Australian
Health Service
Alliance

Access Gap Cover Terms and Conditions

1. ABOUT THE AGREEMENT

What is the Agreement?

1.1 The Agreement sets out the terms and conditions that apply to AGC.

1.2 The Agreement comprises Terms and Conditions, the Billing Guide and the AGC Fee Schedules (any or all of which may be varied from time to time in accordance with clause 1.8).

1.3 In the event of any inconsistency, the Agreement must be interpreted in accordance with the following order of priority:

1.3.1 the terms and conditions set out in Terms and Conditions; then

1.3.2 the terms and conditions set out in the Billing Guide; then

1.3.3 the terms and conditions set out in the AGC Fee Schedules; and then

1.3.4 any other documents or information annexed to the Billing Guide or otherwise incorporated by reference into the Agreement.

1.4 By registering for and participating in the AGC scheme, the Provider acknowledges and agrees that the Provider has read and understood the Agreement and will comply with the Agreement, and will direct the Provider's billing staff to comply with the Agreement.

What is the purpose of the Agreement?

1.5 The purpose of the Agreement is to set out the terms and conditions that apply to AGC, which is an approved "gap cover arrangement" under the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth). AGC aims to minimise or eliminate out-of-pocket expenses for medical services received by an Eligible Fund Member in hospital and thereby provide Funds and Fund Members with certainty as to the total all-inclusive price of Treatment provided by the Provider.

Who are the parties to the Agreement?

1.6 The parties to the Agreement are the Provider, AHSA (in the capacities set out in clause 1.7) and each Fund.

1.7 AHSA enters into the Agreement and is a party to the Agreement both in its own capacity and also in its capacity as agent for each Fund. To avoid doubt, AHSA is the sole party that is entitled to vary the Agreement under clause 1.8 and issue warning notices and terminate the Provider's participation in the AGC scheme under clause 12.

AHSA may vary the Agreement from time to time

1.8 AHSA may vary this Agreement (by varying any or all of the Terms and Conditions, the Billing Guide and the AGC Fee Schedules) from time to time by giving at least 20 business days' notice to the Provider and Funds.

1.8.1 Current versions of the Terms and Conditions, Billing Guide and AGC Fee Schedules can be viewed at this link. (Or go to the AHSA website www.ahsa.com.au - click on 'For Doctors' and then 'Access Gap Cover')

1.8.2 AHSA will also use its reasonable efforts to provide the Provider and Funds with advance notice of proposed changes to the Agreement on an annual basis.

1.9 The Provider acknowledges and agrees that if the Provider submits an AGC claim after AHSA has given notice of variation under clause 1.8, this constitutes the Provider's irrevocable consent to the variation.

2. PROVIDER'S REPRESENTATIONS AND WARRANTIES WHEN SUBMITTING CLAIMS

2.1 Whenever the Provider submits a Claim, the Provider represents and warrants to AHSA and the relevant Fund that:

2.1.1 the information provided by or on behalf of the Provider in relation to the Claim is complete and accurate;

2.1.2 the services in respect of which the Claim is submitted have been provided to the relevant Fund Member; and

2.1.3 all of the terms and conditions of the Agreement, whether they concern the Provider, the services or the Claim, were satisfied at the time of the Treatment being provided and are also satisfied at the time the Claim is submitted.

3. PROVIDER MAY CHARGE A CO-PAYMENT IN SOME CIRCUMSTANCES

Provider may charge Co-Payments for MBS rebateable items

3.1 Each Provider who is involved in providing Treatment for the relevant Episode may elect to charge the relevant Fund Member a Co-Payment for MBS rebateable items only, in accordance with the following rules:

3.1.1 the Informed Financial Consent requirements in clause 6.1 must be complied with before the Fund Member is charged a Co-Payment;

3.1.2 the Co-Payment must be charged directly to the Fund Member and must be disclosed to the relevant Fund in accordance with clause 5.1;

3.1.3 the amount of the Co-Payment that a Provider charges the Fund Member must not exceed $500, subject to clause 3.3, and the Provider must not charge the Fund Member any other amount; and

3.1.4 each Provider must submit a single Claim directly to the Fund in accordance with clause 5.1.2, and only one Co-Payment is permitted per Claim. This rule applies despite the number of items or claim lines in the account for that Episode.

