How to contact Frank

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Welcome to Frank!

Here is some other important information. The legal stuff. You may not need it now, but it's good to have a copy.

Contents

Introduction to Frank

Frank Health Insurance is a business of GMHBA Limited. In this section, references to "Frank" or "Frank Health Insurance" are references to GMHBA Limited trading as Frank Health Insurance.

Application for membership with Frank

When you sign up for health insurance with Frank it's important that you provide us with all the information requested to allow us to maintain an accurate record of your membership. It is also important that the information you provide is true and correct. Frank will consider your membership void if you provide false or incorrect information on your membership application. If your membership is terminated, then premiums received in advance for coverage beyond the termination date will be refunded.

You can make changes to your membership anytime.

Frank uses the terms 'member', 'spouse/partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'member' can authorise changes to the membership unless the member has previously authorised the spouse/partner to make such changes. Similarly, correspondence issued by Frank will be addressed to the member and it is the member's responsibility to notify Frank of any change of address by maintaining the address records in the member area. The completion of the application process and the payment of any premium constitutes an acceptance of any conditions laid down in the regulations of the fund, including the Fund Rules and any fund policies, in force at that time or as they may be amended from time to time. A copy of the Fund Rules can be accessed on request by emailing Frank at frank@frankhealthinsurance.com.au, but be prepared – the Fund Rules are comparable in size to a telephone directory, and you will need to print it yourself.

Frank reserves the right to refuse admission to membership of any level of health insurance.

In the event of any member or person named on the member's membership is convicted in a court of law of assault or similar offence against a staff member related to that staff member's performance of their duties, has obtained or attempted to obtain an improper advantage, for themselves or for any other member or is convicted in a court of law of fraud against Frank, the Board may in its discretion, declare the member's membership void. The status of the member's membership will be assessed with any outstanding claims being honoured and any premiums shall be refunded. Any other rights accrued to the member will be forfeited.

Membership card

When you sign up with Frank Health Insurance, you'll receive a membership card that identifies you as a member. The card shows your membership number and who is covered. Frank's contact details are listed on the back of the card. Have your membership card on hand when you arrange admission to hospital, visit a participating provider or when you call Frank with any questions.

A new card may be issued when you make changes to your membership. Please note that an existing card will become invalid whenever a new membership card is issued. Keep your card safe and please advise Frank if your card is lost or stolen.

Communications from Frank by webmail

Frank understands that paperwork is time-consuming, tedious, and bad for trees. On the other hand, Frank understands that members want to be able to access information relevant to their membership easily and quickly.

Frank will provide you with a great deal of information upon joining, including your:

- Membership certificate
- The Standard Information Statement (SIS) for the product/s you have bought
- A detailed description of the coverage provided by the products you have bought
- Other Important Information relating to your coverage and your membership

Frank understands that you will need this material one day, which may be years after you join, so Frank will be communicating with members via a secure Webmail. Webmail is contained within the Member area and is accessible only with your Member Number (which is on the back of your member card) and password. The information that Frank sends you this way can be viewed in screen, copied to your hard drive or printed out. Information sent to you via Webmail can be personally sensitive so Frank recommends that you guard your password carefully.

As well as the material listed above, Frank will send to your Webmail account your:

- Annual product and rate change email
- Annual Tax Statement and Lifetime Health Cover Statement
- Any other notifications relevant to your membership

You will be asked to consent to receiving communications electronically during the sign-up process. This is the only way that Frank can communicate with you, and acceptance of this is a condition of membership. Receiving these notifications by snail mail is not an option.

Check your cover

Please contact Frank to check what you're going to get back before having treatment or going into hospital. Frank has a range of health insurance options at different levels.

Arrears

Frank members are responsible for ensuring their accounts have sufficient funds available on their nominated direct debit date. Membership will cease when premiums fall into arrears of more than 2 months after the premium due date. To claim benefits a member must be financial at the time of incurring the expense for the service or treatment.

Liabilities of members to Frank

A member can be liable to Frank for unpaid premiums and for overpayments. Overpayments can be made by Frank to a member, either through an error in completing a claim, or an error in processing a claim. If an overpayment is made, the member is liable to repay the amount of the overpayments to Frank on demand. If a member is liable to Frank for unpaid premiums or overpayments then Frank has the right to deduct the amount of that liability from any monies due by Frank to the member on any account.

Audits

Frank undertakes audit activities in order to protect members' assets and contain costs. And as we have online extras claiming with no need to send in receipts we need you to keep your receipts somewhere safe for two years, like your bottom drawer just in case our Audit team wants to check up. But don't send them to us unless we ask.

And from time to time, in the general interest of members, a Frank representative may contact you with a request for assistance to monitor costs – whether relating to benefits paid or charges raised by health care

providers. Your co-operation with such requests is critical to our cost containment efforts, and will be treated in a completely confidential manner.

Refunds

You may cancel your Frank Health Insurance cover from:

- the date you notify Frank in writing of the cancellation (a transfer certificate will be provided to the insured person within 14 days of request); or
- your next direct debit date, whichever is the earlier.

If you cancel your Frank Health Insurance cover within 30 days of joining, you will receive a full refund of any premiums received by Frank, provided you have not made a claim.

Product Information

When to contact Frank

If you have less than 12 months membership on your current hospital cover, make sure you contact us before you are admitted to hospital and find out whether the pre-existing condition waiting period applies to you. We need about 5 working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioner/s. Make sure you allow for this time frame when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and we subsequently determine your condition to be pre-existing, you'll have to pay all outstanding hospital charges and medical charges not covered by Medicare.

