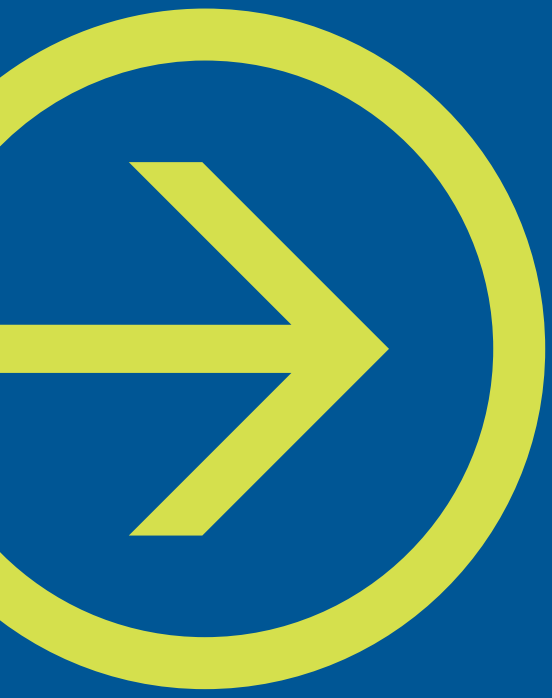


SmartCare+

Your health plan for life

Health insurance policy document

taking care

accuro health insurance

Taking care of

Contents

Welcome to Accuro Health Insurance

Congratulations on your decision to take out health insurance with *Accuro Health Insurance*. We pride ourselves on our personal and friendly service and encourage you to contact us should you have any questions.

How to contact us

Customer service 0800 ACCURO (0800 222 876)

Our customer service team are available from 8.30am until 5pm, Monday to Friday (excluding public holidays). Our helpful staff are ready to assist you with your enquiries regarding *Accuro Health Insurance membership*, your *policy*, your *premiums* or other general enquiries you may have.

To ensure the privacy of all of our *members*, we will ask you a number of identification questions before discussing any matters with you. Please have your membership number available. Your call will be handled in complete confidence.

Member portal

Accuro Health Insurance has launched a member portal where you can log in to your *policy* online to check what you are covered for, update your details, make changes to your *policy*, apply for pre-approval and save and submit *claims*.

To sign up, go to www.accuro.co.nz and click 'Register' (which is at the top right corner). Enter your member number and email address that you have registered with us. An email will then be sent to you confirming your registration. Click on the link in the email to activate your member portal.

In future, you will just need to go to www.accuro.co.nz and click on 'Login' to access your member portal at any time.

Online www.accuro.co.nz

Email info@accuro.co.nz

Fax 04 473 6187

General correspondence

Accuro Health Insurance
PO Box 10075
Wellington 6143

Claims correspondence

Attention: Claims Department
Accuro Health Insurance
PO Box 10075
Wellington 6143

Important information

This document explains what your *policy* covers and should be read in conjunction with your *membership certificate*.

It is important that you read this *policy* document carefully. This will ensure you know what you are covered for, what you need to tell us, how to make a *claim* and any other terms and conditions of your *policy*.

Please keep this *policy* document in a safe place.

We understand insurance can be complex, and *policy* documents are not always easy to understand. If you are unclear about any aspect of this document or would like further information, please call our customer service team, and we will be happy to help.

Welcome to your health plan for life.

Our commitment to you

We at *Accuro Health Insurance* are committed to being there for you, not just as a name on your *policy* but as a partner in providing you peace of mind. If you have any questions about your SmartCare+ *policy* or if we can be of help in any other way, please call our helpful customer service team during normal business hours on 0800 ACCURO (0800 222 876).

14-day free-look period

It is important that you have time to carefully review the *plan(s)* you have selected and confirm that it meets your individual needs. This is why we provide a 14-day free-look period that commences from the date on the *membership certificate* issued by us. During this time, if you change your mind, we will refund any *premiums* paid, as long as no *claim* has been made by any person covered by your *policy*.

Privacy

We comply with the Privacy Act 1993, including the Health Information Privacy Code 1994, and we will use reasonable endeavours to ensure the privacy of your and all *participants*' personal information. By applying for *membership* under the terms of this *policy*, you and any other *participants* agree to the following:

- *Accuro Health Insurance* collects personal information about you and any other *participants* in connection with this *policy*. That information is held at *Accuro Health Insurance's* offices, and you have the right to access and request correction of that information.
- While we treat any personal information as confidential, there may be some situations where we disclose information to a third party including:
  - for evaluation of *claims* under the *policy*
  - for providing on-going client service and information
  - for *participants*, to the main *member* of this *policy* in relation to *claims*, administration and other matters related to the *policy*.

Disclosure

You and any other *participants* seeking insurance under this *policy* have a legal duty to disclose everything you or they knew (or ought to have known) that would have influenced the decision on whether to provide cover. All information provided by you or any *participant* to *Accuro Health Insurance* must be true, correct and complete. If the information provided is untrue, incorrect or incomplete, we may not pay a *claim*. We may also void all or part of your *policy* or cancel it.

Code of practice

This *policy* complies with the Health Funds Association of New Zealand Health Insurance Industry Code. You can obtain a copy of our financial statements for the last reported year by writing to us at Accuro Health Insurance, PO Box 10075, Wellington 6143 or downloading a copy of our annual report from www.accuro.co.nz.

Membership of the Society

Accuro Health Insurance is the trading name for the Health Service Welfare *Society* Limited, which is incorporated under the Industrial and Provident Societies Act 1908. This legislation governs the way that the *Society* is run and the health *benefit plans* it administers. Like all legislation, it is subject to change.

As a *policy* holder with *Accuro Health Insurance*, you are now a *member* of *Accuro Health Insurance*. To this end, throughout this *policy* document, we may refer to you as the main *member* and all other individuals attached to your *policy* as *participants*.

Accuro Health Insurance is a member of the Health Funds Association of New Zealand and the Insurance & Financial Services Ombudsman Scheme.

This *policy* document is subject to change in accordance with prevailing conditions and at the discretion of the *Board* of Directors. We will endeavour to provide reasonable notice (minimum 21 days) prior to such change.

Accuro Health Insurance understands that some of the terms used in this *policy* document may be new. That is why we have provided an explanation for some of the more common health insurance terms. Words printed in italics are key terms as defined in the glossary on pages 17 and 18. Words that are not italicised are given their ordinary meaning.

The pre-approval process

You must seek pre-approval for any *claim* that is likely to exceed $1,000 or where your *procedure and/or medical treatment* requires *hospitalisation*, day-stay or in-patient care.

Failure to do so may prejudice the ability to *claim* for the *procedure and/or medical treatment* costs at a later date. To ensure that the *procedure and/or medical treatment* is covered under your *plan*, it is recommended that you contact us as soon as possible to check eligibility.

You also need to provide estimated charges for your *procedure and/or medical treatment*. A minimum of five working days' notice is required to give us time to do any necessary checks and send out confirmation before the *procedure and/or medical treatment* takes place.

What is the process for seeking a pre-approval?

To apply for a pre-approval, you need to complete a pre-approval form, which can be downloaded from our website www.accuro.co.nz and submitted through your member portal, or contact us on 0800 222 876 to have one posted to you.

The pre-approval will confirm whether your *procedure and/or medical treatment* is covered under your *plan* and whether any conditions apply. It will also provide us with the estimated charges from your health service provider(s).

In some cases, we will also require a medical report to be completed by your doctor. If so, you will be informed of this at the time you call.

What do I need to do?

1. Obtain a pre-approval and medical report form (if required) from *Accuro Health Insurance* by calling 0800 222 876, or download the appropriate forms from our website www.accuro.co.nz or through your member portal.
2. Ask your referring doctor to fill in the medical report (if required).
3. Confirm the main *member's* details in the top section of the pre-approval form and answer all the questions to provide a medical history leading up to the *procedure and/or medical treatment*. Your specialist or doctor may help you complete this form. A copy of the initial medical referral is required, and the specialist's report may be requested at a later stage.
4. Ask the specialist to provide the likely costs for the *procedure and/or medical treatment* and anaesthetic fees. If applicable, call the designated *private hospital* for confirmation of the usual costs for the proposed *procedure and/or medical treatment* including the number of nights, theatre fees and any additional costs such as equipment and physiotherapy. Don't forget to ask if the amounts include GST.
5. Provide full details of assistance from any other source such as *ACC*, other insurers and any other party you will or may receive assistance from.
6. The main *member* and the patient, if 16 years or older, must sign the pre-approval form.
7. Post/fax or scan and email all documentation to *Accuro Health Insurance*, or submit through your member portal.

Will my health service provider(s) give me an estimate of the charges?

You have the right to request an outline of the *procedure and/or medical treatment*, risks associated with the *procedure and/or medical treatment* and an estimate of the charges before the *procedure and/or medical treatment* takes place. This is provided under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Your health service provider(s) will provide you with this information to assist with your pre-approval documentation. Please note that this is an estimate only, and actual costs may vary.

Do all prescription drugs qualify for cover?

