freedom saver flexi-bundle (basic+)

This information is current at the time of publishing (January 2024).

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If you need to use Freedom Saver Flexi-bundle (basic+) cover, this Frank fact sheet details what you need to know; from what's covered to what's excluded plus excesses and waiting periods that apply. This Freedom Saver Flexi-bundle (basic+) offers a 'youth discount'. To be eligible to receive a youth discount, you have to be the Policyholder or Partner and aged between 18-29.
We recommend that you read and retain this fact sheet along with the Private Health Information Statement for this product and Frank's Important Information Guide.

Hospital treatment by clinical category	
Rehabilitation	R
Hospital psychiatric services	R
Palliative care	R
Brain and nervous system	×
Eye (not cataracts)	×
Ear, nose and throat	×
Tonsils, adenoids and grommets	✓
Bone, joint and muscle	×
Joint reconstructions	✓
Kidney and bladder	×
Male reproductive system	×
Digestive system	×
Hernia and appendix	✓
Gastrointestinal endoscopy	×
Gynaecology	✓
Miscarriage and termination of pregnancy	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	×
Pain Management	×
Skin	×
Breast surgery (medically necessary)	×
Diabetes management (excluding insulin pumps)	×
Heart and vascular system	×
Lung and chest	×
Blood	×
Back, neck and spine	×
Plastic and reconstructive surgery (medically necessary)	×
Dental surgery	✓
Podiatric surgery (provided by an accredited podiatric surgeon)	×
Implantation of hearing devices	×
Cataracts	×
Joint replacements	×
Dialysis for chronic kidney failure	×
Pregnancy and birth	×
Assisted reproductive services	×
Weight loss surgery	×
Insulin pumps	×
Pain Management with Device	×
Sleep studies	×

✓ **Included services (we pay benefits towards)**
× **Excluded services (we don't pay benefits)**
R **Restricted services**

Excess

Per person	$750 per year
Couple	$1,500 per policy per year (if more than one person is hospitalised)

Learn more about hospital excess.

What's covered

Freedom Saver Flexi-bundle (basic+) provides benefits towards theatre surgery costs, shared or private room accommodation charges in a participating private hospital* or shared room accommodation charges in a public hospital^ for all procedures unless they are listed as an exclusion for the cover.

Restricted services (R)

These are services which are limited to a minimum (default) benefit as set by the Australian Government for accommodation as a private patient in a shared room of a public hospital. This benefit is not sufficient to cover the cost of a private room in a public hospital or any room in a private hospital, and does not cover theatre costs. If you are admitted to a private hospital for treatment that is restricted by your policy, large out of pocket expenses will apply.

This product includes a restricted benefit for hospital psychiatric services, you can use a one-off waiver to upgrade your cover and get immediate access to applicable services. This waiver is available only once per person, per lifetime and if you have held hospital cover for at least two months.

Emergency Ambulance

Covers emergency ambulance services by a recognised provider Australia wide. Does not include cover for non emergency ambulance transport i.e. from a hospital to your home or ambulance transfers between hospitals. Publicly funded ambulance services and State Government transport schemes are excluded (eg. TAS/ACT/NSW/QLD). Find out more about emergency ambulance services.

Dental Surgery

This product will provide benefits towards the hospital and associated medical fees (bed, theatre, anaesthetists etc.) for inpatient dental surgery. This product does not provide benefit towards the dental treatment received, as this is generally included under ancillary (typically major dental).

* Fixed benefits are payable in non-participating private hospitals. View Frank's participating private hospitals.

^ If you elect to be admitted to a public hospital as a private patient, you are entitled to the minimum benefits payable by private health insurers for a shared room in a public hospital. Electing to be a private patient in a public hospital could result in out of pocket costs to you. Ensure you receive written informed financial consent from your treating doctors and the hospital before any hospital admission.

Waiting periods

Just because you buy hospital cover today, doesn't mean you can claim today. Generally a new health insurance member will need to be with a fund for a period of time before their fund will pay any benefits. This is called a 'waiting period'.

Freedom Saver Flexi-bundle (basic+) has the following waiting periods:

0 days	Hospital treatment for included services as a result of an accident (accident must occur after joining)
2 months	Psychiatric, rehabilitation, palliative care, hospital services and procedures that are not pre-existing conditions
12 months	Pre-existing conditions (PEC)

Accidents

Covers accidental injuries sustained after joining Frank. 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 be supplied to Frank. Frank's definition of 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)

Pre-existing conditions

There's a special waiting period for 'pre-existing conditions'. A health insurer's standard waiting period for a service might be 2 months, but if you have a pre-existing condition relating to that service then the waiting period will be 12 months. Learn more about pre-existing conditions.

If you haven't held your current level of cover for at least 12 months, you are required to go through the PEC check for any hospitalisation. This involves asking your GP and specialist their written opinion on whether your condition is pre-existing. The process can take some time and it's best to get this done as soon as possible to confirm whether Frank can cover your procedure. The documentation will then be assessed by a medical practitioner appointed by Frank, who will decide whether your condition is deemed pre-existing or not.

If you've switched to Frank from another fund on an equal level of cover and have already served waiting periods, you might not have to wait again. Find out more about waiting periods.

