important information guide.

frank.
health insurance

effective April 2025

contents.

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

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

thanks for joining frank.

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

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

Confirmation of terms and conditions of your membership

When signing up to Frank, you agreed to the following terms and conditions:

New membership join process acknowledgement

In these terms, "you" or "your" refers to GMHBA Limited, and "I" or "my" refers to you as the Policy Holder. By typing "yes" I acknowledge and declare that:

- I have read and accept your terms and conditions of membership (as outlined in the Important Information);
- I understand the conditions relating to pre-existing conditions/illnesses, waiting periods;
- I have read and accept your Privacy Statement for Members and I consent to the use and disclosure of my personal information in accordance with this policy;
- The information I have provided to you via my/our application for membership
- is true and correct;
- The information in my/our application for membership is provided with the consent of the individual(s) to whom it relates.
- I confirm that I have the authority to act on behalf of the individual(s) named in my/our application and I have brought your Privacy Statement for Members to their attention; I will make all claims under this policy and will ensure that each claim includes the sensitive information of a spouse/partner or dependant aged 16 years and over only with their consent;
- I understand that my application for membership at the payment of benefits may be declined if any of the information I have provided to you is false;
- Upon acceptance of my application for membership I will have engaged you to provide health insurance to me in accordance with my chosen level of cover;
- I understand that no benefits are payable until my membership payments are up to date;
- I am responsible for this policy and I will communicate to all current and future individuals covered by it, the information contained in your terms and conditions of membership, the existence of the Fund Rules, and the fact that those terms, conditions and rules apply to all of your members; and
- I understand that you have the right to amend your terms and conditions of membership and your Privacy Statement for Members.

Transferring from another health insurer

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

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

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

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

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

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

Under lifetime health cover (LHC), continuity of a member's/partner's certified age at entry (CAE) is possible when transferring from another Australian registered private health insurer.

Recommendation or endorsement

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

who can be covered under your frank membership?

The Member

The member is the name of the person who takes out the health insurance policy.

The member is:

- The primary contact for Frank Health Insurance
- Responsible for paying their Frank premiums
- Nominates who is covered by the policy
- Responsible for keeping their personal and membership details up to date
- Is entitled to access all records, claims history and tax statements relating to their membership

Singles Cover

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

Couples Cover

Covered under this policy are:

- The policyholder
- The policyholder's partner

Family Cover

Covered under this policy are:

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

Single Parent Cover

Covered under this policy are:

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

Dependants including child and student dependants

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

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

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

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

- their new cover starts within 30 days of coming off the family cover, and
- chosen level of cover is equal to or lower than the family cover.

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

Student dependants – other fund members

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

Age-based Discount

All Frank hospital products include a discount based on your age. This means Australians aged 18-29 will be eligible to receive up to 10% discount on their premiums for hospital cover.

The discount will be available on all Frank products and is available to new and existing members.

You can retain your age-based discount until you're 41 providing you remain on a hospital product. These discounts will then be gradually phased out after you turn 41.

To receive the discount, new eligible members can sign up to one of our hospital products and it will be applied automatically to your premium.

Membership for non-residents of Australia

Frank hospital covers are designed for people who have full Medicare eligibility. These covers will not meet the cost of public or private hospital treatment, medical treatment or diagnostic services for people who do not have full Medicare eligibility. People who do not have full Medicare eligibility should contact Frank to discuss appropriate health insurance arrangements or for more information visit frankaustralia.com.au.

Migrants

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

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

managing your cover.

Member Area

Make the most of your cover by managing your membership online through your own online Member Area. Use your Member Area to:

- Lodge selected extras claims
- Check your limits
- Update your details
- Review or change your cover

The Frank App

You can also view and manage your cover on the go with the Frank app. Log in using the same details as your Member Area.

Member card

When you sign up with Frank Health Insurance, the main member (policyholder) will have access to a digital member card via the Frank app. A physical member card will be provided for the policyholder's partner (if applicable) soon after joining. Membership details including your member number and names of the individuals covered as part of the policy are outlined on your member card, in the app and your Member Area. Have your digital or physical member card on hand when you arrange admission to hospital as a private patient, claim extras on the spot at your provider, or when you call us with any questions.