Waiting periods

Waiting periods exist to protect members from claims made by those who join Frank or increase their level of cover because they have a condition or illness that may require treatment.

Waiting periods and benefit limitation periods will apply to:

- New memberships (previously uninsured);
- Additions to a membership (unless the addition/s has already served all waiting and benefit limitation periods with Frank or another insurer) except newborns and adopted and permanent foster children where the family membership has been in existence for at least 2 months, and where the addition/s has already served all waiting and benefit limitation periods with Frank or another insurer,
- Existing Frank memberships, and transfers to Frank from another insurer where:
  (i) the level of cover and/or benefit entitlement is upgraded or increased;
  (ii) any hospital or extras service was not covered by the previous insurer and/or;
  (iii) the waiting and benefit limitation periods have not been completed.

Where a member is transferring from another product or from another health insurer, waiting and benefit limitation periods for hospital treatment that was not covered under the old policy are:

- 24 months - benefit limitation periods apply to gastric banding and all obesity surgeries, psychiatric or renal dialysis (that's means you're covered but for public hospital benefits in a shared room after your other waiting periods have been served)
- 12 months - obstetric or pre-existing condition (other than for psychiatric, rehabilitation or palliative care).
- 2 months - psychiatric, rehabilitation or palliative care.
- 2 months - any other benefit for hospital treatment.
- 0 months - accidents (bodily injuries that happen the day after you join or upgrade to a higher level of cover)

Where a member is transferring from another product or from another health insurer, waiting periods for extras that were not covered under the old policy are:

- 12 months - major dental, podiatric surgery and orthotics (where offered in the cover)
- 6 months - optical benefits
- 2 months - any other extras benefit

The above waiting and benefit limitations also apply to previously uninsured members.
For treatment that was covered under the old policy, at the same or higher level than the new policy, waiting and benefit limitation periods are no longer than the balance of any unexpired waiting or benefit limitation period for the benefit that applied to the person under the policy.

For treatment that was covered under the old policy but at a lower level, the member is entitled to the lower benefits on their old cover during the waiting period.

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover during the waiting or benefit limitation period.

Benefit limitation periods

Benefit limitation periods are important - they stop people from taking advantage of Frank's generous nature. Benefit limitation periods are a restriction on what Frank will pay for a hospital treatment for a period of time. It begins the date you join Frank or switch covers. It means Frank pays public hospital benefits in a shared room, so long as you have served all other waiting periods, but then you'll be back to normal. A benefit limitation period of 24 months applies to:

- Best Hospital cover for gastric banding and all obesity surgeries, psychiatric or renal dialysis; and
- Better Hospital cover for psychiatric.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently if you have less than 12 months membership on your current hospital cover you might have to pay for some or all of the hospital and medical charges if:

- you are admitted to hospital and you choose to be treated as a private patient; and
- we later determine that your condition was pre-existing.

Pre-existing conditions (PEC)

A pre-existing condition is one where signs or symptoms of your ailment, illness or condition, in the opinion of a medical practitioner appointed by Frank (not your own doctor), existed at any time during the six months preceding the day on which you purchased your hospital insurance or upgraded to a higher level of hospital cover and/or benefit entitlement.

The only person authorised to decide that a condition is pre-existing is the medical practitioner appointed by Frank. However, the medical practitioner appointed by Frank must consider any information regarding signs and symptoms provided by your treating medical practitioner/s.

The pre-existing condition rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital cover. The only test is whether or not, in the 6 months prior to joining your current hospital cover signs and symptoms:

- were evident to you; or
- would have been evident to a reasonable general practitioner if a general practitioner had been consulted.

Waiting periods – PEC

A special waiting period applies to obtain benefits for hospital treatment for new members who have pre-existing conditions. Waiting and benefit limitation periods also apply to existing members who have recently upgraded their level of hospital cover. If the ailment, illness or condition is considered pre-existing:

- new members must wait 12 months for any hospital benefits (other than psychiatric, rehabilitation and palliative care).

- members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits (other than psychiatric, rehabilitation and palliative care).
- A 24 month benefit limitation period applies to gastric banding and all obesity surgeries, psychiatric or renal dialysis (where offered in the cover).

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover.

Dependants

1. Previously insured with Frank

Child and student dependants are covered up until they turn 21 years of age. After their 21st birthday they have 2 months to organise health insurance, but their new membership will start from the date they turned 21. They won't have to serve waiting and benefit limitation periods when transferring to an equivalent or lower level of insurance.

2. Previously insured with another insurer

Student dependants whose parents are members of another registered health insurer and were previously insured with their parents, may sign up with Frank within 2 months of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without serving waiting or benefit limitation periods. An acceptable transfer certificate and claims history must be received by Frank.

3. Previously uninsured

Previously uninsured dependants may sign up with Frank and receive immediate Basic Hospital cover benefits, except for any pre-existing condition/illness (other than for psychiatric, rehabilitation and palliative care) and maternity cases for which a waiting period of 12 months will apply. All waiting and benefit limitation periods must be served for extras benefits and hospital benefits which are higher than those available from the Basic Hospital cover.

Planning a child

If you are preparing to start a family and your hospital cover does not include obstetrics, you will need to ensure you upgrade your hospital cover to include obstetrics at least 12 months before you have a child to ensure all waiting periods have been served.

