executive Medicare

Subdivision 279-A—Reimbursement of private health insurers for premiums reduced under scheme

279-1 Who can make reimbursement claims

(1) A private health insurer may claim reimbursement from the Chief Executive Medicare for amounts by which premiums under a *complying health insurance policy issued by the private health insurer are reduced because of the operation of Division 23 if:

(a) the private health insurer is a *participating insurer when the premium is reduced; and

(b) the premium is reduced in the 36 month period ending before the month in which the claim for reimbursement is made.

(2) The claim for reimbursement must be made in accordance with section 279-10.

279-5 Participating insurers

(1) A private health insurer may apply to the Minister, in the *approved form, to become a *participating insurer for the purposes of this Part.

(2) If the Minister approves the application, the private health insurer becomes a *participating insurer.

(3) The Minister must approve the application, unless:

(a) the insurer's status as a *participating insurer has previously been revoked under subsection 206-1(1); and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) the Minister is satisfied that the insurer is continuing, or will continue, to fail to comply with a provision or condition mentioned in that subsection.

Note: Rejections of applications are reviewable under Part 6-9.

(4) The Minister must notify the applicant, within 28 days after the date of the decision, whether the application has been approved or rejected.

(5) If the application is rejected, the Minister must include his or her reasons for rejecting the application in the notice.

279-10 Requirements relating to reimbursement claims

(1) A private health insurer may only make one claim each month for reimbursement from the Chief Executive Medicare of amounts by which premiums under a *complying health insurance policy issued by the private health insurer are reduced.

(2) The claim must:
(a) be made within 7 days after the end of a month; and
(b) be given to the Chief Executive Medicare electronically in accordance with the electronic system approved by the Chief Executive Medicare under section 333-16 for the purposes of this paragraph; and
(c) include the information required by that system to be included in the claim; and
(d) be accompanied by any documents required by that system to accompany the claim.

(3) Before making a claim, a private health insurer must be satisfied that:
(a) the claim only includes amounts by which premiums under a *complying health insurance policy issued by the private health insurer have been reduced because of the operation of Division 23; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) the private health insurer was a *participating insurer when the premiums were reduced; and

(c) the premiums were reduced in the 36 month period ending before the month in which the claim for reimbursement is made; and

(d) the amounts have not previously been reimbursed to the private health insurer under this Division.

279-11 Determination of claim

(1) If:

(a) the Chief Executive Medicare receives a claim in accordance with section 279-10; and

(b) the criteria specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph have been met in relation to the claim;

the Chief Executive Medicare must pay the insurer, in accordance with section 279-15, the amount payable under that section.

Note: A decision under this subsection is able to be automated by a computer program: see section 333-17.

(2) If the criteria specified for the purposes of paragraph (1)(b) are not met in relation to the claim, or part of the claim, the Chief Executive Medicare must:

(a) if the criteria are not met in relation to part of the claim—refuse the claim in part and only pay the insurer, in accordance with section 279-15, the amount payable under that section in respect of such part of the claim that meets the specified criteria; or

(b) otherwise—refuse the claim.

(3) The Chief Executive Medicare must notify the private health insurer if the Chief Executive Medicare makes a decision mentioned in subsection (2).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4) A notice under subsection (3) must include reasons for the decision.

(5) The Chief Executive Medicare is taken, for the purposes of this Part, to have accepted a claim in whole if the Chief Executive Medicare does not notify the private health insurer of a decision mentioned in subsection (2) on or before the day under subsection 279-15(2) by which the claim would have been required to have been paid.

279-15 Amounts payable to the private health insurer

(1) The amount payable to the private health insurer in respect of a claim is the sum of the amounts that are included in the claim as amounts by which premiums under the *complying health insurance policies issued by the private health insurer have been reduced because of the operation of Division 23.

(1A) However, if paragraph 279-11(2)(a) applies in relation to the claim, the amount payable to the private health insurer under subsection (1) of this section must not include any amounts included in the claim that do not meet the criteria specified for the purposes of paragraph 279-11(1)(b).

(2) The amount must be paid to the private health insurer on or before the 15th day of the month in which the claim for reimbursement is made.

(3) The amount must be paid in the way determined, in writing, by the Chief Executive Medicare.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

279-45 Reconsideration of decisions

(1) A private health insurer that has been given a notice under subsection 279-11(3) may request the Chief Executive Medicare to reconsider the decision.

(2) The request must:
  (a) set out the reasons for the request; and
  (b) be made within the period of 28 days after the day on which the Chief Executive Medicare gave the notice.

(3) As soon as practicable after receiving the request, the Chief Executive Medicare must reconsider the decision and:
  (a) affirm it; or
  (b) vary it; or
  (c) revoke it and make a fresh decision.

Note: Decisions on reconsideration are reviewable under Part 6-9.

(4) If the Chief Executive Medicare varies the decision or revokes the decision and makes a fresh decision, the decision as varied, or the fresh decision, as the case may be, has effect according to its terms and is taken always to have had that effect from the time when the original decision was made.

(5) The Chief Executive Medicare must notify the private health insurer stating the Chief Executive Medicare's decision on the reconsideration together with a statement of his or her reasons for the decision.

(6) The Chief Executive Medicare is taken, for the purposes of this Part, to have revoked the decision if the Chief Executive Medicare does not notify the private health insurer of his or her decision on the reconsideration within 28 days after receiving the request.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Subdivision 279-B—Powers of Chief Executive Medicare in relation to participating insurers

279-50 Audits by Chief Executive Medicare

(1) The Chief Executive Medicare may, at any time, audit the accounts and records of a private health insurer that is, or has been, a *participating insurer.

(2) An audit under subsection (1) must relate only to the accounts and records of the private health insurer to the extent that they deal with:
  (a) participation by persons in the *premiums reduction scheme; or
  (b) reductions of premium payable under *complying health insurance policies under the premiums reduction scheme; or
  (c) receipt of money from the Chief Executive Medicare under this Division.

(3) The Chief Executive Medicare must not carry out an audit unless he or she has given notice to the private health insurer concerned stating that an audit is to be carried out.

(4) The private health insurer must ensure that the Chief Executive Medicare has full and free access to all accounts, records, documents and papers of the private health insurer that are relevant to the audit.

(5) The person carrying out the audit may make copies of, or take extracts from, such accounts, records, documents or papers for use in the audit.

(6) Without limiting the powers of the Chief Executive Medicare under this section, the Chief Executive Medicare may, by notice given to a private health insurer, require the insurer to give to the Chief Executive Medicare, within a period specified in the notice beginning at the end of a financial year, a certificate in writing by a

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

registered company auditor as to the correctness of the accounts and records of the insurer for that year to the extent that those accounts and records deal with matters mentioned in paragraphs (2)(a), (b) and (c).

279-55 Chief Executive Medicare may require production of applications

(1) The Chief Executive Medicare may, by notice given to a private health insurer, require the private health insurer:

(a) to produce to the Chief Executive Medicare, within the period and in the manner specified in the notice, applications retained under section 23-45; or

(b) to make copies of any such applications and give them to the Chief Executive Medicare within the period and in the manner specified in the notice.

(2) A period specified under subsection (1) must not be less than one month.

(3) A private health insurer is entitled to be paid by the Chief Executive Medicare reasonable compensation for complying with paragraph (1)(b).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 282—Recovery of amounts and other matters

Subdivision 282-A—When and how payments can be recovered

282-1 Recovery of payments

(1) The following amounts are recoverable as debts due to the Commonwealth:

(d) so much of a payment made under section 279-15 as relates to a *complying health insurance policy that covers a person who was:

(i) a *participant in the premiums reduction scheme for the financial year concerned in respect of the policy; and

(ii) not eligible to participate in that scheme in respect of that policy;

(e) so much of a payment made under section 279-15 as relates to a premium for which a reduction was not allowable under section 23-1;

(f) 150% of so much of a payment made under section 279-15 as:

(i) is not reflected in reductions in premiums payable under complying health insurance policies issued by the private health insurer concerned; or

(ii) relates to a person whose application under subsection 23-15(1) has not been retained by the private health insurer as required by section 23-45; or

(iii) relates to a person whose application under subsection 23-15(1) has been so retained, but has not been produced to the Chief Executive Medicare by the private health insurer in accordance with a requirement made by the Chief Executive Medicare under section 279-55;

(g) so much of a payment made under section 279-15 that is not an amount by which premiums under a complying health

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

insurance policy issued by the private health insurer were reduced because of the operation of Division 23;

(ga) so much of a payment made under section 279-15 in relation to a claim for reimbursement as relates to a premium for which a reduction was made before the 36 month period ending before the month in which the claim was made;

(gb) so much of a payment made under section 279-15 as:

(i) relates to a premium for which a reduction was made while the private health insurer was not a *participating insurer; or

(ii) relates to a premium for which a reduction was made where the amount of the reduction has previously been reimbursed to the private health insurer under Division 279;

(h) interest payable under subsection 282-5(2).

(1A) However, an amount is not recoverable under paragraph (1)(d), (e), (f) or (g) if the situation giving rise to the amount occurred because:

(a) the private health insurer relied on information provided to the private health insurer by, or on behalf of, a person who is, or was, a *participant in the *premiums reduction scheme; and

(b) the provided information was incomplete or inaccurate.

(2) The amounts are recoverable from:

(b) if paragraph (1)(d), (e), (f), (g), (ga) or (gb) applies—the private health insurer to which the payment concerned was made; or

(c) if paragraph (1)(h) applies:

(i) if the payment was made to a private health insurer—that insurer; or

(ii) if the payment was made to an individual—the individual or his or her estate.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) An amount recoverable under subsection (1) is recoverable whether or not any person has been convicted of an offence relating to the payment.

282-5 Interest on amounts recoverable

(1) If the Chief Executive Medicare has served, on an individual from whom an amount is recoverable or the legal personal representative of such an individual, or on a private health insurer from which an amount is recoverable, under subsection 282-1(1) a notice claiming an amount as a debt due to the Commonwealth and:

(a) an arrangement for the repayment of the amount has been entered into between the Chief Executive Medicare and the individual or the individual's legal personal representative, or the private health insurer, as the case may be, within the period referred to in subsection (3), and there has been a default in payment of an amount required to be paid under the arrangement; or

(b) at the end of the period such an arrangement has not been entered into and all or part of the amount remains unpaid;

then, from and including the day after the end of the period, interest becomes payable on so much of the amount as from time to time remains unpaid.

(2) Interest is payable:

(a) at the rate of 15% per annum; or

(b) if a lower rate is specified in the Private Health Insurance (Incentives) Rules for the purposes of this paragraph—that rate.

(3) The period for entering into an arrangement under paragraph (1)(a) is the period of 3 months following the service of the notice under subsection (1), or such longer period as the Chief Executive Medicare allows.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(4) Despite subsection (1), in any proceedings instituted by the Commonwealth for the recovery of an amount due under paragraph 282-1(1)(h), the court may order that the interest payable under that paragraph is, and is taken to have been, so payable from and including a day later than the day referred to in subsection (1).

282-10 Chief Executive Medicare may set off debts against amounts payable

(1) Despite any other provision of Part 2-2 or this Part, if:

(a) except for this section, an amount would be payable by the Chief Executive Medicare to a person or his or her estate, or to a private health insurer, under Part 2-2 or this Part; and

(b) an amount is recoverable under section 282-1 by the Commonwealth from the person or his or her estate, or from the insurer, as the case may be;

the Chief Executive Medicare may set off the whole or a part of the amount referred to in paragraph (b) against the amount referred to in paragraph (a).

(2) If the Chief Executive Medicare decides to make such a set-off in respect of a person or his or her estate, the Chief Executive Medicare must serve on the person or his or her legal personal representative or the legal personal representative of his or her estate a notice of the decision.

(3) If the Chief Executive Medicare makes such a set-off:

(a) the Chief Executive Medicare is liable to pay to the person or his or her estate, or to the insurer, only the amount remaining after the set-off; and

(b) the amount referred to in paragraph (1)(b) is reduced by the amount set off.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

282-15 Reconsideration of certain decisions under this Division

(1) A person (the ***applicant***) may apply to the Chief Executive Medicare for the Chief Executive Medicare to reconsider the following decisions:

(a) a decision that an amount is recoverable as a debt due to the Commonwealth under paragraph 282-1(1)(h) in respect of a payment made to an individual;

(b) a decision under subsection 282-10(1) to set off a debt against an amount otherwise payable to a person (other than a private health insurer) or his or her estate.

(2) The application must:

(a) be in writing; and

(b) set out the reasons for the application.

(3) The application must be made within:

(a) 28 days after the day on which the applicant is notified of the decision; or

(b) if, either before or after the end of that period of 28 days, the Chief Executive Medicare extends the period within which the application may be made—the extended period for making the application.

(4) Upon receiving such an application, the Chief Executive Medicare must:

(a) reconsider the decision; and

(b) either affirm or revoke the decision.

Note: Decisions affirming an original decision of the Chief Executive Medicare are reviewable under Part 6-9.

(5) If the Chief Executive Medicare revokes the decision, the revocation is taken to be a decision:

(a) in the case of a decision mentioned in paragraph (1)(a)—to waive the debt; or

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) in the case of a decision mentioned in paragraph (1)(b)—not to set off a debt against an otherwise payable amount.

(6) The Chief Executive Medicare must give the applicant a notice stating his or her decision on the reconsideration together with a statement of his or her reasons for the decision.