Physical member cards can be requested for the main member (policyholder) and any dependant/s via the app, Member Area or by contacting us.

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

Communications from Frank

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

We'll provide you with lots of information upon joining, including your:

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

We understand that you'll need this material one day, so all information is communicated via your Member Area. The information can be viewed in screen, copied to a drive of your choice or printed out. Information delivered via your Member Area can be personally sensitive so we recommend that you guard your password carefully.

As well as the material listed above, the following communications will be sent to your Member Area:

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

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

When to contact Frank

Make sure you contact Frank before any hospital admission to check your cover level and benefits payable.

Planning a child

If you're preparing to start a family and your hospital cover does not include pregnancy benefits, you'll need to ensure you upgrade your hospital cover to include pregnancy services at least 12 months before you have a child to ensure all waiting periods have been served. If all goes well, a newborn baby is not admitted as a patient in hospital, but if you have complications and your baby requires any accommodation or medical attention, your newborn baby will be covered for accommodation or medical services provided they are added to the policy within 6 months of their date of birth.

A single policy will become a single parent policy, and a couples policy will be come a family policy when the newborn is added to the policy.

Arrears

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

Overseas travel

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

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

Suspensions

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

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

Benefits will not be accrued whist the policy is suspended, e.g. orthodontic sublimits, Frank Flexi Bundle limits.

Periods of suspension do not count towards waiting periods or paid hospital days.

Please see Frank Fund Rules for additional information.

You'll be required to nominate a return date at the time of applying for a suspension. Your membership will be re-activated on this date with your premium automatically direct debited.

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

Your Certified Age of Entry (CAE), for the purposes of calculating Lifetime Health Cover (LHC) loading, may be affected by periods of absence of 3 years or longer.

Cancelling your cover

You may cancel your Frank Health Insurance cover from:

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

A refund of any premiums paid past your date of cancellation will be direct credited to your nominated bank account; refunds cannot be processed within 7 days of your most recent direct debit. If you cancel your Frank Health Insurance cover within 30 days of joining back to the date that you first joined, you'll receive a full refund of any premiums received by Frank, provided you have not made a claim.

waiting periods.

Waiting periods

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

Waiting periods apply to:

- New members (previously uninsured);
- Additions to a membership (unless the addition/s has already served all waiting periods with Frank or another insurer) except newborns and adopted and permanent foster children
- Existing Frank memberships, and transfers to Frank from another insurer where:
  - there is a gap of 30 days or more between a previous policy with Frank or another insurer and a new policy
  - the level of cover and/or benefit entitlement is upgraded or increased;
  - any hospital or extras service was not covered by the previous insurer and/or;
  - the waiting periods have not been completed.

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

- 12 months – pregnancy services or pre-existing condition (other than for psychiatric, rehabilitation or palliative care).
- 2 months - psychiatric, rehabilitation or palliative care.
- 2 months - any other hospital treatment benefit.
- 0 days - accidents and emergency ambulance

The mental health waiver allows members who have served their 2 month waiting for restricted psychiatric benefits to upgrade their cover to a product which includes in-hospital psychiatric treatment without serving an additional 2 month wait. Members can use the Mental Health Waiver once in their lifetime. The waiver applies only to the 2 month waiting for in-hospital psychiatric treatment. Any other applicable waiting periods will still need to be served.

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

- 12 months - major dental, podiatric surgery and orthotics (where included in the cover)
- 6 months - optical (where included in the cover)
- 2 months - any other extras service
- 0 days - ambulance subscription

The above waiting periods also apply to previously uninsured members.

If you've served part of your waiting period with your previous fund, you'll need to serve the remainder of it with Frank.

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

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

Pre-existing conditions

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

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

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

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

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

We need about five to seven working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioner/s. Make sure you allow for this time frame when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and we subsequently determine your condition to be pre-existing, you'll have to pay all outstanding hospital charges and medical charges not covered by Medicare.