If all goes well, a new born baby is not admitted as a patient in hospital, but if you have complications and your baby requires any accommodation or medical attention, you will not be covered for accommodation or medical services unless your child has served the waiting period. So, if you are currently on a singles membership, you will need to change to a family membership at least 2 months before your baby is born. Frank recommends that you change to family membership three months before your baby is due, (you can add an unborn child as an additional person) in case your baby arrives prematurely.

Excess - Hospital only

An excess is the fee you pay in return for lower premiums. An excess applies when you are admitted into hospital as a private patient.

The most you'll pay for excess each calendar year is:

- $500 for Singles
- $1,000 for Couples and Families

If one person from a Couple or Family membership goes to hospital, they will have a maximum excess of $500. It's only when more than one person from the membership is hospitalised that the maximum excess

is $1,000.

For example, if Frank's full benefit for a hospital stay was $5,000 the benefit would reduce by a $500 excess and an adjusted benefit of $4,500 would be paid. If the same person is admitted into hospital again in the same year they would not pay another excess. When Frank says 'year' Frank means calendar year (Jan 1 to Dec 31).

Exclusions

You cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Account/s which have been altered in any way will not be accepted. Providers are required to re-issue any account/s or endorse any alterations.
- Natural remedies (includes Modifast & Optifast).
- Food supplements.
- Dental procedures carried out and charged direct to the member/dependant by a dental mechanic, other than an advanced dental technician.
- A range of dental procedures when provided on the same day e.g. a filling on a tooth that has been removed.
- Dental procedures where a limit on the number you can have has been exceeded.
- Dental procedures unless tooth identifications (ID) are supplied by the provider.
- Services/treatment for which the member and/or dependant has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act.
- Services/treatment rendered more than 12 months prior to the date of claiming.
- Services/treatment which is not covered by your membership and/or is rendered while the membership is in arrears or is suspended.
- Services/treatment rendered by a practitioner not in private practice and/or not recognised by bodies approved by Frank.
- Hiring of equipment (unless otherwise stated).
- Services not rendered face to face (e.g. remotely over the phone).
- Foot orthotics unless they are custom made and provided by a registered podiatrist.
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment.
- Benefits, payable under a hospital or extras cover shall not exceed the fees and/or charges raised for any treatment and/or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source.
- Benefits for services on treatment received overseas.

Restrictions

Benefits may not be paid or may be paid at a lower level where:

- you have already claimed the maximum allowable benefits during a specified period.
- you have transferred to a Frank extras cover from an extras cover by a different insurer and have previously claimed for the service/ treatment.
- the health care account has been incompletely, incorrectly or inappropriately itemised.
- you have an excess to pay on your chosen level of cover.
- Frank believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care

after 35 days continuous hospitalisation. If this is the case, Frank benefits will be reduced to Nursing Home Type Patients benefits and will be paid in accordance with the default benefit determined by the Department of Health & Ageing. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.

- the service/s is subject to a waiting and/or benefit limitation period or other limit which has not been served/met.
- surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact Frank for details.
- no MBS item number is provided by the GP/specialist e.g. cosmetic surgery.
- professional services are provided to the provider or members of the provider's family or to a provider's business partner's family members or any other people not independent from the practice. Family members include: wife/husband, brother/sister, children, parents, grandparents, grandchildren. If this is the case, only wholesale material costs involved in the provision of the service are subject to benefits.
- the claim is for cosmetic surgery. Limited benefits may apply on hospital covers for cosmetic surgery, depending on the medical justification for the surgery.
- the claim is for additional medical gap benefits, where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- there is more than one claim made to the same provider on the same day. But you can claim for more than one service on the same day if performed by different providers. Confused…? It's simple, want to go to Spiro the chiro and Jenny the massage therapist on the same day? You can with Frank.

Suspensions

You can suspend your Frank cover for periods of overseas travel provided you:

- have at least 12 months continuous unsuspended cover with Frank prior to departure; and
- plan to be overseas for at least 2 months; and
- have paid premiums to the date of departure; and
- apply for suspension of your cover prior to departure.

You'll be required to resume your suspended cover within 2 months of returning to Australia and premiums must be paid from the date of re-entry. Your passport, boarding pass or a statutory declaration may be required to be presented to Frank as proof of travel.

A 3 year maximum cover suspension period for overseas travel applies. Only the balance of outstanding waiting or benefit limitation periods need to be served upon resumption of your membership.

Please note that your Certified Age of Entry (CAE), for the purposes of calculating Lifetime Health Cover (LHC) loading, may be affected by periods of absence of 3 years or longer. See the LHC section for details.

Participating providers

A participating provider is a health care provider, with whom Frank has entered into an agreement relating to direct billing and/or fees and benefits. These agreements aim to maximise your cover and minimise your out-of-pocket costs. Frank's participating private hospitals list can be obtained from the Frank website, however it is subject to change without notice. So check with us on 1300 4 FRANK (37265) before confirming your hospital admission. To view the most recent list click here.

a) Participating private hospitals

1. Best Hospital cover

- Members who have taken out Frank's Best Hospital cover, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods are entitled to cover for accommodation, theatre, delivery suite, intensive and coronary care and other agreed hospital charges - less any excess (if applicable). Best Hospital Cover has a 24 month benefit limitation period for the following services: gastric banding and all obesity surgeries, psychiatric and renal dialysis. **During a benefit limitation period these services attract public hospital benefits in a shared room.** Members should present their Frank membership card when attending a participating private hospital.
- Public hospitals: Frank's Best Hospital cover provides cover for hospital accommodation costs when you are admitted to a single or shared room (subject to bed availability) as a private patient in a recognised public hospital.

