Member Guide

myOwn health insurance with AIA Vitality

Effective 1 June 2018

Information within this guide is important. We recommend you read and retain for future use.

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Welcome to myOwn

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Who can be covered by your myOwn policy?

Here's the who's who with respect to your myOwn health policy.

The member is the name of the person the health insurance policy is held under. The member is our primary contact, responsible for paying premiums, can nominate who is covered by the policy, can make changes to membership details and is entitled to all records and claims history and tax statements related to the membership.

All members and people covered under a member's policy must have full Medicare cover eligibility. Temporary residents of Australia that do not have full Medicare eligibility should consider different health insurance arrangements.

There are four categories of myOwn membership:

Singles cover

Singles cover is cover for one person and this person is referred to as the member.

Couples cover

Couples cover covers two people – the member and the member's partner.

Family cover

Family cover provides cover for the member, their partner and their child dependant/s and their student dependant/s.

Single parent family cover

Single parent cover is for one adult member and the member's child dependant/s or student dependant/s.

Child dependants

Cover for child dependants ceases once they turn 21, unless they qualify to remain on the policy as a student dependant. Student dependants are covered up until they turn 25 years of age.

When a child dependant turns 21, they have two months to get their own cover and not have to serve any waiting periods if moving to equivalent or lower cover. Their new membership will be backdated to commence the date they turned 21.

Student dependants also have two months from either turning 25 or ceasing to be a student to get their own cover to avoid having re-serve waiting periods.

For mid-year and end-of-year school, apprenticeship and traineeship leavers, they are covered under their family or single parent cover until 31 March of the following year and will not have to serve waiting periods if they transfer to an equivalent or lower level of cover.

Standard Information Statements

A Standard Information Statement (SIS) is a summary of the key product features of your cover. You will receive a copy of your SIS when you join myOwn.

Changing your details

You can amend your details at any time by logging in to the member's portal and editing your myOwn profile. Alternatively, you can give us a call on 1300 300 338.

Your membership card

This is probably the most important thing we'll ever give you. Whenever you wish to claim, you'll need to make sure you have this card on you.

On it, you'll find your membership number as well as the names of those covered under your cover. You'll also find our contact details located handily on the back for easy reference.

If your card is lost or stolen or if you add a new member to your cover we will send you a new card.

Remember, whenever you get a new card from us, your old one automatically becomes invalid, so throw it away to avoid any confusion.

Changing your cover

This can be done at any time. All you need to do is log in to the member's portal and select your new cover. Alternatively, you can give us a call on 1300 300 338 and we'll make the necessary changes for you.

Please note, waiting periods will apply if you're upgrading your cover.

Planning a child

If you're planning to start or grow your family and your hospital cover doesn't include pregnancy, you'll have to upgrade your cover at least 12 months before giving birth to ensure all waiting periods have been served.

Newborn babies aren't admitted as patients in hospitals unless there are complications or it is a multiple birth. If you have twins, your second child will be admitted or if your baby requires medical attention they will be admitted. In these instances your baby will be covered provided they are added to the policy.

Adding a newborn is easy; you can do this yourself through the membership portal or give us a call and we will add the baby for you.

When to let us know you're going into hospital

If you have less than 12 months membership on your current hospital cover, you'll need to contact us by phone or email before being admitted so we can determine whether the waiting period for pre-existing conditions applies.

It can take up to five working days to complete this assessment, so make sure you factor this in when you book your stay.

If you go ahead with your admission without confirming your entitlements and we subsequently determine your condition to be pre-existing, you'll have to pay all outstanding hospital and medical charges not covered by Medicare.

Putting myOwn cover on hold for overseas travel

We can arrange this for you easily, providing you:

- have at least 12 months continuous unsuspended myOwn membership
- have a minimum of six months active cover since your last overseas suspension
- plan to be overseas for at least four weeks
- have paid your premium to the date of your departure
- apply for your suspension before you leave

All you have to do is let us know when you're departing and when you'll be back, and we'll make sure your membership is paused.

Please note: we will automatically reactivate your membership based on the return date you provide, so if this changes for any reason, you'll need to let us know ASAP.

Also, a little bit of good news: any travel for short periods of time approved by the fund will not impact your LHC loading as you'll still be considered to be maintaining your fund membership. You can suspend your membership for between 4 weeks and 3 years so long as your premiums are up to date. Any waiting periods outstanding at the time of suspension will need to be served once the policy is reactivated.

