fund rules.

frank.
health insurance

effective April 2025

Contents

Important Notes

a. All registered health funds are required to have Fund Rules under the Private Health Insurance Legislation.

b. These Fund Rules set out the general principles and rules of Membership under which Frank Health Insurance conducts its business, excluding Overseas Visitors Health Cover (OVHC) policies.

c. By taking out private health insurance with Frank Health Insurance, you and all the other persons on your Membership become Members and agree to our Fund Rules as amended from time to time.

d. Frank Health Insurance recommend that these Fund Rules be read together with your Member Guide and fact sheet relevant to your Cover.

e. Where terms are capitalised in these Fund Rules, they have the meaning given to them as determined in Section B of these Fund Rules.

A: Introduction

A1: Rules Arrangement

A1.1: Application of Fund Rules

GMHBA Limited issues private health insurance policies under the Frank Health Insurance brand.

These Fund Rules apply to all private health insurance policies under the Frank Health Insurance brand, other than Frank Australia Overseas Visitor Health Cover (OVHC).

A1.2: Content of the Fund Rules

These Fund Rules consist of:

a. The General Conditions (A to G)

A2: Health Benefits Fund

A2.1: Establishment and Administration of the Fund

GMHBA Limited (ABN 98 004 417 092) is a not-for-profit company incorporated in Australia.

A2.2: Purpose of the Fund

GMHBA Limited operates as a Health Benefits Fund for the purposes of its health insurance business and any health-related business in accordance with the Private Health Insurance Act.

A2.3: Purpose of these Rules

These rules govern the operation of the Fund, including the obligations and entitlements of Fund Members, the rules regarding payment of entitlements by Frank Health Insurance and the obligations and entitlements of GMHBA Limited in administering the Fund.

A3: Obligations to Insurer

A3.1: Provision of Information

Any person applying for Membership to the Fund agrees to provide all information requested that is relevant to their application for Membership.

Existing Members must notify the Fund of any changes to their information in the manner and within the timeframe prescribed in these Fund Rules.

All persons included on a health insurance policy are bound by these Fund rules.

A4: Governing Principles

A4.1: Governance of the Fund

The operation of the Fund and the relationship between Frank Health Insurance and their Members is governed by is governed by the laws of Australia including but not limited to:

a. The Private Health Insurance Legislation
b. The Health Insurance Act
c. The National Health Act
d. These Fund Rules
e. Fund Policies, and
f. The Constitution of GMHBA Limited.

A5: Use of Funds

A5.1: Income to be credited to the Fund

Frank Health Insurance shall credit to the Fund:

a. All Premiums paid in relation to Products; and
b. Such other moneys or income as required by the Private Health Insurance Legislation to be credited to the Fund.

A5.2: Payments from Fund

Payments from the Fund may not be made for any purpose other than to:

a. Meet the Membership liabilities in accordance with these Fund Rules;
b. Meet other liabilities or expenses incurred for the purposes of the business of the Fund; and
c. Make distributions, investments and for any other purpose allowed under the Private Health Insurance Legislation.

A6: No Improper Discrimination

A6.1: Community Rating

As required by the Private Health Insurance Act, when conducting the Fund and making decisions in relation to persons applying for Membership or Members, Frank Health Insurance will not take into account:

a. The suffering by a Member of a Chronic Disease, illness or other medical condition;
b. The gender, race, sexual orientation or religious belief of a Member;
c. The age of a Member, except in relation to the calculation of Lifetime Health Cover Loading and Age Based Discounts, or any other extent as which is permitted by the Private Health Insurance Act;
d. Where a person lives, except as permitted by the Private Health Insurance Act;
e. Any other characteristic of a person (including, but not just, matters such as occupation or leisure pursuits) that are likely to result in an increased need for Hospital Treatment or General Treatment;
f. The frequency with which a person needs Hospital Treatment or General Treatment;
g. The amount, or extent, of the Benefits to which a Member becomes, or has become, entitled during a period under his or her Membership, except to the extent allowed under the Private Health Insurance Legislation; or
h. Any other matter set out in the Private Health Insurance Legislation as being improper discrimination.

Notwithstanding the above, Frank Health Insurance can determine a Member's Benefit entitlement under an Extras Product based on the amount of Benefits already received by the Member (that is, annual limits can and do apply). In addition, Frank Health Insurance varies Premiums for a Product depending on the State in which the Member resides.

A7: Changes to Rules

A7.1: Amendments to the Fund Rules

Frank Health Insurance may change the Fund Rules at any time, in a manner consistent with the Private Health Insurance Legislation and any other law.

Where a Member became entitled to receive a Benefit at a time when a previous Fund Rule applied, the Benefit specified in the earlier Fund Rule will be payable.

A7.2: Notification to a Member

a. Where Frank Health Insurance amends or proposes to amend a Fund Rule and the amendment is or might be detrimental to the interests of the Member, Frank Health Insurance will inform the Policyholder of the amendment a reasonable time before the change takes effect.
b. Where an amendment to the Fund Rules requires a change to the Private Health Information Statement (PHIS), Frank Health Insurance will also provide a new PHIS to the Policyholder who is on the particular Product as soon as practicable after it has been updated.
c. A PHIS is available for every Product available to new and existing Members of the Fund. The content of the PHIS will be as outlined in the Private Health Insurance (Complying Product) Rules.
d. An up to date PHIS will be forwarded to anyone on request, and at the very least to Policyholders once every year (without need to be requested).
e. A newly insured 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 Fund when they join.

A8: Dispute Resolution

A8.1: Member Complaints

a. Frank Health Insurance is a signatory to the Private Health Insurance Code of Conduct and is committed to upholding the highest level of customer service to its Members.
b. Frank Health Insurance offers an internal dispute resolution process to its Members through its Complaints Handling Policy.
c. A Member may make a complaint to Frank about any aspect of their Membership at any time.
d. Frank will make all reasonable endeavours to respond to complaints quickly and efficiently.

A8.2: Private Health Insurance Ombudsman

a. The Private Health Insurance Ombudsman assists Members who have been unable to resolve issues directly with the Fund.
b. There is no provision within these Fund Rules which prevents a Member from approaching the Ombudsman at any time.

A9: Notices

A9.1: Correspondence

Frank Health Insurance will send all correspondence addressed to the Policyholder to the most recently advised address, phone number or email address.

A Policyholder who receives written advice from Frank Health Insurance regarding the Membership that is not specific only to that Member, must inform all other Members on the Membership of the contents of that notice.

A9.2: Availability of Fund Rules to Members

A copy of these Fund Rules will be made available to new Members upon joining the Fund and are also available for Members to view online at frankhealthinsurance.com.au.

A10: Winding Up

In the event that GMHBA Limited was to be wound up, the Fund will be wound up according to the requirements of the Private Health Insurance Legislation and the Constitution, and GMHBA Limited will be in constant dialogue with the Australian Prudential Regulation Authority in relation to this matter.

B: Interpretation and Definitions

B1: Interpretation

These Fund Rules shall be interpreted so as not to conflict with the Constitution.

Any terms used in these Fund Rules and in the Constitution shall have the same meaning in these Fund Rules as they bear in the Constitution.

Unless otherwise specified, the meaning attached to the words and expressions in the Private Health Insurance Legislation shall apply to these Fund Rules. These Fund Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Legislation.

Words in the singular number shall include the plural and words in the plural shall include the singular.

B2: Definitions

AHSA Access Gap Cover: The approved scheme used by Frank for the payment of medical Benefits in excess of the Medicare Benefits Schedule to provide a no gap or known gap to members.

Accident: An unforeseen event, occurring by chance and 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 for a service that is included on your policy. For an accident to be covered, treatment must be sought through a Doctor or Emergency Department within 48 hours of sustaining the injury and hospital admission must occur within 90 days. An Accident Declaration form must be supplied.

Accident Protection (selected covers): If you have an accident, you'll be covered for hospital treatments that are excluded or restricted on your cover, when treatment is sought through a doctor or an Emergency Department within 48 hours of sustaining the injury and any hospital admission occurs within 90 days. An Accident Declaration form must be supplied to Frank for benefits to be paid.

Acute Care Certificate: A certificate in a form approved and required by Frank Health Insurance from a medical provider confirming the need for an Admitted Patient to continue to receive acute Hospital care. An Acute Care Certificate is valid for 30 days and is required after 35 days of continuous hospitalisation.

Admitted Patient: means a patient who has been admitted to a Hospital as a patient and is receiving services under the direction of a medical practitioner or dentist.

Adult: A person who is not a Child Dependant or Student Dependant.

Age Based Discount: a premium discount on all hospital covers of two per cent for each year that a person is aged under 30 when they first purchase hospital insurance, to a maximum of 10 per cent for 18 to 25 year olds. The discount then reduces by two per cent each year from age 41.

Ambulance: a registered road vehicle, boat or aircraft operated by an Ambulance Provider and equipped for the transport and/or paramedical treatment of persons requiring medical attention.

a. ***Emergency Ambulance:*** clinically necessary Ambulance treatment and transport and does not include:
    i. Ambulance Transport from a Hospital to your home, or Ambulance transfers between Hospitals
    ii. Any services which are not operated by an Ambulance Provider recognised by Frank Health Insurance
    iii. Any non-emergency services, as determined by the Ambulance Provider

Ambulance Provider: One of the following service providers:

a. ACT Ambulance Service;
b. Ambulance Service of NSW;
c. Ambulance Victoria;
d. Queensland Ambulance Service;
e. South Australia Ambulance Service;
f. St John Ambulance Service NSW (Norfolk Island Only)
g. St John Ambulance Service NT;
h. St John Ambulance Service WA; and
i. Tasmanian Ambulance Service.

