fund rules.

frank.
overseas visitor health cover

effective 1 January 2024

Contents

Important Notes

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

b. By taking out OVHC with Frank OVHC, you and all the other persons on your Membership become Members and agree to our Fund Rules as amended from time to time.

c. Frank OVHC recommend that these Fund Rules be read together with your Important Information Guide and fact sheet relevant to your Cover.

d. 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:

These Overseas Visitors Rules (Working Cover) are the Rules under which we agree to provide you with health insurance.
These Fund Rules apply to Frank OVHC policies only.

A2: Obligations to Insurer

A2.1: 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.

A3: Governing Principles

A3.1: The operation of the Fund and the relationship between Frank OVHC and their Members is governed by:

a. These rules; and
b. Any policies of Frank OVHC as provided to the member.

A3.2: For Visa Compliant Cover, where the DIBP Requirements are in conflict with these Rules, the DIBP Requirements take precedence over these Rules to the extent of the inconsistency.

A3.3: Where there is no clear conflict between the DIBP Requirements and these Rules, these Rules will take precedence.

A4: Dispute Resolution

A4.1: Any Member who has a complaint or concern with any aspect of Frank OVHC service or any information provided, or with the standard of Treatment from any provider of Services covered under their Policies is invited to lodge their complaint with Frank OVHC at any time. Complaints or concerns relating to standards of Treatment or care should also be referred to the Health Care Complaints Commission (HCCC) or similar body.

A4.2: Frank OVHC has a complaint resolution process to ensure that all complaints are resolved as quickly as possible.

A4.3: A Member may also complain to the Commonwealth Ombudsman if they have a dispute with Frank OVHC, which is an independent body established by the Commonwealth Government to resolve complaints and to be an umpire in dispute resolution within the private health insurance industry.

A4.4: The law of Victoria will apply, and the courts of Victoria will have jurisdiction in relation, to disputes arising between Frank OVHC and Members and between Frank OVHC and others who are affected by these Rules regardless of the State or Territory in which the Member or affected person resides.

A5: Changes to Rules

A5.1: Frank OVHC may change the Fund Rules at any time.
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.

A5.2:

a. Where Frank OVHC amends or proposes to amend a Fund Rule and the amendment is or might be detrimental to the interests of the Member, Frank OVHC 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 Policy information, Frank OVHC will also provide new Policy information to the Policyholder who is on the particular Product as soon as practicable after it has been updated.

A6: Notices

A6.1: Frank OVHC will send all correspondence addressed to the Policyholder to the most recently advised email address.
A Policyholder who receives written advice from Frank OVHC 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.

A6.2: 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 www.frankaustralia.com.au.

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.

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

B2: Definitions

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. For an accident to be covered, treatment must be sought through a Doctor or Emergency Department within 48 hours of sustaining the injury. An Accident Declaration form must be supplied.

Acute Care Certificate: A certificate in a form approved and required by Frank OVHC 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.

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.

Emergency Ambulance: trips by, or under an arrangement with, 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

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 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.

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.

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.

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 OVHC.

Combined Product: A Product offered by Frank OVHC 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 OVHC, is a payment of Compensation or damages.

Consultation: An attendance on a patient by a Recognised Provider or Hospital.

Consumables: Medical consumables and 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 hospital or surgical environment.

Cosmetic Surgery: A procedure, operation or treatment undertaken for the dominant purpose of improving appearance or improving self-esteem where:

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.

Country of Citizenship: A person's country of birth, or, to which they hold a passport, other than Australia.

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

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

Department of Immigration and Border Protection (DIBP): The Department of Immigration and Border Protection of the Commonwealth of Australia or its successor or replacement.

DIBP Minimum Benefits: The minimum level of Benefit that must be paid for Treatment under a Visa Compliant Cover.

DIBP Requirements: The requirements for Health Insurance Cover that an overseas visitor must hold as a condition of certain visas to work in Australia, as determined by DIBP from time to time.

