Data Dictionary

HRF 601.0 and HRF 601.1

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About the Data Dictionary

This dictionary is a compilation of definitions for terms used or associated with HRF 601.0 and HRF 601.1 Quarterly data collection in the order in which they appear in the template.

All definitions that come from current legislation are cited underneath.

Current legislation includes:

- *Private Health Insurance Act 2007*
- *Private Health Insurance (Health Insurance Business) Rules 2015*
- *Private Health Insurance (Risk Equalisation Policy) Rules 2015*
- *Private Health Insurance (Risk Equalisation Administration) Rules 2015*
- *Health Insurance Act 1973*

Terms in the leftmost column show the correct style of use for these terms.

All defined terms are listed in the index on page 25.

Part 1 – Policies and insured

adult	Means a person who is not a dependent child. *(Schedule 1, Private Health Insurance Act 2007)*
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. 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. *(Division 69, Private Health Insurance Act 2007)*
coverage requirements	1. An insurance policy meets the coverage requirements in *Division 69*, *Private Health Insurance Act 2007* 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. 3. 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. 4. 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. *(Division 69, Private Health Insurance Act 2007)*
dependent child	Means a person a. who is: (i) aged under 18: or (ii) a dependent child under the rules of the insurer that insures the person; and b. who is not aged 25 or over; and c. who does not have a partner. *(Schedule 1, Private Health Insurance Act 2007)*
holder (of an insurance policy)	Means a person who is insured under the policy and who is not a dependent child. (*Schedule 1, Private Health Insurance Act 2007*)
insured persons	All persons covered by health insurance policies.
Policy holder, Policies, policies (of a health benefits fund)	Means a holder of a policy that is referable to the fund. *(Schedule 1, Private Health Insurance Act 2007)*
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). *(Schedule 1, Private Health Insurance Act 2007)*

Single equivalent unit/s (SEU/s)	Single equivalent units (SEUs) are used as a standard measure of the different categories of policies. The Single equivalent units for each category of policy are: (a) Single (b) Couple (c) 2+ persons no adults (d) Single parent (e) Family (f) 3+ adults (Sub rule 4 of the *Private Health Insurance (Risk Equalisation Policy) Rules 2015* SEUs are calculated as ([Single] + [2+ Persons no adults] + [Single parent]) + 2 x ([Couple] + [Family] + [3+ Adults])
Types of cover All definitions are taken from Sub rule 4(2) of the *Private Health Insurance (Risk Equalisation Policy) Rules 2015*	
2 + persons, no adults	A hospital policy under which 2 or more people are insured, none of whom is an adult.
3 + adults	A hospital policy under which 3 or more people are insured, at least 3 of whom are adults.
couple	A hospital policy under which 2 adults are insured (and no-one else).
family	A hospital policy under which 3 or more people are insured, only 2 of whom are adults.
single	A hospital policy under which only one person is insured.
single parent	A hospital policy under which 2 or more people are insured, only one of whom is an adult.
Types of policies	
Excess & Co-payments	Means an amount of money a policy holder agrees to pay before private health insurance benefits are payable. A co-payment could apply every time a person insured under the policy goes to hospital in a year, or an excess may be capped at a total amount for the year. The terms "Excess" and "Co-payments" are sometimes referred to as "Front-end Deductibles" and are similar in meaning. For taxation purposes those taxpayers who would be subject to the Medicare Levy Surcharge are exempted if they have a hospital treatment policy with an excess no greater than $400

