

Important information guide.



Effective April 2026

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The information within this guide should be read carefully and retained in conjunction with [Frank's Fund Rules](#) and your specific product information.

Frank may make changes to products and benefits from time to time, including adding or reducing the benefits or services available to members. Notice of such changes will be provided in accordance with the Private Health Insurance Act 2007, Private Health Insurance Code of Conduct and Australian Consumer Law.

About your membership.

Thanks for joining Frank

Welcome to Frank, health insurance made easy and affordable. We're an online health fund built for our members, not for profit.

Frank Health Insurance is a brand of GMHBA Limited. References to "Frank" or "Frank Health Insurance" throughout this guide are references to GMHBA Limited trading as Frank Health Insurance.

Communications from Frank

We understand that paperwork is time-consuming and tedious. On the other hand, we also know that members need to be able to easily access relevant information about their membership.

We'll provide you with lots of important links in your welcome email upon joining, including:

- A cover summary outlining all people included on your membership
- Your product fact sheet which gives a detailed description of your cover, inclusions and any waiting periods that may apply
- The Private Health Information Statement (PHIS) for the cover/s you have bought
- Other Important Information relating to your cover and your membership including links to this Important Information Guide, our Fund Rules and our Privacy Statement.

You can find a copy of your welcome email, your product fact sheet/s and other important communications from Frank in your online member area (see page 7).

You would have been asked to consent to receiving email communications during the sign-up process. As an online health fund, your acceptance of this is a condition of membership. Receiving these notifications by snail mail is not an option.

When to contact Frank

We're here if you need and encourage you to get in touch if you have any questions about your membership or cover that we haven't been able to answer [online](#).

Make sure you contact Frank before any hospital admission to check your cover level and benefits payable as well as potential out-of-pocket costs you might be up for.

Who can be covered under your Frank membership?

The primary member/policyholder

The primary member or “policyholder” is the person who takes out the health insurance policy.

The primary member/policyholder is:

- The primary contact for Frank Health Insurance
- Responsible for paying their Frank premiums
- Nominates who's covered by the policy
- Responsible for keeping their personal and membership details up to date
- Able to log in to the Frank app or member area to view and manage the membership, as per the [Frank Privacy Statement](#)
- Entitled to access and provide authority for others (client, spouse or power of attorney) to access all records, claims history and tax statements relating to their membership.

Singles cover

As a single membership only covers one person, the policyholder is the person covered.

Couples cover

Covered under this policy are:

- The policyholder
- The policyholder's partner

A “couple”, for the purposes of couples cover, includes anyone who's married, in a registered relationship, or in a recognised de facto relationship. There's no minimum time duration for the relationship to be considered a “couple”.

Family cover

Covered under this policy are:

- The policyholder
- The policyholder's partner
- The policyholder's one or more dependants

Single parent cover

Covered under this policy are:

- The policyholder
- The policyholder's one or more dependants

Dependants including child and student dependants

Child dependants can be covered on a family or single parent membership up until they turn 21 years of age regardless of their student or employment status.

Child dependants will be removed from the membership on their 21st birthday, unless they qualify as a student dependant.

Student dependant criteria

If the child dependant is single and a full-time student, apprentice or trainee at an eligible educational institution, or completing a life skills course through an approved provider, they can continue to be covered on a family or single parent membership until they turn 25, provided that a student declaration is submitted before their 21st birthday, and then again each following year by 31 March.

End of year school, apprenticeship, traineeship, and university leavers are covered under their parent's family or single parent membership until 31 March the following year, or their 25th birthday, whichever comes first.

Dependants coming off a family policy who take out their own cover within 60 days can transfer any waiting periods already served across to their new membership with us, provided:

- Their new cover starts* within 30 days of coming off the family cover (*Backdating of the policy may be required if cover is taken out between 31 and 60 days after a dependant is removed from the family cover); and
- Chosen level of cover is equal to or lower than the family cover.

Depending on the date that the new cover is taken out, backdating may be required to maintain continuity. Note that to claim benefits their cover must be active on or before the day of treatment.

Student dependants – other fund members

Student dependants who were previously insured with their parents as a member of another registered health insurer, may sign up with Frank within 30 days of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without re-serving waiting periods. An official clearance certificate and claims history must be provided to Frank by the former dependant's previous health fund.

Age-based discount

At Frank, we offer an age-based discount on all our hospital covers for new and existing members aged 18-29. This initiative is backed by the Australian Government, but health funds can choose whether to discount premiums at a rate of 2% for each year members are aged under 30 when they first take out hospital cover. The maximum discount available is 10% for 18-25 year olds. The best part? You get to keep your age-based discount until you turn 41, as long as you maintain hospital cover. Once you turn 41, the discount reduces by 2% each year until it's gone.

There are a few things to note:

- The discount only applies to hospital cover premiums.
- Child and student dependants aged over 18 are not eligible for the age-based discount unless they take out their own cover.
- Where there are one or two adults eligible for an age-based discount on a couple or family policy, the discount is applied as an average of the two.

Find out more about the [age-based discount](#).

Managing your cover

Member area

Make the most of your cover by managing your membership online through the Frank member area. Use your secure member area to:

- View your cover details
- Lodge selected extras claims
- Check your remaining extras limits
- Update your details
- Make a payment
- Review or change your cover
- And more!

To log in, you'll need to use the email and mobile number that Frank has on file for your membership (if you don't have a valid email or mobile number, you'll need to contact us so we can validate your identity). When registering for the first time, you'll also need your member number which is listed in your welcome email and other communications we've sent you, and on your member card.

The member area can be accessed via frankhealthinsurance.com.au or the Frank app. Please note that some services are only available in the member area when accessing via our website.

Remember, only the primary member has login access for the member area and app.

The Frank mobile app

You can also view and manage your cover on the go with the [Frank app](#). Log in using the same details as your member area.

Member cards

When you sign up with Frank Health Insurance, the primary member (policyholder) will have access to a digital member card via the Frank app. A physical member card will be provided for the primary member's partner (if applicable) soon after joining. Membership details including your member number and names of the people covered on your policy are listed on your member card, in the app and your member area.

Have your digital or physical member card on hand when you arrange admission to hospital as a private patient, claim extras on the spot at your provider, or when you call us with any questions.

Physical member cards can be requested for the primary member and any dependant/s via the app, member area or by contacting us.

