Basic Workers Cover

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frank. overseas visitor health cover

Frank Basic Workers Cover provides straight forward health cover to Australian Visitors on 482 and 485 visas.

It meets the Australian Department of Immigration's working visa requirement 8501.

This Frank fact sheet details what you need to know about Basic Workers Cover; from what's covered to what's excluded plus excesses and waiting periods that apply.

We recommend that you read and retain this fact sheet along with Frank's OVHC Important Information.

Hospital Benefits	
Public hospital accommodation	✓
Private hospital accommodation	✓
Shared Room	✓
Single room in a private hospital (where available)	✓
Accidental injury	✓
Operating theatre	✓
Emergency ambulance	✓
Rehabilitation services	✓
Surgically implanted prostheses	✓
Funeral expenses (Up to $5,000 per person)	✓
Repatriation (Up to $10,000 per membership)	✓
Psychiatric services	R
Birth related services	R
Palliative care	R
IVF and assisted reproduction services	×
Bone marrow and organ transplants	×
Non-surgically implanted prostheses and appliances	×
Treatment rendered outside of Australia (including treatment en route to or from Australia)	×
Treatment arranged in advance of arrival	×
Outpatient antenatal or postnatal services	×
Outpatient pathology & radiology	×
Outpatient Services (GP & Specialist consults)	×
Hospital services for which no Medicare benefit is payable (e.g. cosmetic surgery that is not medically necessary)	×

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

Excess

An excess is the amount you pay when you are admitted into hospital as a private patient. Excess fees allow us to keep membership costs low. The most you'll pay is $500 per person per year (up to a max of $1000 for a family).

Per person	$500 per year
Couple/family	$1,000 per policy per year (if more than one person is hospitalised)

What's covered

Basic Workers Cover provides benefits towards theatre surgery costs, shared or private room accommodation charges in a participating private hospital* or shared room accommodation charges in a public hospital^ for all procedures unless they are listed as a reduced benefit for the cover.

* Fixed benefits are payable in non-participating private hospitals.

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

Are there times frank won't pay?

Yes, view the list of things Frank won't pay on for Basic Workers Cover.

Frank medical costs

Every hospital procedure has a minimum benefit payable set by Medicare. This is called the Medicare Benefits Schedule (MBS) Fee. You always get 100% of this back if you have private health insurance. Anything your doctor charges above 100% of the schedule fee is an out of pocket expense. You can check this amount with your doctor.

Reduced benefits (R)

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

Accidents

Covers accidental injuries sustained after joining Frank. An accident is defined as an unexpected or unintentional event resulting in bodily injury that requires urgent and immediate treatment as an inpatient in a hospital. For an accident to be covered, treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury. An Accident Declaration form must be supplied to Frank.

Ambulance Services
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.

Waiting periods
Generally a new health insurance member will need to be with a fund for a period of time before their fund will pay any benefits. This is called a 'waiting period'. This also includes members upgrading to a higher grade of cover.

Basic Workers Cover has the following waiting periods:

12 months	• Pre-existing conditions (other than psychiatric, rehabilitation or palliative care) • Childbirth and related services.
2 months	Psychiatric, rehabilitation, palliative care (regardless of whether or not the condition is pre-exisiting).
0 days	Emergency ambulance and all other services

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

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

Funeral Expenses
Up to a maximum of $5,000 per person. Frank will pay for the costs associated with returning mortal remains or ashes to the country of residence. Funeral and related costs are also covered if the body is buried or cremated at the place of death.

Repatriation
Benefit will be paid up to $10,000 per membership for the repatriation of a member back to their country of origin in the event of terminal illness or a life altering injury.

How to claim
There are typically two types of accounts that need to be settled after being admitted to hospital.

1. The hospital account
The hospital needs to bill Frank to get the process started. Without the hospital account, we cannot prove that you were admitted to hospital and we are unable to pay any of the other accounts.

The hospital usually electronically bills Frank but they may send it via mail which can take a little while.

After Frank receives this account, we'll pay your benefit (as long as you're entitled to one) to the hospital.

If the hospital sends you an account, you should ask if they have also sent the account to Frank. There are a bunch of technical notes that our processing team can only get from the hospital.

2. The medical account
After we have the hospital account, we can pay any eligible medical accounts. Frank prefers your doctor bills us directly and electronically because it saves time and trees. Some doctors can't do this and may give you an invoice.

If your doctor gives you a bill, pay it, fill out a Frank claim form and email both your receipt and claim form to us. If the account is already paid, we'll reimburse you. Otherwise we'll pay the doctor directly.

Anything not covered by Frank is your out of pocket expense. If required, the doctor will bill you for anything outstanding after they have received payment from Frank.

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