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

Emergency admissions

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

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

Waiting periods – Pre-existing conditions

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

- new members must wait 12 months for any hospital benefits (other than psychiatric, rehabilitation and palliative care).
- members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits (other than psychiatric, rehabilitation and palliative care).

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover as long as the service was not excluded.

hospital cover information.

Excess

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

The amount of your excess for hospital visits can vary based on your cover, and is outlined on your product fact sheet

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

Clinical Categories

Frank is required to use standard clinical categories and definitions across all services, including references to inclusions and exclusions. The full list of these categories and definitions is available on pages 31-36.

Informed financial consent

Informed financial consent is where you'll be presented with all costs of your treatment and be made aware of any out of pocket expenses by service providers involved prior to being admitted to hospital.

Before being admitted into hospital as a private patient, you should ask the doctor for an estimate of their fees, whether there are any other doctors likely to be involved in your care (e.g. anaesthetist, assistant surgeon) and how to get information about their fees. You should also check with Frank what benefits could be paid from your hospital cover.

Participating private hospitals

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

Have a look at Frank's participating private hospitals, but remember that it can change without notice. Check with Team Frank before confirming any hospital admission.

Non-participating hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Contact Team Frank for further details as treatment in a non-participating private hospital will result in out-of-pocket expenses. Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

Using your private cover in a public hospital

If you're admitted into a public hospital as a private patient, Frank will pay the minimum benefits for a shared room only for services included under your cover, except for NSW public holidays. For NSW public hospitals, Frank will pay for a private room where the member has; signed the inpatient Election form to be treated as a private patient and ticked yes to a single room if one is available on the Inpatient Election form. When making a decision about which hospital you'll be treated at, keep in mind that not all doctors have admitting rights into all hospitals. Basically, if you have a preferred doctor they might not be allowed treat you in a public hospital. Your doctor will be able to tell you what hospitals they have admitting rights to. Electing to be a private patient in a public hospital could result in significant out-of-pocket costs to you. Ensure you receive written informed financial consent for any hospital admission.

Accidents

An accident is an unforeseen event that occurs by chance. Frank Hospital products cover accidental injuries sustained after joining the fund (joint investigations and reconstructions are covered if they are required as a result of an accident). For an accident to be covered, treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury and the hospital admission must occur within 90 days. An Accident Declaration form must be supplied to Frank.

Accident Protection (selected covers)

Accident Protection means temporarily upgraded cover. You may be eligible to access treatments usually reserved for the highest levels of hospital cover for up to 90 days following an accident.

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

Accident Protection covers accidental injuries occurring by chance and caused by an external force or object, which results in involuntary injury to the body sustained after joining Frank. For an accident to be covered, treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury and the hospital admission must occur within 90 days. An Accident Declaration form must be supplied to Frank in order for benefits to be paid. There are some services that are not eligible to be considered an accident.

Following the initial admission that has occurred within 90 days, if you require a follow up procedure that is directly related to the accident, this will be covered under your accident protection

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

Frank's definition of Accident excludes:

- Medical Conditions (disease or illness that is not immediately due to an external injury)

- Pre-Existing Conditions

- Pregnancy, birth and IVF procedures

- Accidents arising from surgical procedures

- Elective Cosmetic Surgery

- Podiatric Surgery by an accredited podiatrist

- Sudden Illness

- Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner

- Aggravation of an existing condition

- Damage to teeth caused by eating or drinking

- Claims covered by third parties (such as Workcover and TAC)

Emergency Ambulance

When you take out any Frank hospital product or selected Frank ancillary products, you'll be covered for emergency ambulance services Australia wide. This includes all clinically necessary, emergency ambulance transport in any state or territory of Australia.

Emergency Ambulance trips by State or Territory Ambulance Service will be covered where:

- The insured person is not already covered by a

State or Territory Ambulance Service scheme AND

- The service was defined as an emergency by the Ambulance Service OR
- The ambulance attended to an emergency but by the time they arrived, they were no longer required OR
- A treating doctor has defined the trip as medically required transport.

Emergency Ambulance doesn't include:

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

Podiatry surgery

If you go into hospital, and have surgery performed by an orthopaedic surgeon, then this is taken care of with your hospital cover. Your extras cover doesn't get used.