Ambulance Subscription: A membership taken out with a participating Ambulance Provider which provides cover for Ambulance services as defined in the terms of membership.

Ambulance Transport: Where a patient is taken from point A to point B in an Ambulance and may be for emergency or non-emergency reasons.

Arrears: The amount of unpaid premiums whenever the date to which premiums have been paid is earlier than the current date.

Assisted Reproductive Services (ARS): Hospital Treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In vitro Fertilisation (IVF), and Gamete Intrafallopian Transfer (GIFT).

Australia: For the purpose of these Fund Rules includes the six states, Northern Territory, Australian Capital Territory, the Territory of Cocos (Keeling) Islands, Christmas Island and Norfolk Island, but excludes other Australian external territories.

Benefit: An amount of money payable to a Member, on behalf of or for the Benefit of a Member, to a Recognised Provider, medical provider or Hospital by the Fund in accordance with these Fund Rules.

Benefit Replacement Period: A continuous period that must elapse between any two purchases of the same type of General Treatment item before Benefits are payable in respect of the later purchase. Applicable Benefit Replacement Periods are described in the associated Schedules.

Board: The Board of Directors of GMHBA Limited or its delegate as appointed in accordance with the Constitution.

Calendar Year: The period from 1 January to 31 December inclusive.

Certified Age of Entry: A person's certified age of entry is the age they are considered to be when they take out hospital cover. A person's certified age of entry is:

a. 30, regardless of their actual age, if they took out the cover before 1 July 2000
b. Their actual age when they took out the cover, if this occurred after 1 July 2000.

Child: Any one of the following;

a. A natural Child (including a newborn Child)
b. An adopted Child
c. A foster Child
d. A step-Child (that is, a natural, adopted or foster Child of the person's Partner), or
e. A Child being cared for under guardianship arrangements approved by Frank Health Insurance.

Chronic Disease: A disease that has been, or is likely to be, present for at least six months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes, a mental health Condition, arthritis and a musculoskeletal Condition.

Chronic Disease Management Program (CDMP): A program that:

a. Is intended to either:
    i. Reduce complications in a person with a diagnosed Chronic Disease; or
    ii. Prevent or delay the onset of Chronic Disease for a person with identified multiple risk factors for Chronic Disease; and
b. Requires the development of a written plan that:
    i. Specifies the allied health service or services and any other goods and services to be provided
    ii. Specifies the frequency and duration of the provision of those goods and services
    iii. Specifies the date for review of the plan and
    iv. Has been provided to the patient for consent, and consent is given to the program, before services under the program are provided; and
c. Is coordinated by a person who has accepted responsibility for:
    i. Ensuring the services are provided according to the plan; and
    ii. Monitoring the patient's compliance with the agreed goals and activities specified in the plan.

Class: General treatment where all participants are provided with the same intervention simultaneously and all participants in a class do the same thing. The number of people in a class is not significant.

Clinical Categories: A standard way of describing medical treatments as developed by the Department of Health and Aged Care.

Combined Product: A Product offered by Frank Health Insurance which includes a Hospital Treatment Product and General Treatment Product.

Compensation: Any of the following:

a. A payment of Compensation or damages pursuant to a judgment, award or settlement;
b. A payment in accordance with a scheme of insurance or Compensation provided for by Commonwealth or State law (for example, workers Compensation insurance);
c. Settlement of a claim for damages (with or without admission of liability);
d. A payment for negligence; or
e. Any other payment that, in the opinion of Frank Health Insurance, is a payment of Compensation or damages.

Constitution: The Constitution of GMHBA Limited.

Consultation: An attendance on a patient by a Recognised Provider or Hospital. Service must be provided one on one and the Provider must be in attendance and must remain accessible during the entire course of the consultation and treatment.

Consumables: Medical consumables ad equipment includes syringes, needles, sutures, staples, packaging, tubing, catheters, medical gloves, gowns, masks, adhesives and sealants for wound dressing and a whole host of other devices and tools used in a hosptial or surgical environment.

Contribution Group: A group of Members approved by Frank Health Insurance for the purposes of Fund Rule D3.2.

Cosmetic Surgery: A procedure, operation or treatment undertaken for the dominant purpose of improving appearance or improving self-esteem where no MBS item number is used for the procedure and:

a. There is no disease, deformity, injury or disorder; or
b. The deformity is the result of a normal physiological process such a pregnancy and ageing.

Cover: A defined group of Benefits payable, subject to these Fund Rules, in respect of approved expenses incurred by a Member.

Default Benefits: For the purposes of Hospital Treatment, the minimum amount payable by the Fund for that Hospital Treatment, as required in the Private Health Insurance Legislation.

Department of Health and Aged Care: The Department of Health and Aged Care of the Commonwealth of Australia or its successor or replacement.

Dependant: A person who is not married or living in a de facto relationship and is one of the following:

a. A Child Dependant being a Child of the Policy Holder or Principal Member who is under the age of 21.
b. Student Dependant being a Child of the Policy Holder or Principal Member who:
    i. Has reached the age of 21 but is under the age of 25, and
    ii. Is undertaking Full-Time Education,
    iii. Is not married.

Excess: An amount of money a Member agrees to pay a Hospital or Frank Health Insurance towards the accommodation costs of a Hospital admission before Benefits are payable. The Excess is payable per person per Calendar Year.

Exclusion: A clinical category which is not covered on the Membership and for which no benefits are payable.

Extras: A Product offered by Frank Health Insurance which Covers General Treatment only.

Frank Hospital Rewards: Loyalty program closed effective May 1, 2021. Frank Hospital Rewards allowed Frank Health Insurance Members with an eligible Hospital Product to accumulate Frank Hospital Reward Dollars to contribute toward Medical Gap claims.

Accruals on this program ceased as of April 30 2022.

Frank Rewards can only be redeemed by eligible Members for inpatient medical claims for services provided on or before October 31 2024.

Frank Loyalty Benefit: Loyalty program allows Frank Health Insurance Members with an eligible Ancillary Product to increase eligible Annual Limits.

Fraud: dishonestly obtaining a benefit, or causing loss, by deception or other means.

Fund: The Health Benefits Fund conducted by Frank Health Insurance in accordance with the Private Health Insurance Legislation.

General Treatment: Treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment (such as Dental, Optical, Physiotherapy, other therapies and Ambulance). General Treatment also includes Hospital Substitution.

GMHBA Limited: Includes GMHBA Health Insurance and Frank Health Insurance.

Group: General Treatment where the Provider is readily accessible during the entire course of a Group of up to six participants. The session will be of sufficient length to allow feedback and adjustment for each participant to occur. For Group physiotherapy, an individual assessment by a physiotherapist must have been previously provided.

Health Insurance Act: The Health Insurance Act 1973 (Cth).

Health Management Program: A program approved by Frank Health Insurance that is intended to ameliorate a Member's specific health condition or conditions.

Hospital: A facility which the Minister declares in writing is a Hospital and which complies with the Private Health Insurance (Accreditation) Rules.

Hospital Product: A Product offered by Frank Health Insurance which Covers Hospital Treatment and Hospital Substitution only.

Hospital Purchaser-Provider Agreement: An agreement entered into between Frank Health Insurance and a Hospital.

Hospital Substitution: General Treatment that is treatment provided by a provider that is not a declared hospital, but which substitutes for an episode of Hospital Treatment, i.e. it is the same treatment that is usually provided by a hospital. This is approved at Frank's discretion.

Hospital Treatment: Treatment (including the provision of goods and services) that is intended to manage a disease, illness, injury or condition, where the treatment is provided by a person who is authorised by a Hospital to provide the treatment or under the management or control of such a person and is either provided at a Hospital or with the direct involvement of a Hospital.

Implantation of Hearing Device: Hospital Treatment to correct hearing loss, including implantation of a prosthetic hearing device.

Insulin Pump: The provision and replacement of insulin pumps for treatment of diabetes.

Lifetime Health Cover (LHC): Introduced by the federal government on 1 July 2000, allows health funds to charge an extra 2% per year up to a maximum of 70% if they were over the age of 30 when they first took out hospital cover.

Lifetime Health Cover Base Day: The later of 1 July 2000 or the 1st of July following your 31st birthday.

Lifetime Health Cover Loading: If you do not have Hospital Cover on your Lifetime Health Cover Base Day and decide to take out hospital cover after this time, you will pay a 2% loading on top of your premium for every year you are aged over 30. The maximum loading is 70%

Lifetime Limit: The maximum amount that can be claimed on select service in a lifetime.

Medical Devices and Human Tissue Products: In relation to a Hospital Cover: any item on the Federal Government's Medical Devices and Human Tissue Schedule, which for the purpose of these Fund Rules, is the schedule approved by the Minister under the Private Health Insurance (Medical Devices and Human Tissue) Rules

In relation to General Treatment Cover: an external appliance or device approved by the Fund normally associated with a physical replacement of some part of the human body..

Medical Practitioner: A person who:

a. Is registered and licensed as a Medical Practitioner under a law of a State or Territory, and
b. Satisfies the provider eligibility requirements for the payment of Medicare Benefits.

