WHAT IS A RECOVERY PLAN?

A Recovery Plan (Plan) is a document to provide you with certainty about the delivery and payment of your medical treatment, rehabilitation, and training services for your motor accident injuries (MAI). The insurer must tailor each version of a Plan to your circumstances and your specific treatment and care needs.

A Plan includes details of your injuries, treatment goals, your capacity for activities, including work, and the treatment and care approved by the insurer. You are still able to make requests to the insurer for approval of reasonable and necessary treatment and care needs outside of a Plan.

HOW IS A RECOVERY PLAN DEVELOPED?

The insurer will prepare a draft Plan using information gathered from relevant medical reports and records to assess your treatment and care needs. The insurer may also refer you for an assessment of your treatment and care needs with a non-treating health practitioner in preparing a draft Plan.

You and your nominated treating doctor will receive a draft Plan if you are unable to resume your pre-accident activities or work duties within 28 days of the insurer confirming they have received your complete application.

REVIEWING YOUR RECOVERY PLAN

You have the opportunity to review a draft Plan and to ask your doctor to make recommendations about reasonable and necessary treatment and care to be included in a final Plan.

You will need to give your doctor's recommendations to the insurer within 15 business days of being sent a draft Plan. If the insurer does not hear back from you or your doctor within this timeframe the draft Plan will become your final Plan. Otherwise, after your doctor's recommendations are considered by the insurer, a final Plan will be sent to you and your doctor.

The insurer reviews the current Plan **at least every 13 weeks**. They will consult with you and your doctor on any updates to the Plan following the above process. You can also contact the insurer with requests to review/update the current Plan.

Please note: *Your benefits under the MAI Scheme can be suspended by the insurer if you unreasonably fail to undergo all treatment and care in your current Plan.*

HOW ARE DISPUTES RESOLVED?

If the insurer does not approve your request to cover a treatment and care expense, they must provide you with reasons for their decision. You can seek a formal review to change such decisions through the insurer and then externally through the ACT Civil and Administrative Tribunal (ACAT).

FURTHER INFORMATION AND HELP AVAILABLE

To access free assistance and information you can contact the Defined Benefits Information Service, by CARE Inc, via email on DBIS@carefcs.org or phone 1300 209 642.

You can also visit the MAI Commission website for information and copies of forms: act.gov.au/maic