important information guide.

frank.
overseas visitor health cover

effective October 2023

contents.

The information within this guide is important and we recommend you read and retain for future use.

thanks for joining frank.

Introduction to Frank

Frank Overseas Visitor Health Cover is a brand of GMHBA Limited. In this section, references to "Frank" or "Frank OVHC" are references to GMHBA Limited trading as Frank Overseas Visitor Health Cover.

Confirmation of Terms and Conditions of your membership

When you signed up, you agreed to certain terms and conditions. For the record, those Terms and Conditions are printed here:

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;
- I understand that you have the right to accept or refuse my application for membership and 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.

Eligibility for membership with Frank

To be eligible to take out a Frank Overseas Visitor Cover policy, you need to hold (or applying for) a 482 or 485 working visa. If the visa has been granted to a single person, then a single cover must be taken out. If the visa has been granted to a family, then a family cover must be taken out.

Medicare Levy Surcharge

Frank Overseas Visitor Health Cover is not an eligible hospital cover when it comes to the Medicare Levy Surcharge and will not exempt an overseas visitor from paying the surcharge (if their taxable income is over $93,000 as a single or $186,000 as a couple/family).

things you should know

Goods and Services Tax (GST)

A Goods and Services Tax (GST) of 10% applies to Overseas Visitor Health Cover in accordance with the Goods and Services Tax Act 1999. This is included in the advertised premium.

Medicare Eligibility

If you are eligible to receive any entitlement to Medicare, including under Reciprocal Health Care Agreement, you will need to let Frank know as soon as possible. Once you are eligible to receive Medicare benefits, you are no longer able to remain on an Overseas Visitor Cover policy. Please contact us to find the most suitable level of cover for your needs.

Transferring from another Insurer

If you are switching from another fund, Frank will arrange to cancel your previous cover and for them to send us a copy of your clearance/transfer certificate.

You will not need to serve any waiting periods provided you have:

- Have waited no more than 30 days between cancelling your previous cover and joining Frank.
- Served your waiting periods with your previous fund.
- Are on the same or lower level of cover than you were previously.

If you have served part of your waiting period with your previous fund, you'll only need to serve the balance with Frank.

If you are upgrading your cover by moving to Frank, you will only need to serve waiting periods for things you weren't previously covered for.

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.

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. Frank will consider your membership void if you provide false or incorrect information on your membership application. If your membership is terminated, then premiums received in advance for coverage beyond the first month up until 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.

The completion of the application process and the payment of any premium constitute an acceptance of any conditions laid down in the regulations of the fund, including these Fund Rules.

Frank reserves the right to refuse admission to membership of any level of health cover.

In the event that any member or person named on the membership 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.

Refusal of Applications

Subject to the Fund Rules, Frank may refuse to provide a person with Overseas Visitor Health Cover. If Frank refuses an application, Frank will provide a reason to the person.

Community Rating

Frank Overseas Visitor Health Cover is required to comply with Community Rating. Community Rating means Frank will not discriminate between members on the basis of their health or any other reason described below.

When making decisions in relation to members, Frank will disregard the following:

- The suffering by the member of a chronic disease, illness or any other medical condition.
- The gender, race, sexual orientation or religious belief of a person.
- The age of a member.
- Any other characteristics of a person (including but not just relating to matters such as occupation or leisure pursuits) those are likely to result in an increased need for extras or hospital treatment.
- The frequency with which a person needs extras or hospital treatment.
- The amount, or extent, of the benefits to which a member becomes, or has become, entitled during a period.

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.

who can be covered under your frank policy?

The Policy Holder

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

The policy holder is:

- The primary contact for the policy.
- 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 and claims history relating to their membership

Singles Cover

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

Couples Cover

Covered under this policy are:

- The policy holder.
- The policy holder's listed spouse

Family Cover

Covered under this policy are:

- The policy holder
- The policy holder's listed spouse
- The policy holder and/or spouse's listed child dependant/s

Child dependents

Child dependents are covered on a family or single parent membership up until they turn 21 years of age regardless of their student or employment status. Once a child dependent turns 21 they will be removed from the family policy. They can then join on their own policy without having to re-serve waiting periods (with the exception of the balance of any waiting periods still to be served).

Adding a Newborn

If you're currently on a singles membership and would like your baby to be covered by Frank, you will need to upgrade to a single parent or family membership from the date your baby is born. Your baby will not incur waiting periods.

If you're currently on a couples membership, you can add your baby when he or she is born and your membership will automatically update to family cover.