If you need to suspend your membership for any other reason, you will need to let us know in advance by contacting our member service team by phone, email or post.

Cancelling myOwn cover

We'll be sad to see you go, but you can terminate your membership at any time from the date you notify us, either in writing or by giving us a call.

If you cancel within 30 days of joining myOwn, you'll get a full refund of any premiums paid, provided you've not made any claims.

We'll send you a transfer certificate within 14 days of your request to cancel. Where you have accepted an offer or special promotion upon joining, and subsequently cancel your membership within this cooling off period myOwn may deduct the value of the offer from any refund due.

myOwn waiting periods

A waiting period is the time between joining or when upgrading your level of cover and the moment you're allowed to start claiming. Waiting periods exist for all services within both hospital and extras covers and apply to:

- New memberships
- Additional members to a membership (unless the new member/s has previously served all waiting periods on equivalent cover with myOwn or another fund) except for newborns, adopted and permanent foster children where the family membership has been in existence for at least two months.
- Existing members who upgrade their cover to a higher level of cover
- Members who transfer to myOwn health from another fund to a higher level of cover than that of their previous fund or where waiting periods have not been served on their previous fund
- Treatment for a pre-existing condition.

Hospital cover waiting periods (when included on cover)

Waiting periods for Hospital treatment range from 1 day to 12 months.

- There is a 1 day waiting period for ambulance cover and treatment resulting from an accident
- a 12 month waiting period for pregnancy
- a 12 month waiting period for pre-existing ailment, illness or condition (except for psychiatric, rehabilitation and palliative care)
- a 2 month waiting for any other hospital treatment.

Waiting periods for Extras treatments vary by the treatment type between 2 and 12 months – these are listed below:

Extras Cover	Waiting Period
General Dental	2 months
Preventative Dental	2 months
Major Dental	12 months
Orthodontics	12 months
Optical	6 months
Physiotherapy	2 months
Hydrotherapy	2 months
Myotherapy	2 months
Exercise Physiology	2 months
Chiropractic	2 months
Osteopathy	2 months

Extras Cover	Waiting Period
Naturopathy	2 months
Homeopathy	2 months
Acupuncture	2 months
Remedial massage	2 months
Podiatry	2 months
Non-PBS Pharmacy	2 months
Psychology	2 months
Audiology	2 months
Eye therapy	2 months
Speech therapy	2 months
Antenatal and postnatal	2 months
Occupational therapy	2 months
Medically Prescribed Appliances (incl. hearing aids)	12 months
Orthopaedic appliances	2 months
Preventative Health Benefits	**Waiting Period**
Swimming lessons	2 months
Dietetics	2 months
Other including: Bowel cancer identification kits (1 every 2 years), Melanoma Surveillance Photography (1 per year)	2 months

For details on cover benefits visit our website, call 1300 300 338.

Payment

Choose the option that's right for you.

You can choose to pay your premiums weekly, monthly or annually, by credit card (Visa or Mastercard) or direct debit.

If you'd like to change how you pay or how often you pay your premium or access our direct debit service agreement you can do so by calling us on 1300 300 338.

Payment in advance

You can pay your premiums in advance but not by more than 12 months.

What if I'm in arrears?

To claim benefits, you'll need to ensure you pay your premium on time.

If you do fall into arrears of two months or more, we'll have to cancel your membership, which will leave you unable to claim for any services provided. To claim benefits, the membership must be financial at the time of incurring the expense for the service or treatment.

Your privacy

myOwn treats the storage and management of your personal information seriously. To read our Privacy Policy or Privacy Statement visit our website at myown.com.au or call us on 1300 300 338.

Making a claim with myOwn

How to make a claim

Get started with our quick and easy process today.

I need to make a claim

Ok, we're here and we're ready to help. You'll just need to make sure you're financial (up-to-date with your premiums), served all your waiting periods, and seen a recognised provider before you start the claims process.

If possible, it's a good idea to contact us before you commence treatment to get a benefit estimate that will confirm what is payable on your cover.

I'm good to go, how do I get started?

There are a number of ways to make a claim, including:

Electronically

If you have myOwn extras cover, you can use your membership card to claim electronically on the spot provided your health care provider uses the HICAPS system.

Simply hand it to your health care provider once the service has been provided, and they'll process your claim in seconds. You just pay any difference to the provider.