(7) The Chief Executive Medicare must make his or her decision on the reconsideration within 28 days after the day on which he or she received the application for the reconsideration.

(8) The Chief Executive Medicare is taken, for the purposes of this Subdivision, to have made a decision confirming the original decision if the Chief Executive Medicare has not told the applicant of his or her decision on the reconsideration before the end of the period of 28 days.

Subdivision 282-AA—Recovery of certain amounts by Commissioner of Taxation

282-16 Administration of this Subdivision by Commissioner of Taxation

The Commissioner of Taxation has the general administration of:

(a) this Subdivision; and

(b) any other provision of this Act to the extent that it relates to this Subdivision.

282-17 Subdivision operates in addition to Subdivision 282-A

(1) This Subdivision:

(a) operates in addition to Subdivision 282-A; and

(b) does not limit the operation of that Subdivision.

(2) Subdivision 282-A does not limit the operation of this Subdivision.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

No double recovery

(3) Despite subsections (1) and (2):

(a) an amount is not recoverable under section 282-1 to the extent that it has already been recovered in accordance with section 282-18; and

(b) an amount is not recoverable under section 282-18 to the extent that it has already been recovered in accordance with section 282-1.

Note: This section means that an amount that is recoverable under both paragraph 282-1(1)(e) and section 282-18 is recoverable from the private health insurer in accordance with section 282-1 or from the participant in accordance with section 282-18.

282-18 Liability for excess private health insurance premium reduction or refund

(1) This section applies if the amount of a premium payable during a financial year under a *complying health insurance policy is reduced because of the operation or purported operation of Division 23.

(2) Divide the total of the reduction by the number of persons who are *PHIIBs in respect of the premium.

(3) If the amount worked out under subsection (2) exceeds the *share of the PHII benefit of a person who is a *PHIIB in respect of the premium, that person is liable to pay the amount of that excess to the Commonwealth.

(4) If subsection (3) applies, the Commissioner of Taxation must give the person a notice stating that the person is liable to pay the amount of that excess to the Commonwealth.

(5) A notice given to a person under subsection (4) may be contained in a notice of assessment under the *Income Tax Assessment Act 1936*.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(6) An amount that a person is liable to pay under subsection (3) is due and payable at the same time as the income tax the person must pay for the financial year is due and payable under section 5-5 of the *Income Tax Assessment Act 1997*. For the purposes of determining that time, assume that the person must pay income tax for the financial year and that the Commissioner of Taxation makes an assessment of the income tax.

Note: The liability is a tax-related liability: see Part 4-15 in Schedule 1 to the *Taxation Administration Act 1953* for collection and recovery provisions.

(7) If the person is dissatisfied with the notice under subsection (4), he or she may object against it in the manner set out in Part IVC of the *Taxation Administration Act 1953*.

Reallocation of liability between spouses

(8) Subsection (10) applies if:

(a) a person (the ***first person***) is a *PHIIB in respect of the premium; and

(b) the first person is, on the last day of the financial year, married (within the meaning of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*; and

(c) the person to whom the first person is married is also a PHIIB in respect of the premium; and

(d) either:

(i) the first person has made a choice under section 61-215 of the *Income Tax Assessment Act 1997* in relation to the *income year corresponding to the financial year mentioned in subsection (1); or

(ii) the requirement in subsection (9) is satisfied.

(9) The requirement in this subsection is satisfied if:

(a) during an *income year (the ***lodgement year***), the first person lodges his or her income tax return for the income year (the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

return year) corresponding to the financial year mentioned in subsection (1); and

(b) the person to whom the first person is married does not lodge his or her income tax return for the return year before the end of the lodgement year (whether or not he or she is required to lodge such a return).

(10) If this subsection applies:

(a) the amount (if any) that the person to whom the first person is married is liable to pay under subsection (3) in respect of the premium is reduced to nil; and

(b) the first person's liability under subsection (3) is increased by that amount.

282-19 When general interest charge payable

(1) If:

(a) a person is liable under section 282-18 to pay an amount; and

(b) the whole or a part of the amount remains unpaid after the time by which the amount is due to be paid;

the person is liable to pay *general interest charge on the unpaid amount.

(2) A person who is liable under this section to pay *general interest charge on an unpaid amount is liable to pay the charge for each day in the period that:

(a) started at the beginning of the day by which the unpaid amount was due to be paid; and

(b) finishes at the end of the last day at the end of which any of the following remains unpaid:

(i) the unpaid amount;

(ii) general interest charge on any of the unpaid amount.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Subdivision 282-B—Miscellaneous

282-20 Notification requirements—private health insurers

(1) The Chief Executive Medicare may, by notice given to a private health insurer, require the insurer, within the period specified in the notice, to provide information specified in the notice about:

(a) a person who is covered at any time during a financial year specified in the notice by a *complying health insurance policy issued by the insurer; or

(b) a person who paid premiums under such a policy; or

(c) a claim made at any time by the insurer under the *premiums reduction scheme for reimbursement of premiums reduced under Division 23.

(2) The information must be given in the *approved form.

(3) A private health insurer commits an offence if:

(a) the insurer is required by a notice under subsection (1) to provide information within a specified period about a person or matter; and

(b) the insurer fails to comply with the requirement.

Penalty: 20 penalty units.

Note: The obligation to provide information in response to a notice under subsection (1) is a continuing obligation and a private health insurer commits an offence for each day, after the period specified in the notice, until the information is provided (see section 4K of the *Crimes Act 1914*).

(4) Strict liability applies to subsection (3).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

282-25 Use etc. of information relating to another person

A person commits an offence if:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) the person *uses, or *discloses to any person, any information that relates to the affairs of another person and was acquired under or for the purposes of Part 2-2, this Part or paragraph 323-5(c); and

(b) the use or disclosure was not carried out in the performance of a function or obligation, or the exercise of a power, under Part 2-2, this Part or paragraph 323-5(c).

Penalty: Imprisonment for 1 year.

282-30 Information to be provided to the Commissioner of Taxation

(1) The Chief Executive Medicare must, within 120 days after the end of each financial year, give to the Commissioner of Taxation the information that the Commissioner of Taxation, by legislative instrument, determines.

(2) A determination under subsection (1) must not require the Chief Executive Medicare to give:

(a) the *tax file number of any person; or

(b) information about the physical, psychological or emotional health of any person.

282-35 Delegation

The Chief Executive Medicare may, by writing, delegate all or any of his or her powers under Part 2-2 or this Part to a Departmental employee (within the meaning of the *Human Services (Medicare) Act 1973*).

Note: The Minister may also delegate his or her powers under Part 2-2 or this Part (see section 333-5).

282-40 Appropriation

The Consolidated Revenue Fund is appropriated for the purpose of making payments under Part 2-2 and this Part.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-6—Private health insurance levies

Division 304—Introduction

304-1 What this Part is about

Each private health insurance levy is imposed under a levy Act. This Part deals with collection of the levies and other matters relating to their administration.

304-5 Private Health Insurance (Levy Administration) Rules

The collection of *private health insurance levies and other matters relating to administration of the levies are also dealt with in the Private Health Insurance (Levy Administration) Rules. The provisions of this Part indicate when a particular matter is or may be dealt with in these Rules.

Note: The Private Health Insurance (Levy Administration) Rules are made by the Minister under section 333-20.

304-10 Meaning of *private health insurance levy*

Each of the following levies is a ***private health insurance levy***:

(b) levy imposed under the *Private Health Insurance (Complaints Levy) Act 1995* (***complaints levy***);

(d) levy imposed under the *Private Health Insurance (Risk Equalisation Levy) Act 2003* (***risk equalisation levy***);

(da) levy imposed under the *Private Health Insurance (Medical Devices and Human Tissue Products Levy) Act 2007* (***medical devices and human tissue products levy***);

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(e) levy imposed under the *Private Health Insurance (National Joint Replacement Register Levy) Act 2009* (***national joint replacement register levy***).

Note: Private health insurers are also liable to pay levies imposed by the *Private Health Insurance Supervisory Levy Imposition Act 2015* and the *Private Health Insurance (Collapsed Insurer Levy) Act 2003*. This Part does not apply to those levies. The collection of those levies is dealt with in the *Financial Institutions Supervisory Levies Collection Act 1998*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 307—Collection and recovery of private health insurance levies

307-1 When private health insurance levy must be paid

(1) A *private health insurance levy that is imposed on a particular day (the ***imposition day***) becomes due and payable on the day specified as the payment day for that imposition day in:

(a) a determination made by the Minister, by legislative instrument, if the levy is:

(iii) *complaints levy imposed on a supplementary complaints levy administration day (within the meaning of the *Private Health Insurance (Complaints Levy) Act 1995*; or

(iv) *risk equalisation levy imposed on a supplementary risk equalisation levy day (within the meaning of the *Private Health Insurance (Risk Equalisation Levy) Act 2003*; or

(v) *national joint replacement register levy imposed on a supplementary national joint replacement register levy day (within the meaning of the *Private Health Insurance (National Joint Replacement Register Levy) Act 2009*); and

(b) otherwise—the Private Health Insurance (Levy Administration) Rules.

(2) The Minister must obtain, and take into account, advice from *APRA in relation to the day that is to be specified as the payment day in a determination made under subparagraph (1)(a)(iv).

307-5 Late payment penalty

(1) If a *private health insurance levy remains wholly or partly unpaid by a person after it becomes due and payable, the person is liable to pay a late payment penalty under this section.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(2) The *late payment penalty is calculated:
  (a) at the rate specified in the Private Health Insurance (Levy Administration) Rules (which must not be higher than 15%); and
  (b) on the unpaid amount of the levy; and
  (c) for the period:
    (i) starting when the levy becomes due and payable; and
    (ii) ending when the levy, and the penalty payable under this section, have been paid in full.

307-10 Payment of levy and late payment penalty

(1) The following must be paid to the Commonwealth:
  (a) a *complaints levy;
  (b) a *late payment penalty in respect of a complaints levy;
  (c) a *national joint replacement register levy;
  (d) a late payment penalty in respect of a national joint replacement register levy;
  (e) a *medical devices and human tissue products levy;
  (f) a late payment penalty in respect of a medical devices and human tissue products levy.

(2) The following must be paid to *APRA, on behalf of the Commonwealth:
  (a) *risk equalisation levy;
  (b) *late payment penalty in respect of risk equalisation levy.

Note: These amounts are to be credited to the Risk Equalisation Special Account: see section 318-5.

307-15 Recovery of levy and late payment penalty

(1) A *private health insurance levy that is due and payable is a debt due to the Commonwealth.

(2) A *late payment penalty is a debt due to the Commonwealth.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) An amount referred to in subsection (1) or (2) may be recovered as a debt by action in a court of competent jurisdiction by:
  (a) the Commonwealth, in respect of a debt payable to the Commonwealth under subsection 307-10(1); or
  (b) *APRA (as agent of the Commonwealth), in respect of a debt payable under subsection 307-10(2).

307-20 Waiver of late payment penalty

(1) The Minister may waive the whole or part of an amount of *late payment penalty in respect of an unpaid amount of:
  (a) *complaints levy; or
  (b) *national joint replacement register levy; or
  (c) *medical devices and human tissue products levy;
if the Minister considers that there are good reasons for doing so.

(2) *APRA may waive the whole or part of an amount of *late payment penalty in respect of an unpaid amount of *risk equalisation levy if APRA considers that there are good reasons for doing so.

307-30 Other matters

(1) The Private Health Insurance (Levy Administration) Rules may, in relation to *private health insurance levy or *late payment penalty, provide for, or for matters relating to, any or all of the following:
  (a) methods for payment;
  (b) extending the time for payment;
  (c) refunding or otherwise applying overpayments.

(2) The Private Health Insurance (Levy Administration) Rules may specify persons who are liable to pay *medical devices and human tissue products levy.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 310—Returns, requesting information and keeping records: private health insurers

310-1 Returns relating to complaints levy

(1) A private health insurer must lodge a return for each day that, under the *Private Health Insurance (Complaints Levy) Act 1995*, is a census day.

(3) The return must:
  (a) be in the *approved form; and
  (b) be lodged with the Secretary of the Department within 28 days after the census day.

(4) A private health insurer commits an offence if the insurer fails to lodge the return.

Penalty: 60 penalty units.

(5) Strict liability applies to subsection (4).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

310-5 Insurer must keep records

(1) A private health insurer must keep all records that are relevant to either or both of following:
  (a) whether the insurer is liable to pay a *private health insurance levy;
  (b) the amount of the private health insurance levy that the insurer is liable to pay.

(2) The records must be kept in:
  (a) an electronic form; or
  (b) another form approved by:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(i) the Secretary of the Department, if the records relate to *complaints levy; or

(ii) *APRA, if the records relate to *risk equalisation levy.

(3) The records must be retained for a period of 7 years (or a shorter period allowed by the Private Health Insurance (Levy Administration) Rules) starting on the later of:

(a) the day on which the records were created; or

(b) 1 July 2004.

(4) A private health insurer commits an offence if the insurer fails to:

(a) keep the records; or

(b) keep the records in the form required by or under subsection (2); or

(c) retain the records for the period required by or under subsection (3).

Penalty: 60 penalty units.

(5) Strict liability applies to subsection (4).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

(6) Nothing in this section is to be taken to have required an insurer to do an act or thing before the day on which this Act commences.