	for a policy covering a single person or an excess no greater than $1,000 for a policy covering more than one person. Excess & Co-payments Policies- includes all policy holders who contribute to hospital treatment policies under which an agreed, excess, amount is paid by the policy holder for hospital treatment and/or general treatment services, reducing the benefit otherwise payable in exchange for lower premium costs. Note: these can be combined with exclusionary policies.
Excess (also referred to as front-end deductible)	An excess is an amount of money a policy holder agrees to pay for a hospital stay before health fund benefits are payable. For example, if a policy has an excess of $200, the insured person will be required to pay the first $200 of the hospital costs if they go to hospital as a private patient. An excess could apply every time the insured person goes to hospital in a year, or it may be capped at a total amount that will be paid in each year.
co-payment	With a co-payment, a policy holder agrees to pay an agreed amount each time a service is provided. For example, a policy may have a co-payment clause that requires payment for the first $50 for each day's hospital accommodation. If the policy has such a co-payment and they were in hospital for 5 days, they would have to pay $250 ($50 x 5).The total amount of co-payment that can be paid in a year is often limited to a set maximum amount.
Exclusionary Policies	Means where the private health insurance policy features an exclusion for a particular condition and there is no coverage at all for medical treatment as a private patient in a public or private hospital or any other setting for that condition. Exclusionary tables exclude payment of benefits for a particular condition in all settings. (This does not refer to the case where the policy only covers the medical services to a limited extent, only in certain settings or only after a certain time.)
No Excess & No Co-payment	Means all policies other than Excess & Co-payments Policies. The sum of Excess & Co-payments and No Excess & No Co-payments policies will reflect the total hospital treatment policies.
Non-Exclusionary Policies	Means the policy does not have any exclusions (see Exclusionary Policies) The sum of exclusionary and non-exclusionary policies will reflect the total hospital treatment policies. NB: Where a product only relates to select hospitals but covers all treatment in those hospitals the policies should be included in the non- exclusionary category. ***Errors to avoid:*** *The majority of errors for exclusionary policy holders are where treatment is excluded in some, but not all, settings where the product can be utilised but the policy holders are counted as exclusionary. For example, if treatment is excluded in a private hospital but not excluded in a public hospital the member with that product should not be counted as an exclusionary policy holder.*

Changes during the quarter	
Start of quarter	Means the total number of policies and insured persons with Hospital Treatment Only, Hospital Treatment and General Treatment or General Treatment Only at the start of the quarter. This figure should match end of quarter reported under the same categories in the previous quarter's return. ***Note:*** *In the first quarter of reporting (June quarter 2007) under the previous Private Health Insurance legislation, introduced on 1 April 2007, several funds commenced reporting in all states for the first time. Previously they were reporting only in states where they had more than 500 SEU. For these funds, and only in the June quarter 2007, the start of quarter policies and insured persons were the actual policies and insured persons in each state at the end of March 2007.*
New policies/ persons	Policies and insured persons joining but not transferring from another fund. This category should include: New policies • Reinstated policies where these policies were not included in the previous quarter's return because of suspension (note that if a policy is both suspended and reinstated within the quarter to which this return relates they should not be counted as discontinued or reinstated) • Hospital Treatment Only or General Treatment Only policies who take additional cover • Insured persons with a General Treatment Only policy transferring to an existing Hospital Treatment policy (an increase in insured persons, not policies) • Births, or children covered under one parent's cover (increase in insured persons not policies
Transferring from another state	Means policies and insured persons transferring from another state within this fund
Transferring to another state	Means policies and insured persons transferring to another state
Transferring from another Fund	Means policies and insured persons transferring from another fund but not joining. This category should include: • Policies joining as transfers from another fund • Insured persons transferring from another fund to an existing policy (new insured persons, not new policies) • Policies with a Hospital Treatment Only policy with your fund and General Treatment Only policy with another fund who transfer the General Treatment Only policy to your fund (new Hospital and General Treatment policy)

Transferring to another policy	Means policies and insured persons transferring to another policy treatment type. Policy types being "Hospital Treatment Only", "Hospital Treatment and General Treatment" or "General Treatment Only".
Transferring from another policy	Means policies and insured persons transferring from another policy treatment type. Policy types being "Hospital Treatment Only", "Hospital Treatment and General Treatment" or "General Treatment Only".
Discontinued	Means policies and insured persons leaving. Represents the balancing item for the aggregate fund coverage from one quarter to the next. Included in this category is: • Deaths (decrease in insured persons, not necessarily policies) • Suspended policies, where they are not included in the coverage count for risk equalisation purposes • Policies with "Hospital and General Treatment" that drop "Hospital Treatment" cover or drop "General Treatment Cover"
End of quarter	This equals: • policies/insured persons at start of quarter • plus new policies/insured persons joining • plus transfers from another state, fund or policy type • less transfers to another state or policy type • less discontinued coverage
Types of treatment	
Chronic Disease Management Program (CDMP)	See Page 16
Hospital treatment	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; c. either: (i) is provided at a hospital; or (ii) is provided, or arranged, with the direct involvement of a hospital. (Division 121, *Private Health Insurance Act 2007* but subject to 121-15) Definition for Hospital see page 12