A new card may be issued when you make changes to your membership. Whenever a new member card is issued, the existing card will become invalid. Keep your card safe and let us know straight away if your card is lost or stolen.

Product fact sheets

Need-to-know information about what's included on your cover, any waiting periods that may apply and other important details are included in the individual fact sheet for each Frank hospital and extras cover. Think of this as the cheat sheet for understanding your cover.

Fact sheets are provided in your welcome email when you join Frank and can be found in your member area or the Frank app at any time.

Updating your details

Moving house, got a new bank account or need to update your contact information? The primary member can change their details in the member area (when logging in via our website) or by calling us.

A partner, client or power of attorney with authority can also update the membership details but will need to contact Team Frank.

Cover changes

A primary member (or partner or power of attorney with authority) can change their level of cover at any time by contacting us. The primary member can also do this in the member area (when accessing via our website).

Just note that if you change your level of cover, waiting periods will apply for:

- services not previously covered
- reduced hospital excess amounts, and
- higher benefits available on an upgraded cover.

Planning for a child

If you're preparing to start or expand your family and want the option of choosing your obstetrician and giving birth as a private patient in a private hospital, you'll need to have pregnancy and birth included as a clinical category on your hospital cover.

If you upgrade your hospital cover to include pregnancy and birth, you'll need to do this at least 12 months before you plan to give birth. This is to make sure all waiting periods have been served before you claim for pregnancy and birth-related hospital admissions. Don't worry, if a baby is born early, we'll assess waiting periods from the baby's estimated due date.

In a standard delivery, a newborn baby is not admitted as a patient in hospital.

If there are complications and your newborn baby is admitted to hospital and requires any separate accommodation or medical attention; this is where your hospital cover kicks in. They will be covered for hospital accommodation and medical services, provided:

- Waiting periods have been served, and
- The baby is added to your policy within 6 months of their date of birth, and
- Change to family status (from couple to family, for example) if backdated to their date of birth.

Things to keep in mind:

- Any outpatient appointments are not covered by private health insurance. This includes regular obstetrician appointments, blood test etc.
- Any medical services for a newborn not admitted to hospital will be deemed outpatient services and are claimable through Medicare only.
- A single policy will become a single parent policy, and a couples policy will become a family policy when a newborn is added to the policy.

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 fully paid (financial) at the time of incurring the expense for the service or treatment.

Suspensions

Heading overseas? The primary member or partner with authority can suspend your Frank cover for periods of overseas travel, provided you:

- have had at least 12 months continuous unsuspended cover since joining; and
- have had a minimum of six months active cover after any previous suspensions; and
- plan to be overseas for at least 4 weeks and to a maximum of 3 years; and
- have paid premiums up to the date of departure; and
- apply for suspension of your cover prior to departure.

Benefits will not be accrued while the policy is suspended, e.g. orthodontic sub-limits, Frank Flexi Bundle limits.

Periods of suspension don't count towards waiting periods. Only the balance of outstanding waiting periods needs to be served upon resumption of your membership.

Frank-approved overseas travel won't impact the amount you pay for your Lifetime Health Cover (LHC) loading, because you're still considered to be maintaining your hospital cover (if applicable). Just note that paid hospital days don't accrue during periods of suspension so your LHC loading end date (the point at which your loading is removed after 10 continuous years of cover) will be extended for the length of the suspension. Find out more about LHC on page 30.

A 3-year maximum cover suspension period applies per instance of overseas travel.

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.

To arrange the suspension of your cover, give Team Frank a call before you head off. You'll be asked to nominate a return date when you apply for a suspension. Your cover will be automatically reactivated and your premium direct debited on this date. If your reactivation date changes while you're still overseas, it's up to you to let us know.

Further info can be found in Frank's Fund Rules.

Cancelling your cover

You may cancel your Frank Health Insurance cover from:

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

A refund of any premiums paid past your date of cancellation will be direct credited to your nominated bank account; refunds cannot be processed within 7 days of your most recent direct debit.

If you cancel your Frank Health Insurance cover within 30 days of joining back to the date that you first joined, you'll receive a full refund of any premiums received by Frank, provided you have not made a claim.

Waiting periods

What is a waiting period?

A waiting period is the time between when you first take out health insurance or upgrade your cover and when you're actually covered for a treatment or service.

Waiting periods exist to deter people from joining Frank or increasing their level of cover only when they have a condition or illness that may require immediate treatment, which can place pressure on premiums for all members of the fund.

Waiting periods apply to:

- New members (previously uninsured)
- Additional people added onto a membership (unless they've already served all waiting periods with Frank or another insurer), except for newborns, adopted and permanent foster children (where the family membership has existed for at least two months)
- Existing Frank memberships, and transfers to Frank from another insurer where:
 - > there is a gap of 30 days or more between a previous policy with Frank or another insurer and a new policy
 - > the level of cover and/or benefit entitlement is upgraded or increased, or hospital excess is reduced. Note: Waiting periods will apply only for those services not previously covered, and for higher benefits available or reduced excess on the upgraded cover. Provided waits have previously been served, you'll still receive benefits at your existing level of cover during the new waiting period.
 - > any hospital or extras service was not covered by the previous insurer and/or
 - > the waiting periods have not been completed.

Further information on waiting periods relevant to each cover type can be found in the hospital section (page 19) and extras section (page 34) of this guide.

Transferring from another health insurer

The Private Health Insurance Act 2007 states that if a transfer certificate is requested from your old fund, that they must provide it to your new insurer within 14 days of receiving the request.

If you have transferred your health insurance from another health insurer to Frank, you won't have to re-serve any waiting periods if you:

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

If your new cover with Frank provides higher benefits, benefits for services not covered by your previous health insurer or a reduced hospital excess, you'll be regarded as a new member for those higher benefits, additional services, and/or reduced hospital excess, and will be required to serve the waiting periods where these are part of the cover.

If you have transferred to Frank from another health insurer before completing the waiting periods with your previous fund, you'll need to serve the balance of the waiting periods with Frank.

How to claim

Before you can claim

To be able to claim for a treatment or service included on your cover:

- the cover must be active on or before the date of service, and
- relevant waiting periods must have been served.

See previous page for further information on waiting periods that may apply.

Hospital claims

Frank will pay the available hospital benefit direct to the hospital, as long as you are admitted as an insured (private) patient for a service that is included on your hospital cover. You'll need to present your member card upon admission to the hospital, if you are choosing to be treated as a private patient. Remember to get Informed Financial Consent prior to any hospital admission (see page 17 for more information).

