HEALTH INSURANCE
POLICY DOCUMENT

SmartCare+

Here's all you need to know

accuro
HEALTH INSURANCE

Welcome

Thank you for putting your trust in New Zealand's best little health insurer and choosing *Accuro Health Insurance*.

We want you to understand your *Accuro* SmartCare+ *policy* and be confident in your health cover, so please read this document carefully.

We want your experience with us to be as simple as possible, so *we* have tried to make this *policy* document easy to understand, and for you to see clearly what is and isn't covered under your *policy*.

Please do not hesitate to contact us if you have any questions.

Contents

How to contact us

You can contact us if you have any concerns or questions, or if you would like to apply for pre-approval, make a *claim* or make changes to your *policy*.

Phone: 0800 ACCURO (0800 222 876)
Fax: 04 473 6187

Email: info@accuro.co.nz
Web: www.accuro.co.nz

Post: Accuro Health Insurance
PO Box 10075
Wellington 6143

Our operating hours are between 8:30am and 5:00pm, Monday to Friday, excluding public holidays.

You can use the online member portal on our website to update or make changes to your *policy*, submit a pre-approval or *claim*, or to save invoices to submit with a *claim* at a later date.

SmartCare+ at a glance

SmartCare+ is *Accuro's* top individual insurance product and has been designed for people who make their health one of their top priorities. SmartCare+ provides *Accuro members* with our largest range of health insurance *benefits*. Our SmartCare range has been recommended by Consumer Magazine in every health insurance product review since 2008, making it their most recommended health insurance product.

This SmartCare+ *policy* is only for New Zealand residents, New Zealand citizens or those otherwise entitled to funding under New Zealand's public healthcare system, as determined by the Ministry of Health. It has been designed to complement the services that are provided by the public health system and *ACC*.

The New Zealand healthcare system has three main components:

- **Accident Compensation Corporation** (*ACC*) provides comprehensive, no-fault personal injury cover for all New Zealand residents.
- **The public health system** is subsidised by the government and provides cover for all New Zealand residents for acute treatment (when a *surgery* or treatment needs to be undertaken immediately because it is a medical emergency) and some elective treatments, which can take years to occur in the public health system.
- **The private health system** gives you control over when and where you are treated, including being able to choose the doctor, specialist or *hospital* that you prefer. Often people will decide to have elective treatment (when a *surgery* or treatment is scheduled in advance to be undertaken at a later date because it is not a medical emergency) within the private health system as it is quicker.

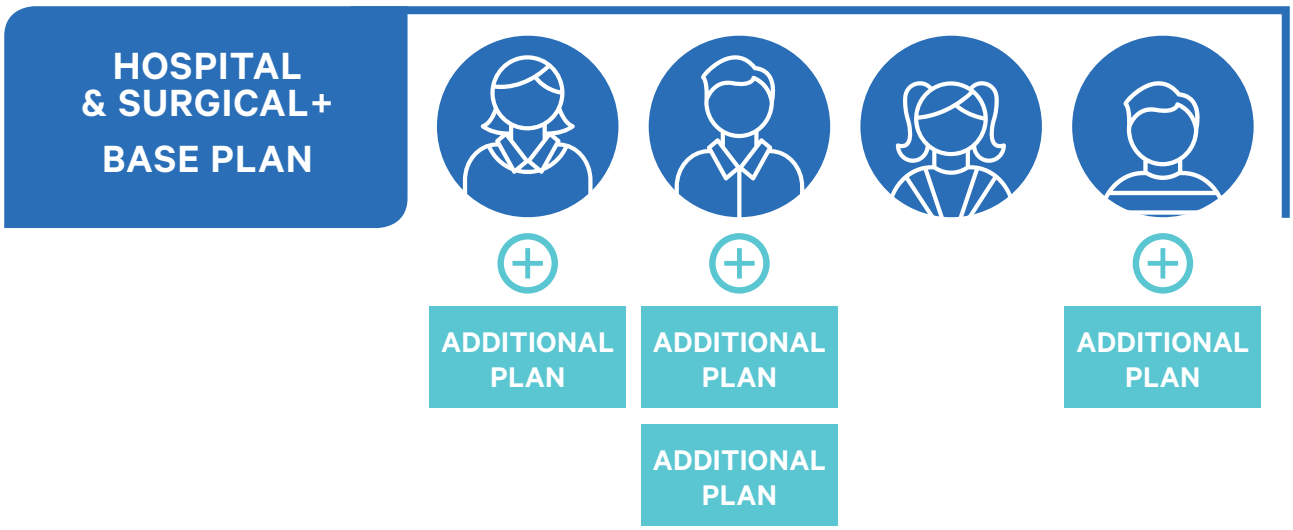
In this *policy* document *we* may refer to you as the main *member* and all other individuals attached to your *policy* as *participants*. Your SmartCare+ *policy* starts from the date on your *Accuro membership certificate* (or the date specified for each added *participant*) and will continue until cover ends due to cancellation or termination. All information given by or on behalf of you or any *participant* when setting up this *policy* or making any changes to it must be true, correct and complete.

Please make sure that you provide us with your most up-to-date contact details, if your circumstances change please get in contact with us.

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 31-32.

How it works

How your SmartCare+ *policy* works is simple - when you take up your *policy*, you start with the base *plan* that everyone on the *policy* must have: the Hospital & Surgical+ base *plan*. You can then choose to add any of *Accuro's* other additional *plans* for yourself or any of the other *participants* on the *policy*.



Main benefits

SmartCare+ Hospital & Surgical+ base plan:	per person per policy year
General *surgery* (Including tests such as CT and MRI scans)	$500,000
Oral *surgery*	$300,000
Private hospital medical admission (Including chemotherapy and radiation treatment)	$300,000
Multiple overseas treatment *benefits*	
Non-PHARMAC subsidised drugs	

Additional plans

SPECIALIST+ PLAN

Cover for specialist consultations and diagnostic tests up to $5,000 for each *benefit*.

GP+ PLAN

Cover for GP and nurse consultations, along with prescription drug costs.

NATURAL HEALTH+ PLAN

Cover for consultations with chiropractors, physiotherapists, osteopaths and other natural health providers.

DENTAL AND OPTICAL+ PLAN

Cover for dental treatment and optical consultations and eyewear.

DAY TO DAY

Covers the everyday costs of staying healthy - such as going to the doctor, dentist or optician.

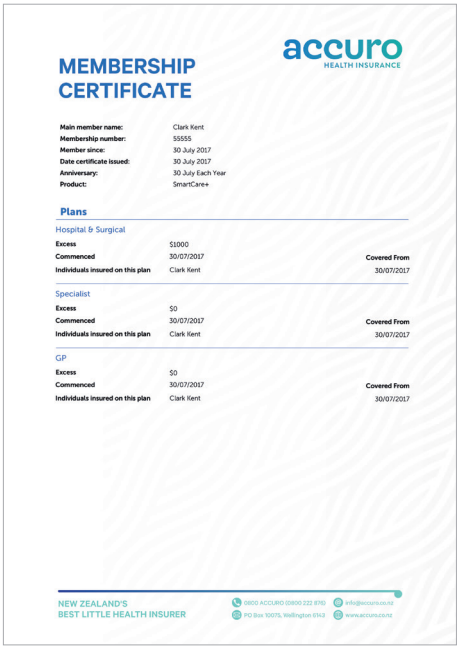
Check your *membership certificate* to see which additional *plans* *participants* on your *policy* have.