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. (Division 69, Private Health Insurance Act 2007) ***Note:*** *In the Act the Coverage Requirements do not permit a general treatment policy only to include hospital-substitute treatment. Policies that include hospital-substitute treatment must also include hospital treatment.*
General Treatment	See page 19
General Treatment only policies	Means policies that cover specified treatments that are general treatment but none that are hospital or hospital-substitute treatment. General Treatment Ambulance Only is included in Total General Treatment Only
General Treatment Ambulance only policies	Means policies that cover ambulance services but does not cover any other hospital or general treatment. A subset of General Treatment Only Policies, covering only ambulance services. Ambulance services associated with the provision of treatment to an insured person are specified as included in General Treatment for the purposes of subsection 121- 10 (2) of the Act.
Hospital Treatment Only Policies	Means policies that specify only treatments that are hospital treatment.
Hospital and general treatment combined	Means policies that specify treatments that are hospital treatment and specify treatments that are general treatment

Part 2 – Total benefits paid - hospital and general treatment

episode/s	Means for a particular type of treatment or place where the treatment was provided: a) for hospital treatment provided at a hospital, the period between the insured person's admission to the hospital and discharge from that hospital, including leave periods, is one episode; and b) for: (i) hospital-substitute treatment; and

	(ii) hospital treatment that is provided, or arranged, with the direct involvement of a hospital, the continuous period between the commencement and cessation of the treatment is one episode, and c) an episode for which a benefit has been paid is to be counted (unless an incomplete episode) *(Part 3, Private Health Insurance (Risk Equalisation Administration) Rules 2015)* ***Note:*** *episodes are not reported until the episode is complete.*
incomplete episode	If an episode is not completed within a quarter but a benefit has been paid in relation to the treatment because of an interim billing arrangement, the episode is reported as one episode only and only in the quarter in which the episode is completed. *(Part 3, Private Health Insurance (Risk Equalisation Administration) Rules 2015)*
Days – Hospital Treatment	Means day/s on which a policy holder or insured person is a patient of a public or private hospital for hospital treatment. Days must reflect the total days related to each episode, including days when no private health insurance benefits are paid. Where a hospital stay includes leave days, those days are not reported on HRF 601.1.
Days - Hospital-substitute Treatment	While there may be no accommodation benefits involved in hospital-substitute there will be days involved in the care. Either one day only or more than one day.
Benefits Paid Chronic Disease Management Program (CDMP)	Means benefits paid for services covered by Chronic Disease Management Programs.
Benefits Paid General Treatment	Means benefits paid for services covered by general treatment
Benefits Paid Hospital Benefits	Means benefits paid for services covered by hospital treatment.
Day Hospital Facilities	Means a private hospital that is not licensed or otherwise permitted to provide treatment that includes part of an overnight stay at the hospital. *(Part 3, Private Health Insurance (Risk Equalisation Administration) Rules 2015)* ***Note:*** *Day hospital facilities are those that were a day hospital facility within the meaning of the National Health Act 1953, and are taken to be private hospitals for the purpose of the Private Health Insurance Act 2007.*