Your *policy* offers different cover for prescription drugs depending on what type of healthcare services they relate to:

- Drugs prescribed and taken in *hospital* are covered as part of *hospital* charges related to *surgical* treatment or related to *non-surgical hospitalisation* under the Hospital and Surgical+ base *plan*.
- Chemotherapy drugs taken as part of a course of chemotherapy treatment are covered as part of the *private hospital* medical admission *benefit* under the Hospital and Surgical+ base *plan*.
- Any other drugs are only covered under the prescriptions and laboratory tests *benefit* in the GP+ *plan*.

Prescription drugs must be listed on the *PHARMAC Schedule*, PHARMAC approved, *medically necessary* and prescribed by a *registered medical practitioner*. You must also be eligible to meet PHARMAC's funding criteria.

As part of the Hospital and Surgical+ base *plan*, the non-PHARMAC drugs *benefit* allows *Medsafe*-registered prescription drugs. Under this *benefit*, prescription drugs must be registered by *Medsafe* for use in New Zealand, where the treatment is prescribed by a *registered medical specialist* as being the appropriate medical treatment for the condition, the treatment and/or condition is not excluded elsewhere in this *policy* document and the drug being prescribed is within the guidelines set by *Medsafe*. All costs under the non-PHARMAC drugs *benefit* are included within the *benefit* maximums of the Hospital and Surgical+ base *plan* only.

What other information do I need to provide?

When you request a pre-approval, we may ask that an additional medical report is completed by the GP who holds the patient's medical history. This allows us to fully assess your *claim* prior to the *procedure and/or medical treatment*. In some cases, we may need to contact you or the health service provider(s) to request additional details to ensure we assess your *claim* correctly.

The claims process

Subject to the terms of this *policy*, we will pay all *reasonable and customary charges* for a *medically necessary procedure and/or medical treatment* up to the relevant maximum cover. If the costs of the *procedure and/or medical treatment* exceed the maximum cover or the *reasonable and customary charges*, we will not pay the difference, and the difference will be your responsibility.

Claims will only be accepted for costs relating to *events* that occur after the *policy* commences. *Claims* and *benefits* will not be paid when *premiums* are in arrears or when your *membership* has ceased for any reason, irrespective of the date of the *event*.

Submitting claims

All *claims* must be received by *Accuro Health Insurance* within 12 months of the date of an *event*. *Claims* made outside the 12-month *claim* period will be declined.

Visits to a *registered medical specialist* must be referred by a general practitioner or dentist. A copy of the referral letter must be attached to the *claim* form.

Medical evidence

Upon request from us, you will need to supply *medical evidence* before we agree to pay any *benefits*. This right of request applies from the pre-approval process to the completion of treatment.

At our request, you will also need to supply *medical evidence* after the *procedure and/or medical treatment* has been concluded. A *procedure and/or medical treatment* includes application for diagnostics or screening procedures. Any costs involved in obtaining the above information will be at your expense.

Treatment in a public facility

Accuro Health Insurance does not pay for any healthcare service undertaken in a *public hospital* or facility controlled directly or indirectly by a DHB unless specifically accepted in writing by *Accuro Health Insurance* prior to any *procedure and/or medical treatment* (except where the contrary is expressly specified in this *policy*).

Payment of claims

Payment is limited to the lesser of the *benefit* levels or the usual *reasonable and customary charges* for any approved *procedure and/or medical treatment* at the time as solely determined by *Accuro Health Insurance*, taking into account circumstances we consider relevant. This means *Accuro Health Insurance* may negotiate with your nominated health service provider(s) or recommend alternative health service providers if the estimated cost received from your chosen provider(s) is above the usual *reasonable and customary charges*.

If we are unable to negotiate a reduction in the cost for your *procedure and/or medical treatment* and you choose to continue with the *procedure and/or medical treatment* under your nominated health service provider(s), you will be responsible for any monetary difference between the *reasonable and customary charges* and the cost for the *procedure and/or medical treatment*, regardless of the *benefit's* maximum cover, and must arrange for payment on this basis directly with your nominated health service provider(s).

Benefits

Benefits are calculated on the net amount paid after deducting any refunds, subsidies or entitlements available from other sources, for example (without limitation), *ACC*, another health insurer, a government-funded agency, Work and Income or your employer.

You or any *participant* shall not receive a *benefit* that, together with any other refunds, subsidies or entitlements, amounts to more than 100% of the actual costs incurred for any *event*.

Where relevant, the minimum or maximum amount that may be *claimed* for each *event* is set out in the *benefits* section of this *policy* document.

You may request us to pay *hospital* and related accounts on your behalf if pre-approval has been sought and obtained before entering *hospital*.

What is the process to make a claim?

When you wish to make a *claim*, our claims staff will be happy to help. If the *procedure and/or medical treatment* is estimated to cost less than $1,000 and does not involve *hospitalisation*, day-stay or in-patient care, you are not required to seek pre-approval for this treatment.

We do, however, recommend that you refer to both your *membership certificate* and this *policy* document to ensure the *procedure and/or medical treatment* you're having is covered by us.

For all *claims* under $1,000, complete a *claim* form, attach the invoices and receipts and GP/specialist referral letter and post, fax or email them to us, or submit through your member portal. We may still require a medical report form to be completed, but we will contact you directly if that is the case.

For all *claims* likely to exceed $1,000 or where your treatment requires *hospitalisation*, day-stay or in-patient care, we recommend that you seek pre-approval from us. Refer to the pre-approval process on page 3 of this policy document for guidance. You may need to complete a *claim* form after the *event*.

What do I need to do?

The *claim* form must be fully completed and signed by the main *member*. Attach all invoices and receipts, as proof of payment, to your *claim* form.

If you prefer to pay smaller accounts such as charges for doctors' visits and prescription charges directly, you need to ensure you receive an invoice and a receipt at time of payment. When your invoices or receipts exceed the minimum amount of $100, you may wish to make a *claim*.

You can access a *claim* form the following ways:

- Download a *claim* form at www.accuro.co.nz.
- Call us on 0800 222 876 during normal business hours.
- Submit a *claim* through your member portal.
- Write to us at:
  Accuro Health Insurance
  PO Box 10075
  Wellington 6143

When do I have to send in my invoices and receipts?

Invoices and receipts must be submitted within 12 months from the date of the *event*, so we suggest you submit a *claim* at least once a year. *Claims* will not be accepted when *membership* has ceased for any reason, irrespective of the date of an *event*.

What are reasonable and customary charges?

Reasonable and customary charges are charges for medical treatment that are determined by *Accuro Health Insurance* to be reasonable and within a range of fees charged under similar circumstances and by persons of equivalent experience and professional status.

These are based on our on-going review of:

- health service providers' charges for a particular healthcare service
- our *claims* statistics
- our experience of the national and regional New Zealand health market.

The charges that are established as a result of this review process are referred to throughout this *policy* document as *reasonable and customary charges*.

What else do I need to know about my claim?

Accuro Health Insurance reimburses *claims* directly to your health service provider(s) if we do not receive receipts as proof of payment.

We may decline any *claims* we consider to be invalid or unjustified in accordance with the terms of this *policy*. If your *premium* payments are in arrears at the time of making any *claim* with *Accuro Health Insurance*, we will not pay your *claim* until your *premiums* are fully up to date.

What happens when my claim involves ACC?

Before we accept a *claim*, you must first make a *claim* to any other insurer you may be covered by or under any contract of indemnity or insurance, and you must advise us that another insurer is involved in a *claim* that has been submitted to us. This includes *ACC*. Any expenses recoverable in this way will be deducted from the reimbursement provided by us under this *policy*.

ACC is New Zealand's *accident* compensation scheme, which provides 24-hour no-fault insurance cover if you are injured.

Special conditions apply to *surgery* or treatment covered by *ACC*.

Under the *ACC* legislation, you can choose between a full payment option (where a provider is fully contracted by *ACC* to provide the *procedure and/or medical treatment* at no cost to the claimant) or a partial payment option (where a provider requests elective treatment for the claimant and either does not have a contract with *ACC* to provide elective services treatment or is a contracted provider who requests elective treatment for the claimant but that treatment is outside the terms of their contract – under this option, *ACC* will only partially fund the elective treatment).

The full payment option should be the first choice, as the claimant will not have to make any contribution towards *surgery* costs. By comparison, under the partial payment option, the claimant will have to make a contribution towards the cost of the healthcare services.

It is the claimant's responsibility to submit all *claims* to *ACC* in the first instance. Where *surgery* is indicated, the claimant must seek or obtain pre-approval from *ACC* for *private hospital* costs.

If *ACC* refuses to cover the *claim* or ceases *claim* cover due to the claimant's failure to comply with *ACC*'s requirements, the claimant will be deemed by us to not have made a reasonable effort to secure cover or maintain cover and will therefore be ineligible to *claim* under this *policy*.

If *ACC* declines *ACC* cover or declines to pay in full for *private hospital surgery*, treatment or any other relevant entitlement, for whatever reason, we reserve the right to insist that the claimant applies to *ACC* for a review of that decision before we accept any *claim*. Reviews of *ACC* decisions must take place within three months of receipt of the deadline letter received from *ACC*.

The claimant must co-operate fully with us in pursuing the review or appeal. Where *ACC* reverses a decision for a previously declined *claim*, we reserve the right to seek reimbursement from *ACC* or the claimant for any related *claims* paid by us.