310-10 Power to request information from insurer

(1) *APRA may, if it believes on reasonable grounds that a private health insurer is capable of giving information that is relevant to:

(a) whether the insurer is liable to pay *risk equalisation levy; or

(b) the amount of risk equalisation levy that the insurer is liable to pay;

request the insurer to give APRA the information or records that are specified in the request, before the end of the period specified in the request.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 310-10

(2) The Secretary of the Department may, if he or she believes on reasonable grounds that a private health insurer is capable of giving information that is relevant to:

(a) whether the insurer is liable to pay *complaints levy; or

(b) the amount of complaints levy that the insurer is liable to pay;

request the insurer to give him or her the information or records that are specified in the request, before the end of the period specified in the request.

(3) A request under subsection (1) or (2):

(a) must be served on the *chief executive officer of the insurer; and

(b) may require the information to be verified by statutory declaration; and

(c) must specify the manner in which the information must be given; and

(d) must contain a statement to the effect that a failure to comply with the request is an offence.

(4) A private health insurer commits an offence if the insurer fails to comply with a request under subsection (1) or (2).

Penalty: 60 penalty units.

(5) Strict liability applies to subsection (4).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 313—Power to enter premises and search for documents related to complaints levy

313-1 Authorised officer may enter premises with consent

(1) A person (an ***authorised officer***) who is authorised in writing by the Minister for this purpose may enter any *premises for the purpose of exercising *search powers in relation to *levy-related documents if:

(c) the *occupier of the premises consents to the entry; and

(d) the officer shows the occupier his or her identity card.

(2) A ***levy-related document*** is a document (including a copy of a document) that contains information relevant to:

(a) whether a private health insurer is liable to pay *complaints levy; or

(b) the amount of complaints levy that the insurer is liable to pay.

(3) Before obtaining the consent of the *occupier, the *authorised officer must inform the occupier that he or she may refuse consent.

(4) An entry by an *authorised officer with the consent of the *occupier is not lawful if the consent of the occupier is not voluntary.

(5) The *authorised officer must leave the *premises if the *occupier asks the officer to do so.

313-5 Authorised officer may enter premises under warrant

(1) If an *authorised officer has reason to believe that there are *levy-related documents on particular *premises, the officer may apply to a magistrate for a warrant authorising the officer to enter

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

the premises for the purpose of exercising *search powers in relation to the documents.

(2) If the magistrate is satisfied by information on oath or affirmation that there are reasonable grounds for believing that there are *levy-related documents on the *premises, the magistrate may issue a warrant.

(3) The warrant must:

(a) authorise one or more *authorised officers to enter the *premises for the purpose of exercising *search powers in relation to *levy-related documents; and

(b) state whether the entry is authorised at any time of the day or night or during specified hours of the day or night; and

(c) authorise the officers to use such assistance and force as is necessary and reasonable to enter the premises for the purpose of exercising search powers in relation to levy-related documents.

(4) The *authorised officers do not have to be named in the warrant.

313-10 Announcement before entry

An *authorised officer executing a warrant under section 313-5 in respect of *premises must, before entering the premises under the warrant:

(a) announce that he or she is authorised to enter the premises; and

(b) before using assistance and force under the warrant to enter the premises—give any person on the premises an opportunity to allow the authorised officer to enter the premises without the use of assistance and force.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

313-15 Executing a warrant to enter premises

Circumstances in which this section applies

(1) This section applies if:
  (a) a warrant under section 313-5 is being executed by an *authorised officer in respect of *premises; and
  (b) the *occupier of the premises is present.

Obligations of authorised officer executing a warrant

(2) The *authorised officer must:
  (a) make a copy of the warrant available to the *occupier; and
  (b) show the occupier the officer's identity card; and
  (c) inform the occupier of the occupier's rights and responsibilities under subsections (3) to (6).

Persons entitled to observe execution of warrant

(3) The *occupier, or a person nominated by the occupier who is readily available, is entitled to observe the execution of the warrant.

(4) The right to observe the execution of the warrant ceases if the *occupier or the nominated person impedes that execution.

(5) Subsection (3) does not prevent the execution of the warrant in 2 or more areas of the *premises at the same time.

Occupier to provide reasonable facilities and assistance

(6) An *occupier commits an offence if the occupier fails to provide the *authorised officer and any person assisting that officer with all reasonable facilities and assistance for the effective exercise of their powers under the warrant.

Penalty: 60 penalty units.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 313-20

313-20 Identity cards

(1) For the purposes of this Division, the Secretary of the Department must issue an identity card to an *authorised officer in the *approved form. It must contain a recent photograph of the authorised officer.

(2) A person commits an offence if:
  (a) the person has been issued with an identity card; and
  (b) the person ceases to be an *authorised officer; and
  (c) the person does not, as soon as it is practicable after so ceasing, return the identity card to the Secretary of the Department.

  Penalty: 1 penalty unit.

(3) Strict liability applies to subsection (2).

  Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

(4) An *authorised officer must carry the identity card at all times when exercising powers or performing functions under this Division as an authorised officer.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-7—Private Health Insurance Risk Equalisation Special Account

Division 318—Private Health Insurance Risk Equalisation Special Account

318-1 Private Health Insurance Risk Equalisation Special Account

(1) The Private Health Insurance Risk Equalisation Special Account (the ***Risk Equalisation Special Account***) is established by this section.

(2) The *Risk Equalisation Special Account is a special account for the purposes of the *Public Governance, Performance and Accountability Act 2013*.

318-5 Credits to the Risk Equalisation Special Account

There must be credited to the *Risk Equalisation Special Account amounts equal to the following:

(a) amounts received by *APRA by way of:
  (i) *risk equalisation levy; or
  (ii) *late payment penalty in respect of unpaid amounts of risk equalisation levy;

(b) any of the following other amounts received by APRA:
  (i) amounts received under paragraph 45(b), or section 46, of the *Private Health Insurance (Prudential Supervision) Act 2015*;
  (ii) repayments of collapsed insurer assistance payments (within the meaning of section 54H of the *Australian Prudential Regulation Authority Act 1998*);

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(c) amounts paid to the Commonwealth or APRA, by a State or Territory, for crediting to the Risk Equalisation Special Account.

Note: An Appropriation Act may contain a provision to the effect that, if any of the purposes of a special account is a purpose that is covered by an item in the Appropriation Act (whether or not the item expressly refers to the special account), then amounts may be debited against the appropriation for that item and credited to that special account.

318-10 Purpose of the Risk Equalisation Special Account

(1) The purpose of the *Risk Equalisation Special Account is for *APRA to make payments to private health insurers in accordance with the Private Health Insurance (Risk Equalisation Policy) Rules.

Note: See section 80 of the *Public Governance, Performance and Accountability Act 2013* (which deals with special accounts).

(2) The Private Health Insurance (Risk Equalisation Policy) Rules must specify:

(a) the circumstances in which private health insurers are to be paid amounts debited from the *Risk Equalisation Special Account; and

(b) the method for working out the amount to be so debited from the Account for payment to a private health insurer; and

(c) the method for working out the amount to be paid, for crediting to the Account, by private health insurers as *risk equalisation levy.

(3) Before making Private Health Insurance (Risk Equalisation Policy) Rules, the Minister must consult *APRA. However, a failure to consult APRA does not affect the validity of those Rules.

Note: This consultation requirement also applies to any repeal or amendment of such Rules: see subsection 33(3) of the *Acts Interpretation Act 1901*.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

318-15 Record keeping

The Private Health Insurance (Risk Equalisation Administration) Rules may set out requirements for private health insurers that are liable to *risk equalisation levy to keep particular kinds of records, and requirements relating to how those records are to be kept.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-8—Disclosure of information

Division 323—Disclosure of information

323-1 Prohibition on disclosure of protected information

Offence

(1) A person commits an offence if:
  (a) the person has, or has at any time had, a duty, function or power (other than an *APRA private health insurance duty, function or power) under this Act; and
  (b) the person *uses or *discloses information; and
  (c) the information is *protected information.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

(2) Subsection (1) does not apply if the *use or *disclosure is:
  (a) required or authorised under a provision of this Act; or
  (b) otherwise required or authorised under an Australian law.

Note 1: The defendant bears an evidential burden in relation to the matter in this subsection. See subsection 13.3(3) of the *Criminal Code*.

Note 2: Provisions of this Act that authorise the use or disclosure of information include sections 323-5, 323-10, 323-15, 323-20, 323-30, 323-33, 323-35, 324-5 and 324-10.

Meaning of APRA private health insurance duty, function or power

(3) An ***APRA private health insurance duty, function or power*** is a duty, function or power of *APRA, or that a person has in the person's capacity as an officer (within the meaning of section 56 of the *Australian Prudential Regulation Authority Act 1998*), under any of the following:
  (a) this Act;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) the *Private Health Insurance (Prudential Supervision) Act 2015*;

(c) the *Financial Institutions Supervisory Levies Collection Act 1998*, as that Act applies in relation to levies imposed on private health insurers;

(d) the *Financial Sector (Collection of Data) Act 2001*, as that Act applies in relation to private health insurers.

Note: The disclosure of information regime for information obtained under APRA private health insurance duties, functions and powers is Part 6 of the *Australian Prudential Regulation Authority Act 1998* (rather than this Division).

Meaning of protected information

(4) Information is ***protected information*** if the information:

(a) relates to a person (including a deceased person) other than the person who obtained or generated the information; and

(b) either:

(i) is obtained or generated by a person in the course of performing or exercising a duty, function or power under this Act (other than an *APRA private health insurance duty, function or power); or

(ii) was information to which subparagraph (i) applied and is obtained by a person by way of a *disclosure under section 323-10, 323-15 or 323-20.

323-5 Authorised disclosure: official duties

A person may *disclose information if the disclosure is made:

(a) in the course of performing or exercising a duty, function or power under this Act, other than an *APRA private health insurance duty, function or power; or

(aa) for the purpose of enabling a person to perform or exercise an *APRA private health insurance duty, function or power; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) for the purpose of enabling a person to perform functions in connection with a *medicare program; or

(c) for the purpose of enabling a person to perform functions under:

(i) a provision of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*; or

(ii) a provision of the *Medicare Levy Act 1986*; or

(iii) a provision of Subdivision 61-G of the *Income Tax Assessment Act 1997*; or

(iv) any other provision of the *Income Tax Assessment Act 1997*, or of any other Act, to the extent that the provision relates to a provision mentioned in subparagraph (i), (ii) or (iii); or

(d) for the purpose of enabling a person to perform functions under Part IID of the *Ombudsman Act 1976*; or

(e) in the course of performing or exercising a duty, function or power under Part VE of the *Health Insurance Act 1973*; or

(f) to the Minister for the purpose of the Minister's performance of the Minister's functions.

323-10 Authorised disclosure: sharing information about insurers among agencies

(1) This section applies to information if the information:

(a) relates to any or all of the following:

(i) a private health insurer;

(ii) an applicant to become a private health insurer;

(iii) a person carrying on *health insurance business;

(iv) a *director or *officer of a person mentioned in subparagraph (i), (ii) or (iii); and

(b) is not information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be *disclosed under this section.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(1A) A person to whom subsection (2) applies may *disclose the information to:

(a) another person to whom subsection (2) applies; or

(b) the Private Health Insurance Ombudsman; or

(c) an APS employee in, or a person holding or performing the duties of an office in, the Statutory Agency of the Commonwealth Ombudsman; or

(d) *APRA; or

(e) an APRA member or APRA staff member (within the meaning of the *Australian Prudential Regulation Authority Act 1998*);

if the disclosure is made in accordance with any requirements in the Private Health Insurance (Information Disclosure) Rules.

(2) This subsection applies to the following persons:

(a) the Minister;

(b) the Secretary of the Department;

(c) an APS employee in, or a person holding or performing the duties of an office in, the Department;

(h) the Chief Executive Medicare;

(i) a Departmental employee (within the meaning of the *Human Services (Medicare) Act 1973*).

323-15 Authorised disclosure: sharing information about insurers other than among agencies

(1) A person may *disclose information to another person if:

(a) the information relates to any or all of the following:

(i) a private health insurer;

(ii) an applicant to become a private health insurer;

(iii) a person carrying on *health insurance business;

(iv) a *director or *officer of a person mentioned in subparagraph (i), (ii) or (iii); and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) the information is not information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be disclosed under this section; and

(c) the disclosure is made in accordance with any requirements in the Private Health Insurance (Information Disclosure) Rules; and

(d) the disclosure is, or is a kind of disclosure, certified by the Secretary by written instrument to be in the public interest.

(3) A certificate under paragraph (1)(d) is not a legislative instrument.

323-20 Authorised disclosure: public interest

(1) A person may *disclose information to another person if:

(a) the information does not relate to any of the following:

(i) a private health insurer;

(ii) an applicant to become a private health insurer;

(iii) a person carrying on *health insurance business;

(iv) a *director or *officer of a person mentioned in subparagraph (i), (ii) or (iii); and

(b) the information is not information of a kind specified in the Private Health Insurance (Information Disclosure) Rules as information that must not be disclosed under this section; and

(c) the disclosure is made in accordance with any requirements in the Private Health Insurance (Information Disclosure) Rules; and

(d) the disclosure is, or is a kind of disclosure, certified by the Secretary by written instrument to be in the public interest.

(3) A certificate under paragraph (1)(d) is not a legislative instrument.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

323-23 Terms and conditions on subsequent use or disclosure following an authorised disclosure under section 323-15 or 323-20

(1) The Secretary of the Department may, by instrument in writing, specify terms and conditions subject to which information that is *disclosed to a person under section 323-15 or 323-20 may be *used or disclosed by the person.