Example: Where an assistant surgeon's fees are claimed together with the surgeon's fees, if the surgeon submits one Claim with both their services and the

assistant services, the maximum total Co-Payment for the Fund Member for both that Claim and the Episode cannot exceed $500 if AGC applies.

3.2 If the Provider charges a Co-Payment but fails to comply with clause 3.1:

3.2.1 the relevant Fund will not pay the Provider AGC Benefits in relation to the relevant claim, and will only pay the Provider an amount up to the relevant MBS fee; and

3.2.2 clause 6.3 also applies.

Special rules: obstetricians

3.3 Obstetricians may elect to charge the Fund Member a Co-Payment not exceeding $800 per Episode for MBS items that relate to "Management of Labour and Delivery".

Provider can opt out of AGC for a particular Episode

3.4 AGC Benefits and the Co-Payment (where the Provider charges a Co-Payment) are maximum fees only under the terms of AGC, and are not prescribed or recommended fees. They are there to assist in eliminating or minimising the Co-Payment costs. Providers must make their own independent decisions as to whether and to what extent they participate in AGC, and also as to the level at which they set their fees.

The Provider can elect to opt the Fund Member out of AGC on an Episode-by-Episode basis for any reason and/or if they wish to charge fees higher than AGC allows. If the Provider does so, the Provider must:

3.4.1 advise the Fund Member about the applicable fees and charges, including any out-of-pocket expenses that the Fund Member must pay; and

3.4.2 otherwise comply with the Law and MBS rules when billing the relevant Fund and the Fund Member.

Communication with Fund Members

3.5 Fund Members may be advised to contact the Provider prior to Admission to confirm whether AGC applies, and if they will incur any out of pocket expenses.

4. PROVIDER MAY ONLY CHARGE PERMITTED FEES UNDER AGC

4.1 If the Provider elects to use AGC with a Fund Member, the Provider must not charge (or, to the extent within the Provider's power, permit a third party to charge) the Fund Member:

4.1.1 any Prohibited Fees; or

4.1.2 any fees or charges that are not Permitted Fees.

5. TOTAL COST OF TREATMENT

5.1 If the Provider elects to use AGC with a Fund Member, the Provider must disclose to the relevant Fund the total cost of the Treatment provided to the Fund Member (inclusive of any Co-Payment).

5.1.1 This information must be disclosed at the time that the Provider submits the relevant Claim.

5.1.2 The Provider must submit directly to the Fund a single Claim that covers an entire Episode, being all MBS services that form part of the Episode for that Provider (from Admission to Separation).

5.1.3 The Fund will share this information with AHSA.

5.2 The Provider acknowledges and agrees that each Fund provides "no gap payment" and "known gap payment" insurance policies to its Fund Members, and for legal reasons it is essential that Funds and Fund Members have absolute certainty as to the total all-inclusive price of Treatment provided by the Provider.

6. INFORMED FINANCIAL CONSENT

Provider must obtain Informed Financial Consent

6.1 If the Provider elects to charge a Co-Payment, the Provider must:

6.1.1 obtain Informed Financial Consent; and

6.1.2 disclose in writing to the relevant Fund Member or his or her nominee (being a near relative or representative of the Fund Member who is acting in his or her interests) any financial interest that the Provider may have in relation to the Treatment being provided to the Fund Member.

6.2 The Provider may use the most recent template "Estimate of Medical Fees" form made available by AHSA from time to time in seeking Informed Financial Consent, or another form that contains the necessary information.

Additional rules where the Provider has engaged in non-compliant billing

6.3 If the Provider engages in billing practices that do not comply with the Agreement and is denied AGC Benefits under clause 3.2 as a consequence, the Provider must not seek payment or reimbursement from the relevant Fund Member of any amount other than out-of-pocket expenses that were previously agreed with that Fund Member.