Day Only	Means a day on which a policy holder or insured person is accommodated as a patient in a public or private hospital for day treatment.
leave periods / leave days	Means a temporary absence from hospital treatment with medical approval for a period no greater than seven consecutive days.
Private Hospitals	Means a hospital in respect of which there is in force a statement under subsection 121-5(8) of the Private Health Insurance Act 2007 that the hospital is a private hospital.
Public Hospitals	Means a hospital in respect of which there is in force a statement under subsection 121-5(8) of the Private Health Insurance Act 2007 that the hospital is a public hospital.
Overnight	Means days on which a policy holder or insured person is a patient of a public or private hospital for hospital treatment for a period of time.
Hospital-Substitute Treatment	See page 10
Treatment greater than one day	For hospital-substitute treatment an episode is to be counted as the continuous period between commencement and cessation of treatment. While there may be no accommodation benefits involved in hospital-substitute there will be days involved in the care. Either one day only or more than one day. The intent is to collect data on the length of care involved in hospital-substitute.
Nursing Home Type Patients	Means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days. (Section 3, Health Insurance Act 1973)
Medical benefits	Means benefits paid under all policies of the fund for services provided as part of hospital treatment or hospital-substitute treatment if a medicare benefit is payable for the service.
Prostheses benefits	Means benefits paid under all policies of the fund for prostheses of the kinds listed in the Private Health Insurance (Prostheses) Rules 2015 (No.1) made under the Act, but only where those Rules provide that there must be a benefit for the provision of the prosthesis in the circumstances specified.
Ineligible benefits	See page 15
Risk equalisation	
Age Based Pool (ABP)	The Age Based Pool (ABP) equalises benefits for the Risk Equalisation Levy. Pooling is based on adding a proportion of applicable benefits, above age 55, in a sliding scale. The amount to be notionally allocated to the ABP in a quarter is to be calculated in accordance with the formula pC, where: a. p is the percentage of the eligible benefit paid having regard to the age cohort, as specified in the ABP table, into which the

<table>
<tr><td></td><td>insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates; and
b. C is the gross benefit in the current quarter.
Where an insured person receives treatment over a number of days such that the age of the insured person on the day or days on which that person receives the treatment falls within more than one age cohort, the amount to be notionally allocated to the ABP must be allocated proportionately in accordance with the number of days during which the insured person was in each age cohort.
(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2015)</td></tr>
<tr><td>ABP table</td><td><table><tr><th>Age cohorts</th><th>Age % of eligible benefits include in pool</th></tr><tr><td>0-54</td><td>0.0%</td></tr><tr><td>55-59</td><td>15.0%</td></tr><tr><td>60-64</td><td>42.5%</td></tr><tr><td>65-69</td><td>60.0%</td></tr><tr><td>70-74</td><td>70.0%</td></tr><tr><td>75-79</td><td>76.0%</td></tr><tr><td>80-84</td><td>78.0%</td></tr><tr><td>85+</td><td>82.0%</td></tr></table>(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2015)</td></tr>
<tr><td>Gross Benefit</td><td>Means the total eligible benefits paid by the insurer in respect of an insured person in a quarter.</td></tr>
<tr><td>High Cost Claimants Pool (HCCP)</td><td>The High Cost Claimants Pool (HCCP) deals with benefits not equalised by the age-based pool. Pooling is based on applicable benefits accumulated by claimant for the current and preceding 3 quarters. The percentage of the benefits to be pooled will be 82%.
A limit is imposed on total pooling under the ABP pool and HCCP of 82% of gross benefits. When assessing HCCP pooling in each quarter, the cumulative residual after ABP pooling is compared with the threshold at that time.
The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula m(R-T) - H, where:
m is 82%
R is the total gross benefit for the current and the preceding 3 quarters less the amount notionally allocated to the ABP in the current and preceding 3 quarters</td></tr>
</table>

	T is the designated threshold **H** is the sum of the amounts notionally allocated to the HCCP in the preceding 3 quarters Subject to a maximum of 82% of gross benefits being included in Risk Equalisation when summing the ABP and HCCP components. *(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2015)*
HCCP Claimants	Means the number of insured persons whose total eligible benefits paid by the insurer exceed the threshold after applying ABP.
HCCP Net Benefits	Means applicable benefits, after age based pooling, that exceed the threshold. 82% of net benefits in excess of the threshold are to be pooled.
HCCP Threshold	Means the designated threshold. The designated threshold is $50,000.
Risk Equalisation Levy	To calculate the amount of levy in respect of a current quarter: a. an amount calculated is first to be notionally allocated to the age based pool (ABP) b. if the amount of gross benefit not notionally allocated to the ABP in the current and preceding 3 quarters, is greater than the designated threshold, a second amount is to be notionally allocated to the high cost claimants pool (HCCP) c. If the (ABP + HCCP)/(Average hospital SEU) for a fund is less than the equivalent state calculation then the insurer must pay into the Risk Equalisation Pool the difference per SEU. d. If the (ABP + HCCP)/(Average hospital SEU) for a fund is more than the equivalent state calculation then the insurer will receive the difference per SEU from the Risk Equalisation Pool. *(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2015)*