Where *ACC* agrees to contribute to the *private hospital* costs, we will cover the difference in cost between the *ACC* contribution and the usual *reasonable and customary charges* or as specified in the *benefits* of this *policy*. Copies of appropriate acceptance documentation from *ACC* must be provided to us prior to our acceptance of the *procedure and/or medical treatment*.

How does my excess work with my claim?

If an *excess* does apply to your *plan(s)* and the amount of the *claim* exceeds the *excess* you have selected for your *plan*, we will deduct this *excess* from the *claim*. If the *claim* is smaller than your *excess*, we will not pay the *claim* until such time that it exceeds the *excess*.

There can be different *excesses* applicable to the Hospital and Surgical+ base *plan* and Specialist+ *plan* that will be listed on your *membership certificate*. The *excess* relates to a number of *benefits* under each *plan* and is applied for the duration of a *claims* year. When a pre-approval is provided, your *excess* will be clearly shown, and you will need to settle this amount with your health service provider.

The *excess* applies once per life assured per *policy year*.

General information

Period of cover

Cover for any SmartCare+ *policy* commences from the date on the *membership certificate* issued by us.

Cover ends when any of the following occur:

- You ask us to cancel your *policy*. You must provide this advice in writing.
- You fail to pay your *premium* for three months or more.
- You or any *participant* breaches the terms of this *policy*.
- When the last *member* covered by this *policy* dies.

All information given by or on behalf of you or any *participant* when arranging this *policy* or making any changes to it must be true, correct and complete.

Are pre-existing conditions covered?

SmartCare+ is designed to provide cover for the treatment of conditions, signs and symptoms that arise after the *policy* has commenced.

We reserve the right to exclude any declared or non-declared *pre-existing condition* from the *policy*. This applies to you and any *participant* at the time of application and/or during the life of the *policy*.

All *pre-existing conditions* and symptoms, including *congenital conditions*, will be excluded from cover under this *policy* and must be disclosed at the time of application for the original *policy*. Any such exclusion(s) will be clearly stated in the *membership certificate* and should be read in conjunction with this *policy* document. We reserve the right to exclude any *pre-existing condition* or *congenital condition* you have not disclosed if we become aware of it.

Declaration of pre-existing conditions

If any *pre-existing condition* that is known about, or ought to have reasonably been known about, is not declared on your application form and then treatment is required for the *pre-existing condition* or any condition that is caused by (in part or full) or is in association with or is otherwise incurred in relation to or as a consequence of the *pre-existing condition*, we may decline your *claim*.

Important information about premiums

Your *premium* must be maintained to ensure continuity of *membership* of *Accuro Health Insurance* and eligibility for *benefits*. You must pay *Accuro Health Insurance* the *premiums* at one of the frequencies provided by us. *Premiums* are payable in advance.

General *premium* increases can be applied at any time and would be in addition to any other adjustments that may be made to the *premiums*.

The *premiums* for your SmartCare+ *policy* are not guaranteed. We reserve the right to review and adjust *premiums* at our discretion to ensure the viability of any *plan* or grouping of *members* and/or *participants* within a *plan*. We will provide you with a minimum of 21 days' prior notice of such a change.

We want to ensure your valuable cover continues. If our communications are returned marked 'gone/no address', we will continue to make deductions until we are advised otherwise. Your acceptance of this *policy* authorises us to do this.

Claims payments will be withheld when *premiums* are in arrears until the arrears are cleared.

We reserve the right to deduct any outstanding *premium* when making payment for an eligible *claim*.

It is important to note that your *policy* will be cancelled when three months' *premiums* or more remain unpaid.

Annual limits

Annual limits last for the duration of a *policy* year and revert to their maximum levels at the start of each *policy* year.

Annual limits cannot be carried over from one *policy* year to the next and cannot be transferred to other *participants* covered by the *policy*.

Who can be added to my policy?

SmartCare+ allows you to add *participants* to your *policy*, providing you the confidence of knowing that your family members are covered should they have a health issue. You will need to complete an application form for all *participants* with details of their medical history.

Premiums for all *participants* will be charged from the date of the addition as part of your normal billing cycle. You are responsible for payment of *premiums* in respect of all *participants* added to the *policy*.

- You can add *dependants/whāngai* onto your *policy* at any time up until they reach 25 years of age.
- You can add a spouse/*partner* onto your *policy* at any time.
- You can add your *parents* onto your *policy* at any time.

We will only charge *premiums* for the first two *dependants/whāngai* under the age of 25 years covered under your SmartCare+ *policy*. This means that, if you have three or more *dependants/whāngai* on your *policy*, you will only be charged the rate for two *dependants/whāngai*.

Once a *dependant/whāngai* reaches 25 years of age, they will start to be charged at an age-related *premium* and will no longer be charged at a *dependant* rate.

Child coverage

Children receive automatic coverage, free of *premiums*, for the first six months after being born, subject to the exclusions specified in the exclusions section. Notwithstanding any other provision in this *policy*, all children are subject to exclusion for *congenital conditions*. To be eligible for free cover, the child must be added to the *policy* before they reach six months of age by completing a short application form.

Once the child has been added to your *policy*, they will remain on it until the main *member* advises otherwise, and the relevant *premium* will be charged once the child has reached six months of age.

If you wish to insure a child who is over the age of six months, we require a full application form to be completed. The child will be subject to medical *underwriting*, and the relevant *premium* will be charged.

How long can dependants/whāngai stay on my policy?

Your *dependants/whāngai* are charged at the *dependant premium* rate until they reach 25 years of age. On reaching age 25, the *premium* payable will be adjusted from a *dependant premium* rate to that of a 25-year-old adult. They will remain on your *policy* and continue to have an age-related *premium* applied unless you request their removal.

Dependants/whāngai aged 25 years and over who have been included in your *policy* may apply to have their own *policy*.

If they do so within 30 days of leaving your *policy*, they will not be required to be underwritten.

How do I remove participants from my policy?

You can remove a *participant* from your *policy* at any time by putting your request in writing to us and signing this request.

It is the responsibility of the main *member* to remove *participants* from the *policy* should circumstances change (for example, following a marital separation).

Is it important to note that, if you remove a *participant* from your *policy* and then wish to add them on again in the future, they will need to complete a new application form, which is then signed by the main *member,* and will be fully underwritten.

Death of the main member

If the main *member* of the *policy* dies, the *partner* who has been included in the *policy* may retain this *policy* while they continue paying the appropriate *premium*. The surviving *partner* is then considered the main *member*.

Upon the death of the main *member* or *partner* (who is covered by this *policy*) or upon the diagnosis of a *terminal illness* prior to attaining the age of 70 years, *Accuro Health Insurance* will continue to provide for the other *participants* covered under this *policy* without requiring further *premiums* for 36 months from the date of death or until the oldest surviving life assured reaches the age of 70, whichever is the earlier. Appropriate certificates and documentation must be provided.

Change in family circumstances

Where there is a rearrangement of a family, a separated *partner* may apply to become a *member* in his or her own right and continue on a separate *policy*.

Suspending your policy

You may contact us requesting suspension of cover for a period of time ranging from two to 24 calendar months. In all cases when applying for suspension of cover, your request must be made in writing.

Application of suspension of cover will be considered for the following reasons:

- Travelling overseas for a period longer than two months (maximum length of suspension – 24 months).
- Taking maternity leave (maximum length of suspension – 12 months).
- Being registered as unemployed for a period longer than two months (maximum length of suspension – six months).
- Being made redundant and/or suffering financial hardship (maximum length of suspension – six months).

To be eligible for suspension of cover, the following conditions must be met:

- The *member* and/or *participant* covered must have been covered by the *policy* for at least 12 months up to the date the suspension is to take effect.
- For overseas travel, we will require evidence of departure and re-entry, and you must return to New Zealand within 24 months of the date the suspension started.
- For maternity leave, we will require evidence from your employer confirming your period of leave (maximum length is 12 months).
- Evidence of redundancy and/or financial hardship must be provided for consideration by the Chief Executive Officer of *Accuro Health Insurance*.
- You must be continuously covered under this *policy* for a period of 12 months between the end of the last suspension and the start date of the next suspension.

We will not pay any *benefits* under the *policy* to you or any *participant* who is suspended in respect of any *event* occurring while cover is suspended.

Cancelling your policy

If you are cancelling your SmartCare+ *policy* within your 14-day free-look period, we will refund all *premiums* paid, as long as no *claims* have been made by a person covered by your *policy*.

You can cancel your *policy* at any other time. *Premiums* received by us in good faith may be retained by us irrespective of the date of cancellation of the *policy*. You are also liable for all *premiums* due up to the date of the cancellation.

In all cases, you need to advise us of your cancellation in writing, signed by the main *member*. We will acknowledge all requests for cancellation of your *policy* on receipt of the written request.

Membership will not be reinstated following cancellation. This does not prevent you from applying to rejoin at a later date, but a new application must be made on our application form.

What happens if I give incomplete, false or misleading information?

Any information you give us or that is given to us on your behalf when making a *claim* must be true, correct and complete.