How your policy works

This *policy* document lists out what all SmartCare+ *policy* holders are covered for (*benefits*) and what's not covered (*general exclusions*). A *general exclusion* is something such as a medical condition or service that *we* have decided that *we* will not cover for anyone who has this type of *policy*.

Your *membership certificate* contains the details that are specific to your *policy* such as what *plans* each person in your family is covered for, as well as any *personal exclusions*. A *personal exclusion* is where *we* have reviewed the medical information provided to us and decided that a certain condition may pose too great a risk to insure against. *Personal exclusions* are excluded for different lengths of time (from 1 year to life), depending on the medical condition.

These two documents make up your *policy*, so please make sure you read these documents and keep them in a safe place.


MEMBERSHIP CERTIFICATE

accuro HEALTH INSURANCE

Main member name: Clark Kent
Membership number: 55555
Member since: 30 July 2017
Date certificate issued: 30 July 2017
Anniversary: 30 July Each Year
Product: SmartCare+

Plans

Hospital & Surgical
Excess $1000
Commenced 30/07/2017 — Covered From
Individuals insured on this plan: Clark Kent — 30/07/2017

Specialist
Excess $0
Commenced 30/07/2017 — Covered From
Individuals insured on this plan: Clark Kent — 30/07/2017

GP
Excess $0
Commenced 30/07/2017 — Covered From
Individuals insured on this plan: Clark Kent — 30/07/2017

NEW ZEALAND'S BEST LITTLE HEALTH INSURER

What is covered (Benefits)

The following section covers the specific *benefits* that are covered under the different *plans* available on SmartCare+.

You will automatically have the Hospital & Surgical+ base *plan*, but please check your *membership certificate* to see whether you have cover under any of the additional *plans*.

If you have an *excess* under one of your *plans*, this applies once per person per *policy year* and is listed on your *membership certificate*.

Hospital & Surgical+ base plan

The following *benefits* apply to the Hospital & Surgical+ base *plan*. Please take the time to read over these and understand them. If you have any queries regarding any *benefits*, then please get in contact with us.

If you are wondering about what type of prescription drugs are covered under your *policy* please refer to the "Prescription Drugs" section on page 24.

Standard benefits:

General surgery

$500,000 per person per policy year
Excess applies

Covers the costs of *reasonable and customary charges* associated with the pre-approved *surgical* treatment of a non-acute medical condition. Covers the procedure(s) and all subsequent eligible treatment or expenses listed below:

- *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 hospitals* have been followed);
- physiotherapy while in *hospital*;
- surgeons' fees;
- anaesthetists' fees;
- costs of essential *prostheses* within the *Accuro* schedule; and
- pre-operative and post-operative diagnostics, consultations or tests provided they occur within one year prior to or after the approved *surgery*.

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*.

If an alternative, less-invasive *procedure and/or medical treatment* is the most suitable method of treatment (in *Accuro's* sole opinion) instead of the proposed *surgery*, *we* will cover the costs associated with this rather than paying the *surgical claim*.

THIS INCLUDES:

Major diagnostic procedures

Covers the costs of *reasonable and customary charges* of diagnostic procedures for angiograms, MRI scans, CT scans, MP scans, and endoscopies, with or without admission to a *private hospital*.

Breast reconstruction

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

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

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.

Oral surgery

$300,000 per person per policy year
Excess applies

Covers the costs of *reasonable and customary charges* associated with oral or maxillofacial *surgery* listed below:

- *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

$300,000 per person per policy year
Excess applies

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.
- Sundries including intravenous fluids, dressings and prescriptions throughout *hospital* admission.
- *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.
- $2,000 per person per *policy year* towards cancer *procedure and/or medical treatment* accessories and support services *benefit*. Cover towards the cost of a wig, hat, scarf or mastectomy bra during or within six months after the cancer *procedure and/or medical treatment*.

Non-PHARMAC subsidised drugs

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 subsidised drugs *benefit* are included within the *benefit* maximum of the *surgical* and non-*surgical benefit*, whichever is applicable for the relevant treatment under the Hospital and Surgical+ base *plan*.

Overseas treatments

Excess applies

Treatment outside of New Zealand

$30,000 per person per *policy year*.

Covers reimbursement of *reasonable and customary charges* for a *surgical* procedure performed at an overseas *hospital*, where the procedure is not available in New Zealand.

To qualify for this *benefit*:

- the *member* or *participant* must be in New Zealand at the time of diagnosis and must not have started in an appropriate medical process in New Zealand;
- the *surgical* procedure requested must be medically necessary, must not be available in New Zealand and not be experimental or being trialled;
- had the *surgical* procedure(s) pre-approved by *Accuro*; and
- meet all *policy* criteria including being subject to all *excess*, *reasonable and customary charges*, maximums and exclusions described elsewhere in this *policy*.

Written confirmation must be provided 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*.

Medical tourism

Covers reimbursement of a *surgical procedure/treatment* performed at an overseas *hospital*, where the procedure is available in New Zealand within the next 6 months.

We will reimburse up to 75% of the *reasonable and customary charges* for the *surgical procedure/ treatment* had it been undertaken in New Zealand, and reimbursement will be paid in New Zealand dollars. This maximum applies per life insured per *policy year*.

To qualify for this *benefit*:

- the *member* or *participant* must be recommended a medical procedure/treatment by a registered medical specialist that is available within New Zealand within the six months following recommendation and the *member* or *participant* has elected to have the treatment overseas;
- had the procedure/treatment pre-approved by *Accuro*; and
- meet all *policy* criteria and is subject to all *excess*, *reasonable and customary charges*, maximums and exclusions described elsewhere in this *policy*.

Accuro will determine, at its sole discretion, the country to which the *member* or *participant* can travel for the required medical treatment. All costs are included within the *benefit* maximum that apply to the *surgical* and non-*surgical benefit*, whichever is applicable for the relevant treatment under the Hospital and Surgical+ base *plan*.

Overseas waiting list benefit

Covers reimbursement of a *surgical procedure/treatment* performed at an overseas *hospital*, where the procedure is not available in New Zealand within the 6 months after recommendation for the relevant procedure/treatment.

We will reimburse the *reasonable and customary charges* for the *surgical procedure/treatment* had it been undertaken in New Zealand, and reimbursement will be paid in New Zealand dollars.

To qualify for this *benefit*:

- the *member* or *participant* must be recommended a medical procedure/treatment by a registered medical specialist 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;
- had the procedure/treatment pre-approved by *Accuro*; and
- must meet all *policy* criteria and is subject to all *excess*, *reasonable and customary charges*, maximums and exclusions described elsewhere in this *policy*.

Accuro will determine, at its sole discretion, the country to which the *member* or *participant* can travel for the required medical treatment. All costs are included within the *benefit* maximum that apply to the *surgical* and non-*surgical benefit*, whichever is applicable for the relevant treatment under the Hospital and Surgical+ base *plan*.

Cover while in Australia

Covers reimbursement of medical costs for non-acute medical conditions that are incurred and treated in Australia.

We will reimburse the *reasonable and customary charges* for the treatment had it been undertaken in New Zealand, and reimbursement will be paid in New Zealand dollars.

The *member* or *participant* must meet all *policy* criteria and is subject to all *excess*, *reasonable and customary charges*, maximums and exclusions described elsewhere in this *policy*.

All costs are included within the *benefit* maximum that apply to the *surgical* and non-*surgical benefit*, whichever is applicable for the relevant treatment under the Hospital and Surgical+ base *plan*

Lithotripsy

$75,000 per person per policy year
Excess applies

Covers the costs of *reasonable and customary charges* associated with this procedure.
Must be performed by a *registered medical practitioner*.