2. Better Hospital cover

- Members who have taken out Frank's Better Hospital cover, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods, will be covered for shared accommodation, intensive and coronary care and other agreed hospital charges - less any excess (if applicable). Better Hospital Cover has benefit exclusions for the following services: Obstetrics, IVF and related services, joint replacement, renal dialysis, gastric banding and all obesity surgeries, dental implants, cosmetic surgery and cataract surgery and corneal transplants. **These excluded services do not attract any benefits.** Better Hospital Cover has a 24 month benefit limitation period for psychiatric services. **During a benefit limitation period this attracts a public hospital benefit in a shared room.** Members should present their Frank membership card when attending a participating private hospital.
- Public hospitals: Frank's Better Hospital cover provides cover for hospital accommodation costs when you are admitted to a shared room (subject to bed availability) as a private patient in a recognised public hospital. **Excluded services do not attract any benefits.**
- Co-payments apply of $100 per day up to $700 per admission for single room accommodation in all public and private hospitals.

Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

b) Non-participating hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Please contact Frank on 1300 4 FRANK (37265) for further details as treatment in a non-participating private hospital will result in out-of-pocket expenses. Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

c) Basic hospital

Members with Basic Hospital cover, who are admitted to a **public hospital** and have served all waiting periods are covered for accommodation costs for a shared room. Basic Hospital cover has benefit exclusions for the following services: Renal dialysis, gastric banding and all obesity surgeries and cosmetic surgery. **These excluded services do not attract any benefits.**

Please Note: Benefits for a single room in a public hospital or for treatment in a private hospital when using Basic Hospital cover will result in significant out-of-pocket expenses. For further information on private patient benefits on Basic Hospital cover, please call on 1300 4 FRANK (37265).

Overseas travel

Frank Health Insurance does not provide benefits for services or treatment received overseas.
Frank advises that you take out travel insurance for the set period of your travel and that it's suitable to the destinations you're visiting.

Extras services purchased over the internet

Benefits will be paid for optical services purchased over the internet from Australian providers where a script is provided. Benefits for services on treatment received overseas are excluded.

Frank's Covers

Basic Hospital Cover

Basic Hospital Cover provides you with cover as a private patient in a public hospital. This cover is suitable if you want a basic level of hospital cover to avoid the Medicare Levy Surcharge or lock in your certified age of entry for Lifetime Health Cover.

Frank gets that.

What's covered

Frank's Basic Hospital cover will cover you for:

- Hospital Accommodation (shared room) in a public hospital
- Accidents (ones that need a hospital not a band aid)
- Cardiac surgery and coronary care (problems with your heart)
- Cataract surgery
- Delivery suite (for babies, not packages)
- Eye surgery
- Intensive care (1-on-1 care 24/7)
- Joint reconstruction (e.g. knee)
- Joint replacement (e.g. hip)
- Medical Gap (Frank will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Frank's medical gap cover scheme. Watch the FrankView video at www.frankhealthinsurance.com.au)
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)
- Obstetrics (childbirth services)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)
- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre in a public hospital (surgery costs, not Shakespeare)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

What's not covered

You don't want to pay for what you don't use. So Basic Hospital doesn't cover:

- Hospital Accommodation (single room) in a Public Hospital
- Full Hospital Accommodation costs in Private Hospitals – Basic Hospital pays fixed benefits per day which will leave you out of pocket if you have a stay in a Private hospital
- Cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number)
- Gastric banding and all obesity surgeries (for weight loss)
- Renal dialysis (for kidney disorders)
- Theatre in a private hospital

Other Relevant Information

Please refer to the Product Information Section for other relevant information on Basic Hospital Cover.

Better Hospital Cover

Some people want the perks of private without the price tag of top cover. They want good coverage, but they don't need everything. They're thinking about the future, but not starting a family.

Frank says, fair enough.

What's covered

Frank's Better Hospital will cover you for:

- Hospital Accommodation (in a shared room)
- Hospital Accommodation in a single room with a co-payment ($100 per day is payable by you, capped at 7 days per admission)
- Accidents (ones that need a hospital not a band aid)
- Cardiac surgery and coronary care (problems with your heart)
- Eye surgery
- Intensive care (1-on-1 care 24/7)
- Joint reconstruction (e.g. knee)
- Medical Gap (Frank will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Frank's medical gap cover scheme. Watch the FrankView video at www.frankhealthinsurance.com.au))
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)
- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre (surgery costs, not Shakespeare)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

What's not covered

You don't want to pay for what you don't use. So Better Hospital doesn't cover:

- Cataract surgery and corneal transplants
- Cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number)
- Delivery suite (for babies, not packages)
- Dental implants performed in a hospital
- Gastric banding and all obesity surgeries (for weight loss)
- IVF and related services
- Joint replacement (e.g. hip)
- Obstetrics (childbirth services)
- Renal dialysis (for kidney disorders)

Other Relevant Information

Please refer to the Product Information Section for other relevant information on Better Hospital Cover.

Best Hospital Cover

Some people want the works. They want total peace of mind. That means coverage for all treatment types and cushy private privileges.

Frank has just the thing.