Details of all claims paid on your behalf can be viewed in the app or your online member area.

Medical claims

Medical benefits cover 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 and your claim for hospital benefits has been assessed and paid.

To submit a claim;

- Either complete a Medicare Two Way claim form when you take your claim to Medicare; or
- Upload a copy of your Medicare Statement of Benefits via the Frank app.

Frank benefits are not payable for services rendered when the patient is not admitted into hospital as a private inpatient.

Find out more about [how to claim](#).

Electronic extras claims

When you have Frank extras cover you can use your Frank member card to claim electronically on-the-spot (if your health care provider has an electronic claiming machine). After the service has been provided, your member card will be tapped at or swiped through the terminal, your claim details entered, and your claim will be processed electronically. 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 check the receipt for the rejection reason. If they're unable to identify the issue at the time of the service taking place they can contact Team Frank.

Online extras claims

If your service provider does not have an electronic claiming terminal, or there is an unexpected rejection of your claim at the point of service, you'll need to pay your account in full and then submit a claim via the Frank app or online member area. You can either claim without submitting a receipt or upload a copy of the receipt at the time of claiming. If you don't include the receipt at time of claiming, you'll need to keep it for 2 years and send to Frank if your membership claims are audited in this time.

In order to submit claims online, the primary member must be registered for online services.

Paid accounts/bills

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

Exclusions

In addition to the services excluded from your cover, 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.
- Any outpatient emergency department medical service fees (e.g. observation, x-rays, drugs and lab tests) where a doctor hasn't written an order to admit you into hospital as an inpatient.
- Any medical treatment that attracts an MBS item number that is provided when you're not admitted to hospital (Example: emergency department treatment, GP/specialist appointments, scans, pathology, etc.).
- Natural remedies (includes herbs, supplements or pills prescribed by a provider).
- 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, is suspended or while serving waiting periods.
- 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 with the exception of approved telehealth services.
- 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 and are not prescribed by a healthcare provider.
- 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, treatment or medical devices/items received or purchased overseas.
- Travel vaccinations not listed on the approved travel vaccinations list.
- Extras services that you are entitled to claim a Medicare rebate for.
- Cosmetic services or treatment rendered by a practitioner.

Restrictions

In addition to any services that are restricted as part of your cover, 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 another extras cover by a different health insurer and have previously claimed for the service/treatment or have used the total Frank annual limit amount with your old fund.
- the health care account has been incompletely, incorrectly or inappropriately itemised.
- you have an excess to pay on your chosen level of hospital 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 of 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, Disability and 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 period or other limit which has not been served/met.
- surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact Team Frank for further details on this.
- no MBS item number is provided by the GP/specialist e.g. cosmetic surgery.
- professional services are provided to the provider, to members of the provider's family, 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.
- 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.

Claims fraud

Frank reserves the right to take the following actions against any member or persons where improper, fraudulent or inappropriate conduct occurs whilst making health insurance claims.

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
- Cancellation of a policy
- Restitution (voluntary or negotiated)
- Prosecution.

Damages or compensation

Where you or your dependants have a right to claim damages or compensation from any other person or body, you're 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 WorkCover, TAC, public liability and third party claims.

Australian Government Rebate on private health insurance

The Australian Government Rebate on private health insurance is an income-tested rebate that can reduce the cost of premiums. The rebate is available to those who have full Medicare eligibility and hold a complying health insurance product (CHIP)* for hospital and/or extras cover.

The rebate amount you're entitled to (as a percentage of your health insurance premium) varies depending on your income tier and the age of the oldest person on the membership.

*All Frank hospital and extras covers are classed as complying health insurance products.

Does the rebate change?

Yes. Rebate percentage levels are usually adjusted annually on 1 April based on the Rebate Adjustment Factor. Income tiers are effective for the full financial year and are subject to change annually on 1 July.

We keep a list of the [current income thresholds and rebate rates](#), as set by the Australian Government. These can also be found on the [Australian Taxation Office \(ATO\) website](#).

To make sure you're receiving the correct rebate on your health insurance premiums, make sure you keep Frank up to date with your expected annual income.

How do I claim it?

You can claim the rebate as a reduction to your premiums or as a tax rebate when you lodge your annual tax return.

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. We'll then deduct the rebate from your premiums.

Hospital cover.

Going to hospital and using your cover

Hospital cover information

Information specific to your hospital cover can be found in your product fact sheet (see page 17). We recommend contacting us as early as possible before any hospital admission so that we can provide an estimate of benefits based on your cover, and potential out-of-pocket costs.

Hospital benefits

If you need to go to hospital for a service that's included on your cover and choose to be admitted as a private patient, hospital benefits help to cover the following services provided by the hospital:

- Hospital accommodation and meals
- Operating theatre fees, dressings and bandages
- Surgically implanted medical devices or human tissue products, up to the approved benefits on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products.

Medical benefits

Hospital cover also contributes toward the cost of receiving inpatient medical treatment and services (while the patient is admitted to hospital), such as doctor or surgeon's fees, anaesthetic, imaging and pathology services.

For benefits to be payable, the patient's cover must be active on or before the day of treatment; and all waiting periods must have been served (see page 10).

Claims for medical benefits need to be assessed by Medicare first (except in the case of claims made through Frank's Access Gap Cover scheme, see page 18) and after the member's hospital benefits have been assessed.

Clinical categories

All Australian health funds are required by the government to use standard clinical categories and definitions across all medical services, including references to inclusions, exclusions and restrictions. The full list of these categories and their definitions is available on pages 23-28.

Participating private hospitals

Frank has agreements with most private hospitals in Australia relating to billing, fees and benefits. These agreements are made through the Australian Health Service Alliance (AHSA). It's important that your hospital is a participating private hospital to avoid significant additional out-of-pocket costs.

Have a look at [Frank's participating private hospital list](#) or check with us before confirming any hospital admission.

Public hospitals are not considered participating private hospitals, as benefits are paid towards all public hospitals (provided you are admitted as a private inpatient – see Using your private cover in a public hospital on the next page).

Non-participating private hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Contact Team Frank 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.

Using your private cover in a public hospital

If you choose to be admitted into a public hospital as a private patient for a service included on your cover, Frank will pay the minimum hospital accommodation benefits payable by private health insurers for a shared room in a public hospital (*except in NSW public hospitals).