Medical Purchaser-Provider Agreement: An agreement entered into between Frank Health Insurance and a Medical Practitioner.

Medical Treatment: Treatment provided by a Medical Practitioner.

Medicare Benefits Schedule (MBS): The 'Medicare Benefits Schedule' means the schedule of items for which Medicare Benefits are payable published by the Department of Health and Aged Care.

Member: A person Covered by a Membership.

Membership: A policy issued by Frank Health Insurance providing Cover for Hospital Treatment and/or General Treatment for which Premiums are paid in accordance with these Fund Rules.

Membership Anniversary Date: The date on which a Membership commenced.

Membership Category: Any one of the following:

a. Single Membership – The Policyholder
b. Couple Membership – The Policyholder and their Partner
c. Family Membership – The Policyholder, their Partner and one or more Dependants
d. Single Parent Membership – The Policyholder and one or more Dependants.

Mental Health Waiver: Members with restricted cover for psychiatric care are able to upgrade their cover to access private hospital coverage for in-hospital treatment without serving a waiting period. Policy holders are only able to use this exemption from the existing two month waiting period once.

Minimum Benefit: See Default Benefits

Minister: The Minister for the Commonwealth Department of Health and Aged Care or his or her delegate with powers vested in the Minister by the Private Health Insurance Legislation.

National Health Act: The National Health Act 1953.

Nursing Home Type Patient (NHTP): A patient in a Hospital who has been a patient for a continuous period exceeding 35 days and for whom an Acute Care Certificate is currently not in force.

NHTP Benefit: The Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

Occupational Therapy: A professional Treatment that is:

a. Approved by Frank Health Insurance; and
b. Provided during a one on one Consultation with a person who is recognised by Frank Health Insurance as an Occupational Therapist.

Optical: The provision of a sight-correcting appliance upon prescription by a Recognised Provider

Orthotic Appliance: An item that:

a. Is approved by Frank;
b. Has been custom made; and
c. Has been provided by a Podiatrist or Orthotist.

Out of Pocket: The difference between the Benefit for a treatment or service and the provider's fees.

Pain Management with Device: Hospital Treatment for the implantation, replacement or other surgical management of a device required for the treatment of pain.

Participating Private Hospital Agreement: An agreement between Frank Health Insurance and a Private Hospital which specifies, amongst other things, the fees that the Private Hospital may raise to Members and the Benefits Frank Health Insurance will pay for certain Hospital Treatment provided to Members.

Participating Private Hospital: A Private Hospital which has entered into a Participating Private Hospital Agreement.

Partner: A legally married spouse or de facto Partner, living together in a bona fide domestic relationship with the Policyholder.

Pharmaceutical Benefits Scheme (PBS): The Schedule of pharmaceutical benefits published by the Department of Health and Aged Care.

Pharmaceutical Co-Payment: An amount that must be paid before a Benefit is available for non-PBS pharmaceuticals.

Pharmacy: A substance which:

a. Had been prescribed by a Medical Practitioner or a dentist
b. Has been supplied by a pharmacist in Private Practice or a Medical Practitioner; and
c. Can only be supplied on prescription under applicable State law;

But does not include:

a. Any item available on the PBS
b. Any item that is not registered as a schedule 4 or schedule 8 medication by the Australian Therapeutic Goods Administration (TGA)
c. Contraceptives, IVF and Fertility medications.

Policyholder: A person in whose name an application for Membership has been accepted and who is responsible for Premium payments.

Pre-Existing Condition (PEC): An ailment, illness or condition, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by Frank Health Insurance (not the Member's own doctor), existed at any time during the six months preceding the day on which the Member purchased a Hospital Product or upgraded to a higher Hospital Product and/or Benefit entitlement.

It is not necessary for a Member to be aware of the ailment, illness or condition for it to be considered pre-existing.

Premium: The amount of money a Policyholder is required to pay Frank Health Insurance for a Membership to remain financial.

Premium Due Date: The due date for Premiums to be paid to Frank Health Insurance by the Policyholder.

Prescribed List of Medical Devices and Human Tissue Products: Medical devices and human tissue product items as determined by the Minister under the Private Health Insurance Act.

Private Health Information Statement (PHIS): A summary of the key features of a Product that contains the information and is in the form set out in the Private Health Insurance (Complying Product) Rules.

Private Health Insurance Act: The Private Health Insurance Act 2007 (Cth).

Private Health Insurance Legislation: The Private Health Insurance Act, Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and their regulations, rules and other instruments under them and consolidations, amendments, reenactments or replacements of any of them, and other related laws.

Private Hospital: A Hospital, including a day Hospital, not operated by a State or Territory Government and declared by the Minister to be a Private Hospital.

Private Patient: A person who is admitted to a Public Hospital or Private Hospital who is not a Public Patient.

Private Practice: A professional practice, whether sole, partnership or group that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party (as is the case with a Public Hospital or publicly funded facility) but through the leveraging of fees directly to recipients of treatment, goods or services.

Product: A defined group of Memberships that Cover the same treatments and provide Benefits that are worked out in the same way for approved expenses incurred by a Member and whose terms and conditions are the same as each other.

Product tier: There are four tiers of hospital products: Gold, Silver, Bronze and Basic. Each product tier has a minimum standard of service that must be covered in accordance with Private Health Insurance Legislation Amendment Act 2018. Insurers will be able to offer additional coverage in Basic, Bronze and Silver tiers, allowing for Basic plus, Bronze plus and Silver plus products also.

Public Hospital: A Hospital which is owned by a State or Territory government, receives government funding and is declared by the Minister as a Public Hospital.

Public Patient: A person admitted to a Public Hospital who receives treatment, goods or services by a doctor appointed by the Public Hospital without charge to the person.

Recognised Provider: A health care practitioner other than a Medical Practitioner in respect of whom Frank Health Insurance will pay Benefits for treatment provided by that provider. Frank Health Insurance have sole and absolute discretion in determining if someone becomes or remains a Recognised Provider and for which of their treatments Frank Health Insurance will pay Benefits.

Restricted Service: Hospital Treatment for which only the Default Benefit is payable.

Sleep Studies: Hospital Treatment for the investigation of sleep patterns and anomalies.

Suspension: The temporary discontinuation of a Membership in accordance with these Fund Rules.

Telehealth: One on one Telehealth Consultations are covered with a Frank recognised provider, for services as approved by Frank. A list of recognised modalities is available and may be changed periodically. Telehealth services are considered a substitutional service, and meet the requirements, to what would otherwise be undertaken as 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.

Transfer Certificate: a certificate issued under section 99-1 of the Private Health Insurance Act.

Waiting Period: A period during which a Member must hold continuous Membership under a particular Product before the Member has an entitlement to receive a Benefit at the level payable on that Product.

C: Membership

C1: General Conditions of Membership

C1.1: Same Membership Category and Covers

All Members under the same Membership shall:

a. Belong to the same Membership Category, and
b. Have the same Cover or Covers

C1.2: Levels of Cover

Subject to other Fund Rules, a Member may (at any one time) have a Membership under only one of the following:

a. Any one Hospital Product that Covers Hospital Treatment;
b. Any one Extras Product that Covers General Treatment;
c. Any combination of a Hospital Product and an Extras Product Covering Hospital Treatment and General Treatment;
d. Any one of the combined package Products Covering Hospital Treatment and General Treatment.

C1.3: Change of Membership Details

Policyholders are required to advise Frank Health Insurance of any changes to Membership details within two months of such changes. Frank Health Insurance is not obligated to allow any changes to have effect greater than two months prior to the date advised. Suspension of a policy cannot be made retrospectively unless with the approval of the Fund.

Changes in Membership details include, but are not limited to:

a. Change of residential and/or postal address;
b. Change of contact details such as email address or telephone number;
c. Change of Premium payment details or Premium payment method;
d. Change of details or method for receipt of Benefits;
e. Change of Dependant status;
f. Change of name;
g. Change of Partner;
h. Additions to a policy such as a newborn baby.

C1.4: Membership Authority

A Policyholder:

a. Is responsible for the payment of Premiums;
b. May make any changes to the Membership as required;
c. Can submit claims on behalf of all Members of the Membership;
d. Can cancel the Membership
e. Can, in writing or in any other approved way, request that the Partner or the holder of a Power of Attorney be treated as authorised to operate the Membership (except to cancel the Membership) as if the Partner or Power of Attorney is the Policyholder. The Policyholder may withdraw this authority at any time by written notice.
f. Can, in writing or in any other approved way, request a person not on the Policy be treated as authorised to access personal and sensitive information including health information about the Membership and claim in accordance with the members preferred refund method on the Policyholder's behalf. This person will not be authorised to make any changes to the Membership.

A Partner may:

a. Make changes to their own details;
b. Submit claims on behalf of all Members of the Membership;
c. If authorised as set out in Rule C1.4.e, make any changes to the Membership as required

Any other Member on the Membership may:

a. Submit claims on behalf of all Members on the Membership.

C2: Eligibility for Membership

C2.1: Membership Eligibility

Frank Health Insurance Products are designed for people who have full Medicare eligibility and, while the Fund will not refuse Membership to people on the basis of their residency or Medicare status, potential Members who are classed as overseas visitors may be responsible for large Out of Pocket expenses if they are not a permanent resident or do not have full Medicare eligibility.

Any person may be eligible for any Product or combination of Products as set out in and in accordance with Fund Rule C1.2.

C2.2: State of Residence

A Member may hold Membership only in respect of the Policyholder's State of Residence.