If the surgery is performed by an approved podiatric surgeon (there are only a few in Australia), then your extras cover will provide benefits towards their fees (if you have podiatry as part of your Extras, have available limits and have served your waiting period). The hospital expenses, theatre, etc. are still covered by your hospital cover. Medical services such as anaesthetist and diagnostic tests will not be covered for podiatry surgery.

To be covered for podiatric surgery, you must use a surgeon on Frank's approved podiatric surgeons list.

Dental Surgery

Dental surgery can be performed both in a dentist's practice, or in hospital. Coverage for dental surgery will depend on factors such as who performs the procedure and where the procedure is done.

Frank suggests you contact us prior to any dental surgery to confirm your coverage.

Private Emergency Attendance Benefit (selected covers)

Some private hospitals charge an Emergency Department attendance fee for outpatient treatment. This fee varies by private hospital. If you are treated in a private Emergency Department and you are not admitted to hospital, you are considered an outpatient. Private Emergency Attendance Benefit is included on selected Frank Hospital covers. Frank is not able to pay any benefits for treatment you receive as an outpatient. To determine if your cover includes Private Emergency Attendance Benefit, please refer to your fact sheet.

Choose your own provider

At Frank, we believe in freedom of choice when it comes to choosing an Extras provider. As long as your provider is registered with the appropriate board in their field, we'll pay benefits based on your level of cover up to your annual limits.

access gap cover

What is Medical Gap?

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

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

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

What is Access Gap Cover?

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

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

There are 2 scenarios for how you may be billed by your specialist doctor when they use the Access Gap Cover scheme:

No Gap – this is where there will be no gap for you to pay following the procedure

Known Gap – this is where you will be charged a maximum Gap of $500 per specialist, per admission and $800 for obstetrics services.

Is your doctor registered for Access Gap Cover benefits?

If your specialist doctor is registered for Access Gap Cover, the gap may be reduced or eliminated for medical services they provide while you are an inpatient in hospital.

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

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

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

extras cover information.

Medicare

Where you are entitled to any rebate or reimbursement from Medicare for an Extras service, you can't claim any out of pocket expenses with Frank.

Insulin pumps

Frank does not pay a benefit for replacement of insulin pumps still under manufacturer's warranty.

Orthotics

Where covered, benefits can only be claimed on orthotics if they are custom made (from a cast or mould taken by you) by a podiatrist or orthotist in a private practice.

Ambulance

VIC, SA, WA and NT residents can claim 80% or 100% of the cost of one ambulance subscription per year (% back will be based on your type of Extras cover). Please note, not all extras products can pay a benefit on the subscription, please refer to your product fact sheets for more information.

Ambulance is covered differently in each state. To make sure you know exactly how it's covered in your state, check out more info online.

General dental rules

General dental rules apply to all Extras products:

- Maximum of six item 222 per visit and a maximum of 24 per calendar year can be claimed (within annual limits). Item 222 cannot be claimed in the same visit as item 111, 115, 231, 232, 242, 243, 250 or 251.
- For items 961 - 972, a maximum of $250 per calendar year can be claimed if the service is provided by a dentist or $300 per calendar year can be claimed if the service is provided by a specialist.

Preventative dental rules

The preventative dental sublimit applies to dental item numbers for Some Extras and Lots Extras products:

011 - 018, 111, 113 - 115 and 121.

Other preventative dental rules (applies to all Extras products):

Other things you need to know about dental cover – all Extras covers

- There are some dental items that have a maximum number of claimable services per visit and per year.
- Frank will only cover the following items when provided by a specialist dentist
  - 018 - Written report (not elsewhere included)
  - 237 - Guided tissue regeneration – membrane removal.
  - 238 - Periodontal flap surgery for crown lengthening - per tooth.
  - 332 - Ostectomy - per jaw.
    A maximum of 2 per visit applies.
- There are also some dental procedures that Frank won't cover when claimed with other items, eg if your bill says you had a tooth filled and removed on the same day, we won't pay for the filling.

If you're worried about what your out-of-pocket dental expenses might be, check the dental item numbers using the benefit quote tool in your online Member Area or contact Team Frank.