Online

Our member's portal is fully equipped to handle most online extras claims. Simply log in and head to the claims section.

To use online claiming, you'll need to:

- have registered to use our member's portal – visit myown.com.au
- agree to our terms and conditions, which include keeping receipts for two years as they may be audited
- have already covered the costs with your provider
- make your claim within two months of getting treatment
- have your receipt in a format that you can upload to our online member portal.

By post

There are a couple of ways to claim by post.

Either:

- fill out a claim form and post directly to us with your itemised receipt and/or account.
- lodge your medical claims at your local Medicare office via a two way claim which will then be forwarded to myOwn for processing.

Just make sure you always supply us with a completed claim form when submitting your claim by post and an itemised account or, if you have paid the account, the original itemised receipt.

Unpaid accounts

All extras claims will need to be paid upfront to your provider and then claimed back through myOwn as outlined above.

For Medical accounts, you may submit unpaid medical accounts to Medicare. Medicare will then pay the provider, send the claim to us and we'll either issue a cheque to the provider or put the money in their account. You'll then get a bill from your provider for the gap.

How will you pay my claim?

Benefits for paid accounts will be paid directly into your nominated bank account.

My claim wasn't paid. Why?

There are instances where benefits are not paid at all or are paid at a lower level.

These are when:

- the treatment is not covered under your policy
- the treatment was not provided by a recognised provider
- the money is payable from more than one source for the same treatment
- the treatment was provided free of charge
- you have transferred to myOwn from another Fund and previously claimed for the treatment
- the treatment was not provided in Australia
- your claim form contains false or misleading information
- you've already claimed the maximum allowable benefits during a specified period
- it's been more than two years since the treatment you're claiming for
- the health care account has been incorrectly itemised
- the service is subject to a waiting period or another limit
- treatment was provided to themselves or by a family member or business associate
- you provide professional services to yourself or your family and/or to a providers business partner and their family members or any other people not independent from the practice
- myOwn believes that you are not receiving acute care after 35 days of continual hospitalisation
- surgery is performed in hospital by a registered podiatrist/podiatric surgeon
- no MBS item number is provided by the medical practitioner
- the MBS item is being performed for a cosmetic reason and not medical

- benefits are only payable for one consultation and/or treatment type on the same day if performed by different providers.
- services are not rendered in person (e.g. treatment over the phone or internet)
- there is an additional medical gap.
- the medical service is rendered by a medical practitioner employed full time in the public sector.

To find out more we recommend checking out your cover's detailed terms and conditions published in our Fund Rules. These are available by calling us on 1300 300 338.

What you need to know about Extras cover

Medicare

If you're entitled to a rebate or reimbursement from Medicare for extras, you can't claim any out-of-pocket expenses with us.

Physiotherapy claims

Any consultation with a physiotherapist must last for a minimum of 15 minutes for it to qualify for our one-on-one physiotherapy benefit.

Health appliances

myOwn does not pay benefits for the hire of any health appliance or equipment.

We will, however, fund the following appliances, providing you lodge a doctor's letter of recommendation with your claim:

- blood glucose monitor
- extremity pump
- nebuliser pump
- sleep apnoea machine
- pressure garments
- myOwn approved orthopaedic appliances
- non-surgical prostheses
- tens machine

Orthodontics

An orthodontic treatment plan certificate – completed by your treating orthodontist/ dentist – is required before any orthodontic benefits can be paid.

You can obtain an orthodontic treatment plan certificate by calling us on 1300 300 338.

For benefit payments, orthodontic treatment is regarded as commencing on the date the appliance was originally fitted.

Orthotic and orthopaedic appliances

To qualify for benefit payments, these must be custom-made by a practitioner podiatrist or orthotist. For an orthosis to be custom made, a plaster cast or mould must be taken. Please note that customising, heat moulding, trimming or adjusting an existing 'off the shelf' appliance does not constitute a custom-made appliance.

Weight loss programs

We'll only cover a weight loss program if it has been recommended, in writing, by a doctor for preventing or improving a specific health condition.

Here are some well-known providers that we're happy to approve:

- Weight Watchers Australia
- Jenny Craig Weight Loss Centres Pty Ltd
- Fernwood Food Coaching

Please note that we only cover weight loss program fees and will not provide any benefits for meals, groceries or exercise components.

Requirements for claiming?