(2) Without limiting subsection (1), the instrument may require the person to give an undertaking in writing with respect to the *use or *disclosure of the information by the person, which may include an undertaking not to disclose any of the information to any other person.

(3) An instrument under subsection (1) is not a legislative instrument.

323-30 Authorised disclosure: court proceedings

A person who has, or has at any time had, a duty, function or power under this Act may *disclose to a court information that relates to another person for the purposes of an action or proceeding before the court to which that other person is a party.

323-33 Authorised disclosure: other permitted disclosures

A person may *disclose information to another person if:

(a) the information is lawfully in the public domain; or

(b) the person to whom the information relates has expressly or impliedly consented to the disclosure; or

(c) the information has lawfully been disclosed to that other person previously; or

(d) the information relates to that other person; or

(e) the disclosure of the information is for the purposes of obtaining or providing legal advice.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

323-35 Authorised use: use of information for authorised disclosure

A person may *use information for the purpose of *disclosing the information under section 323-5, 323-10, 323-15, 323-20, 323-30, 323-33, 324-5 or 324-10.

323-40 Offence: disclosure of information obtained by certain authorised disclosures

A person commits an offence if:

(a) the person obtains information; and

(b) the person does so by way of a *disclosure under section 323-10, 323-15 or 323-20; and

(c) the person discloses the information; and

(d) the disclosure by the person is not:

(i) required or authorised under a provision of this Act; or

(ii) otherwise required or authorised under an Australian law.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

323-45 Offence: soliciting disclosure of protected information

A person commits an offence if:

(a) the person solicits the *disclosure of information from another person; and

(b) the information is *protected information; and

(c) the person knows, or ought reasonably to know, that the information is protected information; and

(d) the disclosure by the person would not be:

(i) required or authorised under a provision of this Act; or

(ii) otherwise required or authorised under an Australian law.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

323-50 Offence: use etc. of protected information after unauthorised disclosure

A person commits an offence if:

(a) information is *disclosed to the person; and

(b) the information is *protected information; and

(c) the disclosure to the person is not:

(i) required or authorised under a provision of this Act; or

(ii) otherwise required or authorised under an Australian law; and

(d) the person knows, or ought reasonably to know, that the disclosure to the person is not so required or authorised; and

(e) any of the following apply:

(i) the person solicited the disclosure of the information;

(ii) the person discloses the information;

(iii) the person *uses the information.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

323-55 Offence: offering to supply protected information

A person commits an offence if:

(a) the person:

(i) offers; or

(ii) holds himself or herself out as being able;

to supply (whether or not to a particular person) information about another person; and

(b) the person knows that the information is *protected information; and

(c) the supply by the person would not be:

(i) required or authorised under a provision of this Act; or

(ii) otherwise required or authorised under an Australian law.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Division 324—Publication of information about treatments covered by health insurance policies etc.

324-1 Objects of this Division

The objects of this Division are:

(a) to improve the transparency of costs associated with the provision of *hospital treatment and *general treatment *covered by *complying health insurance policies; and

(b) to promote efficient access to those treatments; and

(c) to help people make informed decisions about health care.

Note: See also Part VE of the *Health Insurance Act 1973* (publication of information about professional services).

324-5 Publication of information about treatments covered by complying health insurance policies

(1) The Secretary of the Department may publish:

(a) information about *complying health insurance policies and *complying health insurance products offered by private health insurers; and

(b) information relating to *hospital treatment and *general treatment (***covered treatment***) that is *covered by complying health insurance policies and is provided by, or on behalf of, *medical practitioners.

Note: This subsection constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

(2) Without limiting subsection (1), the information that may be published by the Secretary of the Department includes the following:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) information about benefits for particular kinds of covered treatment provided by or on behalf of particular *medical practitioners;

(b) information about fees and charges relating to the provision of particular kinds of covered treatment by or on behalf of particular medical practitioners;

(c) information about *medicare benefits paid in relation to particular kinds of covered treatment provided by or on behalf of particular medical practitioners, including:

(i) the amounts of medicare benefits paid; and

(ii) the extent to which those medicare benefits were assigned under subsection 20A(1) of the *Health Insurance Act 1973*;

(d) information about particular *complying health insurance policies and *complying health insurance products offered by private health insurers, including:

(i) the names of insurers offering the policies and products; and

(ii) the treatments covered by the policies and products; and

(iii) the benefits under the policies and products; and

(iv) the terms and conditions of the policies and products; and

(v) the *risk equalisation jurisdiction of the policies and products;

(e) information about agreements between particular private health insurers and particular medical practitioners for the provision of covered treatment to persons insured by the insurer, including the extent to which particular kinds of agreements apply in relation to particular kinds of treatment;

(f) information about agreements between particular private health insurers and particular *hospitals for the provision of covered treatment to persons insured by the insurer, including the extent to which particular kinds of agreements apply in relation to particular kinds of treatment;

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(g) information relating to particular medical practitioners who provide covered treatment, or on whose behalf covered treatment is provided, to persons insured by a private health insurer, including:
  (i) the practitioners' names; and
  (ii) information about the practitioners' qualifications and specialities; and
  (iii) the languages spoken by the practitioners;

(h) information about the locations and hospitals where particular kinds of covered treatment are provided by or on behalf of particular medical practitioners, including information about fees, charges and benefits for accommodation at those locations or hospitals relating to such treatment.

(3) The Secretary of the Department may also publish any information of a kind specified by the Minister under paragraph (5)(a).

Note: This subsection constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

(4) Information published under this section must be published in the manner, if any, specified by the Minister under paragraph (5)(b).

(5) The Minister may, by legislative instrument, specify any of the following:
  (a) for the purposes of subsection (3)—kinds of information that may be published under this section;
  (b) for the purposes of subsection (4)—a manner or manners in which information must be published under this section.

(6) The Minister may only specify a kind of information under paragraph (5)(a) if the Minister is satisfied that publishing that kind of information would further the objects of this Division.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(7) Information published under this section must not include personal information about an individual who is not, and has not been, a medical practitioner.

(7A) The Secretary of the Department may, on the Secretary's own initiative or as a result of a review under a determination under section 324-7, correct, update, alter or remove information published under this section.

(8) For the purposes of this section, a treatment is taken to be provided on behalf of a medical practitioner if, and only if:

(a) it is provided by another person who is not a medical practitioner; and

(b) that other person provides the treatment, in accordance with accepted medical practice, under the supervision of the medical practitioner.

(9) For the purposes of this section, if:

(a) a treatment is provided by a medical practitioner who is a specialist trainee; and

(b) the specialist trainee provides the treatment under the supervision of another medical practitioner who is present at all times while the specialist trainee provides the treatment; and

(c) the treatment would be taken to have been a service rendered by the other medical practitioner under subsection 3(18) of the *Health Insurance Act 1973* for the purposes of that Act;

then:

(d) the treatment is taken to have been provided by the other medical practitioner; and

(e) the treatment is taken not to have been provided by the specialist trainee.

(10) In subsection (9):

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

specialist trainee has the meaning given by subsection 3(20) of the *Health Insurance Act 1973*.

(11) If information about fees and charges relating to the provision of particular kinds of covered treatment by or on behalf of particular medical practitioners is published under this section, the Secretary must also publish under this section:

(a) if any formulas were used to work out those fees and charges—those formulas; and

(b) if a material reduction in the amounts of those fees and charges occurs after publishing the information and the Secretary becomes aware of the reduction—the reduced amounts (as soon as practicable after the Secretary becomes so aware).

324-7 Review of decision to publish information

(1) The Minister may, by legislative instrument, determine procedures for reviewing decisions to publish information under section 324-5 (including decisions to correct, update, alter or remove such information).

(2) Without limiting subsection (1), the determination may provide for any of the following:

(a) who may, or may not, apply for review of a decision;

(b) kinds of decisions that are, or are not, subject to review;

(c) circumstances in which an application may, or may not, be made;

(d) who is to review a decision.

324-10 Use and disclosure of information

Use or disclosure to assist Secretary or reviewer

(1) A person may *use or *disclose information for the purposes of:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(a) assisting the Secretary of the Department to publish, correct, update, alter or remove information under either or both of the following provisions (the ***publication provisions***):

(i) section 324-5;

(ii) section 124ZY of the *Health Insurance Act 1973*; or

(b) assisting a person to carry out a review under a determination (a ***review determination***) under:

(i) section 324-7; or

(ii) section 124ZYA of the *Health Insurance Act 1973*.

Note: This subsection constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

(2) To avoid doubt, the reference to *using information in subsection (1) includes a reference to linking or matching information.

Disclosure to person about whom information is published

(3) The Secretary of the Department may *disclose information to a person:

(a) in the course of deciding what information to publish about the person under either or both of the publication provisions; or

(b) in the course of deciding whether to correct, update, alter or remove information published about the person under either or both of the publication provisions; or

(c) in order to inform the person about how information published about the person under either or both of the publication provisions was, or is to be, worked out.

Note: This subsection constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Disclosure in the course of review

(4) A person carrying out a review under a review determination may, in the course of carrying out the review, *disclose information to the person who applied for the review.

Note: This subsection constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

Information may relate to other people

(5) To avoid doubt, information disclosed to a person (the ***disclosee***) under subsection (3) or (4) may include information about other people as well as the disclosee, or instead of the disclosee.

324-15 Protection from civil proceedings

The Secretary of the Department is not liable to civil proceedings for loss, damage or injury of any kind suffered by any person as a result of the publication of information under section 324-5.

324-20 Annual report

(1) The Secretary must, as soon as practicable after the end of each financial year that starts after the commencement of this section, prepare a written report in relation to the information published under section 324-5 before the end of that year.

Note: The report is not limited to information published in that year only.

(2) Without limiting subsection (1), the report must include analysis of any trends in the published information, including, for example, trends in relation to:

(a) changes in the median costs of particular kinds of *hospital treatments and *general treatments *covered by *complying health insurance policies; and

(b) variations in those costs between different geographical areas where those treatments are provided.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) The Secretary must give the Minister a copy of the report no later than 3 months after the end of that year.

(4) The Minister must cause a copy of the report to be tabled in each House of the Parliament within 15 sitting days of that House after the Minister receives the report.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-9—Review of decisions

Division 328—Review of decisions

328-1 What this Part is about

Several kinds of decisions made under this Act by the Chief Executive Medicare, *APRA and the Minister are reviewable by the Administrative Review Tribunal.

328-5 ART review of decisions

An application may be made to the Administrative Review Tribunal for the review of any of the following decisions:

Reviewable decisions

Item	Decision	Provision under which decision is made
1	To reject an application for registration of a person in respect of a health insurance policy	section 23-20
2	To revoke a person's registration in respect of a health insurance policy	section 23-35
4	To refuse to make a declaration, or to revoke a declaration, that a facility is a *hospital	subsection 121-5(6)
4A	To specify a condition, in relation to a particular facility, to which a declaration that a facility is a *hospital is subject	paragraph 121-7(1)(b)
5	To decide that a *hospital does not satisfy the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules	section 121-8A

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Section 328-5

Reviewable decisions		
Item	**Decision**	**Provision under which decision is made**
6	To decide to revoke a *hospital's inclusion in a class set out in the Private Health Insurance (Health Insurance Business) Rules	section 121-8C
31	To direct a private health insurer not to make a change that it proposes to make to its *rules	subsection 169-10(2)
32	To refuse a request for a longer period for a private health insurer to respond to a request for an explanation	subsection 191-1(3)
33	To refuse to consent to a private health insurer withdrawing or varying an undertaking	subsection 197-1(3)
34	To give a direction to a private health insurer	section 200-1
35	To revoke a private health insurer's status as a *participating insurer	section 206-1
38	To reject an application to become a *participating insurer	section 279-5
39	On reconsideration of a decision notifying a private health insurer in relation to a claim for payment under Division 279	section 279-45
41	To affirm an original decision by the Chief Executive Medicare that an amount is recoverable as a debt under paragraph 282-1(1)(h) in respect of a payment made to an individual	section 282-15
42	To affirm an original decision by the Chief Executive Medicare to set off a debt against an amount otherwise payable to a person or his or her estate	section 282-15
43	Not to waive, or to waive only a part of, an amount of *late payment penalty	section 307-20

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Part 6-10—Miscellaneous

Division 333—Miscellaneous

333-1 Delegation by Minister

(1) The Minister may, by writing, delegate all or any of his or her functions or powers under this Act (other than a function or power mentioned in subsection (2A)) to:
  (a) the Secretary of the Department; or
  (b) an SES employee, or acting SES employee, in the Department.

(2) Without limiting subsection (1), the Minister may, by writing, delegate all or any of his or her functions or powers under Part 2-2 or Part 6-4 to:
  (a) the Chief Executive Medicare; or
  (b) a Departmental employee (within the meaning of the *Human Services (Medicare) Act 1973*); or
  (c) an APS employee in the Department.

(2A) For the purposes of subsection (1), the Minister must not delegate any of the following functions or powers:
  (a) a function or power under subsection 66-6(2) (*approved application periods for applications under section 66-8 or 66-10);
  (aa) a function or power under subsection 66-8(9) or 66-10(9) (tabling reasons for refusing to approve applications under section 66-8 or 66-10);
  (b) the power to make, vary or revoke a legislative instrument under subsection 324-7(1) (review of decision to publish information).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(3) In performing a function or exercising a power under a delegation, the delegate must comply with any directions of the Minister.

333-5 Delegation by Secretary

(1) The Secretary of the Department may, by writing, delegate all or any of his or her functions or powers under this Act to an APS employee in the Department.