The below table provides a list of dental items that Frank does not pay benefits on:

019	Letter of referral	384	Repositioning of displaced tooth/teeth
018*	Written report (not elsewhere included)	394*	Surgery for osteomyelitis
026	Cone Beam Volumetric Tomography - scan acquisition (per visit)	438*	Hemisection
044	Collection of specimen for pathology examination	664	Fitting of bar for denture - per abutment
047	Saliva screening test	666	Prosthesis with metal frame attached to implants - per tooth
054	Mucosal screening	668	Fixture or abutment screw removal and replacement
059	Comprehensive head and neck cancer examination and risk assessment	669	Removal and reattachment of prosthesis fixed to implant(s) - per implant
061	Pulp testing	689*	Provisional implant
085	Electromyographic recording	711 - 769	Dentures and denture related items
086	Electromyographic analysis	778	Inlay for denture tooth
087 - 091	Cone Beam Volumetric Tomography analysis and/or interpretation	779*	Surgical guide for an immediate denture
119	Bleaching, home application - per arch	915	After-hours callout
122	Topical remineralizing and/or cariostatic agents, home application - per arch	916	Travel to provide services
123	Concentrated remineralizing and/or cariostatic agents, application - single tooth	926	Individually made tray - medicament(s)
131	Dietary advice	927	Provision of medication/medicament
141	Oral hygiene instruction	941	Local anaesthesia
142	Tobacco counselling	944	Relaxation therapy
165	Desensitizing procedure - per visit	945	Low level laser therapy – per appointment
237*	Guided tissue regeneration – membrane removal	948	Dental acupuncture – per appointment
238*	Periodontal surgery for crown lengthening – per tooth	949	Treatment under general anaesthesia/ sedation
332*	Ostectomy – per jaw	985	Repair/addition – snoring or sleep apnoea device
375*	Surgery to salivary duct	990	Treatment not otherwise included (specify)
376*	Surgery to salivary gland	999	GST

* Only Frank Simple Extras, Everyday Extras and More Extras do not pay a benefit on these item numbers.

things frank won't pay

- Maximum of one examination or consultation item per visit. Examination and consultation items include 011-017. Maximum of one 011 service payable per provider per two calendar years.
- Maximum of 3 checkups per person per calendar year. Checkups include items 011, 012 and 014.
- Maximum of 3 scale and cleans per person per calendar year applies. Maximum of one item payable per visit. Scale and cleans includes items 111, 114 and 115. Not payable with 222, 250 or 251.

The preventative dental limit is included within the overall dental limit.

Crown & bridge rules

The crowns and bridgework sub limit applies to the following dental item numbers where major dental is included:

- Crowns include items 611-618 and 671-673
- Bridgework includes items 642-643

Other crown dental rules (applies to all Extras products):

- Maximum 1 crown per tooth is payable every 5 years.

Check dental benefits in your Member Area

Because some dental items have sublimits within the overal dental limit, always check your benefit before receiving treatment. You can get a benefit quote feature in your online Member Area or by contacting Team Frank.

Weight management programs

Weight management benefits are claimable towards the costs or fees associated with membership to a weight management provider. Benefits are not payable towards the purchase of food and/or dietary supplements or exercise components. Approved weight management providers are Jenny Craig, Weight Watchers and Fernwood Food Coaching.

Individual telehealth consulatations

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.

Extras services purchased over the internet

Benefits will be paid for optical items purchased over the internet from Australian providers where a prescription is provided.

Benefits for services or treatment received overseas are excluded.

how to claim.