Dependant: A person who is not married or living in a de facto relationship and is a Child Dependant being a Child of the Policy Holder or Principal Member who is under the age of 21.

Emergency Treatment: Services received in connection with a sudden and unexpected onset of a serious injury or illness requiring medical or surgical attention within 24 hours after the onset, and in the absence of such care the Member could reasonably be expected to suffer serious physical impairment or death.

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

Exclusion: A procedure, condition or service which is not Covered on the Membership and for which no Benefits are payable.

Extras: A Product offered by Frank OVHC which Covers General Treatment.

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

Fund: GMHBA Limited providing Frank OVHC.

Funeral Expenses: Costs associated with a funeral within Australia, for either a burial or cremation.

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, Frank Health Insurance and Frank OVHC

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

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 OVHC which Covers Hospital Treatment and Hospital Substitution only.

Hospital Purchaser-Provider Agreement: An agreement entered into between Frank OVHC 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: Treatment for the provision and replacement of insulin pumps for treatment of diabetes.

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 OVHC and a Medical Practitioner.

Medical Procedure: a service performed on an individual with the intent of improving health, treating illness or injury, or making a diagnosis

Medical Treatment: Treatment provided by a Medical Practitioner.

Medicare Benefits Schedule (MBS): The 'Medicare Benefits Schedule' published by the Department of Health and Aged Care and includes updates published from time to time.

Medicare Eligible Person: A person who is an 'eligible person' under the Health Insurance Act but not due to an agreement between the Commonwealth and another country to be considered as eligible persons under subsection 7(2) of said Act.

Medicare Scheduled Fee: a schedule published by the Department of Health and Aged Care that determines benefit entitlements from the fund.

Member: A person Covered by a Membership.

Membership: A policy issued by Frank OVHC 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 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.

Minimum Benefit: See DIBP Minimum 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.

Out of Pocket: The difference between the Benefit for a treatment or service and the provider's fees. This balance is payable by the Member and not covered by Frank.

Outpatient Services: Attendance to a medical practitioner, either General Practitioner (GP) or Medical Specialist, outside of hospital.

Overseas Visitor: A person who;

a) is not an Australian citizen, does not hold an Australian passport and does not reside permanently in Australia;
b) Holds a valid work Visa

Participating Private Hospital Agreement: An agreement between Frank OVHC and a Private Hospital which specifies, amongst other things, the fees that the Private Hospital may raise to Members and the Benefits Frank OVHC 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.

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 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 OVHC (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 OVHC for a Membership to remain financial.

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

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.

Prothesis: An artificial substitute for a body part that is either implanted or applied surgically as listed on the Prostheses List administered by Department of Health and Aged Care.

Prostheses List: Prostheses items as determined by the Minister under the Private Health Insurance Act.

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.

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

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

Repatriation: Transportation of the policyholder and/or other members on the policy, living or deceased back to their country of origin in the event of terminal illness, life altering injury or death

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

Telehealth: One on one Telehealth Consultations are covered with a FRANK OVHC recognised provider, for services as approved by FRANK OVHC. 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 that shows membership with Frank OVHC to be used for continuity of coverage in the event of policy cancellation to move to another health fund.

Visa: A working visa that permits entry into Australia as determined by Frank but does not include holiday or student visas.

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 of the combined package Products Covering Hospital Treatment and General Treatment.

C1.3: Change of Membership Details

Policyholders are required to advise Frank OVHC of any changes to Membership details within two months of such changes. Frank OVHC 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 about the Membership and claim 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: State of Residence

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

C2.2: Minimum Age of Policyholder

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

C2.3: 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 OVHC 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 21 years of age

A person who ceases to be eligible to be a Dependant Child on a Membership can join Frank OVHC without serving any Waiting Periods (other than the balance of the unexpired Waiting Period for that Benefit under the previous Membership) if:

a. The Benefits provided under the new Product are no higher than the Benefits provided under the previous Membership; and
b. The person applies for a Membership within 60 days of ceasing to be a Dependant Child.
c. The Dependant backdates their policy start date to the date the Dependant was removed from the cover.