C2.3: Minimum Age of Policyholder

Unless otherwise approved by the Fund, persons aged under 18 are not eligible to be a Policyholder.

C2.4: Responsible Person

Under Rule C2.3, the parent or guardian of the Child agrees to take out the Membership on behalf of the Child, to handle the maintenance of the Membership, be responsible for payment of Premiums and notifying Frank Health Insurance of changes to the Membership and the Child will be taken to be the insured person under the Membership, who is entitled to receive Benefits.

C3: Dependants

3.1: Addition to a Membership

Dependants can be added to a Membership at any time as long as the option is available on the product. Where the Membership was a Single Membership prior to a Dependant being added, the Membership Category will be amended from the date the Dependant is added. Premiums for the Membership will be adjusted accordingly.

C3.2: Dependant Coverage

Dependants are covered on a Family or Single Parent Membership until:

a) 21 years of age, or

b) 25 years of age if they are studying full time, are undertaking a recognised apprenticeship or traineeship or are completing a life-skills course.

A person who is no longer eligible to be a Dependant Child on a Membership can start their own policy with Frank Health Insurance without serving any Waiting Periods (other than the balance of any unexpired Waiting Periods for that Benefit under the previous Membership, if applicable) if:

a) The benefits provided on the new policy are equal to or less than the benefits provided on the previous membership; and

b) The person applies for a Membership within 60 days of ceasing to be a Dependant child; and

c) The new policy must commence within 30 days of the person ceasing to be a Dependent child

C4: Membership Applications

C4.1: Application in the approved form

A person may make an application required by these Fund Rules in writing, by telephone or by any other oral or electronic means approved by Frank Health Insurance.

All relevant information reasonably requested by Frank Health Insurance to establish and maintain a Membership must be supplied by the applicant.

Frank Health Insurance may from time to time introduce or vary procedures or requirements with respect to applications made under this Fund Rule.

An application to join the Fund will be accepted by Frank Health Insurance only once the initial payment of the Premium required from the applicant is received by Frank Health Insurance.

C4.2: Refusal of Application to Join

Frank Health Insurance reserves the right to reject any application for admission to the Fund as a Member including where the applicant was a former Member of the Fund whose Membership was cancelled under Fund Rule C8.

Frank Health Insurance will not reject any Membership application for reasons described as improper discrimination under the Private Health Insurance Act.

C4.3: Acceptance of Application to Join

Upon acceptance of a Membership application, Frank Health Insurance will provide the Policyholder with;

a. A copy of these Fund Rules;
b. The relevant up to date PHIS;
c. Details of what the Membership Covers and how Benefits are calculated;
d. A Membership certificate;
e. A digital Member Card for the main member (Policyholder) accessed via the Frank app;
f. A physical Member Card for the Policyholder's Partner (if applicable).

A physical Member Card will be provided for the Policyholder and/or any Dependant/s upon request.

C5: Duration of Membership

C5.1: Commencement of Membership

A Membership commences on the latter of:

a. The time and date on which an application is received by Frank Health Insurance; or
b. The date nominated on the application form, or
c. A date mutually agreed between the Policyholder and Frank Health Insurance,

provided that the Policyholder has paid Premiums from the date of commencement and all application procedures are completed to the satisfaction of Frank Health Insurance.

C5.2: Termination of Membership

A Policy terminates:

a. On the date it is cancelled by a Policy Holder in accordance with Rule C7; or
b. On the date the Policy is terminated in accordance with Rule C8.

C6: Transfers

C6.1: Transfers from another private health insurer within 30 days

Where a person who was insured under a Previous Cover transfers to Frank Health Insurance Product with a break in coverage of 30 days or less:

a. Frank Health Insurance may apply all relevant Waiting Periods to any Benefits under the new Product that were not provided under the Previous Cover;
b. For treatment that was covered under the previous policy but at a lower level, the member is entitled to a benefit based on the most equivalent cover offered by Frank during the waiting period;
c. Frank Health Insurance may apply all relevant Waiting Periods to the unexpired portions of any Waiting Periods not fully served under the Previous Cover.
d. Frank Health Insurance will recognise an age based discount a member was receiving with a previous fund if hospital cover was held at time of transfer, and age based discount is recorded on the transfer certificate provided to Frank.

C6.2: Transfers from another private health insurer outside 30 days

Where a person who was insured under a Previous Cover transfers to a Frank Health Insurance Product with a break in coverage of more than 30 days, the person will be treated as a new Insured Person to the extent permitted under the Private Health Insurance Act and Frank Health Insurance may apply the Waiting Periods in full.

C6.3: Benefits paid under Previous Cover may be taken into account

Where a person who was insured under a Previous Cover transfers to a Frank Health Insurance Product

with a break in coverage of 30 days or less, Frank Health Insurance may take into account any Benefits that have been paid in the relevant Calendar Year under the Previous Cover in calculating Annual Benefits Limits and determining the Benefits payable under the new Product for the remainder of that Calendar Year.

C6.4: Transfers to another private health insurer

If an Insured Person transfers to a policy of private health insurance with another private health insurer, Frank Health Insurance will provide the Policyholder, or another such person as they nominate with a certificate in accordance with the Private Health Insurance Act.

C7: Cancellation of Membership

C7.1: Cancellation Requests

The Policyholder may cancel a Membership by advising Frank Health Insurance in writing or as otherwise agreed by us. The date of cessation of the Membership will be the later of the:

The date requested by the Policyholder (provided the Membership is paid to that date); or

The date of the most recent claim paid in respect of the Membership.

If the Policyholder does not nominate a date of cessation, it will be the date on which Frank Health Insurance received your request for cancellation.

A Partner or Dependant Child who is aged 18 or over may remove themselves from a Membership by notifying Frank Health Insurance in writing. The date of cessation will be the later of the date requested by the Partner or Dependant Child and the date Frank Health Insurance receive the notice.

Frank Health Insurance will issue you a Transfer Certificate within 14 days of you ceasing to be Covered under a Membership.

If a Membership is to be cancelled due to the death of a Policyholder, the cancellation will take effect from the day after his or her death.

C7.2: Refund of Premiums

If you cancel the Membership before the date on which the next Premium is due, Frank Health Insurance will reimburse any Premiums paid in advance of the termination date.

Where a refund is owing following the death of a Policyholder, Frank Health Insurance will refund any Premiums paid in respect of the period after the cancellation date to the Estate of the Policyholder.

C7.3: Cooling Off Period

If a Policyholder has not made a claim, they can cancel their cover within the first 30 days of Membership (cooling off period) and receive a full refund of any Premiums paid.

C8: Termination of Membership

C8.1: Termination Generally

Frank Health Insurance may terminate the Policy of any Policyholder or terminate a Member from a Membership (with advanced written notice) on any of the following grounds:

a. The application for the Membership is discovered to have been incomplete or inaccurate in a material respect;
b. The Membership is in Arrears for a period of more than 2 months.

C8.2: Termination of Membership Where Member Acts Improperly

Frank Health Insurance may, by notice in writing to the Policyholder, terminate the Policy of any Policyholder or terminate a Member from a Membership where, in the opinion of Frank Health Insurance;

a. Any Member had committed or attempted to commit fraud upon Frank Health Insurance;
b. Any Member materially or repeatedly breached any of these Fund Rules or any other term or condition of Membership
c. Any Member included in the Membership has behaved inappropriately towards Frank Health Insurance staff, providers or other Members.

C8.3: Member Entitlements on Termination

Unless Fund Rule 8.1.a or 8.2.a apply:

a. The termination of the Membership will not affect any rights accrued by the Member prior to the date of termination; and
b. The Member will be entitled to a pro-rata refund of any Premium paid for any period beyond the date of termination.

C9: Temporary Suspension of Membership

C9.1: Overseas Travel

Members may suspend their Membership for periods of overseas travel by advising Frank Health Insurance over the phone or as otherwise agreed by Frank Health Insurance provided they:

a. Have held 12 months continuous Membership with the Fund since joining;
b. Have had a minimum of 6 months active Cover since any previous Suspension for overseas travel;
c. Have paid Premiums to the date of departure;
d. Will be overseas for at least 4 weeks and not more than 3 years; and
e. Apply for Suspension prior to departure.
f. A Policyholder with two different types of Cover (i.e a Hospital Product and General Treatment Product) may not suspend one Cover without also suspending the other.

Suspensions can apply to the Membership or individual Members as required, however, dependants cannot remain on a policy without a policyholder.

C9.2: Effect of Suspension

During the Suspension of a Membership:

a. The Policyholder is not required to pay Premiums in respect of the Membership; and
b. Any Member Covered by the Policy is not entitled to payment of Benefits for services provided during the Suspension.

C9.3: Effect of Suspension on Waiting Periods

Periods of Suspension do not count towards Waiting Periods. Therefore, the balance of all outstanding Waiting Periods must be served upon reactivation of Membership.

C9.4: Reactivation of Policy

Memberships will be automatically reactivated based on the date provided by the Member when they initially suspended their cover. If the Member's reactivation date changes whilst overseas it is the Member's responsibility to inform Frank Health Insurance.

D: Contributions

D1: Payment of Premiums

D1.1: Premiums Payable in Advance

Members must pay Premiums in advance.

Available payment frequencies are

a. Direct debit bank account or credit card: Weekly, fortnightly, monthly, quarterly, 6 monthly and yearly.