Medical gap cover and out-of-pocket costs

What is medical gap cover?

Medical Gap Cover is an Australian Government initiative that ensures Public and Private Hospital patients receive benefits towards their Medical costs from either Medicare, their Private Health Fund or both. A schedule of fees, called the Medicare Benefits Schedule or MBS for short, has been set by the Department of Health. The MBS covers all eligible Medical services that can be provided by doctors and specialists when you are an in-patient in a hospital or day surgery. Under the MBS, Medicare will pay 75% of the schedule fee for your in-patient medical treatment and Frank pays the other 25%.

In Australia, Doctors and Specialists are able to set their own fees. This means, in some cases, they will charge higher fees than those set out in the MBS list described above. This higher fee is generally referred to as a "gap" fee or "out of pocket" cost.

Out-of-pocket costs or "gap" fees explained

The difference between the fees set by the MBS and what your doctor chooses to charge is commonly referred to as the 'gap'. If you hold private hospital cover, and are admitted to hospital for a procedure, your doctor can choose to bill above the MBS. This can leave you with a "gap" to pay or out of pocket costs that are not covered by Medicare or Frank. Before you go into hospital, you should discuss these fees with your doctor to understand the cost of your treatment. This is called informed financial consent.

Informed Financial Consent
You should always obtain written informed financial consent detailing any out of pocket costs with respect to medical services from the medical provider/s involved in your procedure prior to your admission to hospital. It is also recommended that you receive written financial consent from the hospital where your procedure will be conducted. If at any stage of this process you are concerned or have questions, just call Frank and we will guide you through the process. We are happy to answer any questions you may have.

What is Access Gap Cover? How Frank is helping to reduce your out of pocket costs.
Frank is partnering with the Australian Health Service Alliance (AHSA) and their Medical Gap initiative called Access Gap Cover. Access Gap Cover is a billing system that provides higher benefits than the schedule of fees set by the Department of Health which aims to reduce or even eliminate your out-of-pocket costs for doctor or specialist fees when you are treated as an in-patient in a hospital or day surgery.

Is your doctor, and any other specialist involved in your treatment, registered for Access Gap Cover?
It is your doctor's choice to participate in Access Gap Cover on a patient by patient basis. If they do, they will need to provide you with a written estimate of fees for your treatment. If you choose a doctor that does not participate in the Access Gap Cover program, you will be covered for the scheduled fee, but you will need to pay the gap. Please note: there may still be out-of-pocket costs even if your doctor uses Access Gap Cover however these costs are capped to ensure you are protected from being charged high out of pocket costs.

The additional medical gap benefit will vary by eligible service so please contact Frank prior to treatment to determine your additional medical gap cover benefit (if applicable).

Choice of doctor in a public hospital
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 what hospitals they have admitting rights to.

Are there times frank won't pay?
If you can claim from someone else you can't claim through Frank (think workers compensation). View the full list of what Frank may not be able to pay on a hospital or medical claim.

More information about what's covered.
Frank has a lot more information about hospital fees, doctors' fees, gap and all the nitty gritty. Find out more about hospital and medical fees.

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Freedom Limit

Sometimes your needs might change a little. $700 shared limit to use across 11 included services. Plus $150 to spend and 100% back on Optical.

Service	Benefit	Per person limits (per calendar year)	Waiting Period
Preventative & General Dental Save 15-40% off# dental treatments performed by any smile.com.au approved dentist across Australia.	Fixed benefits	$700	2 months
Endodontic	Fixed benefits		12 months
Physiotherapy*^	$32		2 months
Group Physiotherapy*^	$14		
Chiropractic*^ Excludes chiropractic x-rays	$28		
Osteopathy*^	$32		
Acupuncture*^	$25		
Exercise Physiology*^	$22		
Remedial Massage*^	$22		
Dietetics*^	$25		
Chinese Medicine*^	$25		
Optical Benefits are only payable towards prescription glasses and prescription contact lenses	100%	$150	6 months

Savings may vary between dentists. It is recommended that members obtain a quote prior to treatment.
* Benefits will only be paid for one consultation and/or treatment per provider per day.
^ You cannot claim on any accessories, exercise equipment, herbs, supplements or pills prescribed by the provider, only consultations.

Loyalty Benefit

The longer you're with us, the more you can claim. Get an extra $100 to spend on your freedom limit (excludes Optical) each full calendar year, with a maximum of $400 after 4 years of continual cover. That means your loyalty benefit will be available on 1 January after you've completed one full membership year.

Do i have my choice of extras provider?

Yes. Frank believes in freedom of choice, so we pay the same benefits to any registered provider. This means you can use your regular dentist, optometrist or physio and still claim.

Are there extras services frank won't pay?

Yes there are. This might make us sound mean but if you have a read, you'll see they're fair.

Where you are entitled to receive a rebate from Medicare for extras treatments you cannot claim any out of pocket expenses with Frank.

If you're interested, check out what Frank may not be able to pay.

Before receiving any treatment, check in with Frank for a quote so that you know what you're covered for, how much we'll pay towards the treatment and any out of pocket expenses that you might face.