Exclusions

In addition to the services excluded from your cover, you cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Account/s which have been altered in any way will not be accepted. Providers are required to re-issue any account/s or endorse any alterations.
- Any outpatient emergency department service fees (e.g. observation, x-rays, drugs and lab tests) where a doctor hasn't written an order to admit you into hospital as an inpatient
- Any medical treatment that attracts an MBS item number that is provided when you're not admitted to hospital (Example: Emergency Department treatment, GP/ specialist appointments, scans, pathology, etc.)
- Natural remedies (includes Modifast & Optifast).
- Food supplements.
- Dental procedures carried out and charged direct to the member/dependant by a dental mechanic, other than an advanced dental technician.
- A range of dental procedures when provided on the same day e.g. a filling on a tooth that has been removed.
- Dental procedures where a limit on the number you can have has been exceeded.
- Dental procedures unless tooth identifications (ID) are supplied by the provider.
- Services/treatment for which the member and/ or dependant has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act.
- Services/treatment rendered more than 12 months prior to the date of claiming.
- Services/treatment which is not covered by your membership and/or is rendered while the membership is in arrears or is suspended.
- Services/treatment rendered by a practitioner not in private practice and/ or not recognised by bodies approved by Frank.
- Hiring of equipment (unless otherwise stated).
- Services are not rendered face to face with exception of approved Telehealth services
- Foot orthotics unless they are custom made and provided by a registered podiatrist.
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment.
- Benefits, payable under a hospital or extras cover shall not exceed the fees and/ or charges raised for any treatment and/ or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source.
- Benefits for services on treatment received overseas.
- Travel vaccinations not listed on the approved Travel Vaccinations list.
- Extras services that you are entitled to claim a Medicare rebate for.
- Cosmetic services or treatment rendered by a practitioner.

how to claim.

Restrictions

In addition to any services that are restricted as part of your cover, benefits may not be paid or may be paid at a lower level where:

- you have already claimed the maximum allowable benefits during a specified period.
- you have transferred to a Frank extras cover from an extras cover by a different insurer and have previously claimed for the service/ treatment or have used the total Frank annual limit amount with your old fund
- the health care account has been incompletely, incorrectly or inappropriately itemised.
- you have an excess to pay on your chosen level of cover.
- Frank believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care after 35 days continuous hospitalisation. If this is the case, Frank benefits will be reduced to Nursing Home Type Patients benefits and will be paid in accordance with the default benefit determined by the Department of Health & Ageing. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.
- the service/s is subject to a waiting period or other limit which has not been served/met.
- surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact Team Frank for further details on this.
- no MBS item number is provided by the GP/ specialist e.g. cosmetic surgery.
- professional services are provided to the provider, to members of the provider's family, to a provider's business partner's family members or any other people not independent from the practice. Family members include: wife/husband, brother/sister, children, parents, grandparents, grandchildren. If this is the case, only wholesale material costs involved in the provision of the service are subject to benefits.
- the claim is for additional medical gap benefits, where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- there is more than one claim made to the same provider on the same day. But you can claim for more than one service on the same day if performed by different providers.

things you need to know.

Hospital Claims

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

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

Medical Claims

Medical benefits cover fees payable to surgeons, anaesthetists and other professionals who may bill you separately from your hospital bills.

Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare and your claim for hospital benefits has been assessed and paid.

To submit a claim;

- Either complete a Medicare Two Way claim form when you take your claim to medicare; or
- Email the Medicare Benefit Statement given to you by Medicare when you claim their benefit

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

Find out more about how to claim.

Extras Claims | Electronic Claiming

When you have Frank extras cover you can use your Frank member card to claim electronically on-the- spot (if your health care provider has an electronic claiming machine). After the service has been provided, your member card will be tapped at or swiped through the terminal, your claim details entered and your claim will be processed electronically. Once your claim is authorised by Frank, you simply pay any difference between the full fee for the treatment and the amount paid by Frank.

If there is an unexpected rejection of your claim at the point of service, your provider should check the receipt for the rejection reason. If they're unable to identify the issue at the time of the service taking place they can contact Team Frank.

Online Extras Claims

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

Manual Extras Claims

In some situations you may not be able to claim online, and you'll need to submit your claim manually to Frank via email. Accounts must have been paid before they can be submitted for claiming.

To submit a claim manually, Frank needs the following information:

- The fully itemised health care account/s, and the receipt/s.

Claims Fraud

Frank reserves the right to take the

following actions against any member or persons where improper, fraudulent or indiscretion occurs whilst making health insurance claims.

Actions that may be taken are:

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

Paid accounts/ bills

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

Damages or compensation

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

Application for membership with Frank

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

You can make changes to your membership anytime.

