

# GLOSSARY OF TERMS

**Access Gap Scheme** means the approved scheme conducted by the Australian Health Service Alliance providing above the Commonwealth Medicare Benefits Schedule (CMBS) benefit payments where medical practitioners charge within agreed fee schedules and provided informed financial consent to patients.

**Accident** means accidental bodily injury caused solely and directly by external means.

**ADA Schedule** means the Schedule of Dental Services published by the Australian Dental Association Incorporated.

**Advanced Surgical Patient** means a patient classification of a Hospital patient for which certain benefits are determined pursuant to the *Private Health Insurance (Benefit Requirements) Rules 2007*.

**Benefit/s** means an amount of money payable or the provision of appliances under a Policy.

**Benefit Limitation Period** means a period:

- a) starting at the time the person becomes insured under the Policy; and
- b) ending at the time specified in the Policy, during which the amount of Benefit in relation to any period is less than the amount for which the person would be eligible during any other period Board means the Board of Directors of Westfund.

**Calendar Year** means the twelve month period from 1 January to 31 December in a year.

**Child** means:

- a natural child;
- an adopted child;
- a foster child;
- a stepchild (that is, a natural, adopted or foster child of the person's Partner) who does not have a Partner.

**CMBS (Commonwealth Medicare Benefits Schedule)** is a schedule of fees for Professional Services which attract Medicare Benefits maintained by the Department of Health and Ageing.

**Complying Health Insurance Policy** is an insurance policy that meets:

- a) the community rating requirements in *Division 66 of the Private Health Insurance Act 2007*; and
- b) the coverage requirements in *Division 69 of the Private Health Insurance Act 2007*; and
- c) if the policy covers hospital treatment – the benefit requirements in *Division 72 of the Private Health Insurance Act 2007*; and
- d) the waiting period requirements in *Division 75 of the Private Health Insurance Act 2007*; and
- e) the portability requirements in *Division 78 of the Private Health Insurance Act 2007*; and
- f) the quality assurance requirements in *Division 81 of the Private Health Insurance Act 2007*; and
- g) any requirements set out in the *Private Health Insurance (Complying Product) Rules* for the purposes of this paragraph

**Complying Health Insurance Product** is a product made up of Complying Health Insurance Policies. A product is all policies that cover the same treatments, and that provide benefits that are worked out in the same way, and whose other terms and conditions are the same as each other.

**Contract** has the same meaning as Purchaser-Provider Agreement.

**Co-Payment** means an amount payable by a Member for each day of Hospital Treatment or Hospital-Substitute Treatment. The Co-Payment is either paid by the Member or subtracted from any Benefit which would otherwise be payable.

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**Day Hospital Facility** means a hospital as defined in the *Private Health Insurance Act 2007* to which a person is usually admitted for Hospital treatment and discharged prior to midnight on the day of admission.

**Default Benefit** means, in the relation to Hospital Treatment, the minimum Benefit payable from a Hospital Policy as prescribed by the Minister from time to time.

**Dental Expert** means a registered dental practitioner appointed by Westfund to determine disputes concerning the payment of dental Benefits.

**Dependant Child** means a person:

- (a) who is:
  - (i) aged under 18; or
  - (ii) a dependent child; and
- (b) who is not aged 25 or over; and
- (c) who does not have a Partner.

**Excess** means an amount payable by a Member for Hospital Treatment or Hospital-Substitute Treatment in a Policy year where the payment would normally attract the benefit in accordance with the Policy. The Excess is either paid by the Member or subtracted from any Benefit which would otherwise be payable.

**Exclusion** means the Policy does not cover treatment for that condition.

**Fund** means the health benefits fund operated by Westfund as a private health insurer under the *Private Health Insurance Act 2007*.

**General Treatment** means 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.

**Hospital** means a private hospital, a public hospital or a day hospital facility declared by the Minister pursuant to s121-5(6) of the *Private Health Insurance Act 2007*.

**Hospital Policy** means a Policy provided to cover the cost of Hospital Treatment and associated Professional Services.

**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.

**Hospital Treatment** means 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:

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(i) is provided at a Hospital; or

(ii) is provided, or arranged, with the direct involvement of a Hospital

**Informed Financial Consent** is the consent to treatment obtained by a doctor from a patient - prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs.

**Known Gap Cover** means that benefits which provide cover for Professional Services where the Member has been provided with Informed Financial Consent up to a specified percentage above the **CMBS** fee, or the cost of the service if less.