You'll need to contact Frank to add your baby to your cover.

managing your cover.

Membership card

When you sign up with Frank Overseas Visitor Health Cover, you'll receive a membership card that identifies you as a member. The card shows your membership number and details who is covered. Have your membership card on hand when you arrange an admission to hospital, visit a participating provider or when you call Frank with any questions.

When visiting an extras provider (i.e. dentist) simply swipe your Frank card for your benefit to be applied at the time of payment, leaving you to only cover the gap amount.

The gap is the difference between what your provider charges and the benefit you are entitled to for the service. This is only applicable where you are covered for extras and the provider is registered to use HICAPS.

A new card may be issued when you make changes to your membership. Your existing card will become invalid whenever a new membership card is issued. Keep your card safe and advise Frank if your card is lost or stolen.

Communication from Frank by email

Frank will only provide you with everything that you need to know about your cover via email upon joining, including your:

- Visa Compliance Letter
- A detailed description of the coverage provided by the products you have bought
- Other Important Information relating to your coverage and your membership

You may need this material one day (which may be years after you join), so we recommend saving this information in a safe place.

Check your cover

Contact Frank before having treatment or going into hospital to confirm what you will be covered for and what benefits you could get back.

Payment Frequencies

Premiums must be paid a month in advance at all times. All premiums must be paid via direct debit out of a bank account or credit card. Frank will debit your account on the 1st of each month.

Rate Changes

Frank 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.

Arrears

Frank members are responsible for ensuring their accounts have sufficient funds available on their nominated direct debit date. If a membership is in arrears, Frank cannot pay benefits until the account is paid up to date.

Membership will cease when premiums fall into arrears of more than 2 months after the premium due date. Reactivating arrears terminated membership is entirely at the discretion of Frank.

using your hospital cover.

Suspensions

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

- have at least 12 months continuous 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 not more than 3 years.
- have paid premiums to the date of departure; and
- apply for suspension of your cover prior to departure.

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.

Cancellations

You may cancel your Frank cover from:

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

If you cancel your Frank cover, any premiums received for the first month of the membership are non-refundable. If you cancel your membership after the first month, any premiums paid ahead of your cancellation date will be refunded.

Termination due to improper behavior

If Frank believes you have received or attempted to receive an advantage (whether monetary or otherwise) that the member knows they are not entitled to or have engaged in inappropriate behavior (including directed at Frank staff), Frank may terminate your policy.

When to contact Frank

Contact Frank before any hospital admission to check whether the treatment is included as part of your cover, whether you have served your waiting periods and what benefits you're eligible for. If your condition is or may be pre-existing, we need about 5 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 determine your condition to be pre-existing, you'll have to pay all outstanding hospital charges and medical charges.

Emergency admissions

In an emergency, we may not have time to determine if you are 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 we later determine that

the condition was pre-existing.

Emergency ambulance cover

Covers emergency ambulance services by, or under an arrangement with, a State or Territory Ambulance Service Australia wide. Does not include cover for non-emergency ambulance transport, i.e. transfers between hospitals that are not medically necessary.

Hospital 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 hosptial 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 only pay the maximum amount per person as opposed to the maximum amount per membership.

Repatriation & Funeral Expenses

Repatriation Benefits will be paid for the repatriation of a living or deceased member back to their country of origin in the event of terminal illness, life altering injury or death, up to annual limits. Funeral expenses will be paid up to annual limits for funeral costs within Australia, for either a burial or cremation.

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 fund) except newborns and adopted or permanent foster children.
- Existing Frank memberships, and transfers to Frank from another insurer where.
  - > 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 (childbirth) and related services
- 12 months – pre-existing conditions (other than psychiatric, rehabilitation or palliative care)
- 2 months - psychiatric, rehabilitation and palliative care (regardless of whether or not the condition is pre-existing)
- 0 days - emergency ambulance and outpatients services (where covered under the policy).

The above waiting periods also apply to previously uninsured members.

For treatment that was covered under the old policy, at the same or higher level than the new policy, waiting periods are no longer than the balance of any un-expired waiting periods for the benefit that applied to the person under the policy.

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 (PEC)

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 6 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 12 months on your current hospital cover, make sure you contact us before you are admitted to hospital to find out whether the pre-existing condition waiting period applies to you.

We need 5 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.

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.

exclusions

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

- 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. Benefits are only payable on itemised and original account/s.
- 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.
- Services/treatment for which the member and/or dependent has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependent 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 not rendered face to face (with exception of approved Telehealth services).
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment. Benefits payable 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.
- Outpatient consultations where there is no corresponding MBS item number or Provider Number listed on the receipt provided to Frank.