(2) In performing a function or exercising a power under a delegation, the delegate must comply with any directions of the Secretary.

333-10 Approved forms

(1) A statement, notice, application or other document is in the ***approved form*** if:

(a) it is in the form approved in writing by the person specified in the table as the approver of that form; and

(b) it contains a declaration signed by a person or persons as the form requires (see section 333-15); and

(c) it contains the information that the form requires, and any further information, statement or document required by the approver, whether in the form or otherwise; and

(d) it is given in the manner (if any) required by the approver.

Person who approves forms

Item	This person ...	is the approver of these forms ...
1	the Secretary of the Department	forms for which there is no other approver specified in this table.
2	the Chief Executive Medicare	forms under Part 2-2 and subsection 282-20(2).

(2) Despite subsection (1), a document that satisfies paragraphs (1)(a), (b) and (d) but not paragraph (1)(c) is also in the *approved form if

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

it contains the information required by the approver. The approver must specify the requirement in writing.

(3) The approver may combine in the same *approved form more than one notice, statement, application or other document.

(4) The approver may approve a different *approved form for different kinds of private health insurers.

(5) The Chief Executive Medicare must not approve a form that requires a person to provide:
  (a) the *tax file number of any person; or
  (b) information about the physical, psychological or emotional health of any person.

333-15 Signing approved forms

A person who is required to do something in an *approved form must, if the form requires it, sign a declaration, or (if allowed by the form) have a declaration signed on the person's behalf.

333-16 Approved electronic system

The Chief Executive Medicare may, by notifiable instrument, approve one or more electronic systems for the purposes of paragraphs 23-15(3)(a), 23-30(2A)(b) and 279-10(2)(b).

333-17 Automation of administrative action

(1) The Chief Executive Medicare may, in writing, arrange for the use, under the Chief Executive Medicare's oversight, of computer programs to take administrative action that must be taken by the Chief Executive Medicare under this Act.

(2) ***Administrative action*** is:
  (a) making, or refusing or failing to make, a decision under a provision mentioned in subsection (3); or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(b) exercising, or refusing or failing to exercise, a power under a provision mentioned in subsection (3); or

(c) performing, or refusing or failing to perform, a function or duty under a provision mentioned in subsection (3); or

(d) doing, or refusing or failing to do, anything (including giving a notice) related to making a decision, exercising a power or performing a function or duty under a provision mentioned in subsection (3).

(3) For the purposes of subsection (2), the provisions are the following provisions of the Act:

(a) subsection 23-16(1) (which deals with registering a person as a *participant in the *premiums reduction scheme);

(b) subsection 23-30(3) (which deals with revoking a person's registration as a participant in the premiums reduction scheme);

(c) subsection 23-40(2) (which deals with variations to registrations);

(d) subsection 279-11(1) (which deals with reimbursement claims);

(e) a provision of this Act prescribed by the Private Health Insurance (Incentives) Rules.

Chief Executive Medicare is treated as having taken administrative action

(4) Administrative action taken by the operation of a computer program under an arrangement under subsection (1) is treated, for all purposes, as administrative action taken by the Chief Executive Medicare.

Substituting administrative action

(5) The Chief Executive Medicare may take administrative action (the ***substituted action***) in substitution for administrative action the Chief Executive Medicare is treated as having taken under

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

subsection (4) if the Chief Executive Medicare is satisfied that the administrative action taken by the operation of the computer program is not correct.

(6) The substituted action takes effect on:

(a) if the Chief Executive Medicare specifies a day on which the substituted action takes effect—that specified day; or

(b) otherwise—the day of the administrative action taken by the operation of the computer program.

(7) The day specified under paragraph (6)(a) may be earlier than the day the substituted action is taken but not earlier than the day of the administrative action taken by the operation of the computer program.

Chief Executive Medicare may still take administrative action

(8) An arrangement under subsection (1) does not prevent the Chief Executive Medicare from taking administrative action under the provisions referred to in subsection (3).

(9) Subsection (5) does not limit any other provision of this Act that provides for the review or reconsideration of an administrative action.

Arrangement not a legislative instrument

(10) An arrangement under subsection (1) is not a legislative instrument.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

333-18 Oversight and safeguards for automation of administrative action

Chief Executive Medicare to ensure administrative action is action that could be validly taken

(1) The Chief Executive Medicare must take all reasonable steps to ensure that administrative action taken by the operation of a computer program under an arrangement under subsection 333-17(1) is administrative action that the Chief Executive Medicare could validly take under this Act.

(2) Without limiting subsection (1), the Chief Executive Medicare must do the things (if any) prescribed by the Private Health Insurance (Incentives) Rules for the purposes of this subsection.

Note: Administrative action may still be invalid even if subsections (1) and (2) are complied with.

(3) A failure to comply with subsection (1) or (2) does not affect the validity of the administrative action taken by the operation of a computer program under an arrangement under subsection 333-17(1).

Notification of substituted decisions

(4) If, under subsection 333-17(5), the Chief Executive Medicare makes a decision in substitution for a decision the Chief Executive Medicare is treated as having taken under subsection 333-17(4), the Chief Executive Medicare must, within 14 days of the making of the substituted decision, cause the person who is the subject of the substituted decision to be notified in writing:

(a) of the substituted decision and of the fact that the substituted decision was made by the Chief Executive Medicare; and

(b) of the person's right (if any) to apply for reconsideration of the substituted decision.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(5) A failure to comply with subsection (4) does not affect the validity of the substituted decision.

Publication

(6) If the Chief Executive Medicare makes an arrangement under subsection 333-17(1) in relation to particular provisions of this Act, the Chief Executive Medicare must cause a statement to be published on Services Australia's website:
  (a) to the effect that the Chief Executive Medicare has made such an arrangement; and
  (b) setting out those particular provisions.

Details in annual report

(7) The Chief Executive Officer of Services Australia, when preparing Services Australia's annual report under section 46 of the *Public Governance, Performance and Accountability Act 2013* for a period, must include the following information in that report:
  (a) the total number of substituted actions taken by the Chief Executive Medicare under subsection 333-17(5) in that period;
  (b) the kind of substituted actions so taken;
  (c) the kind of administrative action taken by the operation of the computer program that the Chief Executive Medicare was satisfied was not correct.

(8) The Chief Executive Officer of Services Australia may also include in the report any other information (other than personal information within the meaning of the *Privacy Act 1988*) about the operation of section 333-17 and this section in that period that the Chief Executive Officer of Services Australia considers appropriate.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

333-20 Private Health Insurance Rules made by the Minister

(1) The Minister may, by legislative instrument, make Private Health Insurance Rules, specified in the second column of the table, providing for matters:

(a) required or permitted by the corresponding Chapter, Part, section or Schedule specified in the third column of the table to be provided; or

(b) necessary or convenient to be provided in order to carry out or give effect to that Chapter, Part, section or Schedule.

Private Health Insurance Rules made by Minister

Item	Private Health Insurance Rules	Chapter/Part/section/Schedule
1	Private Health Insurance (Incentives) Rules	Part 2-2, section 206-1, Part 6-4, section 333-17 and section 333-18
2	Private Health Insurance (Lifetime Health Cover) Rules	Part 2-3
3	Private Health Insurance (Complying Product) Rules	Chapter 3, section 188-1 and Schedule 1
3A	Private Health Insurance (Benefit Requirements) Rules	Part 3-3
3B	Private Health Insurance (Product Premium) Rules	Part 3-3
4	Private Health Insurance (Medical Devices and Human Tissue Products) Rules	Part 3-3
5	Private Health Insurance (Accreditation) Rules	section 81-1
6	Private Health Insurance (Health Insurance Business) Rules	Part 4-2
8	Private Health Insurance (Health Benefits Fund Policy) Rules	Part 4-4
9	Private Health Insurance (Data Provision) Rules	Part 4-5

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Private Health Insurance Rules made by Minister		
Item	**Private Health Insurance Rules**	**Chapter/Part/section/Schedule**
14	Private Health Insurance (Levy Administration) Rules	Part 6-6
15	Private Health Insurance (Risk Equalisation Policy) Rules	Part 6-7
16	Private Health Insurance (Information Disclosure) Rules	Part 6-8

(2) If, under this Act, Private Health Insurance Rules made by the Minister may modify a provision of this Act or another Act (including by modifying the effect, or the requirements, of such a provision), the Rules may do so by adding, omitting or substituting provisions (including effects or requirements of provisions).

Note: There are consultation requirements that apply in relation to the making of Rules mentioned in items 6, 8 and 15 of the above table: see subsections 115-5(2), 131-5(2) and 318-10(3).

333-25 Private Health Insurance Rules made by APRA

(1) *APRA may, by legislative instrument, make Private Health Insurance Rules, known as Private Health Insurance (Risk Equalisation Administration) Rules, providing for matters mentioned in section 318-15.

(2) To the extent that Private Health Insurance Rules made under this section deal with a matter that is dealt with in Private Health Insurance Rules made under section 333-20, they must do so in a way that is not inconsistent with the Rules made under section 333-20.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

333-30 Regulations

The Governor-General may make regulations prescribing matters:

(a) required or permitted by this Act to be prescribed; or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Schedule 1—Dictionary

Note: See section 1-10.

1 Dictionary

In this Act:

accessory has the meaning given by subsection 72-11(3).

adjustment factor for an adjustment year has the meaning given by subsection 22-15(5E).

adjustment year has the meaning given by subsection 22-15(5D).

adult:

(a) when used outside Part 2-3—means a person who is not a *dependent person; or

(b) when used in Part 2-3—means a person who is not:

(i) a *dependent child; or

(ii) a *dependent non-student; or

(iii) a *dependent student.

applicable benefits arrangement means an applicable benefits arrangement within the meaning of the *National Health Act 1953* as in force before 1 April 2007.

approved application period, for an application under section 66-8 or 66-10: see section 66-6.

approved form is a form that meets the requirements in section 333-10.

APRA means the Australian Prudential Regulation Authority.

APRA private health insurance duty, function or power: see subsection 323-1(3).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Australia, when used in a geographical sense, includes Norfolk Island, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island.

authorised officer is defined in subsection 313-1(1).

base rate is defined in subsection 34-1(2).

Chief Executive Medicare has the same meaning as in the *Human Services (Medicare) Act 1973*.

chief executive officer, of a private health insurer, is the person who is primarily and directly responsible to the *directors of the insurer for the general and overall management of the insurer.

complaints levy is defined in paragraph 304-10(b).

complying health insurance policy is defined in section 63-10.

complying health insurance product is defined in section 63-5.

constitutional corporation means a corporation to which paragraph 51(xx) of the Constitution applies.

cost-recovery fee has the meaning given by subsection 72-15(1).

cover has a meaning affected by section 69-5.

declaration of contravention means a declaration under section 203-5.

dependent child means a person who:

(a) is aged under 18; and

(b) does not have a partner.

dependent non-student means a person who:

(a) is aged between 18 and 31 (inclusive); and

(b) is not receiving full-time education at a school, college or university; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(c) is a dependent non-student under the *rules of the private health insurer that insures the person; and

(d) does not have a partner.

dependent person means:

(a) a *dependent child; or

(b) a *dependent non-student; or

(c) a *dependent person with a disability; or

(d) a *dependent student.

dependent person with a disability means a person:

(a) who is aged 18 or over; and

(b) who is:

(i) a person with a disability within the meaning of the expression ***person with a disability*** as defined by the Private Health Insurance (Complying Product) Rules; or

(ii) a person with a disability within the meaning of the expression ***person with a disability*** as defined by the *rules of the private health insurer that insures the person.

To avoid doubt, a ***dependent person with a disability*** may have a partner.

dependent student means a person who:

(a) is aged between 18 and 31 (inclusive); and

(b) is receiving full-time education at a school, college or university; and

(c) is a dependent student under the *rules of the private health insurer that insures the person; and

(d) does not have a partner.

designated change, to a *complying health insurance product: see section 66-7.

director has the same meaning as in the *Corporations Act 2001*.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

disclose, in relation to information, includes divulge or communicate.

employee health benefits scheme is defined in section 121-15.

enforceable obligation is defined in section 185-5.

family tier 1 threshold has the meaning given by section 22-40.

family tier 2 threshold has the meaning given by section 22-40.

family tier 3 threshold has the meaning given by section 22-40.