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 OVHC.

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

Frank OVHC 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 OVHC only once the initial payment of the Premium required from the applicant is received by Frank OVHC.

C4.2: Refusal of Application to Join

Frank OVHC 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 OVHC 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 OVHC will provide the Policyholder with;

a. A copy of these Fund Rules;
b. Details of what the Membership Covers and how Benefits are calculated;
c. A Visa Compliance Letter;
d. A Membership card for each Adult and for any Dependant/s as requested.

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 OVHC; or
b. The date nominated on the application form, or
c. A date mutually agreed between the Policyholder and Frank OVHC,

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

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 OVHC Product with a break in coverage of 30 days or less:

a. Frank OVHC may apply all relevant Waiting Periods to any Benefits under the new Product that were not provided under the Previous Cover;
b. Where a Benefit payable by the Fund under the new Product is higher than that payable under the Previous Cover, the lower Benefit will be paid from the Fund until the required Waiting Period with the Fund has been served;
c. Frank OVHC may apply all relevant Waiting Periods to the unexpired portions of any Waiting Periods not fully served under the Previous Cover.

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 OVHC Product with a break in coverage of more than 30 days, the person will be treated as a new Insured Person and Frank OVHC 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 OVHC Product with a break in coverage of 30 days or less, Frank OVHC 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 health insurance policy with another private health insurer, Frank OVHC will provide the Policyholder, or another such person as they nominate with a transfer certificate.

C7: Cancellation of Membership

C7.1: Cancellation Requests

The Policyholder may cancel a Membership by advising Frank OVHC 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 OVHC received your request for cancellation.

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

Frank OVHC 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 OVHC will reimburse any Premiums paid in advance of the termination date.

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

In the event where a policy is cancelled within the first 30 days of membership, an administration fee equivalent to 1 month premium applies; therefore, no refund is issued.

C8: Termination of Membership

C8.1: Termination Generally

Frank OVHC may terminate the Policy of any Policyholder or terminate a Member from a Membership (with or without 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 OVHC 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 OVHC;

a. Any Member had committed or attempted to commit fraud upon Frank OVHC;

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 OVHC 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 minus an administration fee which is equal to one month's premium.

C8.4: Notification to Department of Home Affairs

In the event where a membership has been terminated, Frank OVHC holds the right to advise the Department of Home Affairs of the termination of membership.

C9: Temporary Suspension of Membership

C9.1: Overseas Travel

Members may suspend their Membership for periods of overseas travel by advising Frank OVHC over the phone or as otherwise agreed by Frank OVHC 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. This must be the date the member returns to Australia. If the Member's reactivation date changes whilst overseas it is the Member's responsibility to inform Frank OVHC.

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 on the first day of each calendar month

D1.2: State Premiums

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

D2: Premium Rate Changes

D2.1: Rate Change

Frank OVHC may change premium amounts due to a change in product, policy type or due to operational expenses. If Frank changes premiums or products, we will advise you with at least 14 days' notice.

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

Premium rates may change as a result of:

a. A change in Product or;

b. A change in Policy Category

D3: Arrears in Contributions

D3.1: 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.

D3.2: 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.