*For NSW public hospitals, Frank will pay benefits for a single room where the member has;

- signed the inpatient Election form to be treated as a private patient and;
- ticked 'yes' to a single room if one is available on the Inpatient Election form.

When making a decision about which hospital you'll be treated at, keep in mind that not all doctors have admitting rights into all hospitals. Basically, if you have a preferred doctor, they might not be allowed to treat you in a public hospital. Your doctor will be able to tell you which hospitals they have admitting rights to.

Be aware that electing to be a private patient in a public hospital could result in significant out-of-pocket costs to you if you decide to proceed with treatment. Make sure you receive written Informed Financial Consent (IFC) for any hospital admission.

Excess

An excess is the fee you pay upfront when you're admitted into hospital as a private patient. All Frank hospital covers feature an excess – this helps us share some of the cost of hospital admissions with our members, in return for lower premiums.

The hospital excess amount can vary based on your cover, and is outlined in your product fact sheet. It has an annual cap, meaning that it is only payable once per person (if applicable) per calendar year.

Where one member on a couples, family or single parent hospital cover is admitted to hospital, they will only pay the maximum excess amount per person as opposed to the maximum amount per membership.

An excess is deducted from the hospital benefit paid by us. For example, if Frank's full benefit for a hospital stay was \$5,000 and you had a \$500 excess on your hospital cover, the benefit would shrink by the amount of the excess, and an adjusted benefit of \$4,500 would be paid to the hospital. You, as the member, would pay your \$500 excess to the hospital directly, usually on the day of admission or beforehand.

Informed Financial Consent

Informed Financial Consent (IFC) is a document provided to you prior to being admitted to hospital (or as soon as possible in the case of emergency admissions) that outlines how much your medical treatment will cost and any out-of-pocket expenses by service providers involved in your treatment.

Before being admitted into hospital as a private patient, always ask your doctor for a written estimate of their fees, whether there are any other doctors likely to be involved in your care (e.g. anaesthetist, assistant surgeon) and if they'll be participating in Access Gap Cover for the billing of your treatment (more on that on page 18). It's also a good idea to get an estimate of fees from the hospital where your procedure will be conducted.

We recommend contacting Frank as early as you can before you go to hospital, so we can confirm any benefits payable from your hospital cover, discuss potential out-of-pocket expenses and help guide you through the hospital admission and claiming process.

Access Gap Cover

What is a medical gap?

In Australia, medical services provided by doctors have a Medicare Benefits Schedule (MBS) fee, set by the Government. This is called the 'scheduled fee'.

For medical services provided by a specialist doctor while you are admitted as an inpatient in hospital, Medicare pays 75% of the scheduled fee and your health insurer pays the remaining 25%.

Specialists are free to charge whatever fee they deem appropriate for their services. If this fee is more than 100% of the scheduled fee, you will need to pay the difference. This is called a medical 'gap' or an out-of-pocket cost.

What is Access Gap Cover?

The Australian Health Service Alliance (AHSA) Access Gap Cover scheme is a billing system that provides higher benefits than the Government's scheduled fee. It can reduce or even eliminate any gap for medical fees when Frank members are treated as an inpatient in hospital.

Specialist doctors who are registered for, and choose to use, the Access Gap Cover scheme for the billing of your treatment get a higher benefit from Frank (more than the standard 25%), in exchange for limiting the gap they charge to you.

There are two scenarios for how you may be billed by your specialist doctor when they use the Access Gap Cover scheme:

- No Gap – this is where there will be no gap for you to pay following the procedure
- Known Gap – this is where you will be charged a maximum gap of \$500 per specialist, per admission, and \$800 for obstetrics services.

Is your doctor registered for the Access Gap Cover scheme?

Specialists can choose to opt in or out of the Access Gap Cover scheme on a patient by patient and procedure by procedure basis – just because they are registered for the scheme doesn't mean they'll always use it. If you choose a doctor that does not participate in the Access Gap Cover scheme for your procedure, you will be covered by Medicare and Frank for the scheduled fee but will need to pay any gap.

Before deciding to have a procedure, you should discuss the cost of treatment with your specialist doctor. Your specialist must advise of any gap that you will have to pay and provide a written estimate of the fees for treatment (see Information Financial Consent on page 17), before you go into hospital.

You may also receive services from an assistant surgeon and anaesthetist for your procedure – they can also choose whether or not to participate in the Access Gap Cover scheme. You may have separate gaps to pay for their services.

Hospital waiting periods

Waiting periods for hospital services – when included on your cover – are as follows:

12 months

- Pregnancy and birth-related admissions
- Pre-existing conditions (other than for psychiatric, rehabilitation or palliative care)

2 months

- Psychiatric, rehabilitation or palliative care
- Any other hospital treatment benefit

0 days

- Accidents and emergency ambulance

See page 10 for further details on waiting periods including definitions and when they may apply.

Mental Health Waiver

The Mental Health Waiver allows members who have served their 2-month waiting period for restricted psychiatric benefits to upgrade their hospital cover to a product which includes in-hospital psychiatric treatment without serving an additional 2 month wait.

Members can use the Mental Health Waiver once in their lifetime.

The waiver applies only to the 2-month waiting period for in-hospital psychiatric treatment. Any other applicable waiting periods will still need to be served.

Please note, to access the mental health waiver, you'll need to upgrade with another fund to a hospital policy that is open to new members and includes the 'Hospital psychiatric services' clinical category.

Pre-existing conditions

A pre-existing condition (PEC) is one where signs or symptoms of your ailment, illness or condition, in the opinion of an independent 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 independent medical practitioner.

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 six months prior to joining your current hospital cover, signs and symptoms:

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

If you have been a member for less than 12 months on your current hospital cover, make sure you contact us before you're admitted to hospital to find out whether the pre-existing condition waiting period applies to you.

We need about five to seven 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 timeframe when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and the assessment determines that the condition is pre-existing, you'll have to pay all outstanding hospital charges and medical charges not covered by Medicare. This could lead to significant out-of-pocket expenses if you proceed with treatment.

You can only claim benefits for a pre-existing condition if the treatment is performed after the pre-existing condition waiting period has been served. We won't pay a claim if you have the treatment during the waiting period and submit a claim for the treatment after the waiting period is over.

Emergency admissions

In an emergency, we may not have time to determine if you're affected by the pre-existing condition rule before your hospital admission. So, 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're admitted to hospital and you choose to be treated as a private patient; and
- it is later determined that your condition was pre-existing.