We may not pay a *claim* and we may void all or part of the *policy* or cancel it if:

- any information given to us is untrue, incorrect or incomplete, or
- if you or any *participant* has not told us about anything else that either you or they know, or
- a reasonable person in the circumstances knew or ought to have known it was relevant to our decision to accept a *claim*.

If we have already paid the *claim*, we can recover from you the amounts paid.

Accuro Health Insurance may cancel your *policy* or reduce cover immediately where it appears to us that a *member, participant* or *dependant/whāngai* covered by the *policy* has provided false, misleading or incomplete information. If this information relates to a *claim*, we may decline your *claim* and recover any amount paid.

If, at any time, we become aware of any *pre-existing condition* that has not been disclosed, we will add this to your *membership certificate*, and it will be recorded as an excluded condition.

In some circumstances, where fraudulent behaviour has been identified, we may take legal action against you and/or the *participant/dependant* involved.

Currency and GST

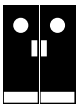
All monetary amounts referred to in all of our material (including this *policy* document) are in New Zealand dollars. All *benefits* and *premiums* are GST inclusive.

Jurisdiction

Accuro Health Insurance conducts all its business in accordance with the laws of New Zealand.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.



Hospital and Surgical+ base plan

General surgery – *excess* applies $500,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* associated with the pre-approved treatment of a non-acute medical condition. Covers the procedure(s) and all subsequent eligible treatment or expenses, including *private hospital* or *public hospital* costs (provided protocols for a *private hospital* set by the Ministry of Health for the treatment of private patients in *public hospital*s have been followed), physiotherapy while in *hospital*, surgeons' fees, anaesthetists' fees, costs of essential prostheses within the *Accuro Health Insurance* schedule and pre-operative and post-operative diagnostics, consultations or tests provided they occur within one year prior to or after the approved *surgery*. Covers the costs of any alternative, less-invasive *procedure and/or medical treatment* that, in *Accuro Health Insurance*'s sole opinion, replaces *surgery* as the most suitable method of treatment for any condition for which *Accuro Health Insurance* would otherwise agree to accept a *surgical claim*. All costs must be associated with the original diagnosis, including complications of the initial *surgery*. **Note:** Oncology consultations and treatment following *surgery* are covered under the *private hospital* medical admission *benefit*.
Breast reconstruction – *excess* applies Included in the general *surgery benefit* aggregated up to $500,000 per person per *policy year*.	Covers the costs of a breast reconstruction of the affected breast only following a mastectomy for the treatment of breast cancer. The reconstruction of the affected breast must occur within 24 months following a mastectomy that has been approved under this *policy*.
Breast symmetry – *excess* applies Included in the general *surgery benefit* aggregated up to $500,000 per person per *policy year*.	Covers the costs of unilateral breast reduction *surgery* on the unaffected breast in order to achieve breast symmetry following a mastectomy for the treatment of breast cancer. The reduction of the unaffected breast must occur within 24 months following a mastectomy that has been approved under this *policy*.
Prophylactic surgery – *excess* applies Included in the general *surgery benefit* aggregated up to $500,000 per person per *policy year*.	Covers the costs of prophylactic *surgery* when required because of an increased risk of developing cancer due to a deleterious (disease-causing) mutation in the *member's* BRCA1 gene or BRCA2 gene. Confirmation is required from the *registered medical specialist* of this deleterious mutation in the BRCA1/ BRCA2 gene.
Major diagnostic procedures – *excess* applies Included in the general *surgery benefit* aggregated up to $500,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* of diagnostic procedures for angiograms, MRI scans, CT scans, MP scans, endoscopies, colonoscopies, hysteroscopies, laparoscopies, cystoscopies and arthroscopies. With or without admission to a *private hospital*.
Oral surgery – *excess* applies $300,000 per person, per *policy year*.	Covers the costs of *reasonable and customary charges* associated with oral or maxillofacial *surgery*. *Benefit* includes the *surgical* removal of impacted or unerupted teeth, *surgical* removal of cysts, soft tissue swellings, *surgical* drainage of oral abscesses and pre-operative and post-operative diagnostics, consultations or tests provided they occur within one year prior to or after the approved *surgery*. This *benefit* does not cover the insertion/removal of dental implants or the exposure of a tooth. Provider must be a New Zealand registered oral or maxillofacial specialist or an accredited *private hospital* or clinic. *Member* or *participant* must be referred by a New Zealand *registered medical practitioner*, dental surgeon or dentist. For the removal of unerupted and impacted teeth, a registered oral surgeon or registered dentist must perform the *surgical* removal, and written confirmation from the oral surgeon or dentist as to the status of the impacted or unerupted teeth is required.
Private hospital medical admission – *excess* applies To a maximum aggregated cover of $300,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* associated with admission to a *private hospital* for reasons other than *surgery* that have occurred as a direct result of the diagnosis of any non-acute medical condition, subject to the exclusions described elsewhere in this *policy*, for which non-*surgical hospital* treatment is recommended by an appropriate *registered medical practitioner* as being necessary to improve the health of the *member* or *participant*. Covers the following costs that are incurred during the period of *hospitalisation* admission: • *Private hospital* accommodation fees. • *Registered medical specialist* fees including fees directly related to the *hospital* admission and that have occurred within six months of the date of admission. • Diagnostic procedures including diagnostic procedures directly relating to the *hospital* admission that occurred within six months of the date of admission. • Sundries including intravenous fluids, dressings and prescriptions throughout *hospital* admission. • **Cancer *procedure and/or medical treatment* accessories and support services *benefit*.** Cover towards the cost of a wig, hat, scarf or mastectomy bras during or within six months after the cancer *procedure and/or medical treatment*.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.

Treatment outside New Zealand – *excess* applies $30,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* for *medically necessary* and recognised *surgical* procedure(s) at an overseas *hospital*. To qualify for this *benefit*, the *member* or *participant* must be in New Zealand at the time of diagnosis, the *member* or *participant* must not have partaken in an appropriate medical process in New Zealand, the *surgical* procedure requested must not be available in New Zealand nor be experimental nor being trialled and it must meet all *policy* criteria and the *member* or *participant* must provide written confirmation from a New Zealand *registered medical specialist* that the *surgical procedure and/or medical treatment* is necessary and not available in any variance in New Zealand. Travel and accommodation for overseas *surgical* procedure(s) are not covered by *Accuro Health Insurance*.
Non-PHARMAC subsidised drugs Non-PHARMAC subsidised drugs are included within the *benefit* maximums that apply to the *surgical* and non-*surgical benefits*, whichever is applicable for the required treatment.	Covers the costs of *reasonable and customary charges* associated with accessing the most effective treatment available, irrespective of whether that treatment qualifies for a government (or quasi-government) subsidy, such as PHARMAC funding. Reimburses the costs of all drugs registered by *Medsafe* for use in New Zealand where: • the treatment is prescribed by a specialist as the appropriate medical treatment for the condition, and • the treatment and/or condition is not excluded elsewhere in this *policy* document, and • the drug is being prescribed within the guidelines set by *Medsafe*. Covers the costs of these drugs over and above any government (or quasi-government) subsidy. All costs under the non-PHARMAC drugs *benefit* are included within the *benefit* maximums of the Hospital and Surgical+ base *plan*.
Medical tourism We reimburse up to a maximum of 75% of the costs of *reasonable and customary charges* that have been incurred for medical treatment had that treatment been undertaken in New Zealand. This maximum applies per life assured per *policy year*.	If the *member* or *participant* is recommended a medical treatment by a *registered medical specialist* that is available within New Zealand within the six months following recommendation and a *claim* for that treatment is pre-approved by *Accuro Health Insurance*, the *member* or *participant* can elect, at their option, to have the treatment undertaken overseas and to *claim* under the medical tourism benefit instead of any other *benefit* provided under this *policy* document. *Accuro Health Insurance* will determine, at its sole discretion, the country to which the *member* or *participant* can travel for the required medical treatment.
Overseas waiting list benefit The *benefit* maximums that apply to this *benefit* will be those that apply to the *surgical* or non-*surgical benefits*, whichever is applicable to the *procedure and/or medical treatment* that is required.	If the life assured requires medical treatment that is able to be provided privately within New Zealand but cannot be provided within six months of the recommended time as a direct result of insufficient medical resources, the overseas waiting list *benefit* will reimburse the costs associated with the *member* or *participant* obtaining the required treatment outside of New Zealand. The amount of reimbursement for treatment costs will be limited to the *reasonable and customary charges* that would be payable in New Zealand for the same *procedure and/or medical treatment*. *Accuro Health Insurance* will determine, at its sole discretion, the country to which the *member* or *participant* can travel for the required medical treatment.
Cover while in Australia The *benefit* maximums that apply to this *benefit* will be those that apply to the *surgical* and non-*surgical benefits*, whichever is applicable to the *procedure and/or medical treatment* that is required.	This *benefit* reimburses medical costs for non-acute medical conditions that are incurred and treated in Australia. The amount of reimbursement will be the usual customary and reasonable charges that would be payable in New Zealand for the same *procedure and/or medical treatment* subject to the *excess*, maximums and exclusions described elsewhere in this *policy*. All maximums, *excesses* and *benefit* amounts referred to in this *policy* document are in New Zealand dollars and paid in New Zealand dollars.
Lithotripsy – *excess* applies $75,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* associated with this procedure. Must be performed by a *registered medical practitioner*.
Public hospital benefit $300 per night. Maximum of 10 nights per *policy year*.	Covers the costs only if admitted to any *public hospital* for four or more consecutive nights.
Minor surgery – *excess* applies $3,000 per *claim*.	Covers the costs of *reasonable and customary charges* for minor *surgery*, including but not limited to removal of moles, cysts and toenails, performed by a New Zealand *registered medical practitioner* in private practice. The procedure must be *medically necessary*, and without it, the *member*'s or *participant*'s physical wellbeing would be affected.
Home nursing $150 per day, up to $6,000 per person per *policy year*.	Covers the costs of home nursing care by a New Zealand registered nurse as a result of a referral by a New Zealand *registered medical specialist*. Post-operative nursing care must commence within six months after related *surgery* or cycle of chemotherapy/radiation treatment has been approved under this *policy*.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.