Public hospital benefit

$3,000 per person per policy year

$300 per night.
Covers the costs only if admitted to any *public hospital* for four or more consecutive nights.

Minor surgery

$3,000 per claim
Excess applies

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* or *participant's* physical wellbeing would be affected.

Home nursing

$6,000 per person per policy year

$150 per day.

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 the related *surgery* or cycle of chemotherapy/radiation treatment has been approved under this *policy*.

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*. *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

$2,000 per person per policy year

$50 per night, up to a maximum of 10 nights per admission.

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.

Transport and accommodation benefit — $3,000 per person per policy year

Covers the costs below 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 to an alternative *private hospital* within New Zealand.

We will reimburse one of the costs below for the *member* or *participant*:

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the *private hospital*
- **Rail transport**
  Return train fares and return taxi fare from the station to the *private hospital*
- **Road transport**
  - Return Bus fares and return taxi fare from the station to the *private hospital*.
  - Return private car journey, calculated off the mileage travelled at $0.30 per km.

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.

THIS INCLUDES

Support person benefits

Covers the costs below if the *registered medical specialist* confirms in writing that a support person is required to accompany the *member* or *participant* to the alternative *private hospital* within New Zealand.

We will reimburse one of the transport costs and accommodation below for the support person:

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the *private hospital*
- **Rail transport**
  Return train fares and return taxi fare from the station to the *private hospital*
- **Road transport**
  - Return bus fares and return taxi fare from the station to the *private hospital*.
  - Return private car journey (if not travelling with the patient), calculated off the mileage travelled at $0.30 per km.
- **Accommodation expenses** incurred up to $200 per night, for a maximum of 10 nights.

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.

Parent accommodation benefit — $3,000 per person per policy year

$300 per night for accommodation.

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* 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 — $400 per person per policy year

$80 per visit.

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 per person

$10,000 payable to the deceased *member* or *participant's* estate.

If a *member* or *participant* on this *policy* dies before the age of 66 years from illness, *we* will pay a funeral support *grant* to the deceased *member* or *participant's* estate via cheque.

Medical misadventure — $30,000 per person per policy

We 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* or *participant* dies as a direct consequence of any erroneous or negligent action, omission or failure to observe reasonable and customary standards by a health 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.

We will deduct any funeral support *grant* previously paid for a *member* from the medical misadventure *benefit*.

ACC top-up benefit — *Excess applies*

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:

- The *member* or *participant* 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 the *member* or *participant* 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 *member* or *participant* holds.
- All cost paid under this *benefit* are included within the *benefit* maximum for the relevant *benefit*, whichever is applicable for the relevant treatment under the Hospital and Surgical+ base *plan* or another applicable *plan* that the *member* or *participant* holds.

Active benefits

No *excess* applies to these *benefits*; however some do have conditions around when they are able to be *claimed* so please read them over carefully.

Best Doctors

Accuro are proud to be the only health insurer in New Zealand that offers access to Best Doctors for all of our *members* with a Hospital & Surgical *plan*. Best Doctors is a global organisation that provides access to over 50,000 of the world's leading medical specialists from the comfort of your own home. If any *member* or *participant* on this *policy* has been diagnosed with an illness, injury or medical condition and would like a second opinion, they can contact Best Doctors at no cost to review their diagnosis and treatment plan.

Best Doctors offers:

» **InterConsultation®**
This service allows you to get an expert medical review for your illness, injury or medical condition, including your treatment plan, from an independent, medical expert. The expert will provide you with a report that empowers you with knowledge of exactly what your condition is and the best treatment plan. The report is designed for you to share with your treating doctor to provide certainty and comfort that you're on the right treatment pathway.

» **Ask The Expert™**
This service allows you to ask all those questions that come up after you have left the doctor's clinic. You can call and discuss any questions or concerns you have with Best Doctors over the phone. Best Doctors will then explore those questions further with the most appropriate Best Doctors specialist from their network, and you'll receive the expert's answers in an easy-to-read report.

» **Ask Best Doctors™**
This service provides access to a range of on-line tools through the Best Doctors member portal.
Tools include DocOnline® which allows you to submit your questions to an experienced NZ GP via their member portal. The GP answers your question, providing any relevant supporting information and posts the response in your inbox.

For more information

The Best Doctors website provides more detail about the services they provide as well as testimonials from individuals they have helped.

Website: www.askbestdoctors.com/nz

You can also contact Best Doctors by:
Phone: 0800 425 005
Email: info@bestdoctors.com

To register

To use Best Doctors' services you will need to register through their member portal by completing these simple steps:

» Go to www.askbestdoctors.com/nz

» Click on the 'Create A Profile' button on the top right hand side of the page

» Enter your First Name and Last Name

» Select 'Health Insurance' from the drop down menu under 'How do you have access to Best Doctors?'

» Enter 'Accuro' as your Insurer

» Enter your personal details and chosen Password

» Select 'Verify Email'

» You will receive a registration confirmation email with a verify link – click on the link to finalise.

Loyalty benefit – healthy weight discount

5% after three years of continuous cover.
10% after six years of continuous cover.
15% after nine years of continuous cover.

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.

Dependants aged 25 years or younger do not qualify for this *benefit*.

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. In this case, the *premium* will revert to a standard *premium* schedule.

Loyalty benefit – health check $150 per person every three policy years

After three years of continuous cover, this *benefit* covers the costs of a health check performed by a New Zealand *registered medical practitioner*.

Dependants aged 25 years or younger do not qualify for this *benefit*. This *benefit* cannot be accumulated over subsequent years.

Loyalty benefit – screening endoscopies $1,000 per person every three policy years

After three years of continuous cover, this *benefit* covers 80% of the *reasonable and customary charges* of colonoscopies and gastroscopies, up to $1,000.

Dependants aged 25 years or younger do not qualify for this *benefit*.
This *benefit* must be taken within 12 months of entitlement and cannot be accumulated over subsequent years.

Loyalty benefit – sterilisation $5,000 per policy

One-off contribution up to $5,000 towards the total costs of the procedure.

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 – bowel screening

A bowel screening kit every three continuous *policy years*.

After 3 years of continuous cover, this *benefit* covers the cost of a Bowel screening kit purchased through our provider. Please contact us if you wish to redeem this *benefit* and we will arrange for a kit to be sent to you.
Dependants aged 25 years or younger do not qualify for this *benefit*.

Additional plans

You can choose to add any of *Accuro's* additional *plans* for yourself or any other *participants* on your *policy*.

These include:

- Specialist+ *plan*
- GP+ *plan*
- Natural Health+ *plan*
- Dental and Optical+ *plan*

The following pages will outline the *benefits* of these additional *plans*. Unless you have requested to have these added to your *policy*, you will not have these *plans*.

If you are unsure if you have cover under these *plans*, then please check your *membership certificate*. *We* recommend that you take the time to read over the *benefits* and understand them. If you have any queries regarding the following *plans* or would like to include an additional *plan* to your *policy*, then please get in contact with us.

You can also add our new Day to Day product.

Day to Day provides a mixture of the *benefits* from the above additional *plans*, up to a maximum of $600 per person per *policy year*.

It was designed to help you cover the everyday costs of staying healthy such as going to the doctor, dentist or optician, obtaining prescription medication or preparing for the winter with an annual flu jab. You can also enjoy the benefits of having natural therapy treatments to help you experience greater health and wellbeing.

If you would like to add Day to Day to your *policy*, you can call us on 0800 222 876 or email us at info@accuro.co.nz and *we* will send you an application form.