7. INDEXATION

7.1 AHSA will use its reasonable efforts to review the AGC Fee Schedules on an annual basis for indexation purposes.

7.2 AHSA will determine the application, timing and level of indexation of AGC Benefits (including whether any indexation is applicable) in its absolute discretion. Where indexation is applied, it:

7.2.1 will be applied to the AGC Benefits above the MBS fee; and

7.2.2 will ordinarily reflect the Australian Medical Association's "Medical Fee Index" that is calculated annually for the various "peer groups" defined by the Australian

Medical Association, but may reflect another index or otherwise be of an amount determined by AHSA in its absolute discretion.

8. WHAT IF MBS ITEMS ARE INTRODUCED, DELETED OR CHANGED?

8.1 AHSA, as agent for each Fund:

8.1.1 may review AGC Benefits that are payable to the Provider if changes are made to existing MBS items, such as MBS fee changes and MBS description changes (including partial or wholesale restructuring of the MBS); and

8.1.2 will use its reasonable efforts to implement MBS changes (including new, deleted and/or replacement items) into the AGC Fee Schedules within the timeframes specified by Medicare.

9. SALARIED DOCTORS AT PUBLIC HOSPITALS

9.1 Despite any other provisions of the Agreement, if the Provider is a salaried officer at a public hospital and elects to use AGC with a Fund Member, the Provider will be reimbursed the amount of the MBS fee only.

10. AUDIT, REPAYMENT AND SET OFF

10.1 The Provider acknowledges and agrees that any of AHSA, the relevant Fund and/or their respective nominees may contact the Provider to request further information about a Claim, including to determine whether the Claim is a Valid Claim or whether AGC Benefits are otherwise payable under clause 11.1.

10.2 The Provider agrees to:

10.2.1 upon reasonable notice under clause 10.1, promptly provide relevant information and grant access to relevant documents and records;

10.2.2 repay the relevant Fund within 21 days of it being established and notified to the Provider that the Provider has received money under the Agreement to which the Provider was not entitled, including where the Provider has not complied with the Agreement; and

10.2.3 if clause 10.2.2 applies, not attempt to seek payment or reimbursement of the relevant amount from the Fund Member.

10.3 A Fund may set off any amount it owes the Provider under the Agreement against any amount that the Provider owes the Fund under the Agreement.

11. PAYMENT CONDITIONS AND TIMING

11.1 The relevant Fund will pay a Valid Claim within 21 days after receipt by the Fund, subject to each of the following requirements being satisfied:

11.1.1 the relevant Medicare rebates have been received in full by the Fund;

11.1.2 the Fund has received the associated hospital claim (which may be required to verify the Fund Member's Admitted status);

11.1.3 the Fund Member is an Eligible Fund Member for the purposes of the Claim; and

11.1.4 the Fund not requiring any further information from the Provider in relation to the Claim, including information that is required to determine whether the Claim is a Valid Claim.

11.2 Payment times may be faster if the Provider uses ECLIPSE.

11.3 Payments will be deposited directly into the bank account nominated by the Provider or the Provider's billing agent or billing staff.

11.4 The relevant Fund is not required to pay any Claim that is not a Valid Claim.

12. TERMINATION AND DISENGAGEMENT

How and when can the Provider stop participating in AGC?

12.1 The Provider may withdraw from the AGC scheme entirely at any time by written notice to AHSA. AHSA will then notify Funds of the change.

12.1.1 The Provider is requested to provide one month's written notice of withdrawal to assist Funds in reconciling any remaining Claims submitted by the Provider.

How and when can AHSA terminate the Provider's participation in AGC?

12.2 AHSA may issue the Provider with a warning notice if the Provider commits a Default.

12.3 AHSA may terminate the Provider's registration in the AGC scheme immediately upon 90 days' written notice if:

12.3.1 AHSA has previously given the Provider a warning notice under clause 12.2; and

12.3.2 the Provider commits a further Default (whether or not the type of Default that was the subject of the warning notice) or fails to remedy an existing Default.