What's covered

Frank's Best Hospital cover will cover you for:

- Hospital Accommodation (shared or single room, subject to availability)
- Accidents (ones that need a hospital not a band aid)
- Cardiac surgery and coronary care (problems with your heart)
- Cataract surgery
- Delivery suite (for babies, not packages)
- Eye surgery
- Gastric banding and all obesity surgeries (for weight loss)
- Intensive care (1-on-1 care 24/7)
- IVF and related services
- Joint reconstruction (e.g. knee)
- Joint replacement (e.g. hip)
- Medical Gap (Frank will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Frank's medical gap cover scheme. Watch the FrankView video at www.frankhealthinsurance.com.au))
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)
- Obstetrics (childbirth services)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)
- Renal dialysis (for kidney disorders)
- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre (surgery costs, not Shakespeare)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

What's not covered

You don't want to pay for what you don't use, so Best Hospital doesn't cover cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number).

Other Relevant Information

Please refer to the Product Information Section for other relevant information on Best Hospital Cover.

Some Extras Cover

You want some Extras, but you don't need to go overboard. Just enough for the usual – dental, optical and the occasional alternative therapy treatment.

Some Extras is available with either 50% back or 80% back – it's up to you. With either variation of Some Extras, the annual limits are the same – and you get it back quicker with 80% back.

What's included in Some Extras:

SOME EXTRAS SERVICE	WAITING PERIOD	SINGLES YEARLY LIMIT	COUPLES/FAMILIES YEARLY LIMIT
AMBULANCE Refund of ambulance subscription fee (one per year)	0 months	50% or 80% of cost	50% or 80% of cost
DENTAL – TOTAL (see Dental Notes)		$500	$500 per person (max. $1000 per family)
General Dental	2 months		
Preventative dental – sub limit (e.g. checkups, scale and clean)		$250	$250 per person (max. $500 per family)
Major Dental	12 months		
Orthodontic – sub limit (e.g. braces) A limit of $900 per course and lifetime limit of $1,050 applies.		$300	$300 per person
Crown and bridgework – sub limit		$225 per crown/bridge $450 per person	$225 per crown/bridge $450 per person
Indirect restorations – sub limit These occur outside of the mouth, e.g. a filling that has been modelled on plaster cast.		$350	$350 per person (max $700 per family)
Implants – sub limit (e.g. a fake tooth that is permanently inserted into your gum)		$400	$400 per person
OPTICAL Includes prescription glasses, contact lenses and frames. Doesn't include non-prescription sunglasses or repairs.	6 months	$120	$120 per person (max. $240 per family)
OTHER THERAPIES Chiropractic, Osteopathy, Naturopathy, Homeopathy, Acupuncture, Physiotherapy, Myotherapy, Hydrotherapy, Remedial Massage (combined) Note: benefits will only be paid for one consultation and/or treatment per provider per day.	2 months	$400	$400 per person (max. $800 per family)

Dental Notes

Dental is complicated. There are over 1000 different treatments and even more rules about what is and isn't covered. Rather than bore you with all the details here, Frank recommends you get in touch before getting treatment. That way you'll know if you're covered.

Sub-limits

The table above shows the yearly limit for each type of dental service. For example, the annual limit for

crown and bridgework is $450. However, there are further sub-limits for each of these services. For example, the individual limit for one crown is $225.

If you're getting treatment, email or chat to Frank first to see if any sub-limits or rules apply to you.

Other Relevant Information

Please refer to the Product Information Section for other relevant information on Some Extras Cover

Lots Extras Cover

Your health is high maintenance. Or perhaps you just like peace of mind. Either way, you want it all. Head to toe coverage, lots of treatment types and big limits.

Lots Extras is available with either 50% back or 80% back – it's up to you. With either variation of Lots Extras, the annual limits are the same – and you get it back quicker with 80% back.

What's included in Lots Extras:

LOTS EXTRAS SERVICE	WAITING PERIOD	SINGLES YEARLY LIMIT	COUPLES/FAMILIES YEARLY LIMIT
AMBULANCE Refund of ambulance subscription fee (one per year)	0 months	50% or 80% of cost	50% or 80% of cost
CHIROPRACTIC / OSTEOPATHY (combined) Includes 1 chiro x-ray per year Note: benefits will only be paid for one consultation and/or treatment per provider per day.	2 months	$400	$400 per person (max. $800 per family)
DENTAL – TOTAL (See Dental Notes)		$2,000	$2000 per person (max. $4,000 per family)
General Dental	2 months		
Preventative dental – sub limit (e.g. checkups, scale and clean)		$500	$500 per person (max $1,000 per family)
Major Dental	12 months		
Orthodontic – sub limit (e.g. braces) A limit of $2,550 per course and lifetime limit of $2,900 applies.		$450	$450 per person
Crown and bridgework – sub limit		$300 per crown/bridge $600 per person	$300 per crown/bridge $600 per person
Indirect restorations – sub limit These occur outside of the mouth, e.g. a filling that has been modelled on plaster cast.		$400	$400 per person (max. $700 per family)
Implants – sub limit (e.g. a fake tooth that is permanently inserted into your gum)		$400	$400 per person
NATUROPATHY / HOMEOPATHY / ACUPUNCTURE / REMEDIAL MASSAGE (combined) Note: benefits will only be paid for one consultation and/or treatment per provider per day.	2 months	$400	$400 per person (max. $800 per family)
OPTICAL Includes prescription glasses, contact lenses and frames. Doesn't include non-prescription sunglasses or repairs.	6 months	$250	$250 per person (max. $500 per family)
PHYSIOTHERAPY / MYOTHERAPY / HYDROTHERAPY (combined) Note: benefits will only be paid for one consultation and/or treatment per provider per day.	2 months	$400	$400 per person (max. $800 per family)
PODIATRY - TOTAL		$400	$400 per person (max. $800 per family)
General consultations	2 months		

LOTS EXTRAS SERVICE	WAITING PERIOD	SINGLES YEARLY LIMIT	COUPLES/FAMILIES YEARLY LIMIT
Surgical procedures	12 months		
Orthotics – sub limit (for your feet) Orthotics must be custom made (alterations on off-the-shelf orthotics don't count)	12 months	$230	$230 per person (max. $460 per family)
PSYCHOLOGY	2 months	$400	$400 per person (max. $800 per family)

Dental Notes

Dental is complicated. There are over 1000 different treatments and even more rules about what is and isn't covered. Rather than bore you with all the details here, Frank recommends you get in touch before getting treatment. That way you'll know if you're covered.