Specialist+ plan

The Specialist+ *plan* is our most popular additional *plan* and can speed up the time to diagnosis by providing access to private tests and specialist consultations. This is an additional *plan* so please make sure to check your *membership certificate* to see if you have cover under this *plan*.

Specialist consultations

$5,000 per person per policy year
Excess applies

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. Including (but not limited to):

- Cardiac surgeons
- Cardiologists
- Ear, nose and throat specialists
- Gastroenterologists
- General surgeons
- Gynaecologists
- Neurosurgeons
- Oncologists
- Ophthalmologists
- Orthopaedic surgeons
- Paediatricians
- Urologists.

THIS INCLUDES

Mental health consultations

$500 per person per *policy year*.

Covers the costs of *reasonable and customary charges* for consultations with a registered psychiatrist (registered under the psychiatry scope with the Medical Council of New Zealand) or psychologist (registered as a psychologist with the New Zealand Psychologists Board) when referred by a *registered medical practitioner*.

Second-opinion benefit

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.

Diagnostic tests

$5,000 per person per policy year
Excess applies

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
- Colposcopy
- 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* as well as being subject to the aggregated annual limit:

- Cardioversion
- Nuclear scanning.

Loyalty benefits

Screening

$250 per person every three 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*. *Dependants* aged 25 or younger do not qualify for this *benefit*.

Pregnancy and infertility treatment

$2,000 per person 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.

Melanoma

$200 per person every three policy years

After three years of continuous cover, this *benefit* covers melanoma investigation.

GP+ plan

The GP+ *plan* is a good choice if you frequently make visits to your doctor, especially for prescriptions. This is an additional *plan* so please check your *membership certificate* to see if you have cover under this *plan*. There is an initial *stand-down period* of 90 days on this *plan*, and to submit a *claim* you must have invoices totalling $100 or more.

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 – $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.

Natural Health+ plan

Take a more holistic approach to your wellbeing with the Natural Health+ *plan* - a good option for those interested in a diverse approach to keeping well. This is an additional *plan* so please check your *membership certificate* to see if you have cover under this *plan*. There is an initial *stand-down period* of 90 days on this *plan*, and to submit a *claim* you must have invoices totalling $100 or more.

Health practitioners — $800 per person per policy year

Osteopath and Chiropractor

Up to $45 per visit and $240 per *policy year* per health practitioner.

Covers the costs of treatment by osteopath and chiropractor health practitioners.

Health Care 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 benefits

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.

Flu vaccination **$40 per person per policy year.**

After three years of continuous cover, this *benefit* covers flu vaccination.

Dental and Optical+ plan

Regular visits to the dentist and optician can save your health and your wallet later on down the track. Keep on top of these costs with the Dental and Optical+ *plan*. This *plan* is especially useful for people who already have corrective eye wear.

This is an additional *plan* so please make sure to check your *membership certificate* to see if you have cover under this *plan*. There is an initial *stand-down period* of 90 days on this *plan*, and to submit a *claim* you must have invoices totalling $100 or more.

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

Consultations

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.

Glasses or contact lenses

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, this *benefit* covers the cost for orthodontic treatment by a registered orthodontist.

Practitioners providing assessments must belong to their professional body.

What's not covered (Exclusions)

Unfortunately, *we* can't cover every kind of medical condition and treatment so there are some things that *we* have to exclude. *We* have listed these *general exclusions* below but if you are unsure of anything or have any questions then please get in contact with us. If there are exclusions personal to you or a *participant*, these will be listed in your *membership certificate*.

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:

Health conditions

- 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.
- Any condition in connection with the use of non-prescription drugs.
- AIDS or HIV infection or any condition arising from the presence of AIDS or HIV infection; sexually transmitted diseases.
- *Congenital conditions* diagnosed within 3 months of birth, including but not limited to the investigation, treatment, complications thereof and/or any residual issues.
- Any *acute care*.

Acute care is covered by the public health system and ACC

- Any health condition as a consequence of war, invasion, act of foreign enemy, terrorism, hostilities (whether war is declared or not), civil war, rebellion, revolution or military or usurped power.
- Any *long-term care*.
- *Palliative care* as defined by *Accuro Health Insurance* (except where the contrary is expressly specified in this *policy*).
- Pregnancy, childbirth, miscarriage or any associated conditions and/or complications for the mother and/or foetus/child.
- 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).
- Termination of pregnancy.
- Any *pre-existing conditions*.

Tests, diagnostic procedures and treatments

- Any expense where there are no symptoms or evidence of a condition detrimental to health, including but not limited to *preventative healthcare services* and treatments, maintenance and/or health surveillance testing; genetic-testing; employment-related examinations or screening; vaccination against any disease or condition, or convalescence.
- *Cosmetic procedure* as defined by *Accuro Health Insurance* and/or other enhancement/appearance medicine.
- Procedures performed for any reason, treatment or consultations relating to obesity and/or weight loss.
- Gender reassignment and/or gender dysphoria.
- Specialised transfusion of blood, blood products, treatment for renal failure and renal dialysis as provided by government-funded agencies; organ donation and receipt.

- Chelation therapy or similar treatment as defined by *Accuro Health Insurance*.
- 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). Radial keratotomy or photo-reactive keratectomy or any related complications.
- 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.
- Dental care; orthodontic, endodontic, orthognathic, periodontal treatment, implants or tooth exposure.
- Any investigation and/or treatment for sleep disturbances, snoring or sleep apnoea.
- Circumcision, except where *medically necessary*.
- Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary*.

Other

- 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.
- 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*).
- Any medical costs incurred outside New Zealand.
- Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand.
- Medical mishap or misadventure.
- Charges for a treatment or procedure not provided by a *registered medical practitioner* practising within his or her scope of practice.
- Avian influenza infection or any condition arising from the presence of avian influenza infection or any other nominated pandemic.
- Disability or illness arising from misuse of alcohol or drugs, participation in a criminal act or intentional self-injury.
- Attempted suicide or suicide within 13 months from the *plan* start date.
- New medical treatments, procedures and technologies that have not been approved by *Accuro Health Insurance*.
- Any costs not specifically provided for under a *benefit* section contained in the *plan*.
- General practitioners' fees, drugs and medication
- Additional *surgery* performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this *policy*.