Frank uses the terms 'member', 'spouse/ partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'member' can authorise changes to the membership unless the member has previously authorised the spouse/partner to make such changes. Similarly, correspondence issued by Frank will be addressed to the member and it is the member's responsibility to notify Frank of any change of address by maintaining the address records in the member area. The completion of the application process and the payment of any premium constitutes an acceptance of any conditions laid down in the regulations of the fund, including the fund rules and any fund policies, in force at that time or as they may be amended at any time. An electronic copy of the fund rules can be accessed on request by contacting Team Frank.

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

medicare levy surcharge (mls).

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

The MLS is an additional tax that Aussies need to pay if they don't have eligible private hospital cover and have a taxable income over $97,000 as a single or $194,000 as a couple/family.

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

- A single person - without dependent children - with a taxable income (including any reportable fringe benefits of $1,000 or more) greater than $97,000
- A family - including a couple and single parent - with a combined taxable income (including any reportable fringe benefits of $1,000 or more) greater than $194,000 (increasing by $1,500 per dependent child, after the first child).

If you're a:	And your combined taxable income is:			
	Base Tier	Tier 1	Tier 2	Tier 3
Single	$97,000 or less	$97,001 - $113,000	$113,001 - $151,000	$151,001 or more
Couple / Family (increases by $1,500 per child for 2+ children)	$194,000 or less	$194,001 - $226,000	$226,001 - $302,000	$302,001 or more
Then your Medicare Levy Surcharge is:				
All ages	Nothing to pay - 0.0%	Tier 1 - 1.0%	Tier 2 - 1.25%	Tier 3 - 1.5%

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

australian government rebate on private health insurance.

What is the rebate?

The Australian Government Rebate on Private Health Insurance is the amount the Government pay toward private health insurance premiums. It provides a subsidy on the cost of taking out private cover depending on your income. The rebate is available to those who have full Medicare eligibility and have a taxable income under $151,000 for singles and $302,000 for families/couples or single parents.

The rebate amount you're entitled to varies depending on your income tier and age.

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

Does the rebate change?

The Government releases new income tiers around 1 July each year. We'll let you know when these are announced.

How do I claim it?

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

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

If you're a:	And your combined taxable income is:			
Single	$97,000 or less	$97,001 - $113,000	$113,001 - $151,000	$151,001 or more
Couple / Family (increases by $1,500 per child for 2+ children)	$194,000 or less	$194,001 - $226,000	$226,001 - $302,000	$302,001 or more
Then your Australian Government Rebate Tier is:				
Aged under 65	24.288%	16.192%	8.095%	0%
Aged 65 - 69	28.337%	20.240%	12.143%	0%
Aged 70 +	32.385%	24.288%	16.192%	0%

Australian Government Rebate is effective April 1, 2025

lifetime health cover loading (lhc).

What is Lifetime Health Cover Loading?

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

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

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

Lifetime health cover applies to hospital cover and does not apply to extras.

Periods of absence

As members may need to discontinue their hospital cover membership for brief periods, lifetime health cover allows a period or periods of absence through a member's lifetime without affecting their CAE. However, after 1094 days absence, their CAE will increase by one year for each additional full year of absence. Members will need to re-serve waiting periods when they return to Frank. Approved periods of suspension will not count towards the 1094 days of absence.

For more information on Lifetime Health Cover please visit:

https://privatehealth.gov.au/health_insurance/surcharges_incentives/lifetime_health_cover.htm

what if something goes wrong?

Unhappy with Frank?

Tell us what is on your mind so we can help resolve the issue.

Our process for dealing with complaints is:

1. Talk to a Frank representative. You can talk to a representative by calling 1300 516 450 or emailing frank@frankhealthinsurance.com.au. We respond to all our phone calls immediately, and will follow up all e-mails within 2-5 working days.

2. Write to us. We will provide an acknowledgement within 5 working days for written correspondence. Where the matter is complex we will attempt to finalise within a month. However where the difficulty of the matter precludes this, we will inform you of the progress.