Federal Court means the Federal Court of Australia.

general interest charge means the charge worked out under Part IIA of the *Taxation Administration Act 1953*.

general treatment is defined in section 121-10.

gold card is defined in subsection 34-15(3).

health benefits fund is defined in section 131-10.

health care provider means:

(a) a person who provides goods or services as, or as part of, *hospital treatment or *general treatment; or

(b) a person who manufactures or supplies goods provided as, or as part of, hospital treatment or general treatment.

health insurance business is defined in Division 121.

health-related business is defined in section 131-15.

holder, of an insurance policy, means a person who is insured under the policy and who is not a *dependent person.

hospital is defined in subsection 121-5(5).

hospital cover is defined in section 34-15.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

hospital-substitute treatment is defined in section 69-10.

hospital treatment is defined in section 121-5.

human tissue product has the meaning given by section 72-12.

improper discrimination:

(a) in relation to an insurer who is not a *restricted access insurer—has the meaning given by subsection 55-5(2); and

(b) in relation to a restricted access insurer—has the meaning given by subsection 55-5(2) as affected by subsection 55-5(3).

income for surcharge purposes, of a person for a financial year, means the income for surcharge purposes (within the meaning of the *Income Tax Assessment Act 1997*) for the person for the *income year corresponding to the financial year.

income year has the meaning given by the *Income Tax Assessment Act 1997*.

indexation factor has the meaning given by section 22-45.

index number has the meaning given by section 22-45.

ineligible for Medicare, in relation to a person, means not an eligible person within the meaning of the *Health Insurance Act 1973*.

insurance is defined in section 5-1.

late payment penalty means a late payment penalty incurred under section 307-5 in respect of a *private health insurance levy.

levy-related document is defined in subsection 313-1(3).

lifetime health cover base day is defined in section 34-25.

medical device has the meaning given by section 72-11.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

medical devices and human tissue products levy is defined in paragraph 304-10(da).

medical practitioner means a medical practitioner within the meaning of the *Health Insurance Act 1973*.

medicare benefit means a medicare benefit under Part II of the *Health Insurance Act 1973*.

medicare eligibility day is defined in subsection 34-25(5).

medicare program has the same meaning as in the *Human Services (Medicare) Act 1973*.

national joint replacement register levy is defined in paragraph 304-10(e).

occupier, of *premises, includes:

(a) the person in charge or control, or apparently in charge or control, of the premises; or

(b) a person who represents, or apparently represents, that person.

officer, of a private health insurer, means:

(a) a *director of the insurer; or

(b) a *chief executive officer of the insurer; or

(c) a person who makes, or participates in making, decisions that affect the whole, or a substantial part, of the business of the insurer.

old Schedule 2 is defined in subsection 34-10(5).

overseas has a meaning affected by section 34-30.

participant, in relation to the *premiums reduction scheme, means a person who is registered as a participant in the scheme under subsection 23-16(1).

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

participating insurer means:

(a) a private health insurer approved by the Minister under subsection 279-5(2); or

(b) a private health insurer that has applied under subsection 279-5(1) to be approved and whose application has not been rejected.

permitted days without hospital cover is defined in section 34-20.

personal information has the same meaning as in the *Privacy Act 1988*.

PHIIB (short for ***Private Health Insurance Incentive Beneficiary***) has the meaning given by section 22-5.

PHII benefit (short for ***Private Health Insurance Incentive benefit***) has the meaning given by section 22-10.

policy holder, of a *health benefits fund, means a *holder of a policy that is *referable to the fund.

pre-existing condition is defined in section 75-15.

premises includes the following:

(a) a structure, building, vehicle or vessel;

(b) a place (whether enclosed or built on);

(c) a part of a thing referred to in paragraph (a) or (b).

premiums reduction scheme means the scheme provided for by Division 23.

private health information statement is defined in section 93-5.

private health insurance arrangement includes any of the following:

(a) a *private health insurance policy or a *product;

(b) an agreement or arrangement between a private health insurer and a *health care provider;

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

(c) an agreement or arrangement between a private health insurer and another person (other than a health care provider) that relates to insurance in relation to *hospital treatment or *general treatment;

(d) an agreement or arrangement between two or more health care providers that relates to insurance in relation to hospital treatment or general treatment;

(e) Private Health Insurance (Complying Product) Rules made for the purposes of item 1 or 5 of the table in subsection 72-1(2);

(f) Private Health Insurance (Medical Devices and Human Tissue Products) Rules made for the purposes of item 4 of the table in subsection 72-1(2);

(g) an arrangement between a private health insurer and a *private health insurance broker;

(h) an arrangement between a private health insurance broker and a person seeking to become insured under a private health insurance policy.

private health insurance broker means a person:

(a) who deals (otherwise than by carrying on *health insurance business) in insurance policies that *cover *hospital treatment or *general treatment or both; and

(b) who acts on behalf of persons seeking to become insured under those policies.

private health insurance levy is defined in section 304-10.

Private Health Insurance Ombudsman means the Private Health Insurance Ombudsman established by section 20C of the *Ombudsman Act 1976*.

private health insurance policy means an insurance policy that *covers *hospital treatment or *general treatment or both (whether or not it also covers any other treatment or provides a benefit for anything else).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

private health insurer means a body that is registered under Division 3 of Part 2 of the *Private Health Insurance (Prudential Supervision) Act 2015*.

product is defined in subsection 63-5(2).

product subgroup is defined in subsection 63-5(2A).

protected information: see subsection 323-1(4).

quarter has the meaning given by the *Income Tax Assessment Act 1997*.

referable: an insurance policy is referable to a *health benefits fund if:

(a) the fund is identified under paragraph 93-15(c) as the fund to which the policy is referable (and the policy has not been made referable to another *health benefits fund under Division 4 of Part 3 of the *Private Health Insurance (Prudential Supervision) Act 2015*); or

(b) the policy has been made referable to the fund under Division 4 of Part 3 of the *Private Health Insurance (Prudential Supervision) Act 2015*.

restricted access insurer has the same meaning as in the *Private Health Insurance (Prudential Supervision) Act 2015*.

risk equalisation jurisdiction is defined in subsection 131-20(1).

risk equalisation levy is defined in paragraph 304-10(d).

Risk Equalisation Special Account: see subsection 318-1(1).

rules, of a private health insurer, means the body of rules established by the insurer that relate to the day-to-day operation of the insurer's *health insurance business and (if any) *health-related business.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

schedule fee means the Schedule fee within the meaning of Part II of the *Health Insurance Act 1973*.

search powers means powers to search for, inspect, take extracts from, and make copies of, documents.

share of the PHII benefit has the meaning given by sections 22-15, 22-20 and 22-25.

singles tier 1 threshold has the meaning given by section 22-35.

singles tier 2 threshold has the meaning given by section 22-35.

singles tier 3 threshold has the meaning given by section 22-35.

tax file number means a tax file number as defined in section 202A of the *Income Tax Assessment Act 1936*.

termination day, in relation to the *health benefits funds of a private health insurer, is defined in subsection 149-20(2).

tier 1 earner has the meaning given by section 22-30.

tier 2 earner has the meaning given by section 22-30.

tier 3 earner has the meaning given by section 22-30.

transfer, in relation to a person, is defined in section 75-10.

up to date, in relation to a *private health information statement, is defined in subsection 93-1(2).

use, in relation to information, includes make a record of.

voluntary deed of arrangement means:

(a) a deed of arrangement agreed on at a meeting of a kind referred to in section 217-45; or

(b) such a deed as varied in accordance with the Health Benefits Fund Enforcement Rules.

---

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

waiting period is defined in section 75-5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Authorised Version C2026C00412 registered 28/09/2026

Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe how an amendment is to be made. If, despite the misdescription, the amendment

Authorised Version C2026C00412 registered 28/09/2026

can be given effect as intended, then the misdescribed amendment can be incorporated through an editorial change made under section 15V of the *Legislation Act 2003*.

If a misdescribed amendment cannot be given effect as intended, the amendment is not incorporated and "(md not incorp)" is added to the amendment history.

Authorised Version C2026C00412 registered 28/09/2026

Endnote 2—Abbreviation key

ad = added or inserted

am = amended

amdt = amendment

C[x] = Compilation No. x

ch = Chapter(s)

cl = clause(s)

cont. = continued

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

gaz = gazette

LA = *Legislation Act 2003*

LIA = *Legislative Instruments Act 2003*

(md) = misdescribed amendment can be given effect

(md not incorp) = misdescribed amendment cannot be given effect

mod = modified/modification

No. = Number(s)

Ord = Ordinance

orig = original

p = page(s)

para = paragraph(s)/subparagraph(s) /sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

pt = Part(s)

r = regulation(s)/Court rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s) /rule(s)/subrule(s)/order(s)/suborder(s)

sch = Schedule(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

sub ch = Sub-Chapter(s)

sub div = Subdivision(s)

sub pt = Subpart(s)

underlining = whole or part not commenced or to be commenced

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Private Health Insurance Act 2007 (C2007A00031)	31, 2007	30 Mar 2007	1 Apr 2007 (s 1-5)	
Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007 (C2007A00032)	32, 2007	30 Mar 2007	sch 3 (items 9D, 9E): 1 July 2007 (s 2(1) item 8)	Act No 32, 2007
Health Legislation Amendment Act 2007 (C2007A00180)	180, 2007	28 Sept 2007	sch 1 (items 1-3, 5): 1 Apr 2007 (s 2(1) items 2, 4) sch 1 (items 4-4B, 6): 29 Sept 2007 (s 2(1) items 3, 5)	sch 1 (items 5, 6)
Private Health Insurance Legislation Amendment Act 2008 (C2008A00054)	54, 2008	25 June 2008	25 June 2008 (s 2)	sch 3 (items 3, 4)
Private Health Insurance Legislation Amendment Act 2009 (C2009A00066)	66, 2009	1 July 2009	sch 1 (items 2-14): 1 July 2009 (s 2(1) items 2-5)	—
Statute Law Revision Act 2010 (C2010A00008)	8, 2010	1 Mar 2010	sch 5 (item 137(a)): 1 Mar 2010 (s 2(1) item 38)	—
Private Health Insurance Legislation Amendment Act (No. 1) 2010 (C2010A00040)	40, 2010	13 Apr 2010	13 Apr 2010 (s 2)	—

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Health Legislation Amendment (Australian Community Pharmacy Authority and Private Health Insurance) Act 2010 (C2010A00063)	63, 2010	28 June 2010	sch 2: 1 July 2010 (s 2(1) item 3)	—
Trade Practices Amendment (Australian Consumer Law) Act (No. 2) 2010 (C2010A00103)	103, 2010	13 July 2010	sch 6 (items 1, 84, 85): 1 Jan 2011 (s 2(1) items 3, 5)	—
Human Services Legislation Amendment Act 2011 (C2011A00032)	32, 2011	25 May 2011	sch 4 (items 506-545): 1 July 2011 (s 2(1) item 3)	—
Acts Interpretation Amendment Act 2011 (C2011A00046)	46, 2011	27 June 2011	sch 2 (items 923-933), sch 3 (items 10, 11): 27 Dec 2011 (s 2(1) items 7, 12)	sch 3 (items 10, 11)
Fairer Private Health Insurance Incentives Act 2012 (C2012A00026)	26, 2012	4 Apr 2012	sch 1 (items 10-40, 48(1)): 1 July 2012 (s 2(1) item 2)	sch 1 (items 15, 48(1))
Statute Law Revision Act 2012 (C2012A00136)	136, 2012	22 Sept 2012	sch 1 (items 100-103): 22 Sept 2012 (s 2(1) item 2)	—
Privacy Amendment (Enhancing Privacy Protection) Act 2012 (C2012A00197)	197, 2012	12 Dec 2012	sch 5 (items 72, 73): 12 Mar 2014 (s 2(1) item 3)	sch 6 (items 1, 15-19)

Authorised Version C2026C00412 registered 28/09/2026

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Act 2013 (C2013A00105)	105, 2013	29 June 2013	sch 1 (items 1, 2, 4), sch 2 (items 1-21, 28(1), (2)): 1 July 2013 (s 2)	sch 1 (item 4), sch 2 (item 28(1), (2))
Private Health Insurance Legislation Amendment (Base Premium) Act 2013 (C2013A00106)	106, 2013	29 June 2013	sch 1 (items 1-3, 6, 13): Taken to have never commenced (s 2(1) items 2, 4, 6) Remainder: 29 June 2013 (s 2(1) items 1, 3, 5, 7)	sch 1 (item 14)
Private Health Insurance Legislation Amendment Act 2014 (C2014A00026)	26, 2014	9 Apr 2014	sch 1 (items 1-11, 13): 9 Apr 2014 (s 2)	—
Statute Law Revision Act (No. 1) 2014 (C2014A00031)	31, 2014	27 May 2014	sch 6 (items 19, 20, 23): 24 June 2014 (s 2(1) item 9)	sch 6 (item 23)
Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Act 2014 (C2014A00062)	62, 2014	30 June 2014	sch 6 (items 66, 67), sch 11 (items 61-72), sch 14: 1 July 2014 (s 2(1) items 6, 14)	sch 14
as amended by				
Public Governance and Resources Legislation Amendment Act (No. 1) 2015 (C2015A00036)	36, 2015	13 Apr 2015	sch 2 (item 7), sch 7: 14 Apr 2015 (s 2)	sch 7

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
as amended by				
Acts and Instruments (Framework Reform) (Consequential Provisions) Act 2015 (C2015A00126)	126, 2015	10 Sept 2015	sch 1 (item 486): 5 Mar 2016 (s 2(1) item 2)	—
Acts and Instruments (Framework Reform) (Consequential Provisions) Act 2015 (C2015A00126)	126, 2015	10 Sept 2015	sch 1 (item 495): 5 Mar 2016 (s 2(1) item 2)	—
Private Health Insurance Amendment Act (No. 1) 2014 (C2014A00123)	123, 2014	26 Nov 2014	26 Nov 2014 (s 2)	—
Private Health Insurance Amendment Act 2015 (C2015A00057)	57, 2015	26 June 2015	sch 1 (items 14-31): 1 July 2015 (s 2(1) item 2) sch 2 (items 2, 3): 26 May 2015 (s 2(1) item 3)	sch 1 (items 25-31), sch 2 (items 2, 3)
Norfolk Island Legislation Amendment Act 2015 (C2015A00059)	59, 2015	26 May 2015	sch 2 (items 306-310): 1 July 2016 (s 2(1) item 5) sch 2 (items 356-396): 18 June 2015 (s 2(1) item 2)	sch 2 (items 356-396)
as amended by				
Territories Legislation Amendment Act 2016 (C2016A00033)	33, 2016	23 Mar 2016	sch 2: 24 Mar 2016 (s 2(1) item 2)	—