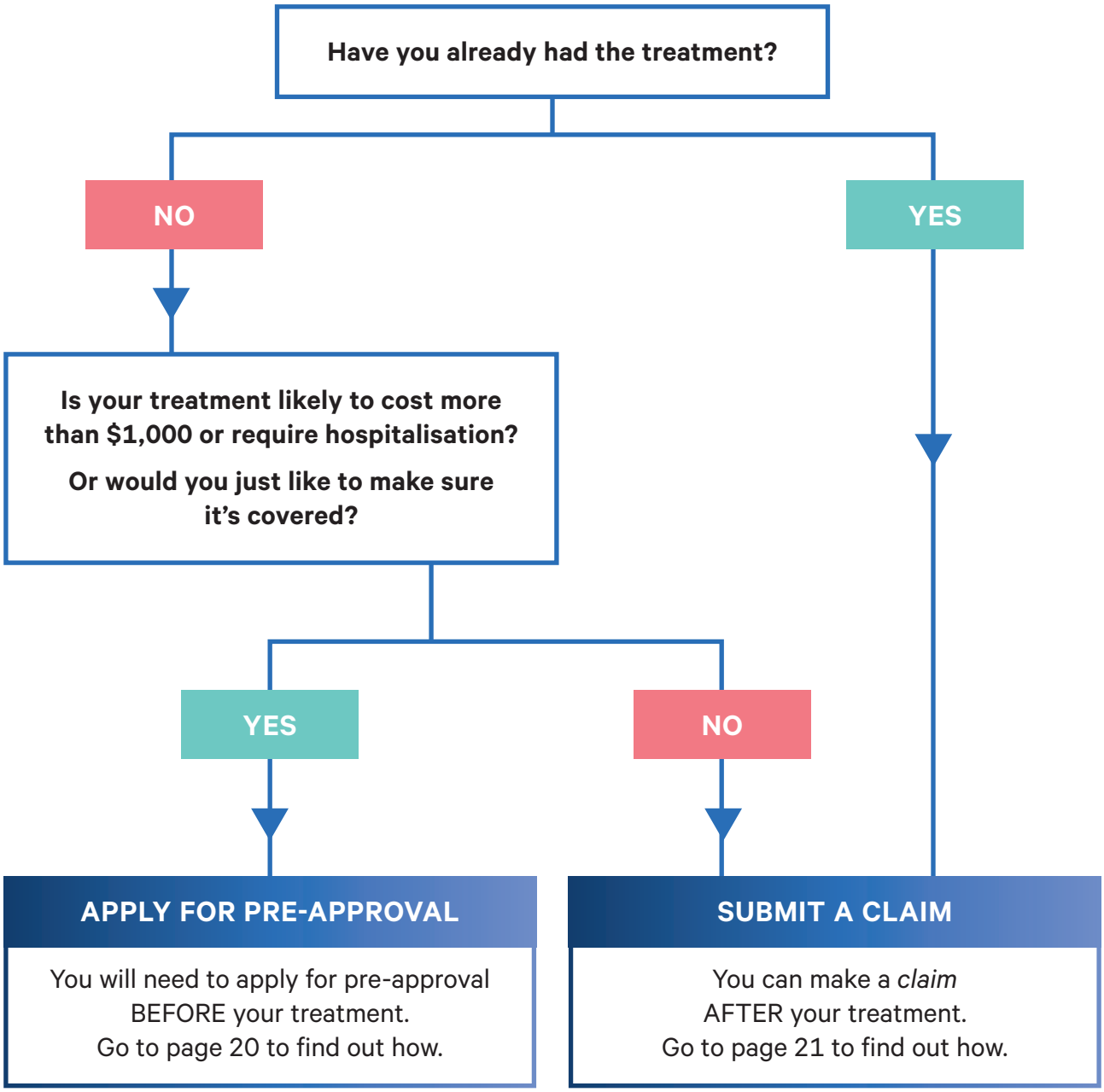
The claiming process

There are two ways that you can submit a *claim* for your *procedure and/or medical treatment*.

The first is to obtain pre-approval for your *claim*, by submitting the details for your *procedure and/or medical treatment* before it takes place in order to confirm that it is covered under your *policy*.

The second option is to submit a *claim* after the *procedure and/or medical treatment* has already taken place.

If you are unsure whether you should obtain pre-approval or just make a *claim* afterwards, use the flow chart below to help.



How to apply for pre-approval for a claim

Pre-approval is when *we* give you confirmation that your *procedure and/or medical treatment* (such as a *surgery*) is, or is not, covered under your *policy* before it occurs. *We* will also advise you of any conditions or *excess* that may apply.

Pre-approval is required for any procedure or medical treatment that is likely to cost $1,000 or more, or where your *procedure and/or medical treatment* requires *hospitalisation*, day-stay or in-patient care. **If in doubt, get pre-approval.** If you fail to obtain pre-approval, this may prejudice your ability to make a *claim*. *We* require 2 working days to process pre-approvals.

The process

Collect a pre-approval form

You will need complete a pre-approval form which can be found on our website, or the online member portal or *we* can post or email a copy to you. This form will need to be signed by the main *member*, and patient if over 16 years of age.

Obtain an estimate of the cost

You will need to obtain an estimate of the cost for the *procedure and/or medical treatment* from the health service provider(s) (and *hospital* if *hospitalisation* is required). Please try to obtain an estimate of the cost for all parts of your *procedure and/or medical treatment* (including number of nights, theatre fees and any additional costs such as equipment and physiotherapy). This allows us to make sure the full cost will be covered. However, *we* understand that this will be an estimate only and the actual costs may vary.

If the cost is above what *we* deem to be a reasonable cost for the type of *procedure and/or medical treatment* (what *we* call our *reasonable and customary charges*, refer to page 25) *we* may ask for further information or recommend an alternative treatment or health service provider. If you choose to continue at the previous cost, you will need to pay the difference between the amount *we* approve and the actual cost for the procedure and/or medical treatment, regardless of the *benefit's* maximum cover.

You will need to let us know if another insurer, including *ACC*, has a responsibility to pay for all or part of the *procedure and/or medical treatment*.

Provide medical evidence

You and all *participants* on your *policy* are required to provide us with all the information *we* reasonably need to assess your pre-approval and/or *claim*. *We* are entitled to request information from the pre-approval process, up to and following a *claim* being made.

You will need to provide some *medical evidence* for why the *procedure and/or medical treatment* is required, so that *we* can make sure that it is covered under your *policy*. This *medical evidence* could be either a copy of the GP referral letter or a letter from the Specialist that confirms why the treatment is required.

You may also need to get *Accuro's* Medical Report form completed by the GP who holds the patient's medical history. This will be required if the patient having the *procedure and/or medical treatment* is within the first five years of their *policy*, and this is the first time they are *claiming* for this medical condition, or where required in order to properly assess the *claim*. Please see the "Medical evidence" section on page 25.

Submit your pre-approval

You can submit your pre-approval via post, email, fax or through the online member portal. In some cases, *we* may need to contact you or the health service provider(s) to request additional details to ensure *we* assess your pre-approval correctly. *We* will get in contact with you if this is the case.

If you are unsure about any of the above including whether you need to supply a Medical Report with your pre-approval, then please get in contact with us by either giving us a call or sending us an email.

How to make a claim

When you are submitting a *claim*, you are asking for payment of a *procedure and/or medical treatment* that has already occurred. All *claims* should be received by *Accuro* within 12 months of the date of the *event*. Any *claim* outside of this 12-month *claim* period may be declined.

Subject to the terms of the *policy*, *Accuro* will pay up to the *reasonable and customary charges* for any *medically necessary procedure and/or medical treatment* covered by a *benefit* under the *policy*, up to the *benefit* maximum. *Claims* may only be made for *events* occurring after the relevant health insurance cover has started.

The process

Collect a claim form

When you do not have pre-approval, you will need to complete a *claim* form which can be found on our website, or the online member portal, or *we* can post or email a copy to you. This form will need to be signed by the main *member*, and patient if over 16 years of age.

Collect invoice and receipts

You will need to include all invoices and the receipts (if you have already paid for the invoices) for the *procedure and/or medical treatment*. *We* need to receive these within 12 months of the *event* date. Any outside this 12-month *claim* period may be declined to the extent that *we* are prejudiced by the delay.

Provide medical evidence

You and all *participants* on your *policy* are required to provide us with all the information *we* reasonably need to assess your pre-approval and/or *claim*. *We* are entitled to request information from the pre-approval process, up to and following a *claim* being made.

You will need to provide some *medical evidence* for why the *procedure and/or medical treatment* is required, so that *we* can make sure that it is covered under your *policy*. This *medical evidence* could be either a copy of the GP referral letter or a letter from the Specialist that confirms why the treatment is required.