Accidents and Accident Protection

Accidents

An “accident” is an unforeseen event that occurs by chance and is caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment.

Frank hospital products cover accidental injuries sustained after joining the fund and while serving waiting periods (provided your cover includes the clinical category related to the treatment of the injury). Joint investigations and reconstructions are covered if they are required as a result of an accident.

For an accident to be covered, treatment must be sought through a doctor or an emergency department within 48 hours of sustaining the injury and the hospital admission must occur within 90 days. An Accident Declaration form must also be supplied to Frank.

Accident Protection (selected covers)

Accident Protection provides temporarily upgraded hospital cover for treatment that’s required as a result of an accident. If you have Accident Protection on your hospital cover, you may be eligible to access treatments usually reserved for the highest levels of hospital cover for up to 90 days following an accident.

We understand that no one sees an accident coming, so you might not have thought to include some services on your cover. That’s why, on eligible products, we’ll cover you in a participating private hospital for services that are normally excluded or restricted on your cover if you need them because of an accident. To determine if your cover includes Accident Protection, please refer to your fact sheet.

See Accidents above for a definition of what constitutes an “accident” for health cover purposes and the below outline of services not eligible to be considered an accident.

Following the initial admission that has occurred within 90 days, if you require a follow up procedure that is directly related to the accident, and is eligible, this will be covered under Accident Protection if included on your hospital cover.

Benefits are limited to inpatient hospital treatment for services with a valid Medicare Benefits Schedule item number.

Frank’s definition of an accident excludes:

- Medical conditions (disease or illness that is not immediately due to an external injury)
- Pre-existing conditions
- Pregnancy, birth and IVF procedures
- Accidents arising from surgical procedures
- Elective cosmetic surgery
- Podiatric surgery by an accredited podiatrist
- Sudden Illness
- Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner
- Aggravation of an existing condition
- Damage to teeth caused by eating or drinking
- Claims covered by third parties (such as Workcover and TAC).

Important information about some hospital services

Emergency ambulance

All Frank hospital covers (and some closed extras covers) cover emergency ambulance services by recognised providers Australia-wide. This includes all clinically necessary, emergency ambulance transport in any state or territory of Australia.

Emergency ambulance trips by a state or territory ambulance service will be covered where:

- The insured person is not already covered by the relevant state or territory ambulance service scheme; and
- The service was defined as an emergency by the ambulance service; or
- The ambulance attended to an emergency but by the time they arrived, they were no longer required; or
- A treating doctor has defined the trip as medically required transport.

Emergency ambulance doesn't include:

- Ambulance transport from a hospital to your home, or ambulance transfers between hospitals
- Call-out fees for non-emergency ambulance transport
- Any services which are not operated by an ambulance provider recognised by Frank
- Any non-emergency services, as determined by the ambulance provider.

See Ambulance on page 32 for more information about non-emergency ambulance coverage on selected Frank extras.

Cosmetic surgery

Limited benefits may apply on hospital covers for cosmetic surgery, depending on the medical justification for the surgery.

We recommend you contact us prior to any planned surgery to confirm your cover and benefits.

Dental surgery

Dental surgery can be performed both in a dentist's practice, or in hospital. Benefits payable for dental surgery will depend on factors such as who performs the procedure and where the procedure is done. If you are admitted to hospital for your dental surgery and this is included on your hospital cover, Frank will pay benefits towards the hospital and associated medical fees e.g. accommodation, theatre, anaesthetists fee etc. provided all waiting periods have been served. Just note this doesn't include benefits for the dental treatment itself – for that you'll need to have major dental included on your extras cover.

Contact Frank before any dental surgery to confirm your coverage.

Insulin pumps

Frank does not pay a benefit for replacement of insulin pumps still under manufacturer's warranty or for pumps supplied in telehealth settings.

Private Emergency Department Attendance Benefit (selected covers)

Some private hospitals charge an emergency department attendance/administration fee for outpatient treatment. This fee varies by private hospital.

Included on selected Frank hospital covers, the Private Emergency Department Attendance Benefit is payable for 50% of the emergency department attendance/administration fee up to \$200 per person on the membership, per year. It is not payable on any fees where a Medicare benefit is claimable, such as medical, radiology or pathology charges.

Members need to submit a paid invoice through the Frank app to claim this benefit, therefore will incur an out-of-pocket cost upfront. A 2-month waiting period applies.

To determine if your cover includes the Private Emergency Department Attendance Benefit, please refer to your fact sheet.

Clinical category definitions

Frank uses standardised clinical categories and definitions for all hospital and medical treatments, as required by the Australian Government. These include things like 'Brain and nervous system', 'Ear, nose and throat' and 'Bone, joint and muscle' etc. Each clinical category has its own set of MBS item numbers. For further information, refer to the definitions below or visit: privatehealth.gov.au

Assisted reproductive services

Hospital treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In vitro Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT).

- Treatment of the female reproductive system is listed separately under Gynaecology.
- Pregnancy and birth-related services are listed separately under Pregnancy and birth.

Back, neck and spine

Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion.

For example: sciatica, prolapsed or herniated disc, and spine curvature disorders such as scoliosis, kyphosis and lordosis.

- Joint replacements are listed separately under Joint replacements.
- Joint fusions are listed separately under Bone, joint and muscle.
- Spinal cord conditions are listed separately under Brain and nervous system
- Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Blood

Hospital treatment for the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants.

- Treatment for cancers of the blood is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Bone, joint and muscle

Hospital treatment for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and bone cancer.

- Chest surgery is listed separately under Lung and chest.
- Spinal cord conditions are listed separately under Brain and nervous system.
- Spinal column conditions are listed separately under Back, neck and spine.
- Joint reconstructions are listed separately under Joint reconstructions.
- Joint replacements are listed separately under Joint replacements.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).
- Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Brain and nervous system

Hospital treatment for the investigation and treatment of the brain, brain-related conditions, spinal cord and peripheral nervous system. For example: stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease.

- Treatment of spinal column (back bone) conditions is listed separately under Back, neck and spine.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Breast surgery (medically necessary)

Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy.

For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia.

- This clinical category does not require benefits to be paid for cosmetic breast surgery that is not medically necessary.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Cataracts

Hospital treatment for surgery to remove a cataract and replace with an artificial lens.