Sub-limits

The table above shows the yearly limit for each type of dental service. For example, the annual limit for crown and bridgework is $600. However, there are further sub-limits for each of these services. For example, the individual limit for one crown is $300.

If you're getting treatment, email or chat to Frank first to see if any sub-limits apply to you.

Other Relevant Information

Please refer to the Product Information Section for other relevant information on Lots Extras Cover.

Customer Satisfaction and Private Health Information

Code of Conduct

Frank Health Insurance is brought to you by GMHBA Limited, proud to be a compliant member of the Private Health Insurance Code of Conduct. The Private Health Insurance Code of Conduct is designed to help you by providing clear information and transparency in your relationships with health insurers.

The Code covers four main areas of conduct in private health insurance ensuring:

- You receive the correct information on private health insurance from appropriately trained staff;
- You are aware of the internal and external dispute resolution procedures with Frank Health Insurance;
- Policy documentation contains all the information you require to make a fully informed decision about your purchase and all communications between you and Frank Health Insurance are conducted in a way that ensures appropriate information flows between the parties; and
- All information between you and Frank is protected in accordance with national and state privacy principles.

You can download the Code at www.privatehealth.com.au/codeofconduct.php

Community Rating

Frank Health Insurance is required to comply with Community Rating. Community Rating means Frank will not discriminate between members on the basis of their health or any other reason described below - basically equal opportunity for private health insurance.

When making decisions in relation to members, Frank will disregard the following:

1. The suffering by the member of a chronic disease, illness or any other medical condition.
2. The gender, race, sexual orientation or religious belief of a person.
3. The age of a member, except in relation to Lifetime Health Cover loadings.
4. Any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that are likely to result in an increased need for extras or hospital treatment.
5. The frequency with which a person needs extras or hospital treatment.
6. The amount, or extent, of the benefits to which a member becomes, or has become, entitled during a period.

Privacy

We value the relationship between Frank and our members. An important part of this relationship is our commitment to protecting the personal information entrusted to us by our members. This commitment is documented in our Privacy Statement for Members http://www.frankhealthinsurance.com.au/legals

Complaints or concerns

Frank thinks that honesty is the best policy. Frank wants you to share what is on your mind. So we can help resolve it.

Just so you know what to expect of Frank this is the process for dealing with complaints:

1. Make a Complaint
   You can make a complaint in whichever is your preferred method. Writing an email is Frank's preferred method to fully understand the complaint before coming up with a resolution, so please email frank@frankhealthinsurance.com.au or if you prefer, visit frankhealthinsurance.com.au, WebChat about it, or call 1300 4 FRANK (37265).
   You will receive an acknowledgement response within 24 hours. If the matter is of a more difficult nature and will take some time to resolve, Frank will keep you informed of the ongoing progress.
2. Unhappy with the resolution of the initial complaint
   If after receiving Team Franks response you are still unhappy, you can request that it be brought to the Team Frank Business Manager's attention. They will then again review the complaint, possibly contacting you for further information, if needed, and get back to you with a response within 5 working days.
3. Free independent advice is available from the Private Health Insurance Ombudsman. You can contact the Ombudsman on freecall 1800 640 695 or Level 22, 580 George Street, SYDNEY NSW 2000.

Insure? Not sure?

If you need more information about private health insurance please refer to the Private Health Insurance Administration Council (PHIAC) guide "Insure? Not sure?" which can be downloaded from www.phiac.gov.au/for-consumers/insure-not-sure/

State of the health funds report

The Private Health Insurance Ombudsman publishes an annual State of the Health Funds Report. This independent report compares service and productivity of private health insurers.

Download the report from www.phio.org.au

Standard Information Statements

A Standard Information Statement (SIS) is available for every product of Frank.
Upon joining, the SIS/s for the Frank products which you have purchased will be sent to your Frank Webmail, and you will receive a notification stating that the SISs are available in your Webmail.
An up to date SIS will be forwarded to your Webmail at least once per year from where it can be read or printed.

Recommendation or endorsement

Frank does not offer health or medical services or advice. Frank does not recommend or endorse any medical practitioner, dentist, therapist, hospital, health or medical service provider, treatment, therapy or the use of any appliance or prosthetic. Frank does not endorse or make any representation whatsoever as to the appropriateness or effectiveness of any service or goods for which a benefit is paid. Members should make and rely on their own enquiries and seek any assurance or warranties directly from the provider of the service or product.

Medicare Levy Surcharge

The Medicare levy surcharge (MLS) is a surcharge on individuals and families on higher incomes who don't have eligible private hospital cover.

The MLS is an additional tax that Aussies need to pay if they don't have eligible private hospital cover and earn over $84,000 as a single or 168,000 as a couple/family. It used to be an extra 1% tax for all high-income earners, but now it can be up to 1.5% extra tax depending on your income. The surcharge is 1% of your taxable income in addition to the normal 1.5% Medicare Levy.