D3.3: Maximum Period of Arrears

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

D3.4: Reinstatement of a Terminated Membership

Where a Membership has been terminated under Rule 5.3, Frank OVHC 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: Treatment to be provided by Recognised Providers

Benefits are payable only where treatment Is provided by a Recognised Provider. Frank OVHC 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 OVHC approved industry body such as the Australian Regional Health Group and Australian Health Practitioner Regulation Agency (AHPRA);
    iii. Approved by Frank OVHC in its absolute discretion

E1.2: Providers who Fail to meet Recognition Requirements

Frank OVHC will decline to pay Benefits in respect to any claim where Frank OVHC 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

E1.3: 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 OVHC Benefit may be reduced by the amount claimable from the other source, and
c. Where in the opinion of Frank OVHC the charge is higher than the Provider's usual charge for the service, Frank OVHC 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. The provider themselves,
    iii. The Partner or Dependants of the provider's business partner, or
    iv. Any other person not independent from the practice.
b. Frank OVHC 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 OVHC 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 OVHC 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 OVHC 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 OVHC or in a way which brings Frank OVHC into disrepute;

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

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

g. Not mislead or deceive Frank OVHC 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 OVHC; 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 Aged Care including the relevant MBS item numbers.

E2: Hospital Treatment

E2.1: 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.

E2.2: Day Hospital Facilities

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

E2.3: 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 OVHC may permit further sub-classifications of Patients when not inconsistent with Private Health Insurance (Benefit Requirement) Rules 2011.

E2.4: 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.

E2.5: 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 OVHC may at its absolute discretion specify.

E2.6: 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 Reduced Benefits Service under the Cover.

   iv. Subject to the service not being a Reduced Benefits 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.

E2.7: 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 Reduced Benefits Service under the Cover;

e. Subject to the service not being a Reduced Benefits 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;

E2.8: 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.

E2.9: 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.

E2.10: 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.

E2.11: 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 OVHC for this purpose.

E2.12: 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.

E2.13: Agreements with Doctors and Hospitals

a. Frank OVHC 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 and/or Co-Payment applying

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 OVHC for further details.

E2.14: 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.

e. 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;

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

E2.15: Surgically Implanted Prosthesis

Frank OVHC will pay benefits for prostheses surgically implanted as part of a hospital treatment when:

a. Prosthesis are provided to a patient with appropriate health insurance cover;
b. Prosthesis are provided as part of hospital treatment or hospital substitute treatment; and
c. There is a Medicare benefit payable for the service.

Frank OVHC will pay an amount equal to the full cost of "no gap" prostheses and an amount equal to the Minimum Benefit for "gap permitted" prostheses.

Non-listed prosthesis: If the prosthesis or medical device is not on the Prostheses List, Frank OVHC is not required, by law, to pay for the non-listed prosthesis.

E2.16: Consumables

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

E2.17: Hospital-Substitute Treatment

Frank OVHC 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 OVHC assesses such certification to be medically reasonable and appropriate.

E2.18: Nursing Home Type Patient

If you become a Nursing Home Type Patient, Frank OVHC 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.

E2.19: Outpatient Services

Frank will pay 100% of the Medicare Scheduled Fee (MBS) for Outpatient consultations with either a GP or specialist on Mid Workers Cover and Mid Workers Plus. Any other charges will not attract a benefit from Frank. Fees for consultations that are over and above the MBS fee will be an out of pocket expense.

E3: General Treatment

E3.1: Annual Limits

Frank OVHC 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 OVHC 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 OVHC, unless otherwise approved; and
c. Where services are provided face to face or as a recognised telehealth service as approved by FRANK OVHC Health Insurance

For the avoidance of doubt, Frank OVHC will not pay Benefits for treatment provided by someone who was not a Recognised Practitioner at the time that person provided the treatment. Frank OVHC has sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their treatments Frank OVHC will pay Benefits. Frank OVHC 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 OVHC and that person comes to an end.

E3.4: Benefit Restrictions

Frank OVHC will only pay Benefits for:

a. One type of service of General Treatment provided by a Recognised Practitioner in Private Practice per day; or
b. More than one type of service of General Treatment provided by a Recognised Practitioner in Private Practice per day where Frank OVHC recognise the Recognised Practitioner as a Recognised Practitioner of each of the professions corresponding to the relevant services.