Chemotherapy, radiotherapy and immunotherapy for cancer

Hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours.

- Surgical treatment of cancer is listed separately under each body system.

Dental surgery

Hospital treatment for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery.

When included on a hospital cover, this pays benefits towards the hospital and associated medical fees (bed, theatre, anaesthetists etc.).

Note: this doesn't cover the dental treatment itself – for that you'd need major dental as an inclusion on your extras cover.

Diabetes management (excluding insulin pumps)

Hospital treatment for the investigation and management of diabetes. For example: stabilisation of hypo- or hyper- glycaemia, contour problems due to insulin injections.

- Treatment for diabetes-related conditions is listed separately under each body system affected. For example, treatment for diabetes-related eye conditions is listed separately under Eye.
- Treatment for ulcers is listed separately under Skin.
- Provision and replacement of insulin pumps is listed separately under Insulin pumps.

Dialysis for chronic kidney failure

Hospital treatment for dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.

Digestive system

Hospital treatment for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids.

- Endoscopy is listed separately under Gastrointestinal endoscopy.
- Hernia and appendectomy procedures are listed separately under Hernia and appendix.
- Bariatric surgery is listed separately under Weight loss surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Ear, nose and throat

Hospital treatment for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer.

- Tonsils, adenoids and grommets are listed separately under Tonsils, adenoids and grommets.
- The implantation of a hearing device is listed separately under Implantation of hearing devices.
- Orthopaedic neck conditions are listed separately under Back, neck and spine.
- Sleep studies are listed separately under Sleep studies.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Eye (not cataracts)

Hospital treatment for the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye.

- Cataract procedures are listed separately under Cataracts.
- Eyelid procedures are listed separately under Plastic and reconstructive surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Gastrointestinal endoscopy

Hospital treatment for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP).

- Non-endoscopic procedures for the digestive system are listed separately under Digestive system.

Gynaecology

Hospital treatment for the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer.

- Fertility treatments are listed separately under Assisted reproductive services.
- Pregnancy and birth-related conditions are listed separately under Pregnancy and birth.
- Miscarriage or termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Heart and vascular system

Hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Hernia and appendix

Hospital treatment for the investigation and treatment of a hernia or appendicitis.

- Digestive conditions are listed separately under Digestive system.

Hospital psychiatric services

Hospital treatment for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.

Implantation of hearing devices

Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device.

- Stapedectomy is listed separately under Ear, nose and throat.

Insulin pumps

Treatment for the provision and replacement of insulin pumps for treatment of diabetes.

Joint reconstructions

Hospital treatment for surgery for joint reconstructions. For example: torn tendons, rotator cuff tears and damaged ligaments.

- Joint replacements are listed separately under Joint replacements.
- Bone fractures are listed separately under Bone, joint and muscle.
- Procedures to the spinal column are listed separately under Back, neck and spine.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).

Joint replacements

Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint.

- Joint fusions are listed separately under Bone, joint and muscle.
- Spinal fusions are listed separately under Back, neck and spine.
- Joint reconstructions are listed separately under Joint reconstructions.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).

Kidney and bladder

Hospital treatment for the investigation and treatment of the kidney, adrenal gland and bladder. For example: kidney stones, adrenal gland tumour and incontinence.

- Dialysis is listed separately under Dialysis for chronic kidney failure.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Lung and chest

Hospital treatment for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest.

For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Male reproductive system

Hospital treatment for the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Miscarriage and termination of pregnancy

Hospital treatment for the investigation and treatment of a miscarriage or for termination of pregnancy.

Pain management

Hospital treatment for pain management that does not require the insertion or surgical management of a device. For example: treatment of nerve pain and chest pain due to cancer by injection of a nerve block.

- Pain management using a device (for example an infusion pump or neurostimulator) is listed separately under Pain management with device.

Pain management with device

Hospital treatment for the implantation, replacement or other surgical management of a device required for the treatment of pain. For example: treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device (for example an infusion pump or neurostimulator).

- Treatment of pain that does not require a device is listed separately under Pain management.

Palliative care

Hospital treatment for care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.

Plastic and reconstructive surgery (medically necessary)

Hospital treatment which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma.

- Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is listed separately under Skin
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Podiatric surgery (provided by a registered podiatric surgeon)

Hospital treatment for the investigation and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, but limited to cover for:

- accommodation; and
- the cost of any item listed in the Federal Government's Medical Devices and Human Tissue Schedule set out in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules.

Note: Insurers are not required to pay for any other benefits for hospital treatment for this clinical category but may choose to do so.

Pregnancy and birth

Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth.

- Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory conditions are covered under Lung and chest.
- Female reproductive conditions are listed separately under Gynaecology.
- Fertility treatments are listed separately under Assisted reproductive services.
- Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.

Rehabilitation

Hospital treatment for physical rehabilitation for a patient related to surgery or illness.

Skin

Hospital treatment for the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin-related condition is also included. For example: melanoma, minor wound repair and abscesses.

- Removal of excess skin due to weight loss is listed separately under Weight loss surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Sleep studies

Hospital treatment for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.

Tonsils, adenoids and grommets

Hospital treatment of the tonsils, adenoids and insertion or removal of grommets.

Weight loss surgery

Hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is an extra tax on people and families on higher incomes who don't have eligible private hospital cover.

Aussies may need to pay the MLS if they don't have eligible private hospital cover for the full financial year and have an annual taxable income that places them above the Base Tier threshold set by the Australian Government.

The amount you may have to pay (0-1.5% of your annual taxable income) is based on your income tier and the government can change the tiers each year on 1 July.

View the [income thresholds and MLS rates for the current financial year](#).

For more information, as well as any relevant exemptions, visit privatehealth.gov.au and contact your tax adviser or the Australian Tax Office with any questions.

Lifetime Health Cover loading

The Australian Government introduced the Lifetime Health Cover (LHC) initiative on 1 July 2000 to encourage more people to take out private health insurance earlier in life, and keep it.

How does it work?

Anyone who takes out hospital cover with a registered health fund will be given a Certified Age at Entry (CAE) status – this represents their age when they first joined a hospital cover after the 1 July 2000.

If you joined a hospital cover before this date, you're assigned a CAE of 30 and you'll pay the base rate (the lowest premium) for your hospital cover. 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% at age 65). Where you have to pay a LHC loading, you'll need to do so for a continuous period of 10 years before the loading will no longer apply and be removed 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 for LHC if you decide to take it out later.