Parts 3-6 – Collections by type of product & age category

Fees excluding Medicare benefit	The fees excluding Medicare benefit must exclude the medicare benefit component of the total fee charged. The difference between fees charged and total benefits paid should be the amount that the patient has to pay (gap). In some cases the fund paying the benefits will be unaware of a discount offered by the provider, for example for early payment. Fees excluding Medicare benefit should be, in cases where the discounted fee is unknown, the invoiced amount less the Medicare benefit. Fees excluding Medicare benefit should be greater or equal to the sum of benefits, medical benefits and prostheses benefits. ***Note:*** *The total fee charged is the total amount the patient and Medicare would have to pay to the provider in the absence of any private health insurance.*

Eligible Benefits	Means a benefit paid by an insurer for any of the following: • planning and coordination services for CDMP • allied health services which are provided as part of a CDMP • hospital-substitute treatment • hospital treatment *(Part 1, Private Health Insurance (Risk Equalisation Policy) Rules 2015)*
Ineligible Benefits	Includes other benefits paid by an insurer that are not eligible.
Fees Charged	Is the known or invoiced fee charged by the provider for general treatment.
Benefits	In parts 3 and 4 means benefits paid for hospital treatment or hospital-substitute treatment. It does not include Medical, Prostheses and Ineligible benefits.
Total Benefits	Means benefits plus Medical and Prostheses benefits. It does not include Ineligible benefits.

Part 7 – Total hospital treatment policies by type of cover

Excess/Co-Payments	*See page 7* In this section Excess/Co-payments refers to the maximum Excess or Co-Payment that could be payable in any one year for a policy. Any policies that commenced cover before 24 May 2000 and are exempt from the Medicare Levy Surcharge should be reported in the categories "Nil" or "<=$500/$1,000". An uncapped co-payment should be included in the >$500/$1,000 per Single/Family Membership.
Full Cover	Means policies that have no restriction on benefits paid after 12 months of cover. This could be regarded as a 100% product, with no exclusions. Policies with a co-payment and no other restriction are defined as having full cover. Where a fixed percentage of benefits is paid (eg. 85% benefit of contract fee) the 15% payable by the member should be regarded as a moiety or co-payment, and therefore full cover. Products that pay, for example, 100% on contracted hospitals but a fixed benefit on non contract hospitals should be regarded as full cover. A Full Cover product may have members reported at all levels of Co-payments.
Reduced cover	Means policies that restrict benefits paid after 12 months of cover. Products that have a fixed benefit regardless of the fees charged are included in the reduced benefits category. A product that pays fixed benefits will have a nil Excess/Co-payment unless a moiety is attached to the product.

Retention index - Hospital Treatment policies	The retention index is designed to provide a performance indicator by showing the percent of policies that have remained active hospital treatment policies of the same fund for two years or more, over all states.
Some lifetime exclusions	Means policies that provide no benefits for certain treatments for the life of the membership. (Note that an exclusionary product excludes certain treatments in all settings. For example, a product that does not pay benefits for certain treatment in a private hospital but does pay benefits for that treatment in a public hospital is not regarded as exclusionary).
General treatment claims processing (excluding hospital-substitute treatment and CDMP)	This data item shows the percent of General Treatment claims (excluding hospital-substitute and CDMP) that were processed within five working days in the current quarter.