You may also need to get *Accuro's* Medical Report form completed by the GP who holds the patient's medical history. Please have a look at the "Medical evidence" section on page 25 for more information on whether a Medical Report is required for your *claim* or not.

We do recommend that you read over both your *membership certificate*, including any exclusions listed on it as well as the "What's not covered" section on pages 17-18 to ensure that the *procedure and/or medical treatment* is covered under your *policy*. If you are unsure, you can always apply for pre-approval beforehand, which will give you confirmation of whether the *procedure and/or medical treatment* will be covered.

Submit your claim

You can submit your *claim* via post, email, fax or through the online member portal. Your member portal also allows you to start a *claim* and then save it, so you can add invoices as you receive them and then submit it all together once you have received everything.
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. *We* will get in contact with you if this is the case.

What happens if you have an excess under your plan?

All relevant *excesses* will be shown on your *membership certificate*. If you have an *excess* under your *policy*, it will be taken off any payment *we* make in relation to your *claim*, either off a reimbursement to yourself or a payment made to your health service provider. You will be responsible for paying the *excess* amount directly to the health service provider.

What if you already have pre-approval?

If you have already been approved to have the *procedure and/or medical treatment* by *Accuro*, then you will just need to forward us copies of the invoice(s), and receipt(s) if you have already paid the provider. Please make sure to include your *membership* number and *claim* number with the invoices. *We* will then assess these and make payment either to the provider(s) directly or *we* will reimburse you if you have already paid for the invoices.

Things to remember

We are only able to accept and provide cover for costs:

- for *events* that occur after your *policy* commences,
- under a *policy* which has *premiums* paid up-to-date,
- for *benefits* listed in the *plans* you have cover for,
- charged at a reasonable and fair cost (fall within our *reasonable and customary charges*),
- and for services only in the private sector (unless expressed otherwise in your *policy* document).

We would recommend that you have a look at the next section, "Policy Conditions," as there are things listed here that may affect your *claim* or the amount *we* are able to pay out for a particular *procedure and/or medical treatment*.

If you are unsure about any of the above including whether you need to supply a Medical Report with your *claim*, then please get in contact with us by either giving us a call or sending us an email.

Policy conditions

ACC claims:

ACC is New Zealand's *accident* compensation scheme, which provides insurance cover if you are injured. Your SmartCare+ *policy* has been set up to complement this and won't cover *claims* related to *accidents* that *ACC* covers. If *ACC* does not cover the full amount for your treatment, then you may be able to *claim* for the difference if you have cover for this treatment under your *policy*.

Special conditions apply to *surgery* or treatment covered by *ACC*. Under the *ACC* legislation, you can choose between a:

- full payment option (*ACC* contracts a provider to provide the *procedure and/or medical treatment* and pays the total cost), or
- partial payment option (*ACC* contracts a provider to provide the treatment but only funds a portion of it).

The full payment option should be your first choice, so you don't have to make any contribution towards the cost of *surgery*. In this case, you must submit all *claims* to *ACC*.

Under the partial payment option, you will have to make a contribution towards the cost of the healthcare services. If ***ACC agrees to partial payment*** and the treatment is covered under your *policy*, *we* will cover the difference up to the *reasonable and customary charges* for this *procedure and/or medical treatment*, or up to the *benefit* limit in your *policy*, whichever is less.

For example, you have an *accident* and need an x-ray. If *ACC* agreed to cover 80% of the cost, and you have the Specialist+ *plan*, *we* would pay the remaining 20%.

If ***ACC declines cover*** for treatment that is covered under your *policy*, *we* might ask them to review or appeal. *We* would need your support in this by providing us the *ACC* decline letter within three months of its issue date, giving authority to our legal representative to review the case and providing any other relevant information. In cases where *ACC* reverses their decision to decline the *claim*, *we* may seek reimbursement from *ACC* or yourself for any related *claims* that *we* have already paid. You need to make a reasonable effort to secure and maintain cover, if ***ACC refuses cover*** for a *claim* or stops *claim* cover because you aren't complying with *ACC*'s requirements, you won't be able to *claim* under your *policy*.

Stand-down period:

Some *plans* have a 90-day *stand-down period* which applies to all *members* and *participants* on this *plan*, this is advised of under the relevant *plans* in the "What is covered" section. There is no cover for any *events* which occur during this *stand-down period*.

Excess:

If an *excess* does apply on your *policy*, then this applies once per person, per *policy year*. There can be different *excesses* applicable to your base *plan* and the Specialist+ *plan*, and the *excess* amount 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 *policy year*.

If you do have an *excess* under one of your *plans* and you *claim* on this *plan*, *we* will deduct the *excess* amount from the payment. If the *claim* is smaller than your *excess* amount, *we* will take this amount as the *excess* and not provide any further payment until the full *excess* amount has been taken.

For example, you have a $1000 *excess* under the Hospital & Surgical+ base *plan* and *claim* for a $950 MRI scan. You need to pay the $1000 *excess* before *we* can reimburse you for anything. The $950 you have already paid would go toward your *excess*, so *we* would not reimburse you for this *claim*. However, if you needed another $950 MRI scan in the same *policy year*, you would only have $50 of the $1000 *excess* left to pay and *we* would reimburse the remaining $900.

When a pre-approval is provided, your *excess* will be clearly shown on the approval letter, and you will need to settle this amount directly with your health service provider.

Policy benefits:

Unless specifically stated in the *policy* document, all *benefit* limits are per person, per *policy year*. The *benefit* limits reset back to their maximum levels at the start of each *policy year* and cannot be carried over from one *policy year* to the next or transferred to other *participants* on the *policy*. Where relevant, the minimum or maximum amount for each *benefit* that may be *claimed* for an *event* is set out in the "What is covered" section of this *policy* document.

We will not pay or reimburse any costs that amount to more than 100% of the actual costs incurred. This means that if any other refunds, subsidies or entitlements are available from another source such as *ACC*, another health insurer, a government-funded agency, Work and Income or your employer, you must *claim* with them first and then *we* will take any reimbursement from them off the total amount before *we* assess the amount against the *benefit* under your *policy*.

Unless specifically stated in your *policy*, *we* are unable to cover any healthcare service undertaken in the public sector, this means a procedure or treatment in a *public hospital* or facility controlled directly or indirectly by a DHB unless accepted in writing by *Accuro* prior to the *event*.

Maximum costs we will pay:

We will pay the cost for a *procedure and/or medical treatment* that falls under your *policy*, up to the relevant *benefit* maximum, or the *reasonable and customary charge* for this procedure, whichever is lesser. If the cost exceeds the maximum cover or the *reasonable and customary charges*, *we* will not be able to pay the exceeded amount, and this will be your responsibility.

If the cost is above what *we* deem to be a reasonable cost for this type of *procedure and/or medical treatment* (our *reasonable and customary charge*) *we* may ask for further information or recommend an alternative treatment or health service provider. If you choose to continue with the *procedure and/or medical treatment* at the previous cost, you will be responsible for any monetary difference between the amount *we* approve and the actual cost for the *procedure and/or medical treatment*, regardless of the *benefit's* maximum cover. You will need to pay this extra amount directly to your health service provider. If you apply for pre-approval, *we* will advise you of this and the maximum amount *we* can provide cover for in the approval letter.

Pre-existing conditions:

A *pre-existing condition* is:

- any health or medical condition that you are aware of or were experiencing signs or symptoms of prior to the *commencement* of your *policy*, or
- a medical *event* that occurred prior to the *commencement* of your *policy*.