Transport and accommodation benefit $200 per night for support person accommodation. Up to $3,000 per person per *policy year*.	**Transfer costs benefit** Covers the costs of air, road or rail transport if the *registered medical specialist* confirms in writing that the condition cannot be treated at a local private facility and the *member* or *participant* needs to travel by air, road or rail for admission to an alternative *private hospital* within New Zealand. This *benefit* covers either return public transport costs (economy airfares, bus fares or train fares) or return road travel, which is calculated from the mileage travelled at an amount determined by us. In addition, a taxi fare from the airport/station to the *private hospital* and return for the *member* or *participant*, if required, is also covered. These costs must directly relate to the *private hospitalisation* under your *policy*. Pre-operative and post-operative consultations/treatments do not qualify. *Claim* must be accompanied by receipts for reimbursement **Support person accommodation benefit** The maximum support person accommodation *grant* payable per life assured is $200 per day for up to a maximum of 10 days. Covers the costs of accommodation expenses actually incurred by the support person. These costs must directly relate to the *private hospitalisation* of the *member* or *participant* under this *policy*. Pre-operative and post-operative consultations/treatments do not qualify. *Claim* must be accompanied by receipts for reimbursement. **Support person transfer costs benefit** Covers the costs of air, road or rail transport if the *registered medical specialist* of the *member* or *participant* confirms in writing that a support person is required to accompany the *member* or *participant* in travelling by air, road or rail for admission to an alternative *private hospital* within New Zealand. This *benefit* covers, for one support person, either return public transport costs (economy airfares, bus fares or train fares) or return road travel, which is calculated from the mileage travelled at an amount determined by us. In addition, a taxi fare from the airport/station to the *private hospital* and return for the support person, if required, is also covered. These costs must directly relate to the *private hospitalisation* of the *member* or *participant* under this *policy*. Pre-operative and post-operative consultations/treatments do not qualify. *Claim* must be accompanied by receipts for reimbursement.
Ambulance transfer $200 per person per *policy year*.	Covers the costs of ambulance transfers to or from a public or *private hospital* within New Zealand and authorised by a *registered medical specialist*. This *benefit* is only available to private fee-paying patient(s) for any non-acute medical condition and where the initial admission to *hospital* was pre-approved by *Accuro Health Insurance*. *Benefit* is available for necessary treatments and not for personal or social reasons.
Health-related appliances $200 per person per *policy year*	Covers the costs of post-operative health-related appliances after an approved *surgery*. Appliances must be purchased and/or hired within six months of the approved *surgery*. This *benefit* does not cover any bond required for the hireage of appliances.
Hospice stay $50 per night. Up to a maximum of 10 nights per admission. Up to a maximum of $2,000 per person per *policy year*.	Covers the cost of *hospice* care where the *member* or *participant* is admitted to a *hospice* and the admission lasts four or more consecutive nights. The *benefit* will be payable for each night after the third night. The *hospice* must hold regular or associate service membership with Hospice New Zealand.
Parent accommodation benefit $300 per night for accommodation. Up to a maximum of 10 days per *policy year*.	Covers the costs of accommodation expenses actually incurred by a parent accompanying a child aged under 18 years who is listed on the *membership certificate*. The child must be undergoing medical treatment approved by *Accuro Health Insurance* in an approved *private hospital* in New Zealand. *Benefit* is for one adult only. *Claim* must be accompanied by receipts for reimbursement.
Speech-language therapy $80 per visit, up to $400 per person per *policy year*.	Covers the costs of post-operative treatment for approved related *surgery*. Treatment must be completed within six months of approved related *surgery* and performed by a New Zealand registered speech-language therapist who is a member of the New Zealand Speech-language Therapists' Association.
Physiotherapy $1,000 per *hospitalisation*.	Covers the costs of post-operative physiotherapy for approved treatment by a New Zealand registered physiotherapist with a current practising certificate who is in private practice, where treatment is required to occur and be completed within 12 months following discharge of the approved related *surgery* under this *policy*.
Funeral support grant $10,000 payable to the deceased *member*'s estate.	If a *member* or *participant* on this *policy* dies before the age of 66 years from illness, *Accuro Health Insurance* will pay a funeral support *grant* to the deceased *member's* estate via cheque.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.

Medical misadventure – no *excess* $30,000 per *member* (who is covered under this *plan*).	*Accuro Health Insurance* will pay a medical misadventure *benefit* if, during the course of any *procedure and/or medical treatment* in a public or *private hospital*, the *member* (who is covered under this *plan*) dies as a direct consequence of any erroneous or negligent action, omission or failure to observe reasonable and customary standards by a care provider of the *hospital*, provided: - the death occurs within 30 days of such a recorded and proven incident, and - a public admission of such an incident and liability is accepted by the public or *private hospital* and verified and confirmed by the relevant government authority, a court of law, a coroner's inquest or the Medical Council of New Zealand. *Accuro Health Insurance* will deduct any funeral support *grant* previously paid for a *member* (who is covered under this *plan*) from the medical misadventure *benefit*.
ACC top-up benefit – *excess* applies Conditions apply. All costs paid under this *benefit* are included within the *benefit* maximums for the Hospital and Surgical+ base *plan benefit* and any other applicable *benefit*s under *plan*s that the participant may hold.	We cover any shortfall between what *ACC* pays for a physical injury and the actual costs of the *surgical procedure and/or medical treatment* in an approved *private hospital* or facility, less any *excess*. This is limited to the appropriate *benefit* maximum, less any *excess*. A copy of *ACC*'s decision must be supplied to us prior to treatment being undertaken. Other terms: • An insured claimant must obtain *ACC*'s acceptance of their *claim* prior to the treatment being performed and provide us with evidence of *ACC*'s acceptance of their *claim* and the amount payable by *ACC* in respect of that treatment. • We may require an insured claimant to apply for a review of *ACC*'s decision. You must reimburse us for any cost subsequently covered by *ACC* as a result of the review. We may request your permission to seek legal advice at our cost to address the review of *ACC*'s decision. • The *surgical* and medical costs must directly relate to the *private hospitalisation*. • Cover is only provided where a *claim* has been paid under the Hospital and Surgical+ base *plan benefit* or another applicable *plan* that the *participant* holds.
Dependants/whāngai Upon *dependants*/*whāngai* reaching the age of 25 years, they will remain on the *policy* at adult rates.	*Dependants*/*whāngai* are covered on their parent's/guardian's/caregiver's *policy* at *dependant premium* rates up to the age of 25 years. To qualify, *dependants*/*whāngai* must be covered by their parent's/guardian's/caregiver's *policy*.
Free cover for children We will cover children for six months from the date of their birth, free of *premium*s.	To be eligible, we must receive a short application form completed for the child before they reach six months of age. Your child will receive automatic coverage for the first six months after being born other than for the exclusions specified in the exclusions section. *Congenital conditions* are excluded. If you wish to insure a child on this *policy* who is over six months of age, we require a full application form to be completed. The child will be subject to medical *underwriting*, and the relevant *premium* will be charged.
Waiver of premium – no *excess* We pay *premium*s for 36 months from date of death or *terminal illness*. Appropriate certificates and documentation must be provided.	If the main *member* or *partner* (who is covered under this *policy*) dies or is diagnosed with a *terminal illness* up to the age of 70, *Accuro Health Insurance* will continue to provide cover for the other *participant*s covered under this *policy* for 36 months or until the oldest surviving life assured reaches the age of 70, whichever is the earlier. Other terms: • The waiver of *premium benefit* starts from the next *premium* payment date following the date of death or diagnosis of a *terminal Illness*. • Once the waiver of *premium benefit* ends, the private medical cover protection *premium*s for all remaining lives assured must be paid by the surviving *member*.
Suspension of cover Overseas travel – for between two and 24 months. Maternity leave – for up to 12 months. Registered as unemployed – for between two and six months. Made redundant and/or suffering financial hardship – for up to six months.	After 12 months of continuous cover of the main *member* or *participant*, the main *member* or *participant* can suspend the *policy* where the main *member* or *participant* is on overseas travel, on maternity leave, registered as unemployed, made redundant and/or suffering financial hardship. Evidence of overseas travel, maternity leave, unemployment, redundancy and/or financial hardship must be provided before *Accuro Health Insurance* will authorise suspension. The main *member* or *participant* must have continuous cover under this *policy* for a 12-month period between a previous suspension and the start date of the next suspension.
Loyalty benefit – sterilisation One-off $5,000 contribution towards total procedure costs per *policy*.	After two years of continuous cover, this *benefit* covers the costs of *reasonable and customary charges* of sterilisation including vasectomies and female sterilisation procedures. Sterilisation does not include reversals.
Loyalty benefit – health check $150 per person every three *policy year*s.	After three years of continuous cover, this *benefit* covers the costs of a health check performed by a New Zealand *registered medical practitioner*. *Dependants*/*whāngai* aged 25 years or younger do not qualify for this *benefit*. If cover is suspended, the suspension period is not included in the calculation of continuous cover. This *benefit* must be taken within 60 days of your entitlement and cannot be accumulated over subsequent years.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.