D1.2: State Premiums

Premiums may differ based on the State or Territory in which the Member permanently resides.

D1.3: Contribution Groups

Frank Health Insurance may, at its discretion, approve any group of Members to be a Contribution Group. A Contribution Group may include, but is not limited to:

a. Employees of an organisation;
b. Members of an association;
c. Frank staff;
d. Brand ambassadors.

D2: Premium Rate Changes

D2.1: Rate Change

Frank Health Insurance may vary the Premiums for any Product in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Act.

D2.2: Premium Rate changes as a result of changes to Products

Premium rates may change as a result of:

a. A change in Premiums in line with the Private Health Insurance Act;
b. A change in Product;
c. A change in the State of Residence; or
d. A change in Policy Category

D2.3: Premium Rate Protection

Subject to changes under Rule D2.2.a where Premiums are paid by or on behalf of a Policy Holder in advance, a Premium Rate change that takes effect during the period in which that Policy Holder's Premiums have been paid in advance will not take effect until the Policy Holder's next Premiums fall due.

D3: Premium Discounts

D3.1: Discounts on Premiums

Discounts may be applied up to 12% per annum in accordance with Private Health Insurance Legislation.

D3.2: Age Based Discounts

Premium discounts of up to 10% will be available to Members aged 18 to 29 on all Hospital Products.

D3.3: Age Based Discount Application

a. The Age Based Discount will be based on a Member's age when they become insured under a Hospital Product.
b. Age Based Discounts start at 10% for Members aged 18-25 and decrease by 2% each year to age 29.
c. Where a Hospital Product Covers more than one Adult the amount of discounted Premiums is calculated by averaging the discounted Premiums applicable to each Member.
d. A member receiving an Age Based Discount will continue to receive the discount until the age of 41 whilst they remain on any hospital product. After age 41, the discount will be removed at a rate of 2% per year until the age of 45.
e. Any Age Based Discount that a Member was receiving at a previous fund will be as outlined in the previous fund's transfer certificate.

D4: Lifetime Health Cover

D4.1: Lifetime Health Cover Application

Subject to Rule D4, Frank Health Insurance must increase the Hospital Policy Premiums applying to an Adult if:

a. The Adult was not Covered by a Hospital Policy on his or her Lifetime Health Cover Base Day; or
b. The Adult ceases to be Covered by a Hospital Policy after his or her Lifetime Health Cover Base Day.

D4.2: Certified Age of Entry

Any increase in Premiums under this Rule must be calculated based on the Adult's Lifetime Health Cover Age as specified in Division 34 of the PHI Act.

Frank Health Insurance must stop increasing Premiums under Rule D4 where required by Division 34 of the PHI Act.

D4.3: Loading Not to Apply

Frank Health Insurance must not increase Premiums under Rule D4 if:

a. At the time the Adult first took out a Hospital Policy with a Private Health Insurer, the 1st of July following the Adult's 31st birthday had not arrived; or
b. The Adult was Covered by a Hospital Policy on and since 1 July 2000; or
c. The Adult was born on or before 1 July 1934; or
d. An Adult who turned 31 on or before 1 July 2000 was overseas on 1 July 2000; or
e. The Adult is the subject of a determination (with effect immediately before 1 April 2007) under clause 10 of Schedule 2 of the National Health Act.

D4.4: Lifetime Health Cover Loading

The Premium payable:

a. Under rule D4.1.a increases by 2% of the Base Rate for each year the Adult's Lifetime Health Cover Age is above 30 up to 70% of the Base Rate; and
b. Under rule D4.1.a increases by 2% for each year the Adult is not Covered by a Hospital Policy (calculated in accordance with section 34-5 of the PHI Act).

D4.5: Lifetime Health Cover Loading for Couples

Where a Hospital Policy Covers more than one Adult the amount of increased Premiums is calculated by averaging the increased Premiums applicable to each Adult in accordance with section 37-20 of the PHI Act.

D4.6: Lifetime Health Cover and Age Based Discount on the Same Policy

In circumstances where an Age Based Discount and Lifetime Health Cover loading are applicable to two different members on the same policy, the discount and loading will be applied to the relevant person's proportion of the policy's base rate for Hospital Cover.

D4.7: Lifetime Health Cover Loading Removal

Lifetime Health Cover Loading is removed after 10 years continuous Cover (not counting any Permitted Days Without Hospital Cover) but may start again if the Member ceases to have a Policy which Covers Hospital Treatment as specified in the PHI Act. Lifetime Health Cover recognises continuous Cover even if the Member has had a Policy which Covers Hospital Treatment from more than one health fund.

D4.8: Continuity of Cover

Continuity for the purposes of Lifetime Health Cover is preserved during a period in which the Member ceases to have a Policy which Covers Hospital Treatment for a cumulative period of 1,094 days or otherwise in accordance with the PHI Act (known as Permitted Days Without Hospital Cover). However, after exceeding 1,094 Permitted Days Without Hospital Cover, a person must pay an additional loading of 2% of the Base Rate Premium for every year without Hospital Cover (excluding Permitted Days Without Hospital Cover) on top of any previous loading. If a person takes out a Hospital Policy again after exceeding 1,094 Permitted Days Without Hospital Cover, the person must re-serve 10 years of continuous Hospital Cover before the loading is removed.

D5: Arrears in Contributions

D5.1: Memberships in Arrears

A Membership (other than a suspended Membership) is in Arrears whenever the date to which Premiums have been paid is earlier than the current date.

D5.2: Treatment During Arrears

Benefits are not payable for treatment provided to a Member during a period of Arrears.

Subject to Rules D5.3 and D5.4, a Policyholder may regain an entitlement to Benefits for such treatment by paying all outstanding Premiums including the minimum amount of advance Premiums relevant to the Policyholder, as specified in Rule D1.1.

D5.3: Maximum Period of Arrears

When a period of Arrears exceeds two months, Frank Health Insurance may terminate a Membership with immediate effect without written notice to the Policyholder.

D5.4: Reinstatement of a Terminated Membership

Where a Membership has been terminated under Rule 5.3, Frank Health Insurance has a discretion to reinstate the Membership at the request of the Policyholder, with continuity of entitlements, subject to payment of all Premiums as required under Rule 5.2.b.

E: Benefits

E1: General Conditions

E1.1: Benefits Available

Details of Benefits available under each Product are set out in the relevant Schedule of these Fund Rules.

E1.2: Treatment to be provided by Recognised Providers

Benefits are payable only where treatment Is provided by a Recognised Provider. Frank Health Insurance recognises the following providers:

a. Hospitals (as defined in these rules), and
b. General Treatment Providers who are:
    i. In independent Private Practice,
    ii. For each relevant class of service or treatment, satisfy all applicable recognition criteria with Medicare or other Frank Health Insurance approved industry body such as the Australian Regional Health Group and Australian Health Practitioner Regulation Agency (AHPRA);
    iii. Approved by Frank Health Insurance in its absolute discretion

E1.3: Providers who Fail to meet Recognition Requirements

Frank Health Insurance will decline to pay Benefits in respect to any claim where Frank Health Insurance has reasonable grounds to believe that at the time the services were provided:

a. At premises or facilities that do not meet the definition of Hospital as set out in these Fund Rules, or
b. By a General Treatment Provider who is not in independent Private Practice or does not satisfy an applicable recognition criterion

E1.4: No Benefit payment unless permitted by legislation

Irrespective of anything else contained within these Rules, Frank Health Insurance will not pay a Benefit to Members for a treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules, unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

E1.5: Benefit Reductions

Benefits may be reduced in the following circumstances:

a. Where the charge is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount of the charge;
b. Where a Benefit is claimable from another source for the same service, the Frank Health Insurance Benefit may be reduced by the amount claimable from the other source, and
c. Where in the opinion of Frank Health Insurance the charge is higher than the Provider's usual charge for the service, Frank Health Insurance may assess the claim as if the Provider's usual charge had been applied.

E1.6: Providers Treating Themselves, Family Members, and Business Partners and Family

a. Subject to b), Benefits are not payable for treatment rendered by a provider to:
    i. The provider's Partner, Dependants, or business partner, or
    ii. Family members of the provider and the providers business partner including: wife/husband, brother/sister, children, parents, grandparents and grandchildren, or
    iii. The provider themselves,
    iv. The Partner or Dependants of the provider's business partner, or
    v. Any other person not independent from the practice.
b. Frank Health Insurance may at its discretion pay Benefits in these cases:
    i. Where it is satisfied that the charge is a legally enforceable debt, or
    ii. In respect of the invoiced cost of materials required in connection with any treatment.

E1.7: Benefit Assessment

Frank Health Insurance may request information from a Policyholder or their health service provider prior to or after the payment of Benefits. Information requested will be directly related to a claim where the Policyholder has made a declaration requesting Benefits be paid to the Policyholder or their health service provider.

Such information may include but is not limited to:

a. Invoices;
b. Receipts;
c. Treatment Plans;
d. Prescriptions;
e. Medical/Patient records and clinical notes.

E1.8: Benefit Restitution

Frank Health Insurance may seek restitution where:

a. A claim contains false or misleading information;
b. A claim is incorrectly assessed;
c. A claim is paid after the termination date of the Membership;
d. Information is received after the claim has been paid which establishes that the Benefit should not have been paid.