Benefits may not be paid or may be paid at a lower level where:

- The health care account has been incompletely, incorrectly or inappropriately itemised.
- You have an excess to pay on your

restrictions

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. 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 which has not been served/met.
- Surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact Frank for details.
- No MBS item number is provided by the GP/Medical Specialist e.g. cosmetic surgery.
- Professional services are provided to the provider or members of the provider's family or to a provider's business, partner's family member 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 cosmetic surgery. Limited benefits may apply on hospital covers for cosmetic surgery, depending on the medical justification for the surgery.
- 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.

Frank Health Insurance has negotiated special agreements with participating private hospitals which provide members (subject to any exclusions and/or restrictions) with hospital cover for accommodation (shared and/or private room depending on level of hospital cover), theatre, delivery suite, intensive/coronary care and a range of services provided by the hospital (subject to any excess and/or co-payment applying). Check with us on +61 3 5202 8770 before confirming your hospital admission. View Frank's participating private hospitals list.

hospitals

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 private 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 in with Team Frank before confirming any hospital admission.

Members who have taken out cover with Frank, who are admitted to a participating private hospital and have served all waiting periods are entitled to cover for accommodation, theatre, delivery suite, intensive and coronary care and other agreed hospital charges - less any excess (if applicable). Members should present their Frank membership card when attending a participating private hospital.

Non-participating hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Contact Frank on +61 3 5202 8770 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.

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

Always get informed financial consent prior to any hospital admission.

medical gap

What is Medical Gap?

When you are treated in a hospital, you usually get a bill from the hospital, and then the doctors, surgeons, anaesthetists etc. send you a bill separately.

Frank will pay a refund on these doctors accounts based on the "Medicare Benefits Schedule" (MBS). That's a fancy name for a list of all the different procedures that a doctor can perform in hospital, and how much Medicare believes is fair to charge for each one.

There's no rule that says a doctor has to charge exactly what Medicare think is fair and often they don't. This sometimes leaves patients financially out of pocket. That's called "the gap". Basically if the Medicare Schedule Fee for a procedure is $100, and your doctor charges $120, then Frank will pay the $100 and you will have to pay the other $20.

In short, Medical gap is the difference between what your doctor charges and what's covered by Frank.

Mind the gap

Want to avoid paying extra when you go into hospital? Fair enough. Just make sure that your hospital is one of Frank's Participating Private Hospitals.

Overseas travel

Frank OVHC does not provide benefits for services or treatment received overseas. We advise that you take out travel insurance for the set period of your travel and that it's suitable to the destinations you're visiting.

Damages or compensation

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

all about claiming

Claiming procedure

Hospital Claims

Hospital claims are paid from Frank direct to the hospital. You will need to present your membership card upon admission and you will not need to contact Frank in most cases.

Medical Claims

Medical benefits cover your fees payable to surgeons, anaesthetists and other professionals who may bill you separately from your hospital bills. You will need to forward us a copy of your invoice with a Frank claim form and we will pay benefits either directly to you if you have already paid your doctor or we will pay benefits to the doctor and they may issue you a bill for the gap.

Outpatient Consultation

Accounts and receipts are to be forwarded to Frank with a claim form and need to include: 1- Provider number of the GP or Medical Specialist who treated you.

2- Medicare Benefits Schedule (MBS) item number for the service/treatment that was provided.

You will have to pay the claim before sending through your invoice. Benefits for these claims will be paid directly into your nominated bank account.

Ancillary Claims

Claims to some ancillary providers can be claimed directly at the provider with your Frank card using HICAPS. If this service is not available, forward the paid account to Frank with a claim form and benefits will be paid directly into your nominated bank account.

code of conduct & audits

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 +61 5202 8770 or emailing frank@frankaustralia.com.au. We respond to all our phone calls immediately, and will follow up all e-mails within 2 working days. If the matter is of a more difficult nature and will take some time to resolve, frank will keep you informed of the ongoing progress.

2. 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 acknowledgment 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@frankaustralia.com.au.

3. Contact our Customer Relationship Team.

If you require further clarification about the decision made at the MSRC, please email us at frank@frankaustralia.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.