Part 8 – Benefits paid for Chronic Disease management Programs

Chronic Disease Management Program (CDMP)	General Treatment cover for a Chronic Disease Management Program. A CDMP is intended to: • reduce complications in a person with a diagnosed chronic disease • prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease • requires the development of a written plan that ❖ specifies the allied health service or services and any other goods and services to be provided ❖ specifies the frequency and duration of the provision of those goods and services ❖ specifies the date for review of the plan ❖ has been provided to the patient for consent ❖ consent is given to the program, before any services under the program are provided • is coordinated by a person who has accepted responsibility for: ❖ ensuring the services are provided according to the plan ❖ monitoring the patient's compliance *(Part 3, Private Health Insurance (Health Insurance Business) Rules 2015)*

Allied Health Services allied health services	Means a health service provided by any of the following allied health professionals who were eligible, at the time the service was provided, to claim a medicare rebate for a service of that type: • an Aboriginal health worker • audiologist • chiropodist • chiropractor • diabetes educator • dietician • exercise physiologist • mental health worker • occupational therapist • osteopath • physiotherapist • podiatrist • psychologist • speech pathologist *(Part 3, Private Health Insurance (Health Insurance Business) Rules 2015)*
Coordination	Coordination ensures that the services are provided to the patient as planned. The plan should be reviewed and adjusted if necessary. Coordination may be undertaken by a health care provider, such as a practice nurse or other allied health professional and overseen by a medical practitioner. The medical practitioner would be involved in the review process. Services provided as part of a CDMP must be coordinated as described in 12(1)(c) of *the Private Health Insurance (Health Insurance Business) Rules 2015.*
Planning	Planning commences with an assessment of the services needed to address the patient's condition and the agreed goals for the program. A plan is then made of the services or goods required and the frequency and duration of the services. Typically, a medical practitioner would undertake the assessment and formulate the plan. The plan should include arrangements to review the program in order to assess whether the intended clinical outcomes are being achieved and that the patient is complying with the plan. Services provided as part of a CDMP must be planned as described in 12(1)(b) of the *Private Health Insurance (Health Insurance Business) Rules 2015.*
Risk Factors for chronic disease	Means, but is not limited to: a. lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and

	b. biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and c. family history of a chronic disease. *(Part 3, Private Health Insurance (Health Insurance Business) Rules 2015)*
Types of Allied Health Professionals The eligibility criteria for allied health professionals providing new Medicare services provides definitions of each type of allied health professional eligible to claim a Medicare rebate for their services. The definitions below are taken from: Eligibility criteria for allied health professionals providing new Medicare services. This document is published by the Department of Health and Ageing and is available at: http://www.medicareaustralia.gov.au/provider/pubs/medicare-forms/files/ma_1449_app_for_initial_medicare_provider_registration_number_for_allied_health_professional.pdf	
Aboriginal Health Workers	Practising in the Northern Territory (NT) must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.
Audiologists	Must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).
Chiropractors	Must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practicing
Diabetes Educators	Must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).
Dietitians	Must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).
Exercise Physiologists	Must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).
Mental Health Workers	'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following: • psychologists; • mental health nurses;

	• occupational therapists; • social workers; and • Aboriginal health workers
Occupational Therapists	In Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.
Osteopaths	Must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising
Podiatrists/ Chiropodists	In all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/ Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (APodA) in any other State or the Australian Capital Territory.
Psychologists, occupational therapists and Aboriginal health workers	Are eligible in separate categories for these items. A **mental health nurse** may qualify if they are – • a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or • a 'Credentialed Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory. To be eligible to provide mental health services for the purposes of this item, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999'.
Psychologists	Must be registered with the Psychologists Registration Board in the State or Territory in which they are practicing
Physio-therapists	Must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.
Speech Pathologists	Practising in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

Part 9 – Benefits paid for General Treatment

General Treatment	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. *(Division 121, Private Health Insurance Act 2007)* Further information about general treatment can be found in Part 3, *Private Health Insurance (Health Insurance Business) Rules 2015*

General Treatment Categories (Template headings)

These are examples only based on the types of services covered under General Treatment Products. This is not a comprehensive listing of all services.

Under the legislation some of the items historically collected in this section are considered to be excluded from General Treatment. Therefore, insurers can only provide benefits for them as part of a complying health insurance product under the provisions of the *Private Health Insurance Act 2007 69-1 (1) (b) and the Private Health Insurance (Complying Product) Rules 2010 6 (2).* Some of them will be considered health related business rather than health insurance business.