Lifetime Health Cover applies to hospital cover only and does not apply to extras.

The Australian Government rebate on private health insurance does not apply to any LHC loading applied to your membership.

Periods of absence

We understand that members may need to suspend 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 cumulative 1094 days without hospital cover (these are "allowable absence days"), their loading will be impacted. Members will need to re-serve waiting periods when they return to Frank. Approved periods of suspension e.g. for fund-approved overseas travel, will not count towards the 1094 days of absence or towards the 10 years of continuous cover.

Switching to Frank

Under Lifetime Health Cover (LHC), continuity of a member's/partner's Certified Age at Entry (CAE) is possible when transferring from another Australian registered private health insurer.

LHC for couples and families

If there is more than one adult on the membership – excluding child and student dependants aged over 18 – the LHC loading is applied to the hospital cover portion of the premium as an average of each adult's individual LHC loading.

Here's some examples:

- Adult 1 on a couples cover has an LHC loading of 10% and adult 2 has a loading of 14%. The LHC loading applied to the membership would be 12%.
- Adult 1 on a family cover has an LHC loading of 4% and adult 2 has no loading. The LHC loading applied to the membership would be 2%.

Learn more about [Lifetime Health Cover](#) or visit privatehealth.gov.au for more information.

Extras cover.

Extras cover information

Extras benefits

A benefit is an amount Frank covers for a service.

Depending on the Frank extras cover, members receive either an agreed percentage or set benefit back on services from a registered provider – as long as the service is included on your cover, all waits have been served and there are benefits remaining.

Benefit limits are listed on the fact sheet for your cover and show the limit type and how much you can expect to receive back for each service.

Medicare

Where you are entitled to any rebate or reimbursement from Medicare for an extras service, you can't claim any out-of-pocket expenses with Frank. As an example, if you have a care plan from your doctor that includes psychology and you receive a Medicare benefit for a psychology consultation, you can't then claim psychology benefits for this service and any out-of-pocket expenses under your extras cover.

Doctor's letter of recommendation

Some extras services require a doctor's letter of recommendation to accompany claims. These will be listed in the fact sheet for your cover. Examples include blood glucose monitors and quit smoking programs.

Orthotics (foot)

Where covered, benefits can only be claimed on orthotics if they are custom made by a registered podiatrist or orthotist in a private practice. For an orthosis to be custom made, a plaster cast, mould or a positive model must be created. Customising, heat moulding, trimming or adjusting an existing 'off the shelf' appliance does not involve this process, and therefore does not constitute a custom-made appliance.

Ambulance

Where included on your cover, VIC, SA, WA and NT residents can claim 80% or 100% of the cost of one ambulance subscription per year (% back will be based on your type of extras cover). Please note, not all extras covers pay a benefit on ambulance subscriptions, and this service is currently included on closed extras covers only. Refer to your product fact sheet for more information.

Ambulance is covered differently in each state or territory. To make sure you know exactly how it's covered in your state or territory, check out more info [online](#).

Individual telehealth consultations

One-on-one telehealth consultations are covered with a Frank recognised provider, for services as approved by Frank. The list of [recognised modalities for telehealth benefits](#) may be changed periodically. Telehealth services are considered a substitutional service and, as long as they meet the requirements of a standard face-to-face consultation, are covered in accordance with industry association guidelines by using appropriate telehealth delivery services that satisfy the requirements of the patient/condition to be treated. Telehealth consultations may not be appropriate for all situations. Benefits are subject to your level of cover, waiting periods and annual limits or sub-limits.

Choose your own provider

At Frank, we believe in freedom of choice when it comes to picking an extras provider. As long as your provider is registered with the appropriate board in their field, operating in a private practice and considered an Australian provider, we'll pay benefits based on your level of cover up to your annual limits or sub-limits.

Need help finding a dentist, optometrist, physio or allied health professional near you? Use this [handy search tool](#) to browse by type, name, specialty or treatment.

Extras services purchased over the internet

Optical and pharmaceutical benefits will be paid for extras services purchased online from Australian providers where a script is provided.

For a company to be considered an Australian provider, an ABN needs to be visible on the company's website. Consistent with current Frank rules, benefits for services or treatment received or purchased overseas are excluded.

Orthodontics

When it comes to orthodontic benefits, we regard the start of any treatment as the date the appliance (braces, removable aligners etc.) is originally fitted.

Benefits can be claimed each calendar year while the treatment is still ongoing, up to any annual limits, sub-limits or the person's lifetime limit (see Limit types on page 34).

Dental benefits

Some dental items have sub-limits within the overall dental limit. This will be outlined in the fact sheet for your cover. It's always a good idea to check your benefits before you get any work done.

If you're worried about what your out-of-pocket dental expenses might be, check the dental item numbers using the benefit quote tool in your online [member area](#) or contact Team Frank.

Extras waiting periods

Need to serve waits before you can start claiming on extras? If it's included on your cover, waiting periods for extras services are as follows:

12 months

- Major dental and orthodontics
- Podiatric surgery and orthotics (foot)
- Hearing aids and blood glucose monitors

6 months

- Optical

2 months

- Any other extras service

0 days

- Emergency ambulance transport (Australia-wide) and ambulance subscriptions (VIC, SA, WA and NT)

Further details on waiting periods, including definitions and an outline of when they may apply, is on page 10.

Limit types

Frank extras have a few different types of limits, and they can vary by service or treatment. You can check these in the fact sheet for your cover at any time.

Annual limits

We run on a calendar year basis (January to December) and our extras annual limits reset or roll over on 1 January.

If you use all your limit in one year, you'll have to wait until 1 January the following year to start claiming benefits again.

Annual limits can apply at the person or membership level. Note that some services also have a multi-year limit or lifetime limit.

Person limits

This is the total amount each person on the membership can claim on a service within a calendar year.

Membership limits

This is the maximum amount that can be claimed for a membership in a calendar year. These limits are shared between all people on the membership.

Sub-limits

This is the total amount you can claim on a particular service or treatment within the overall annual limit.

Combined limits

This is a single limit that can be used across a collection of services.

Lifetime limits

This applies for orthodontic treatment, per person on the membership, and is the maximum amount a person can claim for a service during their lifetime.