Receipts

Benefits are only payable on itemised receipts.

Any receipts that have been altered will not be accepted unless they are reissued and endorsed by your provider.

Replacements

A benefit replacement rule applies to several items/services covered by myOwn's extras cover. This means that after you claim for an item, you must wait a specified period before you can lodge another claim for the same type of item.

This applies to the following:

- dentures
- hearing aids
- nebuliser pumps
- blood glucose monitors
- blood pressure monitors
- sleep apnoea machine
- extremity pumps
- tens machine
- pressure garments
- myOwn specified orthopaedic appliances
- non-surgical prostheses.

Extras purchased over the internet

Benefits will be paid for extras services purchased online from Australian providers (optical and pharmaceutical) where a script is provided.

For a company to be considered an Australian provider, an ABN needs to be visible on the company's website.

Benefits for services, treatments and other costs received overseas are excluded and will not receive any benefit.

Preventative dental item numbers

We've provided a handy table to help you understand what benefits are payable for preventative dental services.

However, we do recommend that you call us for a benefit estimate before commencing any treatment – just to be sure.

Item Number	ADA Schedule	Definition	Service Limits
011	Comprehensive oral examination	Your dentist will evaluate all your teeth and take down your full medical history.	1 per person per calendar year
012	Periodic oral examination	This follow-up consult will record all changes to your teeth since your last visit to the dentist.	2 per person per calendar year
013	Oral examination – limited	This is a 'problem-focused' consult, done immediately prior to required treatment.	No limit
014	Consultation	This is your opportunity to seek advice and discuss treatment regarding a specific condition.	3 per person per calendar year
015	Extended consultation (30 minutes or more)	This is a more in-depth consultation to discuss your treatment options for a specific condition.	No limit
016	Consultation by referral	This is for patients who have been referred by a medical or dental practitioner to discuss a specific condition.	No limit
017	Extended consultation by referral (30 minutes or more)	This in-depth consultation is for patients who have been referred by a medical or dental practitioner to discuss a specific condition.	No limit
018	Written report		No limit
111	Removal of plaque and/or stain	This deep clean is designed to keep your teeth in optimal condition.	1 per visit (not payable with items 114,115,222, 281, 282)
113	Recontouring of pre-existing restorations	This treatment is designed to reshape and repolish your existing fillings.	1 per visit (not payable with restoration items 500 - 599)
114	Removal of calculus (first visit)	This treatment is designed to remove any tartar from the surface of your teeth.	1 per visit (not payable with items 111,115,222,281,282)
115	Removal of calculus (subsequent visit)	This is a follow-up visit to maintain your teeth's tartar-free condition.	1 per visit (not payable with items 111,114,222,281,282)
121	Topical application of remineralising and/or cariostatic agents (one treatment)	This treatment is vital for keeping your teeth cavity-free and in good working condition.	1 per Visit

What are some Extras I can't claim for?

You can only claim on Extras treatments that are specifically included in your cover. Here's a list of some of the treatments (not all) that aren't covered:

General

- Services or treatment for which anyone covered has a right to claim damages or compensation from any other person or body
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act
- Services or treatment rendered more than two years prior to the date of claiming
- Services or treatment not covered by your membership and/or is rendered while the membership is in arrears or is suspended
- Services or treatment rendered by a practitioner not in private practice and/ or not recognised by bodies approved by myOwn Health Insurance

- Accessories, exercise equipment, herbs, supplements or pills prescribed by your provider – you can only claim the consultation itself

Pharmacy

- Contraceptives, fertility and IVF drugs
- Food supplements
- Pharmacy items, where they are available over the counter and purchased with or without prescription
- Liquid filled Temazepam capsules
- Pharmaceuticals purchased overseas and not listed on the Australian Register of Therapeutic Goods (TGA)
- Mass immunization, or services rendered in the course of the carrying out of a mass immunization
- Pharmaceuticals that are not considered an S4 or S8 drug

Dental

- Dental procedures where a limit on the number you can have has been exceeded
- Dental procedures unless tooth Identifications (ID) are supplied by the provider
- Dental procedures carried out and charged by a dental mechanic, other than an advanced dental technician
- A range of dental procedures when provided on the same day for example a filling on a tooth that has been removed. Please contact us for further information relating to these exclusions.
- A benefit will only be paid for a single crown per tooth every five years

Orthopaedic appliances and foot orthotics

- Orthopaedic appliances and foot orthotics that are **not** custom-made by practitioner podiatrist or orthotist. For an orthosis to be custom made, a plaster cast or mould must be taken. Benefits are not paid for items that are customised, heat moulded, trimmed or adjustments of existing 'off the shelf' appliances.