Accidental Death/ Funeral Expenses	Funeral parlour, burial or cremation expenses. These benefits are being phased out under 69-1 (1) (b) of the Act and 6 (2) Complying Products Rules.
Acupuncture/ Acupressure	Acupuncture, Acupressure
Ambulance	Emergency ambulance transport, anywhere in Australia to the nearest appropriate hospital able to provide the level of care required, provided by an Ambulance Service OR Non-emergency ambulance transport, anywhere in Australia, provided by an Ambulance Service.
Chiropractic	Chiropractic, Chiropractic X-Rays
Community, Home, District Nursing	Treatment for illness, disease, incapacity or disability when the purpose of treatment is dependent on nursing care excluding hospital-substitute treatment
Dental	Comprehensive examination or consultation Dental X-ray Clean, polish, Fluoride treatments Scale & clean Custom-made mouth-guard Tooth fillings Crowns and bridges Full upper or lower Denture Major dental work Periodontics, endodontics, dentures and surgical extraction of teeth.

Dietetics	Dietitian and nutritionist
Domestic Assistance	A benefit for home assistance provided by councils
Ex gratia Payments	Payments for services not covered under the rules of the insurer. For example, the insurer may pay for drugs not normally covered as a gesture of good will.
Hearing Aids and Audiology	Hearing Aids, Hearing Aid repair Cochlear Speech Processor
Hypnotherapy	Hypnotherapy
Maternity Services	Pre and post-natal consultation and classes, Midwife delivery services
Natural Therapies	Alexander technique, Aromatherapy, Naturopathy, Biochemist, Bowen Therapy, Feldenkrais, Herbalist, Homeopathy, iridology, Kinesiology and One on One Pilates, Rolfing, Reflexology, Remedial Massage, Shiatsu
Occupational Therapy	Occupational Therapy
Optical	Single Vision glasses, Bifocal glasses Multi-focal glasses, Contact lenses disposable and hard Disposable contacts, Prescription - sight correcting lenses, Frames, Repair
Orthoptics (Eye Therapy)	Eye therapy
Osteopathic Services	Osteopathy
Overseas	Means a cover provided to a person who is not an Australian resident, is not entitled to full Medicare benefits and is visiting Australian on a temporary or long stay visa for holiday, study or work purposes. Residents of Norfolk Island and other residents of Australian territories are deemed to be “overseas visitors” when visiting Australia. After 1 July 2008, overseas cover is not health insurance business.
Pharmacy	Pharmaceutical, Hormonal implants, Skin contraceptives, Preventive vaccines - Hepatitis A/B Injections, Flu, Travel and other approved vaccines
Physiotherapy	Physiotherapy
Podiatry (Chiropody)	Podiatry, Biomechanical Assessment, Casts, Orthotics - custom made sporthotics or formthotics
Preventative health products/ Health management programs	Weight loss/ Weight management programs Quit smoking, nicotine replacement therapy, Disease management association fees (Asthma, Diabetes, Heart, Arthritis and Coeliac), Cancer Council UV products (30+ sunscreen, rash vests and suits, hats, wrap sunglasses)

Prostheses, Aids and Appliances	Post operation aids (eg. surgical stockings), Braces and supports (eg. crutches), Medical aids (including Irlen lens), Non-surgical prosthesis (including wigs), Artificial appliances, Wheel chairs, Walking frame, Nebuliser, TENS machine, asthma spacer, blood glucose monitor
Psych/Group Therapy	Psychology
School	Benefits paid, as a result of a personal injury to a student covered by the policy while at school or travelling to or from school or any associated school activity and not paid or payable from any other source. This benefit is for essential health care services, other than services provided in hospital or those attracting a Medicare benefit.
Sickness and Accident	Accident means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary personal hurt or damage to the body of a person covered by a policy, which requires immediate medical advice or treatment from a registered practitioner. This General Treatment benefit is for essential health care services, other than services provided in hospital or those attracting a Medicare benefit. ***Note:*** *The term "Sickness and Accident" historically included the business of undertaking liability to pay a lump sum, or make periodic payments, on the occurrence of a personal accident, disease or sickness, or was contingent on some treatment or services being provided to the insured, or on the payment of fees or charges for any treatment or services. The Act does not recognise payment of benefits in these circumstances as health insurance business.* *(Division 121, Private Health Insurance Act 2007 and Part 4, Private Health Insurance (Health Insurance Business) Rules 2015).*
Speech Therapy	Speech therapy
Theatre Fees	Procedure room, Outpatient theatre fee, Medical gases (such as oxygen)
Travel and Accommodation	Accommodation expenses for parent/partner to accompany a patient who is an in-patient of a public or private hospital. Travel costs where a patient receives treatment at a hospital more than a specified distance from a patient's home. In circumstances where the patient chooses not to be an in-patient.