**Major Dental** means crowns, bridges, veneers, implants, dentures, and orthodontia.

**Medical Adviser** means a qualified medical practitioner appointed by Westfund to give technical advice on professional matters, in particular in relation to Pre-Existing Condition rulings.

**Medical Gap** is the difference, if any, between the cost of a Professional Service and the combined Medicare Benefit and Westfund Benefit.

**Medically Recommended Aids** means mammary prostheses (cancer patients), wigs (cancer patients), burn suits, orthopaedic boots (boots individually hand made to correct abnormality), surgical stockings (ie anti-embolism compression stocking/hosiery), peak flow meter, sleep machine, oral appliance for diagnosed snoring, nebuliser, blood glucose monitor, blood pressure monitor, tens machine.

**Medicare Benefit** means a Medicare benefit under *Part II of the Health Insurance Act 1973*. The Medicare Benefit is 75% of the **CMBS** fee for in-hospital Professional Services.

**Member** means an insured person under a Policy.

**MIMS** means the Monthly Index of Medical Specialties, a subscription providing medical practitioners and healthcare professionals with drug information.

**Partner** means a person who:

- is married to the relevant person, or
- lives with the relevant person in a relationship on a bonafide domestic basis.

**PBS** means the Commonwealth Government's Pharmaceutical Benefits Scheme.

**PBS Item** means any drug listed in the Pharmaceutical Benefits Schedule.

**Pharmaceutical Benefits Schedule** means the Schedule of Pharmaceutical Benefits kept by the Commonwealth Department of Health and Ageing.

**Policy** means a Hospital Policy or a General Treatment Policy or a combined Hospital and General Treatment Policy that provides entitlement to Benefits payable in respect of approved expenses incurred by the Members of that Policy as specified in these rules.

**Policy Year** means a year from the date of commencement of a Policy or from the anniversary date of the commencement of a Policy.

**Pre-Existing Condition** means an ailment, illness or condition that, in the opinion of a medical practitioner appointed by the

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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. In forming the opinion, the medical practitioner must have regard to any information in relation to the ailment, illness or condition that the medical practitioner who treated the ailment, illness or condition gives him or her.

**Premium** means an amount of money a Member is required to pay for a specified period for a Policy.

**Prescribed 35 Day Period** means that the patient has been in a Hospital (or hospitals) for 35 days without a break of 7 days or more during the last 12 months from the date of the first admission.

**Primary Member** means a person in whose name the Policy is registered with Westfund and who is a policy holder as defined in the *Private Health Insurance Act 2007*.

**Professional Service** means a service provided by a medical practitioner to, or in respect of, an inpatient of a Hospital for which a Medicare Benefit is payable.

**Purchaser-Provider Agreement** means a Hospital Purchaser-Provider Agreement or a Medical Purchaser-Provider Agreement or a Practitioner Agreement which is an agreement between Westfund and a provider in respect of the provision of services to Members.

**Recognised Provider** means a provider recognised by Westfund for the purpose of paying Benefits. To become a Recognised Provider, the provider must, among other things, satisfy the standards in the *Private Health Insurance (Accreditation) Rules*. Recognised Providers include Hospitals, medical practitioners providing a Professional Service and providers of General Treatment that meet Westfund's Recognition Criteria.

**Recognition Criteria** in relation to Recognised Providers of General Treatment are:

- the provider is professionally qualified or belongs to a professional body recognised by Westfund;
- the provider is in independent private practice;
- the provider is registered, or holds a licence under State or Territory legislation;
- other recognition criteria determined by Westfund.

**Restricted Benefit** means a benefit which is covered under a Policy but which is only covered to a limited extent (meaning out of pocket costs to the Member).

**Standard Information Statement** for a Complying Health Insurance Product is a statement about the product that contains the information, and is in the form, set out in the *Private Health Insurance (Complying Product) Rules*.

**Usual Customary and Reasonable Charge** means in relation to a service, the usual or customary fee charged for that service by other similarly qualified practitioners or a reasonable charge for that service as determined by Westfund having regard to the usual or customary charges for a similar service and/or advice from the practitioner's professional association or body.

**Waiting Period** means the period that applies to a person for a Benefit under an insurance policy being the period:

- a) starting at the time the person becomes insured under the Policy; and
- b) ending at the time specified in the Policy; during which the person is not entitled to the Benefit.