People may have to pay the Medicare levy surcharge if they or any of their dependants do not have eligible cover and they are:

- A single person - without dependent children - with a taxable income (including any reportable fringe benefits of $1,000 or more) greater than $84,000
- A family - including a couple and single parent - with a combined taxable income (including any reportable fringe benefits of $1,000 or more) greater than $168,000 (increasing by $1,500 per dependent child, after the first child).

	Nothing to pay	**Tier 1**	**Tier 2**	**Tier 3**
Singles	$84,000 or less	$84,001-97,000	$97,001-130,000	$130,001 or more
Couples/Families (Increases by $1,500 per child after your first)	$168,000 or less	$168,001-194,000	$194,001-260,000	$260,001 or more
	Medicare Levy Surcharge			
All ages	0.0%	1.0%	1.25%	1.5%

If you're thinking about dropping your hospital cover, be aware if you do change your mind and want to take it out again then whichever health insurer you join then you may need to re-serve your waiting periods plus Lifetime Health Cover loading may apply.

Contact your tax adviser or the Australian Taxation Office for further details about the Medicare levy surcharge.

Australian Government Rebate on Private Health Insurance

The Australian Government Rebate on Private Health Insurance is available to those who have full Medicare eligibility and earn under $130,000 for singles and $260,000 for families/couples or single parents. The table below gives you the full details.

	Unchanged from before 1st July 2012	Tier 1	Tier 2	Tier 3
Singles	$84,000 or less	$84,001-97,000	$97,001-130,000	$130,001 or more
Couples/Families (Increases by $1,500 per child after your first)	$168,000 or less	$168,001-194,000	$194,001-260,000	$260,001 or more
	Australian Government Rebate on Private Health Insurance			
Under 65 years	30%	20%	10%	0%
65-69 Years	35%	25%	15%	0%
70 years and over	40%	30%	20%	0%

You can claim the rebate as a reduction to your premiums, as a tax rebate when you lodge your annual tax return or as a direct payment from the Government through any Medicare office.

The easiest way for you to claim the rebate is to complete the application form for the Australian Government Rebate on Private Health Insurance during the application process with Frank. Frank will then deduct the rebate from your premiums.

Frankly, if you don't have eligible private hospital insurance and earn over $84,000 for singles and $168,000 then you'll have to pay the Government's Medicare Levy Surcharge. So Frank's low cost covers might even save you tax.

Lifetime Health Cover loading

The Federal Government introduced the Lifetime Health Cover (LHC) initiative on the 1st of July 2000. From this date, anyone who joins a hospital cover of a registered health fund will be given a Certified Age at Entry (CAE) status - which represents their age when they first joined a hospital cover after the 1st of July 2000.

If you joined a hospital cover before this date you are assigned a CAE of 30 and you'll pay the base rate (the lowest premium) for your hospital cover. The premiums returned on the Quick Quote are quoted at base rates. If you joined after this date and are aged 31 or over, and therefore have a CAE of over 30, you'll pay a 2% loading for each year your CAE is above 30 to a maximum loading of 70%. Where you have had to pay a LHC loading, and have done so for a continuous period of 10 years, the loading will no longer apply on the day after the last day of the 10 year period. If you're over the age of 30, the sooner you take out hospital cover, the less you'll pay later.

In summary, the Federal Government's LHC loading applies if you were aged 31 or over on the 1st of July just passed and are taking out hospital cover for the first time. Under LHC, in addition to the rates on the Quick Quote, a 2% loading is applied for each year you are aged over 30 when you join. The Australian Government Rebate on private health insurance may apply to your total premiums depending on your income, including any LHC loading. Lifetime health cover applies to hospital cover and does not apply to extras.

To view the FrankView video explaining Lifetime Health Cover, head to www.frankhealthinsurance.com.au.

Periods of absence

As members may need to discontinue their hospital cover membership for brief periods, lifetime health cover allows a period or periods of absence through a member's lifetime without affecting their CAE. However, after a total of two years absence, their CAE will increase by one year for each additional full year of absence. Members will need to re-serve waiting and benefit limitation periods when they return to Frank.

Membership suspension

Approved periods of suspension, which will not affect a member's CAE are explained under 'Suspensions' in the Product Information section

All about Claiming

Damages or compensation

Where you or your dependants have a right to claim damages or compensation from any other person or body, you are required to pursue that entitlement prior to lodging a claim for benefits with Frank. A claim should only be lodged with Frank if action at law is unsuccessful. A letter of denial is required. This includes WorkCare, TAC, public liability and third party claims.

Claiming procedure

How to claim with Frank:

1. Hospital claims - are paid from Frank direct to the hospital. You will need to present your membership card upon admission, and you will not need to contact Frank in most cases. Details of all claims paid on your behalf can be viewed in your online member area.

2. Extras Claims - When you have Frank extras cover you can use your Frank membership card to claim electronically on-the-spot when this facility is available at your health care provider. After the service has been provided, your membership card will be swiped through the terminal, your claim details entered and your claim will usually be processed electronically within seconds. Once your claim is authorised by Frank, you simply pay any difference between the full fee for the treatment and the amount paid by Frank. If there is an unexpected rejection of your claim at the point of service, your provider should contact Frank on 1300 4 FRANK (37265) to clarify the issue at the time of the service taking place.

3. If your service provider does not have an electronic terminal, you will need to pay your account with your service provider in full and then claim online with Frank. Simply visit the Frank website and log in to your member area. You will need to keep your receipt for 2 years and send to Frank if requested during an audit in this time.