Part 10 – Lifetime Health Cover

Lifetime Health Cover	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. The amount of the increase is worked out as follows: (Lifetime health cover age – 30) x 2% x *Base rate

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.
Lifetime health cover base day	Is generally the 1 July following the adult's 31st birthday. *(Division 34, Private Health Insurance Act 2007)*
base rate	Means the amount of premiums that would be payable for hospital cover before any discounting. If the person was born on or before 1 July 1934 then Lifetime health cover does not apply to the person. *(Division 34, Private Health Insurance Act 2007)*
Certified age of entry	Is the lifetime health cover age.
Loading	Is the percent above the base rate that the adult must pay for membership = (Lifetime health cover age – 30) x 2% up to a maximum of 70%.
Loading removed	A private health insurer must stop charging premiums above the base rate for hospital cover in respect of an adult, if the adult has had hospital cover: 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 (none of which count towards the 10 years). *(Division 34, Private Health Insurance Act 2007)* ***Note:*** *Permitted days without hospital cover is defined in 34-20 of the Act.*

Part 11 – Total hospital treatment medical services statistics

Agreement	Means an agreement entered into between a medical practitioner, within the meaning of that term in subsection 3 (1) of the Health Insurance Act 1973, and an insurer under which the practitioner agrees to accept payment by the insurer in satisfaction of the amount that would, apart from the agreement, be owed to the practitioner in relation to the treatment provided to the insured person.
No Gap Agreement	Means an agreement where the medical practitioner agrees to accept a payment by the insurer in full satisfaction of the amount owed so that there no gap, or no out of pocket expenses to be paid by the insured person.
Known Gap Agreement	Means an agreement where the medical practitioner agrees to accept a payment by the insurer in part satisfaction of the amount owed and the patient has provided informed financial consent so that the gap or out of pocket expenses to be paid by the insured person are known in advance.

No Agreement	Is where there is no agreement in place.
Amount charged	Is the amount accepted in full payment (if known), or the invoice amount. For analytical purposes the amount charged and related data are collected in ranges with reference to the MBS where the amount charged is: > MBS to 125% MBS Fee >125% to 150% MBS Fee >150% to 200% MBS Fee >200% MBS Fee
Medicare benefit	Is the amount calculated by reference to the fees for medical services set out in the table of schedule fees. Schedule fee, in relation to a professional medical service, means the fee specified in the table in respect of the service. A Medicare benefit in respect of a professional service is: a. in the case of a service provided: (i) as part of an episode of hospital treatment; or (ii) as part of an episode of hospital-substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer; an amount equal to 75% of the Schedule fee.
Fund Benefit	Is the amount the fund pays in full or part satisfaction of the amount owed to the provider in excess of the Medicare benefit.
Gap	Is the amount paid by the insured person, or their out of pocket expense, and is calculated as: (Amount charged) – (Medicare benefit) – (Fund benefit) = Gap
No of services	Is the number of medical services for the category.
% of services	Is the number of medical services for the category as a percent of the total number of medical services over all categories.
Amount charged % of MBS	Is the total amount charged in the category divided by the Medicare benefit schedule (MBS) fee. This is calculated as: (amount charged)/[(Medicare benefit)/(0.75)] ***Note:*** *that the Medicare benefit is 75% of the schedule fee.*

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