12.4 When AHSA terminates the Provider's registration in the AGC scheme:

12.4.1 all of the registered Provider's Provider Numbers will be removed from AGC;

12.4.2 the relevant Fund will pay the 25% portion of the applicable MBS fee for all of the Provider's Claims that are submitted after the date of termination, but only if Medicare has also paid the applicable amount for the relevant Treatment; and

12.4.3 AHSA may, in its absolute discretion, permit the Provider to re-register and participate in the AGC scheme at a later date, subject to any conditions that AHSA considers fit.

12.5 AHSA may immediately terminate the Provider's registration in the AGC scheme by written notice to the Provider if any of the following occurs:

12.5.1 the Provider is not, or ceases to be, a Medical Practitioner;

12.5.2 the Provider is not, or ceases to be, a member of a recognised medical indemnity fund or otherwise does not hold professional indemnity insurance of a minimum amount of $5 million per claim;

12.5.3 the Provider commits multiple or recurring breaches of the Agreement, whether or not remedied and whether or not AHSA has previously issued the Provider with a warning notice; or

12.5.4 the Provider commits a crime or other wrongful act which AHSA considers may have the potential to adversely affect the reputation of AHSA, any Fund and/or the AGC scheme.

12.6 The Provider must notify AHSA immediately in writing if the Provider is not, or ceases to be:

12.6.1 a Medical Practitioner; or

12.6.2 a member of a recognised medical indemnity fund or otherwise does not hold professional indemnity insurance of a minimum amount $5 million per claim.

How and when can AHSA remove a Provider Number from AGC?

12.7 AHSA may remove a particular Provider Number of a Provider from AGC if:

12.7.1 the Provider Number was registered with AGC more than three years ago; and

12.7.2 no Fund has received a Claim in relation to that Provider Number in the preceding three years.

12.8 If AHSA removes a Provider Number from AGC under clause 12.7, AHSA may agree to re-register the Provider Number upon written request by the relevant Provider, in AHSA's absolute discretion.

How and when can AHSA withdraw a Provider's name from facilities?

12.9 AHSA may, without notice to the Provider, withdraw a Provider's name and/or other information from its own "Doctor Search" facility and/or any other similar facility that it utilises on behalf of Funds, and/or from publications and communications, if:

12.9.1 AHSA does so for all Medical Practitioners registered for AGC within a discipline;

12.9.2 AHSA reasonably considers that the Provider has committed a Default; or

12.9.3 either the Provider does not have in place all necessary registrations, licences and/or other authorisations, or restrictions have been placed on the Provider's registrations, licences and/or authorisations.

13. COLLECTION, USE AND DISCLOSURE OF PROVIDER INFORMATION

13.1 As a condition of AGC registration and making a Claim, the Provider acknowledges and agrees that AHSA and each Fund may, in their absolute discretion:

13.1.1 collect information from the Provider's registration forms and other communications with AHSA and/or Funds (including information from Claims). The information that may be collected includes:

13.1.1.1 personal information (such as name, practice address, and other contact details);

13.1.1.2 information relating to the Provider's field of practice and additional qualifications or specialties; and

13.1.1.3 information (including past Claims data) relating to the charges rendered, services provided (including where a Provider operates and their surgical partners) and participation in the AGC scheme,

(together, **Provider Information**);

13.1.2 disclose Provider Information and other information about the Provider to the public, including Fund Members and referring doctors, including for the purposes of identifying Medical Practitioners participating in the AGC scheme, and setting out information relating to the charges rendered, quality of service and statistical information relating to participation in the AGC scheme; and

13.1.3 use Provider Information for internal statistical analysis.