Pressure garments

- Pressure garments purchased for reasons other than the treatment of burns, varicose veins, lymphedema or post-operative surgery up to 60 days from hospital discharge only.

Where can I find recognised Extras providers?

You can only claim on Extras benefits where treatment is received in person from a recognised provider, in Australia. To find out if your provider is recognized you can call us on 1300 300 338 (we're open from 8am to 6pm AEDT).

You cannot claim for treatments you provide to yourself or to members of our family or business partners and members of their family.

What you need to know about Hospital cover

Medical Benefits

Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except where your claims are made through myOwn's gap cover) and your claim for hospital benefits has been assessed. Benefits are not payable for services rendered when the patient is not a hospital inpatient.

Participating private hospitals

myOwn has contracts with hundreds of private hospitals across the country. To ensure that your hospital is a participating private hospital, please call us on 1300 300 338. myOwn pays benefits to all public hospital facilities – so we haven't listed them specifically.

Non-participating private hospitals

We recommend you contact us prior to your admission to find out if the hospital you are to admitted to is on our participating hospital list. If it isn't you may not be covered in full for your accommodation or theatre costs for these admissions. Contacting us first means you'll know what types of benefits you will receive and information on your out-of-pocket costs.

Hospital covers

If you have hospital cover, it's important to understand what's covered and not covered under your level of cover. myOwn has created Fact Sheets on each individual product which you will be provided with anytime you change your cover or at any other time upon request. We recommend referring to this information for specific details regarding your hospital cover.

Excess

myOwn's range of hospital covers feature an excess to lower premiums by allowing members to share some of the cost of hospital admissions. The excess is calendar year based.

On couples and family cover each person (other than dependants who do not pay an excess) will only have to pay a maximum of $500 excess per calendar year and the excess is also capped at a maximum of $1,000 per calendar year for the policy. Singles and Single Parent covers will only have to pay $500 excess per admission capped at $500 per calendar year. An excess is payable for all admissions to hospital.

Dependant excess

No excess applies for child and student dependants on all myOwn covers.

Excess Refunds

Where your policy includes an Excess Refund, it means that if you hold this policy or another eligible policy for at least 6 months and hold Silver AIA Vitality status or higher, myOwn will refund 100% of your hospital excess. You will need to pay your excess when you're admitted to hospital and then you can claim this amount back.

To be eligible for this you must hold Silver AIA Vitality status at the time you are admitted to hospital.

To get your refund, you make a claim email or mail, call us on 1300 300 338 to find out more. When you submit your claim you will need to include your receipt showing the Excess paid. You can make your claim anytime up to two years, and valid claims will be paid into your nominated bank account.

Only one refund will be paid per member per calendar year because each member only pays one excess per calendar year.

Medical Gap Cover

What is the 'Gap'?

The Federal Government sets a schedule of fees for eligible services provided by doctors to inpatients in hospital. Medicare pays 75% of these fees and health funds like myOwn pay the remaining 25%.

Doctors and providers are not restricted to charging this fee and are able to set their own fees, which can be higher than the schedule fees. If your doctor chooses to charge a fee higher than the Government schedule fee there will be a charge remaining known as the 'gap'. This gap and can leave you with significant out of pocket expenses, unless your doctor participates in myOwn's Access Gap Cover Program.

Does myOwn cover this?

Yes, with our Access Gap Cover Program, we provide higher benefits than the Federal Government's set schedule fee if your doctor participates – leaving you with reduced, or even eliminated out-of-pocket expenses.

Is my Doctor registered for Access Gap Payments?

The best way to find out is to ask them. Every doctor is different and some will even opt in or out on a patient-by-patient basis.

If your doctor participates in myOwn Access Gap Cover they can either choose to participate as a 'No Gap' or 'Known Gap' as follows:

1. 'No Gap' – Your doctor participates in Access Gap Cover and charges you no out-of-pocket for the treatment you receive as an inpatient.

OR

2. 'Known Gap' – Your doctor participates in Access Gap Cover and charges you a reduced out-of-pocket for the treatment you receive as an inpatient and you will be aware the costs before surgery.