E1.9: Limitations on Consultations provided on the Same Day

Frank Health Insurance has limitations on Consultations provided on the same day.

a. More than one consultation and/or treatment type per day has been claimed and performed by the same provider within a group of chiropractors (excluding X-Ray), acupuncturists, osteopaths, physiotherapists, myotherapists and remedial masseuses.

E1.10: Obligations of Recognised Providers

A Recognised Provider must:

a. Undertake in a diligent and professional manner the provision of treatment, goods or services to Members and maintain the quality of the treatment, goods or services;

b. Comply with each law, and each requirement arising from a law, and hold and maintain every required licence, permission and registration necessary to provide treatment, goods or services to Members including as required by the Private Health Insurance (Accreditation) Rules;

c. Conform to the general standards required by all relevant regulatory bodies;

d. Not act contrary to the interests of Frank Health Insurance or in a way which brings Frank Health Insurance into disrepute;

e. Promptly advise Frank Health Insurance of any event or occurrence that the Recognised Provider is aware of which may reasonably be expected to lead to a complaint about Frank Health Insurance from any person;

f. Not provide information to Frank Health Insurance which is false or misleading;

g. Not mislead or deceive Frank Health Insurance in any other manner including by failing to provide true and full information at any time;

h. Not act or attempt to act improperly so as to:

   i. Obtain an unfair advantage for himself/herself or another person; or

   ii. Cause loss or damage to Frank Health Insurance; and

i. Only provide a treatment, good or service to a Member while engaging in Private Practice if they do not otherwise make that treatment, good or service available to persons while not engaging in Private Practice;

j. Benefits will be paid in accordance with the Clinical Categories as set by the Department of Health and Age Care including the relevant MBS item numbers.

E2: Hospital Treatment

E2.1: Hospital Benefits Payable according to the Schedules

The Benefits payable in respect of Hospital Treatment and the conditions relevant to those Benefits are set out in these Fund Rules and associated Schedules.

E2.2: Same Day Patients

Benefits for same day Hospital accommodation are payable only where the Member is an Admitted Patient or where a Benefit is payable under a Hospital Purchaser-Provider Agreement with that Hospital.

E2.3: Day Hospital Facilities

Benefits for Admitted Patients of Day Hospital Facilities are payable in accordance with Private Health Insurance (Benefit Requirment) Rules 2011 issued by the Minister.

E2.4: Patient Classification Principles

a. Benefits for accommodation in Private Hospitals are payable according to the classification of the Patient.

b. Patients are classified in accordance with Private Health Insurance (Benefit Requirement) Rules 2011 issued by the Department of Health and Aged Care. These patient classifications are:

   i. Surgical

   ii. Advanced Surgical

   iii. Obstetric

   iv. Other (Medical)

   v. Psychiatric Care

   vi. Palliative Care, and

   vii. Rehabilitation

c. Frank Health Insurance may permit further sub-classifications of Patients when not inconsistent with Private Health Insurance (Benefit Requirement) Rules 2011.

E2.5: Patient Classification: Surgical and Advanced Surgical Patients

Subject to Rule E2.11, the Benefit payable under the surgical and advanced surgical classifications applies:

a. From the date of admission, where the operative procedure is performed on the first or second day of admission, or

b. From the date of the procedure, where the operative procedure is performed on the third day of admission or later.

E2.6: Patient Classification: Obstetrics Patients

a. The Obstetric classification applies only where childbirth occurs following the mother's admission to a Hospital.

b. Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from the date of admission.

c. Where labour commenced after admission, the obstetric classification applies from the earliest of:

   i. The date on which labour commenced, or

   ii. The date on which an obstetric procedure took place, or

   iii. Any other date that Frank Health Insurance may at its absolute discretion specify.

E2.7: Patient Classification: Rehabilitation Patients

Benefits for Rehabilitation Patients are payable subject to the following conditions:

a. Rehabilitation Patient means an Admitted Patient or Outpatient receiving treatment for rehabilitation.

b. Rehabilitation program means a program that is approved by your treating specialist and/or hospital to which benefits will be paid by the fund.

c. Benefits at the Rehabilitation Patient rate are payable subject to the following conditions:

   i. Rehabilitation treatment in a Private Hospital must be provided as part of an approved rehabilitation Program

   ii. The Fund may require the treatment to be supported by a Rehabilitation Care Certificate in a form approved by the Fund or some other form of documentation to support the need for the Patient to participate in a Program to assist in recovery from an Acute Catastrophic Illness or Injury.

   iii. The service is not a Restricted Service under the Cover.

   iv. Subject to the service not being a Restricted Service under the Cover, Benefits for Rehabilitation Patients who receive treatment in other than an approved rehabilitation Program are payable at the applicable Other (Medical) Patient rate.

E2.8: Patient Classification: Psychiatric Patients

Benefits for Psychiatric Care patients are payable subject to the following conditions:

a. Treatment must be supported by a Psychiatric Care Certificate;
    i. A further psychiatric care certificate is required:
    ii. For each period specified in any certificate where treatment as a Psychiatric Care beyond 35 days is provided; and
b. For any subsequent readmission as a Psychiatric Care patient that does not constitute Continuous Hospitalisation
c. Psychiatric Care Benefits are not payable for any Member under the custodial care of a State or Territory.
d. The service is not a Restricted Service under the Cover;
e. Subject to the service not being a Restricted Service under the Cover, Benefits for Psychiatric Patients who receive Treatment in other than an approved psychiatric Program are payable at the Other (Medical) Patient rate;
f. The member has used the Mental Health Waiver to upgrade their level of cover.

E2.9: Counting of Days

a. The day on which a person became an Admitted Patient and the day of discharge are counted as one day for the purpose of assessing Benefits payable;
b. Days spent in a special unit (such as an intensive care, critical care, coronary care, or high dependency nursing care unit) do not interrupt the counting of days in relation to the Patient classification on entering the unit. To avoid doubt, Benefits payable upon discharge from the special unit will be paid at the classification applicable upon entering the unit, after taking into account any days spent in the unit.

E2.10: Patient Classification: Multiple Procedures

Subject to these Fund Rules, where a Patient undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines the Patient's classification.

E2.11: Patient Classification: Subsequent Procedures

Where a Patient undergoes a subsequent operative procedure during the same period of hospitalisation:

a. Where the procedure results in the Patient having a higher classification, the Patient's classification increases from the date of the procedure; and
b. Where the procedure would otherwise have resulted in the Patient moving to a lower classification, the Patient's classification is unchanged.

E2.12: Special Care Unit Patients

The higher Benefits for Patients of Special Care Units are payable only for periods during which the Patient occupies a bed in a facility approved by Frank Health Insurance for this purpose.

E2.13: Continuous Hospitalisation

a. Where an overnight Admitted Patient is discharged, and within seven days is admitted to the same or a different Hospital for the same or a related Condition, the two admissions are regarded as forming one period of continuous hospitalisation.
b. In the case where the Hospitals are different, Benefits at the Advanced Surgical, Surgical or Obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

E2.14: Agreements with Doctors and Hospitals

a. Frank Health Insurance has negotiated Participating Private Hospital Agreements. These agreements provide Members Covered by a Hospital Product or Combined Product (subject to any Exclusions and/or restrictions) with Cover for accommodation (shared and/or private room depending on level of Hospital Product), theatre, delivery suite, intensive/coronary care and a range of services provided by the Participating Private Hospital (subject to any Excess).
b. Where a Member is charged for a professional Medical Treatment or service where a Medical Purchaser-Provider Agreement applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the Medical Purchaser-Provider Agreement.
c. Fixed Benefits are payable for hospitalisation in non-Participating Private Hospitals. Significant Out of Pocket expense may be incurred for treatment in non-Participating Private Hospitals. Members should contact Frank Health Insurance for further details.

E2.15: AHSA Access Gap Cover

The Schedules referred to in these Fund Rules shall provide that the Benefits under AHSA Access Gap Cover arrangements are payable subject to the following conditions:

a. A Medical Practitioner who provides Hospital Services under AHSA Access Gap Cover shall give the Member written advice of any amount the Member can reasonably be expected to pay for those services:
    i. If possible, the advice shall be given before such services are provided, or otherwise as soon as practical, and
    ii. The recipient of the advice shall acknowledge receipt of the advice.

E2.16: Pharmaceuticals provided in Hospitals

a. Where a Hospital Product includes Benefits for PBS Medications the Benefit will meet the full cost of the pharmaceutical if it is directly related to the treatment for which the Insured Person was admitted;
b. The full cost referred to in a) includes the patient Co-Payment, and any special or patient contribution, brand premium or therapeutic premium otherwise payable by the patient under the Pharmaceutical Benefits Scheme; and
c. Benefits for non-PBS medications supplied to Insured Persons are payable in accordance with the agreement with the Hospital if:
    i. The Benefit is specifically included in the agreement with the Hospital; and
    ii. The pharmaceutical is directly related to the treatment for which the Insured person is admitted.
d. The Benefits described in E2.15.a–c are only payable for pharmaceutical items that are:
    i. Approved by the Therapeutic Goods Administration Council for use in Australia for

the use prescribed during the admission;

ii. Published within the MIMS schedule; and

iii. Where the item is intrinsic to the patient's episode of care. No Benefits are payable for:

i. Contraceptive drugs;

ii. Drugs issued for the sole purpose of use at home;

iii. Ward drugs;

iv. Pharmacy items charged in a Public Hospital;

e. Any agreement under a Hospital Purchaser-Provider Agreement may override this Rule.