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions) Act 2015 (C2015A00087)	87, 2015	26 June 2015	sch 1 (items 42-177, 179, 180): 1 July 2015 (s 2(1) items 2-5) sch 2: 27 June 2015 (s 2(1) item 9)	sch 2
Budget Savings (Omnibus) Act 2016 (C2016A00055)	55, 2016	16 Sept 2016	sch 6: 17 Sept 2016 (s 2(1) item 6)	—
Private Health Insurance Legislation Amendment Act 2018 (C2018A00101)	101, 2018	21 Sept 2018	sch 1, sch 2 (items 1, 2), sch 5 (items 1-30): 1 Apr 2019 (s 2(1) items 2, 5) sch 4, sch 5 (items 33-35): 22 Sept 2018 (s 2(1) items 4, 7) sch 5 (items 31, 32): 1 Jan 2019 (s 2(1) item 6)	sch 1 (item 2), sch 4
Health Legislation Amendment (Data-matching and Other Matters) Act 2019 (C2019A00121)	121, 2019	12 Dec 2019	sch 1 (item 8): 13 Dec 2019 (s 2(1) item 1)	—
Private Health Insurance Amendment (Income Thresholds) Act 2021 (C2021A00052)	52, 2021	24 June 2021	1 July 2021 (s 2(1) item 1)	sch 1 (item 10)
Private Health Insurance Legislation Amendment (Age of Dependants) Act 2021 (C2021A00060)	60, 2021	29 June 2021	sch 1 (items 2-22): 1 Apr 2021 (s 2(1) item 1)	sch 1 (item 22)

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Private Health Insurance Legislation Amendment (Medical Device and Human Tissue Product List and Cost Recovery) Act 2023 (C2023A00008)	8, 2023	16 Mar 2023	sch 1 (items 1-20, 24, 25), sch 2: 1 July 2023 (s 2(1) item 1)	sch 1 (items 24, 25), sch 2 (items 11-15)
Administrative Review Tribunal (Consequential and Transitional Provisions No. 1) Act 2024 (C2024A00038)	38, 2024	31 May 2024	sch 12 (items 33, 46): 14 Oct 2024 (s 2(1) item 2)	—
Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Act 2025 (C2025A00008)	8, 2025	14 Feb 2025	sch 2 (items 23-25): 15 Feb 2025 (s 2(1) item 7)	—
Aged Care and Other Legislation Amendment Act 2025 (C2025A00045)	45, 2025	19 Sept 2025	sch 3 (item 253): 1 Nov 2025 (s 2(1) item 6)	—
Health Legislation Amendment (Miscellaneous Measures No. 1) Act 2025 (C2025A00054)	54, 2025	4 Nov 2025	sch 2 (items 1-34): 1 Apr 2026 (s 2(1) item 3)	sch 2 (items 25-34)
Regulatory Reform Omnibus Act 2025 (C2025A00073)	73, 2025	4 Dec 2025	sch 3 (item 1): 5 Dec 2025 (s 2(1) item 10)	—

Authorised Version C2026C00412 registered 28/09/2026

Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Act 2026 (C2026A00090)	90, 2026	18 Sept 2026	sch 1 (items 2-3, 4-33, 35, 36), sch 2 (items 1-17): 19 Sept 2026 (s 2(1) items 2, 5, 6)	sch 1 (items 3, 35, 36), sch 2 (items 14, 15, 17)

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
Chapter 1	
Part 1-1	
Division 1	
s 1-10	am No 32, 2011; No 87, 2015
s 1-15	ad No 59, 2015
Division 3	
s 3-1	am No 87, 2015
s 3-5	am No 105, 2013
s 3-15	rs No 87, 2015
Chapter 2	
Part 2-1	
Division 15	
s 15-1	am No 105, 2013
Part 2-2	
Part 2-2 heading	rs No 105, 2013
Division 20	
s 20-1	am No 32, 2007
	rs No 105, 2013
s 20-5	am No 105, 2013
Division 22	
Division 22	ad No 26, 2012
Subdivision 22-A	ad No 26, 2012
s 22-1	ad No 26, 2012
s 22-5	ad No 26, 2012
	am No 60, 2021
s 22-10	ad No 26, 2012
s 22-15	ad No 26, 2012
	am No 105, 2013; No 26, 2014; No 60, 2021

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 22-20	ad No 26, 2012
s 22-25	ad No 26, 2012
	am No 60, 2021
Subdivision 22-B	
Subdivision 22-B heading	ad No 26, 2012
s 22-30	ad No 26, 2012
	am No 60, 2021
s 22-35	ad No 26, 2012
	rs No 52, 2021
s 22-40	ad No 26, 2012
	am No 52, 2021
s 22-45	ad No 26, 2012
	am No 123, 2014; No 55, 2016; No 52, 2021
Subdivision 22-C	
Subdivision 22-C heading	ad No 106, 2013
	rep No 26, 2014
s 22-50	ad No 106, 2013
	rep No 26, 2014
s 22-55	ad No 106, 2013
	rep No 26, 2014
s 22-60	ad No 106, 2013
	rep No 26, 2014
s 22-65	ad No 106, 2013
	rep No 26, 2014
Division 23	
Subdivision 23-A	
Subdivision 23-A heading	rs No 26, 2012
s 23-1	rs No 26, 2012
s 23-5	rep No 26, 2012
s 23-10	rep No 26, 2012

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
Subdivision 23-B	
s 23-15	am No 32, 2011; No 26, 2012; No 54, 2025
s 23-16	ad No 54, 2025
s 23-20	am No 32, 2011; No 54, 2025
s 23-25	am No 32, 2011
	rep No 26, 2012
s 23-30	am No 32, 2011; No 54, 2025
s 23-35	am No 32, 2011
s 23-40	am No 32, 2011; No 54, 2025
s 23-45	am No 32, 2011
Division 26	rep No 105, 2013
s 26-1	am No 32, 2007; No 26, 2012
	rep No 105, 2013
s 26-5	rep No 26, 2012
s 26-10	am No 32, 2011
	rep No 105, 2013
s 26-15	rs No 32, 2011
	rep No 105, 2013
s 26-20	am No 32, 2011
	rep No 105, 2013
s 26-25	am No 32, 2011
	rep No 105, 2013
s 26-30	am No 32, 2011
	rep No 26, 2012
Part 2-3	
Division 34	
s 34-25	rs No 63, 2010
	am No 32 and 46, 2011; No 59, 2015
s 34-30	am No 63, 2010; No 59, 2015
Division 37	
s 37-5	am No 63, 2010; No 46, 2011

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 37-7	ad No 63, 2010
Part 2-4	
Part 2-4	ad No 101, 2018
Division 42	
s 42-1	ad No 101, 2018
Division 45	
s 45-1	ad No 101, 2018
Chapter 3	
Part 3-1	
Division 50	
s 50-5	am No 8, 2023
Part 3-2	
Division 55	
s 55-5	am No 54, 2008; No 66, 2009; No 101, 2018; No 90, 2026
s 55-10	rs No 101, 2018
s 55-15	ad No 54, 2008
Part 3-3	
Division 63	
s 63-5	am No 66, 2009; No 60, 2021
Division 66	
s 66-1	am No 90, 2026
s 66-5	am No 101, 2018; No 90, 2026
s 66-6	ad No 90, 2026
s 66-7	ad No 90, 2026
s 66-8	ad No 90, 2026
s 66-10	rs No 90, 2026
s 66-11	ad No 90, 2026
s 66-12	ad No 90, 2026
	ed C42
s 66-13	ad No 90, 2026
s 66-15	am No 90, 2026

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 66-25	ad No 101, 2018
Division 72	
s 72-1	am No 40, 2010; No 8, 2023; No 8, 2025; No 45, 2025; No 73, 2025
s 72-10	am No 40, 2010; No 8, 2023
s 72-11	ad No 8, 2023
s 72-12	ad No 8, 2023
s 72-15	rs No 8, 2023
s 72-20	rs No 8, 2023
s 72-25	ad No 8, 2023
s 72-27	ad No 8, 2023
s 72-30	ad No 8, 2023
s 72-35	ad No 8, 2023
s 72-40	ad No 8, 2023
s 72-45	ad No 8, 2023
Division 78	
s 78-1	am No 101, 2018
Division 84	
s 84-1	am No 180, 2007
s 84-10	am No 87, 2015
Part 3-4	
Division 90	
s 90-1	am No 87, 2015
Division 93	
s 93-1	am No 101, 2018
s 93-5	am No 101, 2018
	ed C32
s 93-10	am No 101, 2018
s 93-15	am No 101, 2018
s 93-20	am No 87, 2015; No 101, 2018

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
Division 96	
Division 96 heading	rs No 87, 2015
s 96-1	am No 87, 2015; No 101, 2018
s 96-5	am No 87, 2015; No 101, 2018
s 96-10	am No 87, 2015; No 101, 2018
s 96-15	am No 87, 2015
s 96-20	am No 87, 2015
s 96-25	am No 87, 2015
Division 99	
s 99-1	am No 136, 2012
Chapter 4	
Chapter 4 heading	rs No 87, 2015
Part 4-1	
Division 110	
s 110-1	rs No 87, 2015
Part 4-2	
Part 4-2 heading	rs No 87, 2015
s 115-1	rs No 87, 2015
s 115-5	rs No 87, 2015
Division 118	rep No 87, 2015
s 118-1	rep No 87, 2015
s 118-5	rep No 87, 2015
Division 121	
s 121-5	am No 101, 2018
s 121-8	ad No 101, 2018
s 121-8A	ad No 101, 2018
s 121-8B	ad No 101, 2018
s 121-8C	ad No 101, 2018
s 121-8D	ad No 101, 2018
s 121-10	am No 101, 2018; No 8, 2025
Part 4-3	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 126-1	rep No 87, 2015
s 126-5	rep No 87, 2015
s 126-10	am No 54, 2008
	rep No 87, 2015
s 126-15	rep No 87, 2015
s 126-20	am No 180, 2007; No 54, 2008; No 26, 2014
	rep No 87, 2015
s 126-25	rep No 87, 2015
s 126-30	rep No 87, 2015
s 126-35	rep No 87, 2015
s 126-40	rep No 87, 2015
s 126-42	rep No 87, 2015
s 126-45	am No 54, 2008
	rep No 87, 2015
Part 4-4	
Division 131	
s 131-1	rs No 87, 2015
s 131-5	rs No 87, 2015
s 131-20	ad No 87, 2015
s 131-25	ad No 87, 2015
Division 134	rep No 87, 2015
s 134-1	rep No 87, 2015
s 134-5	rep No 87, 2015
s 134-10	rep No 87, 2015
Division 137	rep No 87, 2015
s 137-1	rep No 87, 2015
s 137-5	rep No 87, 2015
s 137-10	rep No 87, 2015
s 137-15	rep No 87, 2015
s 137-20	rep No 87, 2015
s 137-25	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 137-30	rep No 87, 2015
Division 140	rep No 87, 2015
s 140-1	rep No 87, 2015
s 140-5	rep No 87, 2015
s 140-10	rep No 87, 2015
s 140-15	rep No 87, 2015
s 140-20	rep No 87, 2015
Division 143	rep No 87, 2015
s 143-1	rep No 87, 2015
s 143-5	rep No 87, 2015
s 143-10	rep No 87, 2015
s 143-15	rep No 87, 2015
s 143-20	rep No 87, 2015
Division 146	rep No 87, 2015
s 146-1	rep No 87, 2015
s 146-5	rep No 87, 2015
s 146-10	rep No 87, 2015
s 146-15	rep No 87, 2015
Division 149	rep No 87, 2015
s 149-1	rep No 87, 2015
s 149-5	rep No 87, 2015
s 149-10	rep No 87, 2015
s 149-15	rep No 87, 2015
s 149-20	rep No 87, 2015
s 149-25	rep No 87, 2015
s 149-30	rep No 87, 2015
s 149-35	rep No 87, 2015
s 149-40	rep No 87, 2015
s 149-45	rep No 87, 2015
s 149-50	rep No 87, 2015
s 149-55	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 149-60	rep No 87, 2015
Division 152	rep No 87, 2015
s 152-5	rep No 87, 2015
s 152-10	rep No 87, 2015
s 152-15	rep No 87, 2015
Part 4-5	
Part 4 5 heading	rs No 87, 2015
Division 157	
s 157-1	rs No 87, 2015
s 157-5	am No 87, 2015
Division 160	rep No 87, 2015
s 160-1	rep No 87, 2015
s 160-5	rep No 87, 2015
s 160-10	rep No 87, 2015
s 160-15	rep No 87, 2015
s 160-20	rep No 87, 2015
s 160-25	rep No 87, 2015
s 160-30	rep No 87, 2015
s 160-35	rep No 87, 2015
Division 163	rep No 87, 2015
s 163-1	rep No 87, 2015
s 163-5	rep No 87, 2015
s 163-10	rep No 87, 2015
s 163-15	rep No 87, 2015
s 163-20	rep No 87, 2015
Division 166	rep No 87, 2015
s 166-1	rep No 87, 2015
s 166-5	rep No 87, 2015
s 166-10	rep No 87, 2015
s 166-15	rep No 87, 2015
s 166-20	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 166-25	rep No 87, 2015
Division 169	
Division 169 heading	rs No 87, 2015
s 169-1	rep No 87, 2015
s 169-5	rep No 87, 2015
s 169-10	am No 87, 2015
s 169-15	rep No 87, 2015
Division 172	
Division 172 heading	rs No 87, 2015
s 172-1	rep No 87, 2015
s 172-5	am No 103, 2010
s 172-15	am No 87, 2015
Chapter 5	
Part 5-2	
Division 180	
s 180-1	am No 87, 2015
Division 185	
s 185-1	am No 87, 2015
s 185-5	am No 54, 2008
	rs No 87, 2015
s 185-10	rep No 87, 2015
Division 191	
s 191-1	rs No 87, 2015
s 191-5	am No 87, 2015
Division 194	
s 194-1A	ad No 87, 2015
s 194-1	am No 87, 2015
s 194-5	am No 87, 2015
s 194-10	am No 87, 2015
s 194-15	am No 87, 2015
s 194-25	am No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 194-30	rep No 87, 2015
s 194-35	am No 87, 2015
Division 197	
s 197-1	am No 87, 2015
s 197-5	am No 87, 2015
Division 200	
Division 200 heading	rs No 87, 2015
s 200-1	am No 54, 2008; No 87, 2015
s 200-5	am No 87, 2015
Division 203	
s 203-1	am No 87, 2015
s 203-10	am No 87, 2015
s 203-15	am No 87, 2015
s 203-20	am No 87, 2015; No 90, 2026
s 203-25	am No 87, 2015
s 203-60	am No 87, 2015
Division 206	
s 206-1	am No 105, 2013
Part 5-3	rep No 87, 2015
s 211-1	rep No 87, 2015
s 211-5	rep No 87, 2015
s 211-10	rep No 87, 2015
s 211-15	rep No 87, 2015
s 214-1	rep No 87, 2015
s 214-5	rep No 87, 2015
s 214-10	rep No 87, 2015
s 214-15	rep No 87, 2015
s 214-20	rep No 87, 2015
s 214-25	rep No 87, 2015
s 214-30	rep No 87, 2015
s 214-35	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 214-40	rep No 87, 2015
s 214-45	rep No 87, 2015
s 217-1	rep No 87, 2015
s 217-5	rep No 87, 2015
s 217-10	rep No 87, 2015
s 217-15	rep No 87, 2015
s 217-20	rep No 87, 2015
s 217-25	rep No 87, 2015
s 217-30	rep No 87, 2015
s 217-35	rep No 87, 2015
s 217-40	rep No 87, 2015
s 217-45	rep No 87, 2015
s 217-50	rep No 87, 2015
s 217-55	rep No 87, 2015
s 217-60	rep No 87, 2015
s 217-65	rep No 87, 2015
s 217-70	rep No 87, 2015
s 217-75	rep No 87, 2015
s 217-80	rep No 87, 2015
s 220-1	rep No 87, 2015
s 220-5	rep No 87, 2015
s 220-10	rep No 87, 2015
s 220-15	rep No 87, 2015
Chapter 6	
Part 6-1	
Division 230	
s 230-1	am No 105, 2013; No 57, 2015; No 87, 2015; No 38, 2024
Part 6-2	rep No 57, 2015
s 235-1	rep No 57, 2015
s 235-5	rep No 57, 2015
s 238-1	am No 62, 2014