As *Accuro's* policies are set up to cover treatment of signs, symptoms and conditions that arise after the *policy* has commenced, you must disclose all *pre-existing conditions* (including *congenital conditions*) for all *participants* at the application of your *policy* to allow us to assess these. Not all *pre-existing conditions* will warrant an exclusion to be placed, however our *underwriters* do need to know about all previous and current signs, symptoms and conditions to allow them to fully assess your application. Any exclusions that have been placed due to your *pre-existing conditions* or any other *participant's pre-existing conditions* will be clearly listed on the back of your *membership certificate*.

If a *procedure and/or medical treatment* is required for a *pre-existing condition* that was not advised of on the application form, which you or the *participant* knew about or should have known about, *we* may decline the *claim* for the *pre-existing condition* or any related condition and/or exercise any other remedies available to us. *We* reserve the right to exclude any declared or non-declared *pre-existing condition* or *congenital condition* from your *policy* at any time.

Waiver of premium:

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, *we* will continue to provide cover for the other *participants* covered under this *policy* for 36 months or until the oldest surviving *participant* 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, *premiums* for all remaining *participants* must be paid by the remaining or new main *member*.

Prescription drugs:

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

- Drugs prescribed and administered 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* which is an additional *plan*.

Unless where advised of differently in the *policy*, 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 and the drugs must be funded in respect to the relevant *claim*.

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.

Reasonable and customary charges:

This is the cost for a *procedure and/or medical treatment* that *Accuro* in its sole discretion deems to be reasonable and within a range of cost charged for the same procedure under similar circumstances.

For procedures that have a *reasonable and customary charge* applied to them, *we* look at the average cost of the same procedure done throughout New Zealand. Once *we* have the average cost, *we* then add an extra amount on top to set the *reasonable and customary charge* for this type of procedure. *We* understand some health service providers do charge more than others, which is why *we* add the extra amount as a buffer.

For example, a hip replacement *surgery* has an average cost of $22,500 throughout New Zealand. Once *we* add a buffer of 20%, *we* have a *reasonable and customary charge* of $27,000 for this procedure. This means that if you were to have a standard hip replacement *surgery*, *we* would provide cover up to $27,000 for the costs associated with the *surgery*, and any costs over these you would need to cover.

This is in place to ensure health service providers are fair with the amount they charge for procedures, and not charge more than required. These charges are referred to through this *policy* document as *reasonable and customary charges*.

Medical evidence:

You and all *participants* on your *policy* are required to provide us with all the information *we* reasonably need to assess a pre-approval or *claim*. *We* are entitled to request information from the pre-approval process, up to and following a *claim* being made. *We* required this *medical evidence*, such as a copy of the GP referral letter or a letter from the Specialist that confirms why the treatment is required so that *we* can make sure that this *procedure and/or medical treatment* is covered under your *policy*.

Unless you have provided your full medical history at the time of application, if you are within the first five years of your *policy* and have not *claimed* for this condition before then *we* will require *Accuro's* Medical Report form to be completed by the GP who holds the patient's medical history. This is required to give us the history of the condition, what the symptoms were and when they first became apparent. Often the GP referral or Specialist letter will not provide this comprehensive information *we* need, which is why *we* ask for this medical report form to be completed by the GP.

Unfortunately, any costs associated with obtaining the above *medical evidence* will be at your own expense.

Your policy's premium:

Your *premium* must be maintained to ensure continuity of *membership* with *Accuro* and eligibility for *benefits*. It is your responsibility to make sure that your *policy* is paid up to date for yourself and all *participants* on your *policy*, and *we* will do our best to provide you with up-to-date information around your *policy* and *premiums*.

You must pay *Accuro* the *premiums* at one of the frequencies provided by us and must be paid 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* is not guaranteed. *We* reserve the right to review and adjust *premiums* at our discretion to ensure the viability of any *plan* or *policy*. *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.

If the *premiums* have not been paid on your *policy*, your *policy* will fall into arrears and you will start to receive letters advising you of this. *Claims* payments will be withheld when *premiums* are in arrears until the arrears are cleared. It is important to note that your *policy* will be cancelled when three months of *premiums* or more remain unpaid on your *policy*. Cancellation will be effective from the date that *Accuro* sends notice of cancellation.

If your *premiums* are in arrears or when your *membership* has ceased for any reason, *we* are unable to provide any cover for any services outside of the period that you have paid *premiums* for. *We* are only able to assess cover for a *claim* when the *premium* for your *policy* is up to date for the period that the services took place.

Making changes to your policy

14-day free look period

We provide a 14-day free-look period that commences from the start date on the *membership certificate* or 5 working days after you receive the *policy* documents (whichever is later), to allow you to review your *plan(s)* and make sure they are right for you. If you want to make changes to your *policy* you are able to do so within this 14-day period, and if you do feel that it's just not right for you and wish to cancel within this 14-day period *we* will refund any *premiums* paid, as long as no *claim* has been made under the *policy*. To cancel within the 14-day free look period you need to advise us of your request for cancellation in writing, signed by the main *member*.

Adding additions to the policy

To add a *participant* to your SmartCare+ *policy*, you will need to complete a full application form for each *participant* and answer the heath questions or provide their full medical history.

You can apply to add your *parents*, spouse/partner and *dependants/whāngai* under the age of 25 years onto your *policy* at any time. *Accuro* will assess and make a decision for the addition of any *participant* on the basis of the health information received. Cover for a *participant* commences from the start date listed on the *membership certificate* issues with the *participant* listed as covered.

If you are adding a *dependant* on to your *policy* who is under six months of age, you can add them onto your *policy* by completing a Making Changes form with no *personal exclusions*. Please note the exclusions listed on pages 17-18 will still apply including *congenital conditions*. They will also be eligible to receive cover free of *premiums* for the first six months after being born. The relevant *premium* will then be charged once the child has reached six months of age. If you wish to add a child who is six months of age or older onto your *policy*, you will need to complete a full application form, and the child will be subject to medical *underwriting*.

Once a *participant* has been added to your *policy*, they will remain on it until the main *member* advises otherwise. The main *member* is responsible for advising *participants* of all matters in relation to the *policy* and any changes to the *policy* or the *participant's* cover.

Premiums for added *participants* will be charge from the *commencement* date for the *participant* as shown on the schedule as part of the normal billing cycle.

How long can dependants/whāngai stay on my policy?

Any *dependants* added onto the *policy* before they reach 25 years of age will be classified as a *dependant* and charged at a *dependant* rate. Once they reach 25 years of age they will start to be charged at the rate for a 25-year-old. They will remain on your *policy* and continue to have an age-related *premium* applied unless you request their removal. Any *participant* aged 25 years and over who has been included on 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 the 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, and will be fully *underwritten*.

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*.

Death of the main member

If the main *member* of the *policy* dies, the partner who has been included on the *policy* may retain the *policy* while they continue paying the appropriate *premium*. The partner is then considered the main *member*. Please see the "Wavier of *premium*" section on page 24 for further information around whether the waiver of *premium* is applicable.

How can a policy end?

Cover for your SmartCare+ *policy* ends when:

- You ask us to cancel your *policy*. The main *member* must provide this in writing to us and sign the request.
- 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.

Suspending your policy

You may contact us to request 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).

Please contact us if you wish to apply to suspend your *policy* for any of the above reasons, and *we* will advise if any further documentation or evidence is required to do so. Please be aware that *we* will not pay any *benefits* under the *policy* to you or any *participant* on your *policy* who is suspended at the time the *event* occurred.

The main *member* or *participant* must have continuous cover under this *policy* for a 12-month period before this is applicable and must have a 12-month period between the previous suspension and the start date of the next suspension.