Once you've reached your lifetime limit, you won't be eligible to claim any further orthodontic benefits during your lifetime at this level of cover, and your benefits won't re-accrue or reset. This information is shared between health funds, and your lifetime limit will not reset if you transfer your policy to a cover with equivalent benefits. The only way to increase your lifetime limit is to switch to an extras cover with a higher lifetime limit for orthodontic benefits.

Multi-year limits

The maximum amount you can claim, every few years. Multi-year limits reset after the specified number of years on the anniversary date for each claim in a particular service category.

Annual limit rollover

Members on Frank Bundables, available when taken out with eligible hospital covers, can enjoy another 12 months to claim unused benefits on their extras cover with Frank's awesome annual limit rollover.

How does it work? Stick with Frank on your Bundables extras cover for 12 months to become eligible. Then, when the new year rolls around, you'll be able to carry over unused benefits and enjoy an extra 12 months to claim.

Your new year's annual limit will need to be reached before you can start spending the limit rolled over from the previous calendar year.

Benefit types

When you claim for an eligible service on your extras cover, you'll only pay the difference between what you get back from Frank and the cost set by your provider.

With set benefits you'll receive a set amount back from Frank to cover part of your cost for each item or service, up to your annual per person or per membership limit.

Percentage back extras cover allows you to get a percentage of the overall charge back each time you claim, up to your annual per person or per membership limit.

Switching to Frank

When you transfer your extras cover to Frank, your annual limits will be adjusted by benefits already paid by your previous health insurer in the current calendar year.

Estimate your refund

To help make an informed decision about an upcoming service or treatment, use the benefit quote tool in your online member area to estimate how much you'll get back from Frank for a particular service. You'll just need the item numbers on hand. Team Frank is also here to help, if you need.

Other info.

Things you need to know

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. Your membership will be considered void if you provide false or incorrect information on your 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 at any time.

Frank uses the terms 'primary member/policyholder', 'spouse/partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'primary member' can authorise changes to the membership unless the primary member has previously authorised the spouse/partner to make such changes. Similarly, correspondence issued by Frank will be addressed to the primary 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 at any time. An electronic copy of the [Fund Rules](#) is available on our website.

In the event that any member or person named on the member's policy 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 paid in advance refunded. Any other rights accrued to the member will be forfeited.

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](#) which is provided to all new members on joining.

Proof of age

When you join Frank and you are not transferring from another fund, you (and your partner and family members) may need to provide a copy of one of these acceptable forms of proof of age:

- Current passport
- Current photo driver's license
- Original birth certificate

In line with our data retention and destruction processes, these documents will only be sighted and not retained.

Private Health Information Statements

A Private Health Information Statement (PHIS) is available for all health insurance policies in Australia and gives a summary of the key product features. Health funds are required to provide PHIS by law, so you can review and compare health insurance products more easily. The policyholder will be given an up-to-date copy of the relevant PHIS, details about what the policy covers and how benefits are provided and a statement identifying the referable health benefits funded when they join Frank.

An up-to-date PHIS will be provided on request and to members once every year (without the need to be requested). If more than one adult is included on the policy, Frank will only provide a PHIS to the policyholder.

Glossary

Need a hand decoding health insurance terminology? We keep a handy glossary on our [website](#).

Overseas travel

Frank Health Insurance does not provide benefits for services or treatment received overseas.

We advise that you take out travel insurance that's suitable to the destinations you're visiting for the set period of your travel.

You may be able to suspend your Frank cover for periods of overseas travel. Conditions apply, see page 9 for more details.

Membership for non-residents of Australia

Frank hospital covers are designed for people who have full Medicare eligibility. These covers will not provide coverage for 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 to discuss appropriate health insurance arrangements or visit [Frank Overseas Visitor Health Cover](#) for more information.

Migrants

If you don't have full Medicare eligibility Frank covers won't meet the cost of public or private hospital treatment, medical treatment or diagnostic services in Australia.

Proof of residency may be required by Frank. Lifetime Health Cover regulations also apply to migrants. Contact Team Frank for details.

Recommendation or endorsement

Frank does not offer health or medical services or advice. We do 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. We do 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.

State of the Health Funds Report

Every year the Private Health Insurance Ombudsman (PHIO) publishes a State of the Health Funds Report. The aim of this report is to give people extra information to help them make decisions about taking up private health insurance. The report provides general independent comparative information on the performance and service delivery of all health funds.

It does not provide detailed information on health fund products. A copy of this report can be downloaded from www.ombudsman.gov.au.

Claim audits

Frank undertakes audit activities in order to protect members' assets and contain costs. As we have online extras claiming with no need to send in receipts, you'll need to keep your receipts somewhere safe for two years just in case our audit team wants to check up.

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 ultimately helps us keep premium increases to a minimum. Any requests will be treated in a completely confidential manner.

Liabilities of fund 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 we have the right to deduct the amount of that liability from any monies due by Frank to the member on any account.

What if something goes wrong?

Unhappy with Frank? Tell us what's on your mind so we can help resolve the issue.

How to make a complaint

- **Call 1300 437 265** Monday to Friday, 8:30am-5pm
- **Contact us via webchat** Monday to Friday, 9am-4:30pm
- **Email** frank@frankhealthinsurance.com.au
- **Log in to the [member area](#) or [Frank app](#)** to make an enquiry and submit your feedback.

We will respond to phone calls and webchats immediately during our operating hours, and we will follow up on all other contact methods within 5 business days. Where the matter is complex, we will attempt to finalise this within 20 business days. However, where the difficulty of the matter precludes this, we will inform you of the progress.

For more information on how to make a complaint and our internal process, see our [Complaints Handling Process](#).

If you're still dissatisfied with the outcome of your complaint, you can receive free, independent advice from the Private Health Insurance Ombudsman.

Hotline: 1300 362 072

International: +61 2 5117 3600

Website: www.ombudsman.gov.au

Post: Commonwealth Ombudsman,
GPO Box 442, Canberra ACT 2601

Private Health Insurance Code of Conduct

Frank Health Insurance is brought to you by GMHBA Limited, a fully compliant member of the Private Health Insurance Code of Conduct.

The Private Health Insurance Code of Conduct is designed to reinforce existing regulatory obligations and establish a minimum standard of business practice for all participants of the code, and helps 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're 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 Private Health Insurance Code of Conduct at: privatehealthcareaustralia.org.au



frank.
health insurance

frankhealthinsurance.com.au

[Contact Team Frank](#) | [webchat](#) | call 1300 437 265

Frank Health Insurance is brought to you by GMHBA Limited
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