Just remember to check with your doctor before agreeing to any treatment.

Ambulance claims

All myOwn's hospital and hospital and extras packages covers cover you for emergency ambulance services in Australia. Emergencies are circumstances when immediate hospital treatment is required for a serious and acute injury or condition where the viability or function of an organ or body part is threatened. myOwn covers you for all clinically necessary ambulance services for emergencies in Australia.

myOwn pays ambulance benefits when the service is not publicly funded.

Check with your state Ambulance authority to ensure you have the right level of cover for non-emergency ambulance transport within Australia because without the right level of cover you may face significant out-of-pocket costs for non-emergency ambulance transport.

Note: Transport for non-emergencies will result in significant out-of-pocket costs. Publicly funded ambulance services and State Government transport schemes are excluded (eg. TAS/NSW/QLD).

What you need to know about Government surcharges and incentives

What is the Medicare Levy Surcharge?

The Medicare Levy Surcharge (MLS) is a surcharge (extra tax) that people above a certain income threshold have to pay if they don't have eligible private hospital cover.

It's calculated in three tiers for singles and couples/families/single parents:

Singles

Tier 1

If your income is between $90,001 and $105,000, you'll pay a surcharge of 1%

Tier 2

If your income is between $105,001 and $140,000 you'll pay a surcharge of 1.25%

Tier 3

If your income is more than $140,000 you'll pay a surcharge of 1.5%

Couples/families/single parents

Tier 1

If your income is between $180,001 and $210,000, you'll pay a surcharge of 1%

Tier 2

If your income is between $210,001 and $280,000 you'll pay a surcharge of 1.25%

Tier 3

If your income is more than $280,000 you'll pay a surcharge of 1.5%

Find out more at privatehealth.gov.au or ato.gov.au

Australian Government Rebate on private health insurance

Many Australians with private health insurance currently receive a rebate from the Australian Government to help cover the cost of their premiums.

The rebate is income tested and you can claim it, either:

- as a reduction of your myOwn premium; or as
- a lump sum payment when lodging your tax return

The rebate uses the same threshold tiers as the Medicare Levy Surcharge and the policy holders age to determine the rebate amount.

Income	Base Tier	Tier 1	Tier 2	Tier 3
Single	$90,000	$90,001 – $105,000	$105, 001 – $140,000	>$140,000
Couple	$180,000	$180,001 – $201,000	$210,001 – $280,000	>$280,000
Age				
<65	25.415%	16.943%	8.471%	0%
65 – 69	29.651%	21.180%	12.707%	0%
70 +	33.887%	25.415%	16.943%	0%

Check out the Private Health Insurance Rebate Calculator on the ATO website to see how much you could get back.

Lifetime Health Cover (LHC)

LHC was introduced on July 1, 2000 to encourage Australians to take out (and maintain) private hospital cover at a younger age.

If you haven't covered yourself with a basic hospital cover by 1 July following your 31st birthday, the Government will add a two per cent loading to your premium for every year you're not insured.

In other words…

If you take out hospital cover at the age of 40, you'll pay 20 per cent more than someone who first took out hospital cover when they were 30. The maximum loading is 70 per cent.

The LHC loading is removed once a person has held hospital cover and paid the loading for 10 continuous years.

Discover more about LHC at privatehealth.gov.au

What to do if there's a problem

We're here and we're ready to help. If there's anything you're not happy with, please let us know as soon as possible so we can get started on resolving it for you. We aim to resolve problems at their first point of contact.

Phone us

Our team is available between 8am and 6pm, Monday to Friday AEST. So, if there's anything you want to chat through, give them a call on 1300 300 338.

Email us

You can email us at service@myown.com.au

Write to us

You can write to us at:
myOwn health insurance
PO Box 7302
Melbourne VIC 3004

We will answer all written correspondence within five days. If the matter requires a bit more thought, we'll try and get it sorted within two weeks.

Whatever happens, we'll always keep you fully up-to-date with our progress.

What to expect from us when we are solving a problem for you

We're committed to a quick and fair resolution of all complaints so this is what you can expect from us:

- We'll acknowledge receipt of complaints within two business days (where they aren't resolved immediately). This acknowledgment will include a reference number for your records
- If we are unable to deal with your complaint we'll advise you as soon as possible and provide advice on who you can go to next
- If there are any delays in us responding to you when we say we will, we'll advise you and provide a reason
- If one of our Member Service Consultants can't resolve your problem, then it will be escalated to our Member Service Manager (or someone with equivalent decision-making authority) and finally to our Chief Health Insurance Officer. If the problem is still unresolved the matter can be taken to the Private Health Insurance Industry Ombudsman.