Loyalty benefit – discounts for those with healthy weight	After three years of continuous cover and on confirmation from your GP that your body mass index (BMI) is between 18.5 and 24.99, your *premium* on the Hospital and Surgical+ base *plan* will be discounted.
By 5% after three years of continuous cover. By 10% after six years of continuous cover. By 15% after nine years of continuous cover.	*Dependants*/*whāngai* aged 25 years or younger do not qualify for this *benefit*. If cover is suspended, the suspension period is not included in the calculation of continuous cover. Confirmation from your GP stating your BMI must be received within 60 days of your third, sixth and ninth *policy* anniversary dates. Your BMI discount entitlements are assessed every three years after your health check by a GP. If you are already enjoying a BMI discount, you will only lose this entitlement if your BMI falls outside the 18.5–24.99 range or if we do not receive confirmation of your BMI status on time. In this case, the *premium* will revert to a standard *premium* schedule.
Loyalty benefit – screening endoscopies	After three years of continuous cover, this *benefit* covers 80% of the *reasonable and customary charges* of colonoscopies and gastroscopies.
80% of the cost up to $1,000 every three *policy years*.	*Dependants*/*whāngai* aged 25 years or younger do not qualify for this *benefit*. If cover is suspended, the suspension period is not included in the calculation of continuous cover. This *benefit* must be taken within 12 months of entitlement and cannot be accumulated over subsequent years.

Benefits

The limits shown apply for each person on this *policy*. If there is an *excess* on the *policy*, the *excess* applies once per life assured per *policy year*. Please see the righthand column for a full explanation of what is covered.

Specialist+ plan

Please check your *membership certificate* to see if this *benefit* applies to you.

Specialist consultations – *excess* applies Aggregated maximum of $5,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* of *registered medical specialist* consultations when referred by a *registered medical practitioner*, even when *hospitalisation* is not required. Specialist consultations include (but are not limited to) the following: • Cardiac surgeons • Cardiologists • Ear, nose and throat specialists • Gastroenterologists • General surgeons • Gynaecologists • Neurosurgeons • Oncologists • Ophthalmologists • Orthopaedic surgeons • Paediatricians • Urologists.
Mental health consultations $500 per person per *policy year*. Included in the specialist consultations *benefit* aggregated up to $5,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* for consultations with a registered psychiatrist or psychologist when referred by a *registered medical practitioner*. Any psychiatrist needs to be registered under the psychiatry scope with the Medical Council of New Zealand, and any psychologist needs to be registered as a psychologist with the New Zealand Psychologists Board.
Diagnostic tests – *excess* applies Aggregated maximum of $5,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* of the following diagnostic procedures directly relating to a medical condition when referred by a *registered medical specialist*: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray. The following tests are covered to a maximum of $1,500 per *event*: • Cardioversion • Nuclear scanning.
Second-opinion benefit – *excess* applies Included in the specialist consultations *benefit* aggregated up to $5,000 per person per *policy year*.	Covers the costs of *reasonable and customary charges* if a *member* or *participant* receives a diagnosis or has been recommended a treatment plan by a *registered medical specialist* that is covered under this *policy* and they wish to consult an alternative *registered medical specialist* to obtain a second opinion. *Accuro Health Insurance* will cover the costs of the second-opinion consultation up to an aggregated maximum of $5,000 per annum.
Loyalty benefit – screening $250 contribution per person every three continuous *policy years*.	After three years of continuous cover, this *benefit* covers the costs of a mammogram or prostate check performed by a New Zealand *registered medical practitioner*, up to *benefit* maximums. *Dependants*/*whāngai* aged 25 or younger do not qualify for this *benefit*. If cover is suspended, the suspension period is not included in the calculation of continuous cover.
Loyalty benefit – pregnancy and infertility treatment $2,000 per policy per year.	After three years of continuous cover, this *benefit* covers obstetric care during pregnancy and infertility diagnosis and treatment by a *registered medical specialist*. This *benefit* does not cover antenatal ultrasounds.
Loyalty benefit – melanoma $200 every three *policy years*.	After three years of continuous cover, this *benefit* covers melanoma investigation.

Benefits

The limits shown apply for each person on this *policy*. The GP+, Natural Health+ and Dental and Optical+ *plans* are by reimbursement only. Please see the righthand column for a full explanation of what is covered.

GP+ plan Please check your *membership certificate* to see if this *benefit* applies to you.

A *stand-down period* of 90 days applies. The minimum *claim* is an aggregation of invoices and receipts totalling $100.

GP benefit Up to $55 per doctor visit. Up to $70 per home visit by doctor. Up to $70 per after-hours visit by doctor.	Covers the costs of GP visits, including home and after-hours visits.
Registered nurse benefit Up to $35 per visit.	Covers the costs of practice nurse visits.
Prescriptions and laboratory tests benefit Laboratory tests up to $80 per year. Prescriptions – $20 per item, up to $400 per year.	Covers the costs of prescriptions and laboratory tests (ordered by a New Zealand *registered medical practitioner* or *registered medical specialist*).
Loyalty benefit – preventative checks $200 every three *policy years*.	After three years of continuous cover, this *benefit* covers the costs of a preventative mammogram or prostate check every three years. If cover is suspended, the suspension period is not included in the calculation of continuous cover. We will advise you when you are eligible to take up this *benefit*. This *benefit* must be taken within 60 days of your entitlement and cannot be accumulated over subsequent years.

Natural Health+ plan Please check your *membership certificate* to see if this *benefit* applies to you.

A *stand-down period* of 90 days applies. The minimum *claim* is an aggregation of invoices and receipts totalling $100.

Health practitioners Total cover for this *benefit* is limited to $800 per person per *policy year*.	
Up to $45 per visit and $240 per *policy year* per health practitioner.	Covers the costs of treatment by osteopath and chiropractor health practitioners.
Up to $45 per visit and $200 per *policy year* per health practitioner.	Covers the costs of treatment by the following health practitioners: physiotherapist, dietitian, acupuncturist, naturopath, homeopath, medical herbalist, remedial body therapist, reflexology treatment, nutritionist, podiatrist.
Loyalty benefit – sick leave $100 per week, up to $500 per person per *policy year*.	After three years of continuous cover, this *benefit* provides income during sick leave without pay. To qualify for this *benefit*, a *member* or *partner* (who is covered under this *plan*) must present a certificate from their employer confirming unpaid sick leave. In addition, a medical certificate obtained from a *registered medical practitioner* must be presented.
Loyalty benefit – flu vaccination $40 per person per *policy year*.	After three years of continuous cover, this *benefit* covers flu vaccination.

Dental and Optical+ plan Please check your *membership certificate* to see if this *benefit* applies to you.

A *stand-down period* of 90 days applies. The minimum *claim* is an aggregation of invoices and receipts totalling $100.

Dental cover 80% of the cost. $500 per person per *policy year*.	Covers the costs of dental treatment by a registered dental practitioner including dental check, cleaning, scaling, teeth removal, X-rays and fillings. The registered dental practitioner must be registered with the Dental Council of New Zealand and hold a current annual practising certificate. Excludes orthodontic, periodontal or orthognathic treatments unless specifically provided for.
Optical cover	
80% of the cost. $60 per visit, up to $300 per person per *policy year*.	Covers the costs of optometrist or orthoptist consultations. Practitioners providing assessments must belong to their professional body.
80% of the cost. $300 per person per *policy year*.	Covers the costs of prescription glasses or contact lenses.
Loyalty benefit – orthodontic 80% of the cost. $750 per person per *policy year*.	After three years of continuous cover, the dental *benefit* will be extended to orthodontic treatment. Practitioners providing assessments must belong to their professional body.

Accuro Health Insurance membership

All applications for *membership* and subsequent alterations to a *policy* must be made in writing by completing all sections of our application form.

Full details of the *member* and all proposed *participants* are required.

All previous medical history must be disclosed in the health declaration on the application form.

The rights and obligations of the *member* and *Accuro Health Insurance* are set out in the composite set comprising:

- the individual *member's* application form and all material provided by or on behalf of the *member* in support of the application
- the individual *member's membership certificate*
- the terms of the *policy* as specified in this *policy* document and current at the time of *claim*
- the rules of the *Society*.

All *members* are bound by and subject to the rules of the *Society* and this *policy* document.

The rules of the *Society* may change from time to time in accordance with the powers of amendment they contain.