4. In some situations you may not be able to claim on-line, and you will need to submit your claim via snail mail. You will need to submit your claim via snail mail if the service occurred more than 6 months before the date of claiming, or the service was for orthodontic treatment.

To submit a claim by snail mail, Frank needs the following information:

- A completed claim form; and
- The fully itemised health care account/s, and the original receipt/s. Photocopies/facsimiles of accounts and/or receipts cannot be accepted.

An orthodontic treatment plan certificate, completed by the treating orthodontist/dentist, is also required before orthodontic benefits will be paid. You can obtain an orthodontic treatment plan certificate by calling our customer service centre on 1300 4 FRANK (37265). For the purpose of benefit payments, orthodontic treatment is regarded as commencing on the date the appliance is originally fitted. Limits apply every calendar year.

This paperwork should be sent to: Frank Health Insurance Claims PO Box 69. Geelong, VIC, 3220.

Frank reserves the right to take the following actions against any member or persons where improper, fraudulent or indiscretion occurs whilst making claims from Frank.

Actions that may be taken are:

- Suspension of electronic claiming for the period of time determined by Frank depending on the severity of the incident
- Restitution (voluntary or negotiated)
- Prosecution

Paid accounts/ bills

Benefits for paid accounts will be deposited directly into the members' previously nominated bank account.

Unpaid accounts (other than hospital accounts)

Claims for unpaid accounts will not be paid.

Medical benefits

Medical benefits cover your fees payable to surgeons, anaesthetists and other professionals who may bill you separately from your hospital bills. Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except in the case of claims made through our medical gap cover) and your claim for hospital benefits has been assessed and paid. Our benefits are not payable for services rendered when the patient is not a hospital inpatient.

Important Information prior to signing up

Transferring from another health insurer

You can transfer your health insurance from another health insurer to Frank without serving any new waiting periods or benefit limitation periods provided that you:

- have served all waiting periods or benefit limitation periods with your previous health insurer; and
- transfer to any equivalent or lower level of cover within 30 days of your membership ceasing with your previous health insurer.

Frank recommends that your cover starts immediately after your previous cover ends. If your new cover with Frank provides higher benefits or benefits for services not covered by your previous health insurer, you'll be regarded as a new member for those higher benefits, and/or additional services, and will be required to serve the waiting and benefit limitation periods - but only for the higher benefits/additional services.

If you transfer to Frank from another health insurer before completing the waiting periods or benefit limitation periods with your previous health insurer, you'll need to serve the balance of the waiting periods or benefit limitation periods with Frank (see earlier heading 'waiting periods' and 'benefit limitation periods').

When you transfer to Frank your benefit entitlements may be adjusted by benefits already paid by your previous health insurer. Under lifetime health cover, continuity of a member's/partner's certified age at entry (CAE) is possible when transferring from another Australian registered private health insurer.

Membership for non-residents of Australia

Frank hospital covers are designed for people who have full Medicare eligibility. These covers will not meet the cost of public or private hospital treatment, medical treatment or diagnostic services for people who do not have full Medicare eligibility. People who do not have full Medicare eligibility should contact Frank on 1300 4 FRANK (37265) to discuss appropriate health insurance arrangements.

Migrants

Frank congratulates you on migrating to Australia and hopes that it all works out for you. Again, you will want to be eligible for Medicare before you sign up to any of Frank's products.

Migrants who sign up with Frank within 2 months of arriving in Australia shall receive the following concessions:

- No 2 month waiting period for any level of hospital cover.
- No 12 month waiting period for pre-existing conditions/illnesses will apply to Basic Hospital cover.

All other waiting and benefit limitation periods for hospital and extras will apply. Proof of residency may be required by Frank. Lifetime health cover regulations also apply to migrants. Contact Frank for details.

Confirmation of Terms and Conditions of your membership

Frank believes in laying it all out so that we know where we stand.

When you signed up, you agreed to certain terms and conditions. For the record, those Terms and Conditions are reprinted here:

New Membership Join Process

Acknowledgement
In these terms, "you" or "your" refers to GMHBA Limited, and "I" or "my" refers to you as the Policy Holder.

By typing “yes” I acknowledge and declare that:

1. I have read and accept your terms and conditions of membership (as outlined in the Important Information);
2. I understand the conditions relating to pre-existing conditions/illnesses, waiting and benefit limitation periods;
3. I have read and accept your Privacy Statement for Members and I consent to the use and disclosure of my personal information in accordance with this policy;
4. The information I have provided to you via this online application for membership is true and correct;
5. The information in this online application for membership is provided with the consent of the individual(s) to whom it relates. I confirm that I have the authority to act on behalf of the individual(s) named in this online application and I have brought your Privacy Statement for Members to their attention;
6. I will make all claims under this policy and will ensure that each claim includes the sensitive information of a spouse/partner or dependant aged 16 years and over only with their consent;
7. I understand that my application for membership at the payment of benefits may be declined if any of the information I have provided to you is false;
8. I understand that you have the right to accept or refuse my application for membership and upon acceptance of my application for membership I will have engaged you to provide health insurance to me in accordance with my chosen level of cover;
9. I understand that cover does not commence until payment is received;
10. I am responsible for this policy and I will communicate to all current and future individuals covered by it, the information contained in your terms and conditions of membership, the existence of the Fund Rules, and the fact that those terms, conditions and rules apply to all of your members; and
11. I understand that you have the right to amend your terms and conditions of membership and your Privacy Statement for Members.