Commonwealth Ombudsman

We will always do our best to resolve any issue you have, but if you're not happy with our solution you can contact the Commonwealth Ombudsman.

Phone: 1300 362 072

Mail: Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Website: ombudsman.gov.au

Glossary

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. An accident does not include any unforeseen conditions the onset of which is due to medical causes nor does it include pre-existing conditions, falling pregnant or accidents arising from surgical procedures. For an accident to be covered treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury.

Calendar year

A period of 12 months from 1 January through to 31 December.

Compensation

This includes:

- A payment by way of damages;
- A payment under a scheme of insurance or compensation provided by the Commonwealth or State law (for example, workers compensation insurance or compulsory third party motor vehicle accident insurance);
- Settlement of a claim for damages (with or without admission of liability);
- A payment for negligence;
- A benefit paid by another private health insurer; or
- Where you are entitled to any rebate or reimbursement from Medicare for any Extras service, you cannot claim any out of pocket expenses with us;
- Any other payment that in the Fund's reasonable opinion is a payment in the nature of compensation or damages or payment from a third party.

Cosmetic surgery

A 'cosmetic service' is an operation, procedure or treatment carried out for the dominant purpose of improving appearance or boosting self-esteem, where:

- there is no disease, deformity, injury or disorder; or
- the deformity is the result of a normal physiological process such as pregnancy and ageing.

Benefit Replacement Rule

A benefit replacement rule applies to the Medically Prescribed appliances and non-surgical prostheses covered by myOwn's extras cover. This means that after you claim for an item, you must wait a specified period before you can lodge another claim for the same type of item. These periods vary by the treatment claimed so please call myOwn on 1300 300 338 for more information.

Exclusions

These refer to services that you're not covered for. So, if you find yourself in need of a treatment that's listed as an exclusion in your cover, you will not receive any benefit and will have a significant out-of-pocket expense.

Inpatient

A person who has been admitted to hospital.

Medical adviser

A medical practitioner appointed by myOwn to decide if a condition is pre-existing. The medical adviser must consider any information regarding signs and symptoms provided by your treating medical practitioners.

Non-participating hospital

This refers to any hospital that myOwn does not currently have an agreement with. If you receive treatment from a non-participating hospital, significant out-of-pocket expenses may incur.

Maximum Pharmaceutical Benefits Scheme (PBS) amount

The maximum PBS amount for 2018 is $39.50. Pharmacy benefit applies after the maximum amount of $39.50 has been deducted and is capped at $40 per item.

Participating Private Hospital Agreement

myOwn has negotiated special agreements with a range of participating private hospitals to provide members (subject to any exclusions and/or restrictions) with hospital cover that includes:

- accommodation
- theatre
- access to a delivery suite
- intensive/coronary care
- a range of other services provided by the hospital

To find out if the hospital you would like to be treated in is a participating private hospital call us on 1300 300 338 Monday to Friday between 8am and 6pm AEDT.

Private practice

All general treatment (Extras cover) services must be provided by practitioners in a private practice that is appropriately registered with recognised bodies approved by myOwn.

Psychiatric care

This refers to any treatment provided by a hospital which is licensed to deliver psychiatric treatment for conditions such as depression, anxiety and drug and alcohol dependence.

Recognised provider

myOwn is committed to paying benefits for Extras services provided by a myOwn recognised provider.

Restricted benefits (partially covered)

Restricted benefits mean that myOwn will pay the minimum amount set by the Australian Government for accommodation as a private patient in a shared room in a public hospital. Staying in a single room in a public hospital or treatment in a private hospital will result in significant out-of-pocket expenses.

Public hospital

This refers to a hospital that is owned and/or funded by the Government. If you're admitted as a private patient in a public hospital, you'll only be covered for a shared room. Electing to be a private patient in a public hospital could result in significant out-of-pocket costs to you. Ensure you receive written informed financial consent for any hospital admission.

Please note that our public hospital coverage does not help you jump the public hospital queue. This is determined by the hospital and we have no say in who gets served first.

myOwn

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