14. PRIVACY

14.1 The Provider warrants and represents to AHSA on a continual basis that:

14.1.1 any Personal Information that the Provider discloses to AHSA under the Agreement has been collected and disclosed in accordance with the Privacy Act; and

14.1.2 AHSA is authorised to use and disclose any such Personal Information for such of the AHSA Purposes as require the use of Personal Information, including that the Provider has duly notified and obtained any necessary consents from the individuals whose Personal Information is being used or disclosed to provide that Personal Information to AHSA and for AHSA to use that Personal Information for AHSA Purposes.

14.2 The Provider's obligations under this clause 14 are in addition to, and do not restrict, any obligations the Provider may have under the Privacy Act and that would apply to the Provider but for the application of this clause 14.

15. NOTICES

15.1 A notice, consent, information, application or request that must or may be given or made to a party under the Agreement is only given or made if it is in writing and:

15.1.1 emailed to the party's current email address for notices (including, in the case of the Provider, as specified by the Provider when registering for AGC);

15.1.2 faxed to the party's current facsimile number for notices (including, in the case of the Provider, as specified by the Provider when registering for AGC); or

15.1.3 delivered or posted to that party at its registered office (or, in the case of the Provider, such street or postal address as may be specified by the Provider when registering for AGC).

15.2 If a party gives the other party 3 business days' notice of a change of its address, fax number or email address, a notice, consent, information, application or request is only given or made by that other party if it is delivered, posted, faxed or emailed to the latest address, fax number or email address.

15.3 A notice, consent, information, application or request is to be treated as given or made at the following time:

15.3.1 if it is delivered, when it is left at the relevant address;

15.3.2 if it is sent by post, 3 business days after it is posted;

15.3.3 if it is sent by fax, as soon as the sender receives from the sender's fax machine a report of an error-free transmission to the correct fax number; or

15.3.4 if it is sent by email, on the earlier of:

15.3.4.1 the sender receiving an automated message confirming delivery; or

15.3.4.2 provided no automated message is received stating that the email has not been delivered, 3 hours (being between 8.30 am and 5.00 pm on a business day) after the time the email was sent by the sender, such time to be determined by reference to the device from which the email was sent.

15.4 If a notice, consent, information, application or request is delivered, or an error free transmission report or acknowledgement in relation to it is received, after the normal business hours of the party to whom it is sent, it is to be treated as having been given or made at the beginning of the next business day.

16. MISCELLANEOUS

16.1 Neither the Provider nor any Fund may assign, novate or transfer any of its rights or obligations under the Agreement, or attempt or purport to do so, unless it has first obtained AHSA's written consent. If AHSA wishes to assign, novate or transfer any of its rights or obligations under the Agreement, AHSA must notify the Provider and each Fund in writing prior to the date of assignment, novation or transfer but to avoid doubt does not require the consent of any other party to such assignment, novation or transfer. The Agreement will not continue for the benefit of, or bind any successors in title or assignees of a party unless the party has complied with its obligations under this clause 16.1.

16.2 No term or condition of the Agreement will be construed adversely to a party solely on the ground that the party was responsible for the preparation of the Agreement or that provision.

16.3 Unless the Agreement expressly provides otherwise, a party may give or withhold an approval or consent in that party's absolute discretion and subject to any conditions determined by the party. A party is not obliged to give its reasons for giving or withholding a consent or approval or for giving a consent or approval subject to conditions. Where the Agreement refers to a matter being to the "satisfaction" of a party, this means to the satisfaction of that party in its absolute discretion.

16.4 Nothing in the Agreement constitutes:

16.4.1 a Fund or AHSA as an employee, agent, representative, partner or joint-venturer of the Provider; or

16.4.2 the Provider as an employee, agent, representative, partner or joint-venturer of any Fund or of AHSA.

16.5 Liability for each Fund under the Agreement is several but not joint. Nothing in the Agreement makes any Fund liable for the acts or omissions of any other Fund.

16.6 The Agreement contains everything the parties have agreed in relation to the subject matter it deals with. No party can rely on an earlier written document or anything said or done by or on behalf of another party before the Agreement was entered into.