Independent advice
If you're still dissatisfied with the outcome, free independent advice is available from the Commmonwealth Ombudsman. You can contact the Ombudsman on 1300 362 072 or GPO Box 442, Canberra, ACT, 2601. 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 Overseas Visitor Health Cover 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:

- 1. You receive the correct information on health cover from appropriately trained staff;
- 2. You are aware of the internal and external dispute resolution procedures with Frank Overseas Visitor Health Cover;
- 3. Policy documentation contains all the information you require to make a fully

informed decision about your purchase and all communications between you and Frank are conducted in a way that ensures appropriate information flows between the parties; and

- 4. 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/

Claim Audits

Frank undertakes audit activities in order to protect members' assets and contain costs. 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 members to Frank

A member can be liable to Frank for unpaid premiums and for overpayments. Overpayments could be made by Frank to a member 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 when requested. If a member is liable to Frank for unpaid premiums or overpayments, the fund has the right to deduct the amount of that liability from any monies payable by Frank to the member on any account.

Australian health care glossary

Australian health care glossary

Health cover can be confusing. To help, we've provided a list of definitions for commonly used words or phrases. If you still need help understanding the health system or your cover, get in touch with Frank. Afterall, we're here to help.

Accident: An unexpected and unintentional event that results in harm, injury, damage or loss where medical treatment is sought from a Doctor or an emergency department within 48 hours of sustaining the injury.

Admitted patient: A person who is formally admitted into hospital to receive hospital treatment or care

Adult: Defined in the Private Health Insurance Act as a person who is not a dependent

Australian Health Service Alliance (AHSA): An organisation that acts on behalf of a number of health funds to arrange contracts between hospitals, doctors and health service providers.

Ambulance services: The services provided by an approved ambulance service (or a third party approved by the ambulance service) to transport a person, when medically necessary, to a hospital for admission or for emergency treatment

Benefits: The money payable from the Fund to the member or on their behalf for approved services claimable under their level of cover

Calendar year: The period between 1 January and 31 December

Claim: A formal request to the Fund for payments of benefits.

Compensation: The payment, or possibility of payments, by a third party for expenses incurred by the member.

Condition: An illness, injury, disease or disorder of the body for which you need treatment

Contracted Rate: The cost for the hospital stay, as agreed between the AHSA and the hospital.

Commencement Date: Start date of the membership.

Cosmetic Surgery: Surgery to improve your appearance that is not medically necessary.

Dependant: Someone who is on the same visa as, lives at home with and is a child dependent under 21 years of the member.

Emergency Department: A department at the hospital for emergency treatment. You usually arrive there by ambulance or by your own means without an appointment. It can also be known as "emergency room", "accident and emergency (A&E)" or "casualty".

Excess: The amount you need to pay for your hospital admission before Frank will start paying benefits.

Hospital: A facility for medical and surgical treatment or for caring for the unwell or injured. This is further defined under Section 121-5(60) of the Private Health Insurance Act.

In-patient: Any person who is formally admitted to a hospital for medical care or surgical treatment with a doctor's order. The day before you are discharged is your last inpatient day.

Australian health care glossary

Medical Specialists: Doctors who have completed advanced education and training in a specific area of medicine. You usually need a letter of referral from your general practitioner (GP) to make an appointment to see a medical specialist.

Medicare Benefits Schedule (MBS): The Government sets a list of medical fees for each medical service - called the Medicare Benefits Schedule - based on a fair price and how much Australia can afford to pay for the total health system.

Participating Hospital: These are hospitals with which Frank has an agreement.

Out of Pocket: This is the amount you pay toward your medical expenses. This is calculated as follows: total fee – benefits from Frank = out of pocket expense.

Outpatient: A person who is getting emergency department services, observation services, outpatient surgery, lab tests, X-rays or any other hospital services where the doctor hasn't written an order to admit you as an inpatient. In these cases, you're an outpatient even if you spend the night in hospital.

Overseas Visitor: A temporary visa holder who is not in Australia for only study purposes. This includes family members on the same visa.

Pre-existing Condition: An ailment, illness or condition where signs or symptoms existed in the 6 months prior to joining Frank. This is decided by an independent Medical Advisor by Waiting Period: The length of time you have to wait before being eligible for health insurance benefits obtaining information from your doctor. If your condition is deemed pre-existing, there will be a 12 month waiting period before treatment benefits can be provided.

Premiums: The money paid to Frank for your membership.

Provider: This includes hospitals and medical practitioners.

Public Hospital: A hospital administered by a state or territory government.

Repatriation: The process of returning a person to their place of origin or citizenship.

frank.
overseas visitor health cover

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

frank overseas visitor health cover is brought to you by GMHBA Limited

ABN 98 004 417 092 last updated October 2023