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
	rep No 57, 2015
s 238-5	am No 8, 2010
	rep No 57, 2015
s 241-1	rep No 57, 2015
s 241-5	rep No 57, 2015
s 241-10	rep No 57, 2015
s 241-15	rep No 57, 2015
s 241-20	rep No 57, 2015
s 241-25	rep No 57, 2015
s 241-30	rep No 57, 2015
s 241-35	rep No 57, 2015
s 241-40	rep No 57, 2015
s 241-45	rep No 57, 2015
s 241-50	rep No 57, 2015
s 241-55	rep No 57, 2015
s 241-60	rep No 57, 2015
s 241-65	rep No 57, 2015
s 244-1	rep No 57, 2015
s 244-5	rep No 57, 2015
s 244-10	rep No 57, 2015
s 244-15	rep No 57, 2015
s 244-20	am No 103, 2010
	rep No 57, 2015
s 247-1	rep No 57, 2015
s 247-5	rep No 57, 2015
s 247-10	rep No 57, 2015
s 247-15	rep No 57, 2015
s 247-20	rep No 57, 2015
s 247-25	rep No 57, 2015
s 250-1	rep No 57, 2015
s 250-5	rep No 57, 2015

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 250-10	am No 197, 2012
	rep No 57, 2015
s 253-1	rep No 57, 2015
s 253-5	rep No 57, 2015
s 253-10	am No 46, 2011
	rep No 57, 2015
s 253-15	rep No 57, 2015
s 253-20	rep No 57, 2015
s 253-25	rep No 57, 2015
s 253-30	rep No 57, 2015
s 253-35	am No 62, 2014
	rep No 57, 2015
s 253-40	rep No 62, 2014
s 253-45	rep No 57, 2015
s 253-50	rs No 62, 2014
	rep No 57, 2015
s 253-55	rep No 57, 2015
s 253-60	rep No 57, 2015
s 256-1	rep No 57, 2015
s 256-5	rep No 57, 2015
s 256-10	rep No 57, 2015
Part 6-3	rep No 87, 2015
s 261-1	rep No 87, 2015
s 261-5	rep No 87, 2015
s 264-1	am No 62, 2014
	rep No 87, 2015
s 264-5	rep No 87, 2015
s 264-10	rep No 87, 2015
s 264-15	am No 62, 2014
	rep No 87, 2015
s 264-20	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 264-25	rep No 87, 2015
s 267-1	rep No 87, 2015
s 267-5	rep No 87, 2015
s 267-10	rep No 87, 2015
s 267-15	am No 62, 2014
	rep No 87, 2015
s 267-20	rs No 62, 2014
	rep No 87, 2015
s 270-1	rep No 87, 2015
s 270-5	rep No 87, 2015
s 270-10	am No 46, 2011
	rep No 87, 2015
s 270-15	am No 31, 2014
	rep No 87, 2015
s 270-20	rep No 87, 2015
s 270-25	rep No 87, 2015
s 270-30	rep No 87, 2015
s 270-35	rep No 87, 2015
s 270-40	am No 62, 2014
	rep No 87, 2015
s 270-45	am No 180, 2007
	rep No 62, 2014
s 273-1	rep No 87, 2015
s 273-5	rep No 87, 2015
s 273-10	am No 62, 2014
	rep No 87, 2015
s 273-15	rep No 87, 2015
s 273-20	rep No 87, 2015
s 273-25	rep No 87, 2015
Part 6-4	
Part 6-4	rs No 105, 2013

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
Division 276	
s 276-1	am No 32, 2011; No 105, 2013
Division 279	
Division 279 heading	rs No 105, 2013
Subdivision 279-A	
s 279-1	am No 32, 2011
	rs No 54, 2025
s 279-10	am No 32, 2011
	rs No 54, 2025
s 279-11	ad No 54, 2025
s 279-15	am No 32, 2011; No 136, 2012; No 54, 2025
s 279-20	am No 32, 2011
	rep No 54, 2025
s 279-25	am No 32, 2011
	rep No 54, 2025
s 279-30	am No 32, 2011
	rep No 54, 2025
s 279-35	rep No 54, 2025
s 279-40	am No 32, 2011
	rep No 54, 2025
s 279-45	am No 32, 2011; No 54, 2025
Subdivision 279-B	
Subdivision 279-B heading	rs No 32, 2011
s 279-50	am No 32, 2011; No 136, 2012
s 279-55	am No 32, 2011
Division 282	
Division 282 heading	rs No 105, 2013
Subdivision 282-A	
s 282-1	am No 32, 2011; No 26 and 136, 2012; No 105, 2013; No 54, 2025
s 282-5	am No 32, 2011
s 282-10	am No 32, 2011

Authorised Version C2026C00412 registered 28/09/2026

Endnote 4—Amendment history

Provision affected	How affected
s 282-15	am No 32, 2011; No 105, 2013
Subdivision 282-AA	
Subdivision 282-AA heading	ad No 26, 2012
s 282-16	ad No 26, 2012
s 282-17	ad No 26, 2012
s 282-18	ad No 26, 2012
	am No 105, 2013
s 282-19	ad No 26, 2012
Subdivision 282-B	
s 282-20	am No 32, 2011; No 54, 2025
s 282-25	am No 26, 2012; No 90, 2026
s 282-30	am No 32, 2011
s 282-35	am No 32, 2011
Part 6-5	rep No 87, 2015
s 287-1	rep No 87, 2015
s 287-5	rep No 87, 2015
s 290-1	rep No 87, 2015
s 290-5	rep No 87, 2015
s 290-10	rep No 87, 2015
s 293-1	rep No 87, 2015
s 293-5	rep No 87, 2015
s 293-10	rep No 87, 2015
s 293-15	rep No 87, 2015
s 296-1	rep No 87, 2015
s 296-5	rep No 87, 2015
s 296-10	rep No 87, 2015
s 296-15	rep No 87, 2015
s 296-20	rep No 87, 2015
s 296-25	rep No 87, 2015
s 299-1	rep No 87, 2015
s 299-5	rep No 87, 2015

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 299-10	rep No 87, 2015
s 299-15	rep No 87, 2015
s 299-20	rep No 87, 2015
s 299-25	rep No 87, 2015
Part 6-6	
Division 304	
s 304-10	am No 66, 2009; No 87, 2015; No 8, 2023
Division 307	
s 307-1	am No 66, 2009; No 87, 2015
s 307-5	am No 66, 2009
s 307-10	am No 66, 2009; No 87, 2015; No 8, 2023
s 307-15	am No 87, 2015
s 307-20	am No 66, 2009; No 87, 2015; No 8, 2023
s 307-25	rep No 87, 2015
s 307-30	am No 8, 2023
Division 310	
Division 310 heading	rs No 66, 2009
s 310-1	am No 87, 2015
s 310-5	am No 87, 2015
s 310-10	am No 87, 2015
Division 313	
Division 313 heading	rs No 66, 2009; No 87, 2015
s 313-1	am No 87, 2015
s 313-20	am No 87, 2015
Part 6-7	
Part 6-7	rs No 87, 2015
Division 318	
s 318-1	rs No 87, 2015
s 318-5	rs No 87, 2015
s 318-10	rs No 87, 2015
s 318-15	rs No 87, 2015

Endnote 4—Amendment history

Provision affected	How affected
Part 6-8	
Division 323	
s 323-1	am No 87, 2015; No 121, 2019
	rs No 90, 2026
s 323-5	am No 32, 2011; No 26, 2012; No 57, 2015; No 87, 2015; No 90, 2026
s 323-10	am No 32, 2011; No 57, 2015; No 87, 2015; No 90, 2026
s 323-15	am No 90, 2026
s 323-20	am No 90, 2026
s 323-23	ad No 90, 2026
s 323-25	am No 87, 2015
	rep No 90, 2026
s 323-30	am No 90, 2026
s 323-33	ad No 90, 2026
s 323-35	rep No 87, 2015
	ad No 90, 2026
s 323-40	am No 90, 2026
s 323-45	am No 90, 2026
s 323-50	am No 90, 2026
s 323-55	am No 90, 2026
Division 324	
Division 324	ad No 90, 2026
s 324-1	ad No 90, 2026
s 324-5	ad No 90, 2026
s 324-7	ad No 90, 2026
s 324-10	ad No 90, 2026
s 324-15	ad No 90, 2026
s 324-20	ad No 90, 2026
Part 6-9	
Division 328	
s 328-1	am No 32, 2011; No 57, 2015; No 38, 2024

Authorised Version C2026C00412 registered 28/09/2026

Provision affected	How affected
s 328-5	am No 32, 2011; No 105, 2013; No 57, 2015; No 87, 2015; No 101, 2018; No 38, 2024
Part 6-10	
Division 333	
s 333-1	am No 32, 2011; No 87, 2015; No 90, 2026
s 333-10	am No 32, 2011; No 87, 2015; No 54, 2025
s 333-16	ad No 54, 2025
s 333-17	ad No 54, 2025
s 333-18	ad No 54, 2025
s 333-20	am No 57, 2015; No 87, 2015; No 60, 2021; No 8, 2023; No 54, 2025; No 90, 2026
s 333-25	rs No 87, 2015
Schedule 1	
Schedule 1	am No 66, 2009; No 63, 2010; No 32, 2011; No 46, 2011; No 26, 2012; No 197, 2012; No 105, 2013; No 106, 2013; No 26, 2014; No 57, 2015; No 59, 2015; No 87, 2015; No 101, 2018; No 60, 2021; No 8, 2023; No 54, 2025; No 90, 2026

Authorised Version C2026C00412 registered 28/09/2026

Endnote 5—Editorial changes

In preparing this compilation for registration, the following kinds of editorial change(s) were made under the *Legislation Act 2003*.

Subsection 66-12(1)

Kind of editorial change

Update to a cross-reference

Details of editorial change

Schedule 2 item 8 of the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Act 2026* instructs to repeal and substitute section 66-10 and insert sections 66-6 to 66-8 and 66-11 to 66-13.

The newly inserted subsection 66-12(1) refers to "66-8 or 66-10" instead of "section 66-8 or 66-10".

This compilation was editorially changed to update the cross-reference by inserting "section" before "66-8 or 66-10" in subsection 66-12(1).

Authorised Version C2026C00412 registered 28/09/2026