16.7 A party may exercise a right, power or remedy at its discretion, and separately or concurrently with another right, power or remedy. A single or partial exercise of a right, power or remedy by a party does not prevent a further exercise of that or any other right, power or remedy and failure by a party to exercise, or delay by a party in exercising a right, power or remedy does not prevent its exercise. Except where expressly stated to the contrary in the Agreement, the rights of a party under the Agreement are cumulative and are in addition to any other rights available to that party whether those rights are provided for under this agreement or by Law.

16.8 Each party must at its own expense promptly execute all documents and do or use reasonable efforts to cause a third party to do all things that another party from time to time may reasonably request in order to give effect to, perfect or complete the Agreement and all transactions incidental to it.

16.9 The Agreement is governed by the law of Victoria, Australia. The parties submit to the non-exclusive jurisdiction of its courts and courts of appeal from them. The parties will not object to the exercise of jurisdiction by those courts on any basis.

16.10 Each provision of the Agreement is individually severable. If any provision is or becomes illegal, unenforceable or invalid in any jurisdiction it is to be treated as being severed from the Agreement in the relevant jurisdiction, but the rest of the Agreement will not be affected. The legality, validity and enforceability of the provision in any other jurisdiction will not be affected.

16.11 Time is of the essence for the performance by each party of its obligations under the Agreement.

16.12 A waiver of any right, power or remedy under the Agreement must be in writing signed by the party granting it. A waiver only affects the particular obligation or breach for which it is given. It is not an implied waiver of any other obligation or breach or an implied waiver of that obligation or breach on any other occasion. The fact that a party fails to do, or delays in

doing, something the party is entitled to do under the Agreement does not amount to a waiver.

16.13 To the maximum extent permitted by Law, all conditions and warranties that would be implied (by Law, custom or otherwise), including any implied term of good faith, are expressly excluded.

17. DEFINITIONS AND INTERPRETATION

Definitions

17.1 In the Agreement the following definitions apply:

Access Gap Cover or **AGC** means the "no and known gap" medical gap cover scheme administered by AHSA and provided by Funds, as described in and governed by the Agreement.

Admission means:

(a) the process whereby a hospital accepts responsibility for a Fund Member's Treatment, following a clinical decision based upon specified criteria that the individual requires same-day or overnight care or treatment, being either a formal or statistical admission; and

(b) a similar process where a Fund Member receives Treatment in the home under a "Hospital in the Home" program, and that Treatment is provided or arranged with the direct involvement of a hospital,

but to avoid doubt excludes emergency room treatment of a Fund Member.

Admitted Patient means, with respect to Treatment received as part of Admission, a Fund Member who is Admitted.

AGC Benefits means the benefits payable under the AGC Fee Schedules (including where described as "AHSA $ Benefit" or "AHSA % Benefit") to Medical Practitioners who are registered for AGC in relation to claims that comply with the terms and conditions of the Agreement that are made by or on behalf of those Medical Practitioners.

AGC Fee Schedules means the documents itemising AGC Benefits with reference to the MBS, as may be amended or replaced by AHSA from time to time in accordance with this Agreement. Current versions of the AGC Fee Schedules can be viewed at this link. (Or go to the AHSA website www.ahsa.com.au - click on 'For Doctors' and then 'AGC Fee Schedules')

Agreement has the meaning given in clause 1.2.

AHSA Purposes include each of the following:

(a) AHSA exercising its rights, fulfilling its functions and performing its obligations under the Agreement, including administering AGC;

(b) AHSA exercising its rights, fulfilling its functions and performing its obligations as agent for each Fund, including assisting each Fund to comply with its statutory reporting obligations;

(c) AHSA using information from the Provider and other Medical Professionals who participate in the AGC scheme to populate its data warehouse, and drawing on the information to provide services to Funds and other persons;

(d) AHSA negotiating with the Provider or other persons providing health services on behalf of one or more Funds;

(e) AHSA analysing the markets for private health insurance and health services and reporting on this to, or on behalf of, one or more Funds; and

(f) AHSA doing any other matter or thing required by Law.