Please note that if you suspend your *policy*, the period that your *policy* is suspended for will not be deducted from the timeframe for any *personal exclusions* you or any *participants* have on the *policy*.

For example, you have a five year *personal exclusion* for a hernia, and you suspend your *policy* for 12 months, after one year of cover. You will not be able to *claim* for treatment relating to the hernia for the first year of cover, while suspended, or for the four years following suspension.

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.

Where the *policy* or cover for a *participant* is cancelled by the *member*, the date of cancellation depends on the frequency for which *premiums* are payable:

- If *premiums* are paid at a frequency of monthly or less, the date of cancellation is the next due date for *premium* payments following the receipt of the cancellation request by *Accuro*.
- If *premiums* are paid at a frequency greater than monthly, the date of cancellation is the expiry of the month in which *Accuro* receives the cancellation request, with the *member* being entitled to a pro-rata refund of *premiums* paid where applicable.

Other important information

This *policy* has no surrender value. *Accuro* is not liable for the standard or effectiveness of the procedures and/or medical treatment provided in relation to the cover under this *policy*.

Privacy statement

We ensure that our privacy practices comply with the Privacy Act 1993 and Health Information Privacy Code 1994 and industry best practice. By applying for *membership* under the terms of this *policy*, you agree to the collection and use of your information in accordance with the *Accuro Health Insurance* privacy statement.

Information we collect
We collect information from you when you become a *member* of *Accuro*, sign up for information or provide us with information in making an application or a *claim* under a *policy*. *We* also collect information from you when you use our website including by use of cookies.

Some examples of personal information *we* may collect from you are:

- Information such as your name, contact details, date of birth and gender;
- Payment information such as your credit card and bank account number;
- Social contact information;
- Health information such as medical records;
- *Claims* information and information relating to any other insurance applied for or obtained or *claims* previously made by you; and
- Website information such your IP address and browser type.

We may also collect personal information about you from third parties such as your GP or a *hospital*. *We* will only do this if you have been told first or where permitted by law.

How we use personal information collected
We will only disclose your personal information in accordance with this privacy statement, the Privacy Act 1993, or after notifying you at the time of collection. *We* may use personal information to:

- Identify you;
- Evaluate and assess your application for a *policy* and *claim(s)* under your policies;
- Provide on-going client service and information;
- Produce reports and summary data;
- Improve and better understand our business including our website;
- Manage a relationship with you, including contacting you about our products and services;
- Improving our range of products, services and promotions (including assessing trends and customer interests or preferences);
- Managing and monitoring our business risks;
- Recovering any unpaid debts or other monies owing;
- Comply with our legal and regulatory obligations; and
- For any other matter related to any *policy* taken out by you.

While *we* treat any personal information as confidential, there may be some situations where *we* disclose information to third parties including trusted service providers for the above purposes and for reporting, summary or statistical purposes.

If you or any person covered by your *policy* with *Accuro* provide us with incomplete or inaccurate information *we* may decline your *claim*, void or cancel your *policy* as allowed by law.

Storage and security of your personal information
The intended recipient of the information is *Accuro*. That information is held in hard copy and/or electronically at *Accuro's* registered office and/or with our trusted data storage providers. Personal information may also be stored in third party storage facilities and in cloud storage located inside and outside New Zealand.

We take all reasonable steps to ensure that the personal information *we* hold is protected against loss, unauthorised use, unauthorised access, unauthorised modification, unauthorised disclosure, and any other misuse.

We retain your personal information only for as long as it is required for lawful purposes. *We* will take all reasonable steps to ensure that the personal information is securely destroyed when *we* no longer require it.

Accessing and correcting your personal information
Subject to the Privacy Act 1993, you are entitled to ask us to confirm whether *we* hold personal information about you or not. You are entitled to have access to that personal information. You are also entitled to ask us to correct any of your personal information if you believe it is inaccurate. You can request a copy of or ask us to correct your personal information by writing to us at info@accuro.co.nz or Accuro Health Insurance, PO Box 10075, Wellington 6143.

Changes to our Privacy Statement
We may update our privacy statement and recommend that you refer to *Accuro's* website for changes.

Health Funds Association of New Zealand

Accuro 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* may collect, use and disclose personal information and health information about you and persons covered by your *policy* for the purposes of the Integrity Registry.

Accuro is authorised to collect, use and disclose personal information and health information about you and persons covered by your *policy* for the purposes of the Integrity Registry. You authorise disclosure of personal and health information to HFANZ or its agents and HFANZ members for the above purposes.

You have 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.

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* must be true, correct and complete. If you have not disclosed information or 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 or amend the terms applying to you or a *participant*.

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 (*Accuro*) 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.

Membership is available to anyone (individual or group) who is accepted by *Accuro* for *membership* and is permitted to become a *member* under the rules of the *Society*. As a *policy* holder with *Accuro*, you are now a *member* of *Accuro*. 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*. Your *membership* ceases when this *policy* comes to an end.

Accuro 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 policies and at the discretion of the *Board* of Directors. This is to ensure that the cover provided reflects current trends and is commercially sustainable. *We* will endeavour to provide reasonable notice (minimum 21 days) prior to such change and you may cancel the *policy* at any time (see "How can a *policy* end" on page 26).

Accuro 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. This must be signed by the main *member* and relevant *participant* over the age of 16.

The rights and obligations of the *member* and *Accuro* are set out in the documents below:

- the individual *member's* application form and all material provided by or on behalf of the *member* in support of the application and any *claim*
- 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* on request.

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 and in accordance with your duty of disclosure.

We may not pay a *claim* and *we* may void all or part of the *policy*, cancel it or amend the terms applying to you or a *participant* 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 that 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 may cancel your *policy* or reduce cover immediately where it appears to us that a *member*, *participant* or *dependant* 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 conducts all its business in accordance with the laws of New Zealand.

If you have a concern

We pride ourselves on providing great service to all of our *members*, so if you have a concern or are not happy about something then please let us know. *We* will work with you to try and resolve this as quickly as *we* can.

If you are unhappy with a *claim* or pre-approval decision, or you wish to put your concern in writing to us, then please contact our Member Engagement Manager via email at info@accuro.co.nz or post a letter to the below address:

Accuro Health Insurance
PO Box 10075
Wellington 6143

When *we* receive a request to review a *claim* or pre-approval decision *we* will investigate and reply to you as soon as practically possible. *We* may also ask for additional medical information if reviewing a *claim* or pre-approval, which may cause some delay. If you are unhappy with the response from the Member Engagement 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.

If a deadlock with a *claim* or pre-approval decision has been reached after the above internal complaints process has been followed, you can choose to take it to the Insurance & Financial Services Ombudsman.

Insurance & Financial Services Ombudsman - IFSO

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

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 or **Accuro** means the Health Service Welfare *Society* Limited.

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* or *participant'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 3 months 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 or *whāngai*) who has been accepted before the age of 25 years as a *participant* on the *member's policy*.

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*.

General exclusion means a medical condition or service that is not covered for any *member* or *participant* on this type of *policy*.

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 *claim* 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.

Personal exclusion means a medical condition (current or previous) that is not covered for a particular *member* or *participant* under the *plan* for a period of time.

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*, and this *policy* document and any alterations.

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 health or medical condition that you are aware of or were experiencing signs or symptoms of prior to the *commencement* of your *policy*, or
- a medical *event* that occurred prior to the *commencement* of your *policy*.

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 conditions*.

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*. A *Whāngai* is considered a *dependant* under this *policy*.

We means *Accuro Health Insurance*.

accuro
HEALTH INSURANCE