A copy of the current rules is available from *Accuro Health Insurance* on application.

How do I make a complaint?

We aim to provide all *members* with efficient and courteous service. In the event that a *member* is unhappy with our service or a decision in respect to a *claim*, the *member* should write in the first instance to:

Operations Manager
Accuro Health Insurance
PO Box 10075
Wellington 6143

We will investigate and reply to you as soon as practically possible. We may also ask for additional medical information if reviewing a *claim*. If you are unhappy with the response from the Operations Manager, you can write to the Chief Executive Officer at the same address. The Chief Executive Officer will respond to you as soon as practically possible.

Accuro Health Insurance is a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 and is a member of an approved dispute resolution scheme operated by the Insurance & Financial Services Ombudsman (IFSO).

After you have followed our internal complaints process outlined above, if your complaint relates to a *claim* and deadlock has been reached, you can write to the IFSO within two months of being notified by us in writing that a deadlock has been reached or, if we do not notify you that a deadlock has been reached, within three months of the date of your initial complaint.

You can obtain more information on the IFSO from the website www.ifso.nz.

The IFSO's address is:

Insurance & Financial Services Ombudsman
PO Box 10845
Wellington 6143

Accuro Health Insurance is a member of the Health Funds Association of New Zealand (HFANZ). On behalf of its *members*, HFANZ manages an Integrity Registry for the purposes of detecting and preventing fraud and other serious probity concerns. The Integrity Register is operated by PricewaterhouseCoopers (PwC). *Accuro Health Insurance* may collect, use and disclose personal information and health information about the *member* for the purposes of the Integrity Registry.

Accuro Health Insurance is authorised to collect, use and disclose personal information and health information about the *member* for the purposes of the Integrity Registry. The *member* authorises disclosure of personal and health information to HFANZ or its agents and HFANZ members for the above purposes.

The *member* has rights of access to and correction of information held on the Integrity Registry. The contact details for doing so are Accuro Health Insurance, PO Box 10075, Wellington 6143 or HFANZ Integrity Registry Privacy Officer, Health Funds Association of New Zealand, PO Box 25161, Wellington 6146.

Exclusions

At *Accuro Health Insurance*, we aim to fully explain what is not covered in your *policy*. Unless specifically provided for in the *plan(s)* you select, SmartCare+ does not cover any *claims* in relation to the following:

1. Health conditions

1.1 Psychiatric, psychological and/or neurodevelopmental disorders (which includes treatment or counselling), including but not limited to pre-senile dementia, senile illness or dementia, geriatric care including geriatric *hospitalisation*, intellectual disability (intellectual developmental disorder), autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disorders, motor disorders (including but not limited to Tourette's disorder) or dyslexia.

1.2 Any condition in connection with the use of non-prescription drugs.

1.3 AIDS or HIV infection or any condition arising from the presence of AIDS or HIV infection; sexually transmitted diseases.

1.4 *Congenital conditions* diagnosed within five years of birth, including but not limited to the investigation, treatment, complications thereof and/or any residual issues.

1.5 Any *acute care*.

1.6 Any health condition as a consequence of war, invasion, act of foreign enemy, terrorist insurrection, hostilities (whether war is declared or not), civil war, rebellion, revolution or military or usurped power.

1.7 Any *long-term care*.

1.8 *Palliative care* as defined by *Accuro Health Insurance* (except where the contrary is expressly specified in this *policy*).

1.9 a) Pregnancy, childbirth or any associated conditions and/or complications for the mother and/or foetus/child.

b) Treatment, investigation and diagnosis of infertility and assisted reproduction; sterilisation; contraception of any kind and intrauterine devices (except a Mirena when used for medical reasons).

c) Termination of pregnancy.

1.10 Any *pre-existing conditions*.

2. Tests, diagnostic procedures and treatments

2.1 *Preventative healthcare services* and treatments, maintenance and/or health surveillance testing; employment-related examinations or screening; vaccination against any disease or condition; convalescence; any expense where there are no symptoms or evidence of a condition detrimental to health.

2.2 *Cosmetic procedure* as defined by *Accuro Health Insurance* and/or other enhancement/appearance medicine.

2.3 Procedures performed for any reason, treatment or consultations relating to obesity and/or weight loss; gender reassignment.

2.4 Specialised transfusion of blood, blood products, treatment for renal failure and renal dialysis as provided by government-funded agencies; organ donation and receipt.

2.5 Chelation therapy or similar treatment as defined by *Accuro Health Insurance*.

2.6 Investigations or treatment for the correction of visual errors or astigmatism, including but not limited to consultations, *surgery* or laser treatment; *surgically* implanted intraocular lens(es).

2.7 Specialised tertiary treatments such as transplants, including but not limited to heart, lung, kidney, liver and bone marrow transplants as provided by government-funded agencies.

2.8 Dental care; orthodontic, endodontic, orthognathic, periodontal treatment, implants or tooth exposure.

2.9 Radial keratotomy or photo-reactive keratectomy or any related complications.

2.10 Any investigation and/or treatment for sleep disturbances, snoring or sleep apnoea.

2.11 Circumcision, except where *medically necessary*.

2.12 Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary*.

3. General

3.1 Personal health-related appliances, for example (without limitation), hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats and artificial limbs; medical devices, for example (without limitation), cardiac pacemakers, nerve appliances, cochlear implants or penile implants; *surgical* or medical appliances, for example (without limitation), glucometers, oxygen machines, respiratory machines, diabetic monitoring equipment or blood pressure monitoring equipment; any personal incidental expenses incurred whilst in *hospital*, for example (without limitation), use of phone, family meals, soft drinks or alcoholic beverages.

3.2 Any expense recoverable from a third party under any contract of indemnity or insurance or any statutory scheme or any government-funded scheme/agent (for example, *ACC*).

3.3 Any medical costs incurred outside New Zealand.

3.4 Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand.

3.5 Medical mishap or misadventure.

3.6 Charges for a treatment or procedure not provided by a *registered medical practitioner* practising within his or her scope of practice.

3.7 Avian influenza infection or any condition arising from the presence of avian influenza infection or any other nominated pandemic.

3.8 Disability or illness arising from misuse of alcohol or drugs; participation in a criminal act; intentional self-injury or attempted suicide or suicide.

3.9 New medical treatments, procedures and technologies that have not been approved by *Accuro Health Insurance*.

3.10 Any costs not specifically provided for under a *benefit* section contained in the *plan*.

3.11 General practitioners' fees, drugs and medication.

3.12 Additional *surgery* performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this *policy*.

The *Board* of Directors at *Accuro Health Insurance* reserves the right at all times to vary the *benefits* and/or exclusions however it deems appropriate. In all matters that require interpretation, the *Board* of Directors' decision shall be final. We will endeavour to provide reasonable notice (minimum 21 days) prior to such change.

Glossary

ACC means the Accident Compensation Corporation of New Zealand.

Accident means an *accident* as defined in the Accident Compensation Act 2001.

Accuro Health Insurance means the Health Service Welfare *Society* Limited in connection with the operation of the *plans*.

Acute care means care provided in response to a condition or disease that warrants immediate *hospital* admission or care within 48 hours of doctor/*hospital* admission for treatment or monitoring.

Benefit means the reimbursement available for *members* for specific types of expenses and specified in this *policy* document and includes *grants*.

Board means the current *Board* of Directors of the *Society*.

Claim means the request by a *member* for refund of costs as described in this *policy* document appropriate to the *member's* chosen *plan(s)* and for which the *member* is eligible.

Commencement means the date on which *membership* begins, as specified in the *membership certificate*.

Congenital condition means a health anomaly or defect that is present at birth, whether it is inherited or due to external factors such as drugs or alcohol or any other cause, and is recognised at birth or diagnosed within the first five years of life.

Cosmetic procedure means any procedure, *surgery* or treatment that is carried out to improve or enhance appearance whether or not undertaken for physical, psychological or emotional reasons.

Dependant means a *member's* child (including any stepchild or adopted child) who has been accepted as a *participant* in the *member's plan*.

Event means (without limitation) the date of birth, death, visit, consultation, test, *surgery*, repair, treatment or supply or the period of absence from work, duration of treatment or time in *hospital*.

Excess means any amount specified on your current *membership certificate* that is excluded from payment.

Grant means a payment of a fixed amount as listed in this *policy* document or that may be made at the discretion of *Accuro Health Insurance*.

Hospice means a healthcare facility providing *palliative care* services for patients with a *terminal illness* that holds regular or associate service membership with Hospice New Zealand.

Hospital means a *hospital* providing *hospital* care as defined in the Health and Disability Services (Safety) Act 2001 but not including a *hospice*, nursing home or convalescent care facility, even if it is associated with a *hospital*.

Long-term care means either *public* or *private hospital*-based services provided on an on-going basis where a health condition, as determined by *Accuro Health Insurance*, has been or is likely to be present for more than six months.

Medical evidence means (without limitation) medical records, medical history and correspondence or supportive screening information for the treatable condition.

Medically necessary means healthcare services that, in the opinion of *Accuro Health Insurance*, are necessary for the care or treatment of a nominated health condition.

Medsafe means the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the Ministry of Health and is the authority responsible for the regulation of therapeutic products in New Zealand. *Medsafe* administers the Medicines Act 1981 and Medicines Regulations 1984.