Billing Guide means the "AGC Billing Guide" issued by AHSA from time to time. The Billing Guide can be viewed on AHSA's website at this link and may also be issued by AHSA in print form. (Or go to the AHSA website www.ahsa.com.au - click on 'For Doctors' and then 'Access Gap Cover')

Claim means a claim for AGC Benefits made by or on behalf of the Provider that complies with the terms and conditions of the Agreement.

Co-Payment means an out-of-pocket cost payable by the relevant Fund Member to the Provider for MBS rebateable items, of an amount not exceeding an amount determined under clause 3.

Default means any of the following occurring:

(a) the Provider fails to obtain Informed Financial Consent in breach of clause 6;

(b) the Provider raises charges under AGC which exceed the maximum permitted Co-payment amount under the Agreement, in breach of clause 4;

(c) the Provider raises charges under AGC that are not Permitted Fees, in breach of clause 4;

(d) the Provider raises charges without disclosing them to the Fund, in breach of clause 5, whether or not the charges are permitted under the Agreement; and

(e) the Provider does not repay amounts demanded by a Fund under clause 10.2.2 without deduction or withholding within 15 business days' of receiving that demand, other than where the Provider disputes that demand in good faith.

ECLIPSE means the Medicare billing system for the electronic lodgement of medical claims.

Eligible Fund Member means a Fund Member who meets the relevant eligibility requirements under the Agreement.

Emergency Admission with respect to a Fund Member has the following meaning:

(a) where reasonable medical practice required the Fund Member to be admitted to hospital within 24 hours, regardless of when such admission actually occurred; or

(b) such other meaning as may be given to it by the Australian Commission on Safety and Quality in Health Care from time to time.

Episode means the period of Admitted Patient care between a formal or statistical Admission and a formal or statistical Separation, characterised by only one care type.

> **Example:** If an Admitted Patient changes care type (in the same or different hospital), such as "Acute" to "Rehabilitation", then back to "Acute", this would constitute three separate Episodes. This would apply even if there has not been more than a 7 day break between to two acute Episodes, as there was a Separation between each care type.

Fund means a private health insurer that is registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) and that has appointed AHSA as its agent for various purposes including the administration of the Agreement, which may be subject to exceptions (such as by geographic region or by product). A list of AHSA Participating Funds can be viewed on AHSA's website at this link and may also be issued by AHSA in print form. (Or go to the AHSA website www.ahsa.com.au - click on 'For Doctors' and then 'Participating Fund Contact List')

Fund Member means an individual who is insured under an insurance policy issued by the relevant Fund, whether or not the individual is the policy holder or is otherwise responsible for the membership.

Informed Financial Consent means the Provider obtaining the relevant Fund Member's informed consent to Treatment by informing, or procuring that the relevant hospital informs, the Fund Member of all out-of-pocket uninsured charges the Fund Member is likely to incur in the course of the Treatment. The Fund Member or his or her nominee (being a near relative or representative of the Fund Member who is acting in his or her interests) must be provided with that information in writing:

(a) in the case of an Emergency Admission or other unplanned admission, before any services are provided or delivered to that Fund Member (where the circumstances reasonably permit), or otherwise as soon as the circumstances reasonably permit after the relevant services are provided or delivered; and

(b) in all other cases, at the earliest opportunity before any services are provided or delivered to that Fund Member.

"Law" means any applicable statute, regulation, by-law, ordinance or subordinate legislation in force from time to time anywhere in Australia, whether made by a State, Territory, the Commonwealth, or a local government, and includes the general law and equity as applicable from time to time.

Medical Practitioner has the meaning given to it in the *Health Insurance Act 1973* (Cth).

Medicare Benefits Schedule or **MBS** means the current schedule of medical items and fees set by the Commonwealth of Australia under the *Health Insurance Act 1973* (Cth).

Permitted Fees means clinical fees that:

(a) solely relate to a Professional Service that is described by an MBS item number;

(b) if the Provider so elects, include an additional amount up to the Co-Payment in relation to the Professional Service referred to in paragraph (a); and

(c) to avoid doubt, do not include a cost of goods or services which are not part of the MBS service specified on the relevant account and do not include any Prohibited Fees.