E2.17: Surgically Implanted Medical Devices and Human Tissue Products

Frank Health Insurance will pay Benefits for medical devices and human tissue products listed on the Prescribed List which are surgically implanted as part of Hospital Treatment when:

a. Prescribed List products are provided to a patient with appropriate health insurance cover
b. Prescribed List products are provided as part of hospital treatment or hospital substitute treatment,
c. There is a Medicare benefit payable for the service, and
d. Medical devices and human tissue products is approved for use in Australia by the Department of Health and Aged Care .

Frank Health Insurance will pay an amount equal to the full cost of "no gap" price listed in the Prescribed List and an amount equal to the Minimum Benefit for "gap permitted" medical devices and human tissue products.

Non-listed medical devices and human tissue products: If the medical devices and human tissue products or medical device is not on the Prescribed List, Frank Health Insurance is not required, by law, to pay for the non-listed medical devices and human tissue products.

E2.18: Hospital-Substitute Treatment

Frank Health Insurance will only Cover Hospital-Substitute Treatment that is provided by a Recognised Practitioner who is a general or specialist nurse where:

a. A Medical Practitioner has certified that the treatment being provided replaces hospitalisation; and
b. A Medical Practitioner appointed by Frank Health Insurance assesses such certification to be medically reasonable and appropriate.

E2.19: Consumables

All dressings, single-use equipment, single-use medical devices and disposables (including laparoscopic and robotic disposables unless approved by Frank Health Insurance prior to surgery) are included in the procedure and/or accommodation rates and will not be paid for separately by the fund.

E2.20: Nursing Home Type Patient

If you become a Nursing Home Type Patient, Frank Health Insurance will pay Nursing Home Type Patient Benefits for the duration of your classification as a Nursing Home Type Patient. Patients who require stays more than 35 days may become nursing home type patients (NHTP), services are paid at a different rate compared to an acute care patient. You will be required to make a contribution to the cost of your care at a rate as declared by the Minister from time to time to cover the cost of your accommodation.

E2.21: Accident Protection (Selected Covers)

To be eligible for Accident Protection coverage, the accident must not be the result of;

- 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)

E3: General Treatment

E3.1: Annual Limits

Frank Health Insurance will pay Benefits for General Treatment (other than Hospital-Substitute Treatment) up to any limit per period (if any) that applies to your Cover.

E3.2: Recognised Providers

Frank Health Insurance will only pay Benefits for General Treatment (not where provided as part of Hospital Treatment) where it is provided:

a. By or on behalf of a Recognised Practitioner in Private Practice;
b. On premises registered with Frank Health Insurance, unless otherwise approved; and
c. Where services are provided face to face or as a recognised telehealth service as approved by Frank Health Insurance.

For the avoidance of doubt, Frank Health Insurance will not pay Benefits for treatment provided by someone who was not a Recognised Practitioner at the time that person provided the treatment. Frank Health Insurance has sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their treatments Frank Health Insurance will pay Benefits. Frank Health Insurance may choose to "de-recognise" someone from being a Recognised Practitioner for reasons including, but not limited to, fraudulent behaviour or the agreement governing the relationship between Frank Health Insurance and that person comes to an end.

E3.3: Doctors Letter of Recommendation

The following services require a Doctor's Letter of Recommendation in support of claims:

a. Blood Glucose Monitor, and
b. Quit Smoking Programs

E3.4: Agreements with General Treatment Providers

Frank Health Insurance may, from time to time, enter

into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in general information about our Products. Lists of providers of General Treatment with whom Frank Health Insurance have agreements are available on our website.

E3.5: Benefit Restrictions

Frank Health Insurance will only pay Benefits for one type of service of General Treatment provided by a Recognised Practitioner in Private Practice per day.

E4: Other

E4.1: Frank Hospital Rewards (Program closed effective May 1, 2021)

Members who held an eligible Frank Hospital Product were eligible for Frank Hospital Rewards.

Frank Rewards accrued from the join date and were applied each year on a Member's Anniversary Date to a maximum capped amount. Once the capped amount was reached, no further Frank Hospital Rewards were accrued until the balance returns to a figure less than that of the cap.

Frank Hospital Rewards were accrued at the following rates:

	Single Reward Dollars per year (capped at $500)	Couple/Family/ Single Parent Family Reward Dollars per year (capped at $1000)
Frank Top Hospital (Silver+)	$75	$150
Frank Silver Plus Hospital	$75	$150
Frank Silver Hospital	$55	$110
Frank Essentials Bundle (Silver)	$55	$110
Frank Bronze Plus Max Hospital	$55	$110
Frank Bronze Hospital	$40	$80
Frank Basic Hospital Plus (Basic+)	$40	$80
Frank Basic Hospital (Basic+)	$40	$80
Frank Starter Bundle (Basic)	$40	$80

Members received their final Frank Rewards accrual as a pro-rata amount, calculated on the closure date of April 30 2021, on their next Membership Anniversary Date (or April 1 2022 for members joining prior to April 1 2014) up to April 30 2022.

If a member transferred from an eligible policy to an ineligible policy prior to October 31 2024, any outstanding Frank Rewards balance was forfeited. Eligible members had until October 31 2024 to use any remaining Frank Rewards for inpatient medical claims for services provided on or before this date. Any balance outstanding was forfeited on November 1 2024. Frank Rewards could only be claimed against Medical Out of Pocket costs. This occurred automatically within 60-90 days of Frank Health Insurance receiving a Member's hospital account.

E4.2: Frank Loyalty Benefit

Members who hold eligible products will be eligible for the Frank Loyalty Benefit. Frank Loyalty Benefit increases the eligible Annual Limits after each full calendar year is served up to a maximum of 4 years of continual cover. The increased benefit will be available on 1 January after each full calendar year has been served. Loyalty Limit applies to specific services as outlined within the product.

Franks Loyalty Benefit is accrued at the following rates:

Eligible Products	Loyalty Benefit per full calendar year served	Maximum number of continual calendar years served eligible for Loyalty Benefit	Mamimum increased benefit
Frank Freedom Starter Flexi-Bundle (Basic)	$50	4 years	$200
Frank Freedom Saver Flexi-Bundle (Basic+)	$100	4 years	$400

F: Limitation of Benefits

F1: Excess

The amount of the Excess and relevant limits and conditions are specified in the Schedule relevant to the Policyholder's Cover.

F2: Waiting Periods

Waiting Periods will apply to:

a. New Memberships (previously uninsured);
b. Additions to a Membership (unless the addition/s has already served all Waiting Periods with GMHBA Limited or another private health insurer) except newborns and adopted and foster children; and
c. Existing Memberships and transfers to GMHBA Limited from another private health insurer where the level of cover and/or benefit entitlement is upgraded or increased (including by reducing the Excess payable) and/or where the Waiting Periods have not been completed.

F2.1: Application of Waiting Periods

Unless otherwise permitted by Frank Health Insurance, subject to Fund Rule C6, a Member must serve the Waiting Periods set out in this Fund Rule F2 before Benefits are payable by Frank Health Insurance under a Product.

F2.2: Waiver in Case of Accidents

Frank Health Insurance may at its discretion waive the two-month Waiting Period in rules F2.3 for treatment required as the result of an Accident occurring within the two-month period.

F2.3: Waiting Periods: Hospital Treatment

The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital-Substitute Treatment (where relevant to the Policyholder's Cover):

a. Obstetrics related Services – 12 months
b. Treatment for Pre-Existing Conditions (as provided in Rules F2.5 to F2.7) other than items listed in points c) and d) – 12 months
c. All Rehabilitation and Palliative Care regardless of whether it is a Pre-Existing Condition – 2 months
d. Psychiatric treatment – 2 months unless the Member takes up the Mental Health Waiver once-per-lifetime upgrade in accordance with the Private Health Insurance (Complying Product) Rules 2015
e. Hospital treatment for included services as a result of an accident (accident must occur after joining) - 0 days
f. All Other Services – 2 months.

F2.4: Waiting Periods: General Treatment

The following Waiting Periods apply to a Benefit for General Treatment for the services shown (where relevant to the Policyholder's Cover):

All services and items except those listed below – 2 months

a. Optical services – 6 months;
b. Medically prescribed health appliances such as Blood Glucose Monitor, Extremity Pump, Pressure Garments, Sleep Apnoea Monitor, Tens Monitor, Blood Pressure Monitor, Nebuliser Pump, Frank Health Insurance approved orthopaedic appliances, non-surgical medical devices and human tissue products – 12 months;
c. Major Dental treatment including crowns and bridgework, oral surgery, endodontics, dentures and orthodontics – 12 months.

F2.5: Pre-Existing Condition (PEC): Waiting Period

a. Frank Health Insurance may refuse or reduce Benefits in respect of a Pre-Existing Condition that is the subject of treatment within the first twelve months of Membership of any Cover;
b. This rule also applies where a Member transfers to another Cover which provides higher Benefits for the relevant treatment.

F2.6: PEC: Information from Treating Practitioner(s)

Subject to the Private Health Insurance Act:

a. Frank Health Insurance may appoint a medical or other relevant practitioner to determine whether or not a condition for which treatment may be provided and Benefits may be claimed is a Pre-Existing Condition.
b. A practitioner appointed under a) shall take into account:
    i. Information provided by the practitioner(s) who treated the Member in the six months prior to their becoming a Member or changing their Cover, and
    ii. Any other material that Frank Health Insurance consider as relevant to the claim.
c. Frank Health Insurance may suspend consideration of a claim until such time as:
    i. The Member (or Policyholder where appropriate) authorises the release of the information referred to in b), and
    ii. This information has been provided to Frank Health Insurance, and
    iii. The relevant practitioner referred to in a) has reviewed the information referred to in b), and
    iv. Frank Health Insurance is in receipt of the PEC form from the relevant practitioner referred to in a).
d. The PEC report from the relevant practitioner referred to in a) will determine whether the Pre-Existing Condition Waiting Period will be applied.