F: Limitation of Benefits

F1: Excess

The amount of the Excess and relevant limits and conditions are specified in the fact sheet 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 Frank OVHC or another health insurer) except newborns and adopted and foster children; and
c. Existing Memberships and transfers to Frank OVHC from another 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 OVHC, subject to Fund Rule C6, a Member must serve the Waiting Periods set out in this Fund Rule F3 before Benefits are payable by Frank OVHC under a Product.

F2.2: 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. Childbirth and related Services – 12 months
b. Treatment for Pre-Existing Conditions (as provided in Rules F3.5 to F3.7) other than the Covered by c) and d) – 12 months
c. All Rehabilitation, Palliative Care and Psychiatric treatment regardless of whether it is a Pre-Existing Condition – 2 months
d. Accidents, Ambulance and all other services – 0 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;

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

a. Frank OVHC 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)

a. Frank OVHC 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 OVHC consider as relevant to the claim.

c. Frank OVHC 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 OVHC, and

   iii. The relevant practitioner referred to in a) has reviewed the information referred to in b), and

   iv. Frank OVHC 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 OVHC 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 OVHC'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

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 Procedures provided to a Member who is an Outpatient;

m. Services or treatment rendered by a practitioner not in private practice;

n. Outpatient consultations where there is no corresponding MBS item number or Provided Number listed on the receipt provided to Frank

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.

F4: Restricted Benefits

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

F5: Compensation Damages and Provisional Payment of Claims

F5.1: Definitions

In Fund Rule F7:

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.

F5.2: Obligations of a Member

Subject to Fund Rule F7.8, 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.

F5.3: Entitlement of Benefits for an Injury

a. Subject to Fund Rule F7.5, 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 F7.3a) include expenses incurred after the Member has received any Compensation.

F5.4: 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

F5.5: 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 F7.2;

   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.

F5.6: Where Benefits have been paid by GMHBA Limited

a. Subject to Fund Rule F7.9, 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 F7.2.

F5.7: 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 F7.2 or F7.6; 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.

F5.8: 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.

F5.9: 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 F7.2, 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.

F5.10: 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.

F5.11: 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 F7.11a) 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.

F5.12: Cancellation/Termination of Membership

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

G: Claims

G1: General

G1.1: Form of Claim

Claims for Benefits must:

a. Be in a manner approved by Frank OVHC
b. Be supported by accounts and/or receipts on the provider's letterhead or showing the provider's official stamp, and showing the following information:
    i. The provider's full name, provider number, qualification and address;
    ii. The patient's full name and address;
    iii. The date of service;
    iv. A description of the service and all relevant MBS item numbers;
    v. (if applicable) Tooth numbers where a Dental treatment has taken place on an individual tooth;
    vi. The amount charged; and
    vii. Any other information that Frank OVHC may reasonably request.

G1.2: Documents to Remain Property of Frank OVHC

All documents submitted in a claim become the property of Frank OVHC, unless otherwise agreed by the Fund.

G1.3: Claims to be Lodged Within 12 months

Benefits are not payable when a claim for Benefits is lodged more than 12 months after the date of service. Frank OVHC may waive this rule at its discretion.

G1.4: Claims to be Paid Within Two Months

Subject to Fund Rules F3.6.c and G1.3, Frank OVHC shall, within two months of receipt of a claim, assess it and pay any Benefits payable under these Fund Rules.

G1.5: Claims to be Paid after Treatment Provided

Benefits are only payable after treatment has been provided.

G1.6: Incorrect or Fraudulent Claims

If a claim is found to be incorrect or fraudulent, Frank OVHC may at its discretion:

a. Suspend all claiming;
b. Offset the amount paid against future claims or Premiums;
c. Seek repayment of the funds;
d. Notify the appropriate authorities.

G2: Other

G2.1: Manner of Benefit Payment

Frank may pay Benefits by cheque payable to a provider or electronic funds transfer in accordance with arrangements it determines from time to time.

frank.
overseas visitor health cover

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contact team frank | webchat | call +61 3 5202 8770
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