Member means a person who has been accepted as a *member* or associate *member* of *Accuro Health Insurance* and by whom or on whose behalf *premiums* are currently being paid to *Accuro Health Insurance*.

Membership certificate means the most recent *membership certificate* issued to a *member* that confirms initial acceptance or subsequent alteration to a *plan*.

Palliative care means the care of patients with life-limiting illnesses having the primary aim of improving the quality or quantity of life until the death of that patient. *Palliative care* may also positively influence the course of the illness. A life-limiting illness is one that cannot be cured and may at some time result in the person dying (whether that is years, months, weeks or days away).

Parent means a *member's parent* who has been accepted as a *participant* in the *member's plan*.

Participant means a *partner*, *parent*, *dependant* or *whāngai* accepted by *Accuro Health Insurance* who is named on the *member's membership certificate* and for whom *premiums* are current at the time of application for any *benefit*.

Partner means the spouse or de facto *partner* of a *member* where the parties are living together in a relationship in the nature of a marriage or civil union.

PHARMAC Schedule means the list of pharmaceuticals that are approved for public prescription in New Zealand and funded by the Pharmaceutical Management Agency.

Plan means a specified range of *Accuro Health Insurance benefits*.

Policy means your contract with *Accuro Health Insurance* and includes the *membership certificate*, general *policy* terms and conditions and this *policy* document.

Policy year means the 12-month period that starts from midnight on the *policy commencement* date and ends at midnight on the first annual renewal date. Each subsequent *policy year* commences at midnight on the annual renewal date and continues for a 12-month period.

Pre-existing condition means any sign, symptom, health condition, medical condition or health *event* (whether declared or non-declared) that occurred or existed prior to the *commencement* of the *member* or *participant* to which the sign, symptom, condition or *event* relates.

Premium means the amount paid to *Accuro Health Insurance* by or on behalf of a *member* to maintain *membership* and eligibility for *benefits*.

Preventative healthcare services means healthcare services and treatments that seek to reduce or prevent the risk of an illness, disease or medical condition developing in the future.

Private hospital means a privately owned *hospital* that is licensed as a *private hospital* in accordance with the Health and Disability Services (Safety) Act 2001. Mobile treatment facilities are not recognised as *private hospitals*.

Procedure and/or medical treatment means a particular course of action required to manage a health condition, including but not limited to diagnosis, medical screening, *surgical* procedures, therapeutics or rehabilitation.

Prosthesis means an artificial extension that replaces a missing/malfunctioning part of the body, such as artificial replacement of hips or knees.

Public hospital means a *hospital* service or institution licensed in accordance with the Health and Disability Services (Safety) Act 2001 directly or indirectly owned or funded by the New Zealand Government or any of its agencies.

Reasonable and customary charges means charges for medical treatment that are determined by *Accuro Health Insurance* in its sole discretion to be reasonable and within a range of fees charged under similar circumstances by persons of equivalent experience and professional status in the area in which the medical treatment is provided.

Registered medical practitioner means a healthcare practitioner, other than you or any member of your immediate family, who holds a current annual practising certificate issued by the Medical Council of New Zealand and is practising as a medical practitioner in New Zealand.

Registered medical specialist means a health service provider who is a member or fellow of an appropriately recognised specialist medical college and must have Medical Council of New Zealand registration and a current annual practising certificate in that speciality, or a healthcare provider having Medical Council of New Zealand registration and a current annual practising certificate and who has a formal collegial relationship in accordance with the requirements of the Medical Council of New Zealand with a health service provider who is a member or fellow of an appropriately recognised specialist medical college and has Medical Council of New Zealand registration and has a current annual practising certificate in that speciality. This does not include those holding Medical Council of New Zealand registration for emergency medicine, family planning and reproductive health, general practice, medical administration, public health medicine, sexual health medicine or urgent care. The list of specialities excluded in the definition of *registered medical specialist* may be amended by *Accuro Health Insurance* from time to time at the sole discretion of *Accuro Health Insurance*.

Society means the Health Service Welfare *Society* Limited incorporated under the Industrial and Provident Societies Act 1908.

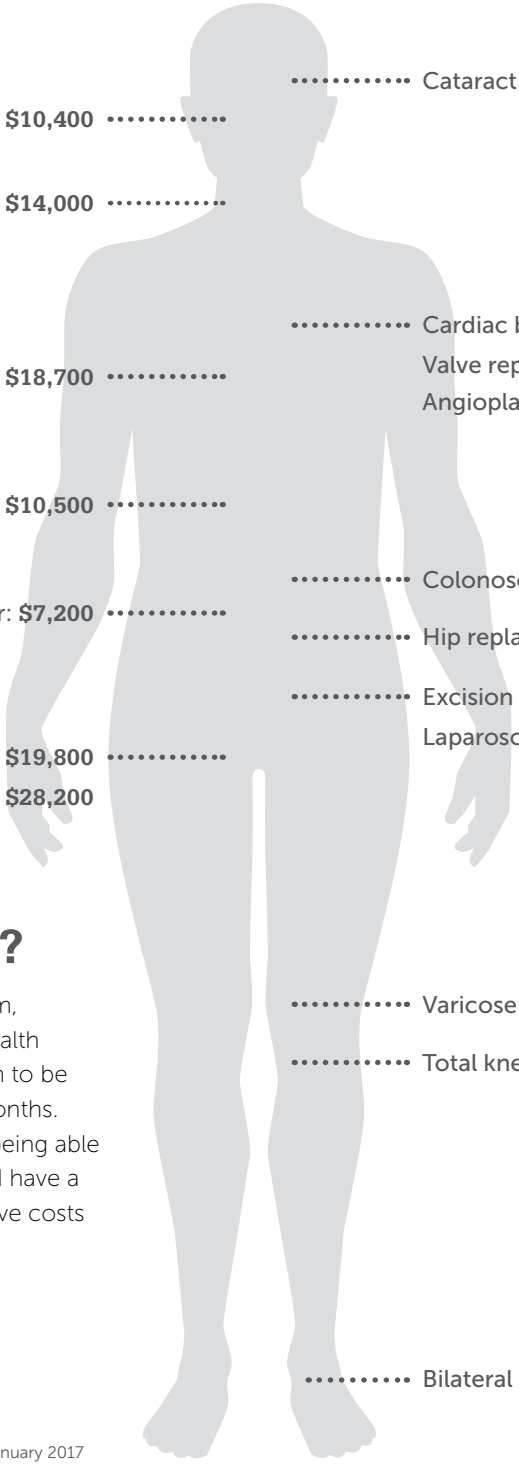
Stand-down period means the period of 90 days after the *commencement* date or, in the case of a *participant* added to a *plan*, 90 days after the date on which that *participant* is added during which *events* are not claimable.

Surgery or **surgical** means an operation or *surgical* procedure used to treat disease, injury or deformity.

Terminal illness means that your life expectancy, due to sickness and regardless of any available *procedure and/or medical treatment*, is not greater than 12 months. This must be in the opinion of a *registered medical specialist* and, if we require, in the opinion of one of our *registered medical specialists* and in our assessment, having considered medical or other evidence we may require.

Underwriting means to assess the information provided by the applicant on the application form. Depending on this information, the *underwriter* may request additional information regarding medical history in regards to *pre-existing condition*s.

Whāngai means a child from your extended whānau who you raise or bring up within your family who has been accepted as a *participant* in the *member's plan*.



Cataract removal: **$4,200**

Endoscopic (sinus) surgery: **$10,400**

Thyroidectomy: **$14,000**

Cardiac bypass: **$51,600**
Valve replacement: **$59,000**
Angioplasty: **$26,500**

Radical mastectomy: **$18,700**

Laparoscopic cholecystectomy: **$10,500**

Colonoscopy: **$2,100**

Hernia repair: **$7,200**

Hip replacement: **$22,600**

Excision of endometriosis: **$14,000**
Laparoscopic hysterectomy: **$16,000**

Prostate removal: **$19,800**
Prostate brachytherapy: **$28,200**

Varicose veins: **$6,700**

Total knee replacement: **$22,400**

Bilateral bunions: **$14,700**

How much can it cost?

New Zealand has an excellent public health system, but it does not have unlimited resources. Many health complaints may not be considered urgent enough to be seen by a publicly funded specialist within four months. Even if your condition is not life-threatening, not being able to get the treatment you need straight away could have a huge impact on your life. Above are some indicative costs for common procedures.

SOURCE: Accuro claim experience – indicative cost of surgery as at January 2017

accuroconnect

OUR MEMBER BENEFITS PROGRAMME

At Accuro, our purpose is to take care of you. We believe that goes beyond just helping with major medical costs when the worst strikes. It's also about keeping you at your best day to day. We want you to enjoy being part of the Accuro community and enjoy being well.

The member benefits programme brings you a fantastic range of discounts off health and wellbeing products and services in New Zealand: gym memberships, organic and gluten-free food, day spas, acupuncture and more.

To access your member benefits, download the Accuro App from the App Store or Google Play, and enter your login details. Login details are in your *Accuro Connect* e-newsletter, or you can **call us on 0800 222 876** and start enjoying the benefits!

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