F2.7: PEC Waiting Period Not to Apply Where the Fund Alters the Cover

a. Where Frank Health Insurance has changed the terms of a Cover, any higher or additional Benefits now available to existing Members of the Cover are not subject to an additional Pre-Existing Condition Waiting Period.
b. This Fund Rule has no effect on any other Waiting Period or condition that applies to a newly available Benefit.

F3: Exclusions

F3.1: Exclusion of Benefits

Benefits are not payable in the following cases:

a. For any treatment or service occurring within the Waiting Periods;
b. For any treatment or service during a period where contributions are in Arrears or the Membership is suspended;
c. For any treatment or service for which no fee was charged;
d. Treatment where the Member is eligible for free treatment under any Commonwealth or State Government Act or program;
e. For treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at Frank Health Insurance's discretion;
f. If a Membership application or claim contains false, misleading or fraudulent information.
g. For any treatment, service or good provided or purchased overseas or for businesses located overseas,
h. For pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS),
i. For pharmaceuticals not considered as a S4 or S8 drug by the Therapeutic Goods Administration;
j. All contraceptives
k. For treatment provided more than 12 months ago;
l. For Medical Treatment provided to a Member who is an Outpatient;
m. Services or treatment rendered by a practitioner not in private practice;
n. Foot orthotics by any provider who is not a podiatrist or orthotist.
o. Cosmetic services or treatment rendered by a provider.

In addition to the above, a Cover may exclude Benefits for Hospital Treatment as detailed in the associated Schedules to these Fund Rules.

F3.2: Non-Residents

Hospital and Medical Benefits to Members who are Non-Residents of Australia are limited by their Medicare entitlements.

F4: Benefit Limitation Periods

Effective 1 July 2018, no Benefit Limitation Periods apply to any Cover.

F5: Restricted Benefits

A Cover may restrict Benefits for Hospital Treatment as detailed in the associated Schedules to these Fund Rules.

F6: Compensation Damages and Provisional Payment of Claims

F6.1: Definitions

In Fund Rule F6:

a. A reference to a "Claim" includes a claim, demand, action, proceeding, litigation, judgment or award other than a claim for Benefits;
b. A reference to an "injury" includes a condition, ailment or injury for which Benefits would or may otherwise be, payable by GMHBA Limited for expenses incurred in relation to its treatment; and
c. A reference to a Member receiving Compensation includes:
    i. Compensation paid to another person at the direction of the Member, and
    ii. Compensation paid to another Member on the same Membership in connection with an injury suffered by the Member.

F6.2: Obligations of a Member

Subject to Fund Rule F6.8, a Member who has, or may have, a right to receive Compensation in relation to an injury, must:

a. Inform GMHBA Limited as soon as the Member knows or suspects that such a right exists;
b. Inform GMHBA Limited of any decision of the Member to Claim for Compensation;
c. Include in any Claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be payable;
d. Take all reasonable steps to pursue the Claim for Compensation to GMHBA Limited's satisfaction;
e. Keep GMHBA Limited informed and updated as to the progress of the Claim for Compensation, and
f. Inform GMHBA Limited immediately upon the determination or settlement of the Claim for Compensation.

F6.3: Entitlement of Benefits for an Injury

a. Subject to Fund Rule F6.5, and unless otherwise permitted under this Fund Rule, Benefits are not payable for expenses incurred in relation to the injury where the Member has received, or may be entitled to receive, Compensation in respect of that injury.
b. The expenses referred to in Fund Rule F6.3a) include expenses incurred after the Member has received any Compensation.

F6.4: GMHBA Limited May Provisionally Withhold Payment

Where a Member appears to have a right to make a Claim for Compensation in respect of an injury but that right has not been established, GMHBA Limited may, at its discretion, elect not to assess a claim for Benefits in respect of expenses incurred in relation to that injury until the Member has taken all reasonable steps to pursue enquiries in relation to the Claim for Compensation to GMHBA Limited's satisfaction.

F6.5: Provisional Payments

a. Where a Claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalized, GMHBA Limited may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.

b. In exercising its discretion, GMHBA Limited may consider factors such as unemployment or financial hardship or any other factors it considers relevant.

c. A provisional payment is conditional upon the Member signing a legally binding undertaking and acknowledgement supplied by GMHBA Limited, which contains an agreement by the Member, in consideration for the payment:

    i. To comply with Fund Rule F6.2;

    ii. That it is bound by these Fund Rules;

    iii. To disclose to GMHBA Limited on request, all matters pertaining to the progress of the Claim for Compensation and details of any determination made or any settlement reached in respect of the Claim for Compensation and that the provision of such information to GMHBA Limited does not constitute a waiver of any legal professional privilege or any other forms of privilege;

    iv. To repay to GMHBA Limited the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim for Compensation, whether or not the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future for which Fund Benefits are otherwise payable; and

    v. That GMHBA Limited has specified rights of subrogation whereby GMHBA Limited acquires all rights and remedies of the Member in relation to the Claim for Compensation.

F6.6: Where Benefits have been paid by GMHBA Limited

a. Subject to Fund Rule F6.9, where:

    i. GMHBA Limited has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury; and

    ii. The Member has received Compensation in respect of that injury,

the Member must repay to GMHBA Limited the full amount that GMHBA Limited paid in relation to the injury, upon the determination or settlement of the Claim for Compensation.

b. This Fund Rule applies whether or not:

    i. The determination or settlement sum includes the full amount that GMHBA Limited paid; or

    ii. The terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which Benefits are otherwise payable; or

    iii. The relevant Member complied with their obligations under Fund Rule F6.2.

F6.7: Rights of GMHBA Limited

If a Member makes a Claim for Compensation in relation to an injury and fails to:

a. Comply with any obligation in Fund Rule F6.2 or F6.6; or

b. Include in their Claim for Compensation any payments of Benefits by GMHBA Limited in relation to any injury,

GMHBA Limited may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:

    i. Assume that all expenses in relation to the injury have been met from the Compensation payable or received pursuant to the Claim for Compensation; and/or

    ii. Pursue the Member for repayment of all Benefits paid by GMHBA Limited in to the injury; and/or

    iii. Assume the legal rights of the Member in respect of all or any parts of the Claim for Compensation.

F6.8: Claim Abandoned Where:

a. a Member has or may have a right to make a Claim for Compensation in respect of an injury, and

b. GMHBA Limited reasonably determines that the Member has abandoned or chosen not to pursue that Claim,

Benefits are payable (subject to other Fund Rules) if the Member signs a legally-binding undertaking supplied by GMHBA Limited by which the Member agrees, in consideration for the payment of Benefits, not to pursue that Claim.

F6.9: Requirements to Repay Benefits may be Waived

Where, in respect of a Member's Claim for Compensation in relation to an injury:

a. The Member has complied with Fund Rule F6.2, and

b. GMHBA Limited has given prior consent to the settlement of the Claim for an amount that is less than the total Benefits paid or which would otherwise have been payable by GMHBA Limited,

GMHBA Limited may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the Member need not repay any part or the full amount of the Benefits paid by GMHBA Limited in respect of that injury.

F6.10: Benefits for Expenses Subsequent to Compensation

GMHBA Limited may, in its absolute discretion, pay Benefits where:

a. Expenses have been incurred as a result of:

    i. A complication arising from an injury that was the subject of a Claim for Compensation, or

    ii. The provision of a service or item for treatment of an injury that was the subject of a Claim for Compensation, and

b. That Claim has been the subject of a determination or settlement, and

c. There is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F6.11: Future medical expenses

a. Where it is anticipated that a Member has future medical needs in relation to an injury, the Member must use reasonable endeavours to procure an award or settlement of a Claim for Compensation that includes a specified allocation for future medical expenses.

b. On request by GMHBA Limited, a Member must provide evidence to GMHBA Limited to establish whether a determination or settlement of a Claim for Compensation includes an allocation for future medical expenses.

c. Where a determination or settlement of a Claim for Compensation includes an allocation for future medical expenses in relation to an injury:

    i. the Member must use that allocation to pay for treatment of that injury;

    ii. the Fund may refuse to pay Benefits for treatment relating to that injury until the allocation is exhausted;

    iii. the Member must keep and provide to GMHBA Limited evidence to establish that the allocation has been exhausted on expenses for treatment of that injury; and

    iv. if the Member cannot provide such evidence, or the allocation has been exhausted on expenses other than for treatment of that injury, GMHBA Limited may refuse to pay Benefits for treatment relating to that injury.

    v. Where a Member has complied with their obligations in Fund Rule F6.11a) but a determination or settlement of a Claim for Compensation does not include a specified allocation for future medical expenses, GMHBA Limited may in its absolute discretion agree to pay Benefits for treatment rendered after the determination or settlement in relation to the relevant injury.

F6.12: Cancellation/Termination of Membership

a. A Member's obligations under these Fund Rules continue despite any termination or cancellation of Membership.

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ABN 98 004 417 092 last updated April 2025