Personal Information has the meaning given to it in the Privacy Act.

Pre-Existing Ailment has the meaning given in the *Private Health Insurance Act 2007 (Cth)*.

Privacy Act means *Privacy Act 1988* (Cth).

Professional Service has the meaning given in the *Health Insurance Act 1973* (Cth).

Prohibited Fees means non-clinical fees or charges including administrative charges, admission fees, processing fees, booking fees or reservation fees, technology fees, entertainment levies, insurance levy fees, hospital facility fees or similar amounts.

Provider means a Medical Practitioner who is registered for AGC at the relevant time.

Provider Information has the meaning given in clause 13.1.1.

Provider Number means a unique number issued by the relevant Commonwealth department to eligible health professionals who participate in the Medicare program.

Separation means the process by which an Episode for an Admitted Patient ceases.

Treatment means any form of care, hospital treatment or other medical treatment that the Fund is permitted by Law to pay for (in whole or in part) at the relevant time.

Valid Claim means a Claim which satisfies all of the following requirements:

(a) the Claim is a claim for which Medicare pays a benefit and Medicare has not rejected the claim;

(b) the Claim is submitted to a Fund in respect of an Eligible Fund Member;

(c) the Claim is submitted by the Provider or on the Provider's behalf by their staff or billing agent;

(d) the Provider has not billed the Eligible Fund Member directly in respect of the Claim (other than a Co-Payment, if applicable); and

(e) the Claim otherwise complies with the Agreement.

Interpretation

17.2 In the interpretation of the Agreement, the following provisions apply unless the context otherwise requires:

17.2.1 a reference to "dollars" or "$" means Australian dollars and all amounts payable under this agreement are payable in Australian dollars;

17.2.2 an expression importing a natural person includes any company, trust, partnership, joint venture, association, body corporate or governmental agency;

17.2.3 where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning;

17.2.4 a word which indicates the singular also indicates the plural, a word which indicates the plural also indicates the singular, and a reference to a gender also indicates the other genders;

17.2.5 a reference to the word "include" or "including" is to be interpreted without limitation;

17.2.6 a reference to a clause, schedule or attachment is a reference to a clause, schedule or attachment of or to the Agreement or any component of the Agreement;

17.2.7 a reference to any document or agreement is to that document or agreement as amended, novated, supplemented or replaced;

17.2.8 any schedules and attachments form part of the Agreement;

17.2.9 headings are inserted for convenience only and do not affect the interpretation of the Agreement; and

17.2.10 a reference to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision, in either case whether before, on or after the date of this agreement. Without limitation, references to the *Private Health Insurance Act 2007* (Cth) include rules made under that Act as in force from time to time.

Business day; References to and calculations of time

17.3 In the Agreement, unless the context otherwise requires:

17.3.1 a reference to a business day means a day other than a Saturday or Sunday on which banks are open for business generally in Melbourne, Victoria;

17.3.2 a reference to a day (rather than a business day) means a calendar day, including Saturdays, Sundays and public holidays;

17.3.3 a reference to a time of day means that time of day in the place whose laws govern the construction of the Agreement;

17.3.4 where a period of time is specified and dates from a given day or the day of an act or event it must be calculated exclusive of that day; and

17.3.5 a term of the Agreement which has the effect of requiring anything to be done on or by a date which is not a business day must be interpreted as if it required it to be done on or by the next business day.

Reasonable efforts

17.4 Any provision of the Agreement which requires a party to use its reasonable efforts to procure that something is performed or occurs or does not occur does not impose an obligation to:

17.4.1 pay any money or to provide any financial compensation, valuable consideration or any other incentive to or for the benefit of any person, except of any such payment, compensation, consideration or income expressly contemplated in the relevant provision; or

17.4.2 commence any legal action or proceeding against any person, except where that provision expressly specifies otherwise.