3. Write to the Member Services Review Committee (MSRC). If after receiving our response you are still not satisfied, you can write to the Member Services Review Committee (MSRC). We have appointed a panel of senior management who meet weekly to discuss any issues received from members. The aim of the MSRC is to listen to you and to provide decisions that are fair and equitable for all our members. You will receive an acknowledgement of your correspondence within five working days of the committee's weekly meeting. You are welcome to write to the MSRC by email to frank@frankhealthinsurance.com.au.

4. Contact our Member Resolutions Team. If you require further clarification about the decision made at the MSRC, please email us at frank@frankhealthinsurance.com.au. We will acknowledge your correspondence within five days of receipt. Where the matter is complex we will attempt to finalise within a month, however where the complexity of the matter precludes this, we will keep you informed of the progress.

If you're still dissatisfied with the outcome, free independent advice is available from the Private Health Insurance Ombudsman. To make a complaint, contact the Commonwealth Ombudsman at www.ombudsman.gov.au.

Independent advice

Free independent advice is available from the Commonwealth Ombudsman. You can contact the Commonwealth Ombudsman on freecall 1300 737 299. Find out more at ombudsman.gov.au.

State of the health funds report

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

Download the report from ombudsman.gov.au.

code of conduct.

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

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

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

You can download the Code Of Conduct at privatehealthcareaustralia.org.au/codeofconduct/

Privacy

We value the relationship between Frank and our members.

An important part of this relationship is our commitment to protecting the personal information entrusted to us by our members.

This commitment is documented in our Privacy Statement for Members.

audits.

Claim Audits

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

From time to time, in the general interest of members, a Frank representative may contact you with a request for assistance to monitor costs – whether relating to benefits paid or charges raised by health care providers. Your co-operation with such requests is critical to our cost containment efforts, and will be treated in a completely confidential manner.

Liabilities of fund members to Frank

A member can be liable to Frank for unpaid premiums and for overpayments. Overpayments can be made by Frank to a member, either through an error in completing a claim, or an error in processing a claim. If an overpayment is made, the member is liable to repay the amount of the overpayments to Frank on demand.

If a member is liable to Frank for unpaid premiums or overpayments then we have the right to deduct the amount of that liability from any monies due by Frank to the member on any account.

clinical categories.

Rehabilitation

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

Hospital psychiatric services

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

Palliative care

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

Brain and nervous system

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

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

Eye (not cataracts)

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

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

Ear, nose and throat

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

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

Tonsils, adenoids and grommets

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

Bone, joint and muscle

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

- Chest surgery is listed separately under Lung and chest.

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

Joint reconstructions

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

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

Kidney and bladder

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

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

Male reproductive system

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

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

Digestive system

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

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

Hernia and appendix

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

- Digestive conditions are listed separately under Digestive system.

Gastrointestinal endoscopy

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

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

Gynaecology

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

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

Miscarriage and termination of pregnancy

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

Chemotherapy, radiotherapy and immunotherapy for cancer

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

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

Pain management

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

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

Skin

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

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

Breast surgery (medically necessary)

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

tumours, asymmetry due to breast cancer surgery, and gynecomastia.

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

Diabetes management (excluding insulin pumps)

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

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

Heart and vascular system

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

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

Lung and chest

Hospital treatment for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest.

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

Blood

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

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

Back, neck and spine

Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion. For example: sciatica, prolapsed or herniated disc, and spine curvature disorders such as scoliosis, kyphosis and lordosis.

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

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

Plastic and reconstructive surgery (medically necessary)

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

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

Dental surgery

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

Podiatric surgery (provided by a registered podiatric surgeon)

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

- accommodation; and
- the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules, as in force from time to time.

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

Implantation of hearing devices

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

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

Cataracts

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

Joint replacements

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

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

Dialysis for chronic kidney failure

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

Pregnancy and birth

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

- Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory

conditions are covered under Lung and chest.

- Female reproductive conditions are listed separately under Gynaecology.
- Fertility treatments are listed separately under Assisted reproductive services
- Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.

Assisted reproductive services

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

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

Weight loss surgery

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

Insulin pumps

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

Pain management with device

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

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

Sleep studies

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

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