

These are the Terms and Conditions governing the *Benefits* available to *Members of Accuro Health Insurance* and other *Participants* as described in the *Schedule of Benefits* and the *Constitution* of the Health Service Welfare Society Limited. *Accuro Health Insurance* is a trading name for the Health Service Welfare Society Limited (the *Society*). The Terms and Conditions should be read in conjunction with the *Schedule of Benefits*. The *Board of Directors* of the *Society* reserves the right at all times to vary these Terms and Conditions however it deems appropriate.

1. Membership

- 1.1 Membership is available to anyone (individual or group) who is accepted by *Accuro Health Insurance* for membership or permitted to become a *Member* under the *Constitution*.
- 1.2 A *Member* may apply to include a *partner* and/or *dependants*.
- 1.3 *Dependants* aged 25 years and over have premiums based on age and will automatically remain on the *Member's Plan* unless removal is requested.
- 1.4 *Dependants* aged 25 years and over who have been included in the *Member's Plan* may apply to have their own plan. If they do so within 30 days of leaving the *Member's Plan*, they will not be required to be underwritten.
- 1.5 *Partners* who have been included in the *Plan* of a deceased *Member* may retain Membership while they continue paying the appropriate *subscriptions*.
- 1.6 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 in a separate *Plan*.
- 1.7 A *Member* may contact *Accuro Health Insurance* requesting suspension of cover for the following reasons:
 - *Member* and/or *Participant* covered is travelling overseas for a period longer than two months (maximum length of suspension is 12 months); or
 - *Member* and/or *Participant* covered is taking maternity leave (maximum length of suspension is 12 months); or
 - *Member* and/or *Participant* covered is registered as unemployed for a period longer than two months (maximum length of suspension is six months); or
 - *Member* and/or *Participant* covered is made redundant and/or suffers financial hardship. This suspension is at the discretion of the Chief Executive Officer (maximum length of suspension is six months).

To be eligible for suspension the following conditions must be met:

- Request for suspension must be in writing;
- *Member* and/or *Participant* covered must have been covered by the policy for at least 12 continuous months up to the date the suspension is to take effect;
- For overseas travel *Accuro Health Insurance* will require evidence of departure (before suspending the *Member's policy*) and re-entry (before reinstating the *Member's policy*);

- *Member* and/or *Participant* covered must return to New Zealand within 12 months of the date the suspension started;
- Evidence of maternity leave must be provided before agreeing to a suspension of the *policy*;
- Evidence of registered unemployment must be provided before agreeing to a suspension of the *policy*;
- Evidence of redundancy must be provided for consideration by the Chief Executive Officer.
- Person covered must be continuously covered under this *policy* for a period of 12 months between the end of the last suspension and the commencement date of the next suspension.

Accuro Health Insurance will not pay any *benefits* under the *policy* in respect of any *event* occurring while cover is suspended.

2. Applications For Membership

- 2.1 All applications for Membership and subsequent alterations to a *Plan* must be made in writing by completing all sections of the *Accuro Health Insurance* application form.
- 2.2 Full details of the *Member* and all proposed *Participants* are required.
- 2.3 All previous medical history must be disclosed in the health declaration on the application form.
- 2.4 A new child is not automatically enrolled and the *Member* must apply in writing on an application form to have a new child included in the *Plan*. Four months free cover is provided for a first child added to the *Plan* at time of birth on the condition that the child must be continuously covered on the *policy* for a minimum of 24 months.
- 2.5 *Accuro Health Insurance* reserves the right to exclude any declared or non-declared health condition, or symptom of an existing or potential health condition from the *Plan*. This applies to the *Member* and any *Participant* at the time of application and/or during the life of the *policy*. All symptoms and conditions including *congenital conditions* must be disclosed at the time of application. Any such exclusion(s) will be clearly stated in the *Membership Certificate*.

3. Policy Purpose

Your *policy* is designed to assist you with meeting the financial costs associated with your health and wellbeing.

What your Policy Covers

Please refer to the *Schedule of Benefits* of the *Plan* relevant to your *Membership Certificate*.

4. Commencement of Membership and Cover Start Date

- 4.1 Membership commences from the date on the policy issued by *Accuro Health Insurance*.
- 4.2 On receipt of the confirmation of Membership from *Accuro Health Insurance* the *Member* has a free look period of 14 days in which the *Plan* may be declined. Any *subscriptions* paid will be refunded if the *Plan* is declined within the free look period, provided that during this period no *claim* has been made in respect of any person covered by this application.

5. Subscriptions

- 5.1 *Subscriptions* must be maintained to ensure continuity of Membership and eligibility for *benefits*.
- 5.2 *Claim* payments will be withheld when *subscriptions* are in arrears until the arrears are cleared. A *Member* shall not be deemed to be in arrears if payment is late only because of processing delay by the *Member's* employer.
- 5.3 Membership will be terminated when three months *subscriptions*, or more, remain unpaid.
- 5.4 *Accuro Health Insurance* reserves the right to deduct any outstanding *subscription* when making payment for an eligible *claim*.

6. The Prior Approval and Claims Procedure

A *Member* must seek prior approval for any *claim* that is likely to exceed \$1,000. Failure to do so will prejudice the ability to *claim* for the treatment costs at a later date. However, to ensure that the medical treatment or procedure is covered under the *Schedule of Benefits* of the *Member's Plan* it is recommended you contact us as soon as possible to check eligibility. You also need to provide estimated charges for your medical treatment or procedure. A minimum of five working days notice is required to give *Accuro Health Insurance* time to do any necessary checks and send out confirmation before the procedure takes place.

Subject to the terms of this *policy*, *Accuro Health Insurance* will pay all *reasonable and customary charges* for medically necessary treatment up to the relevant maximum cover. If the costs of the medical treatment or procedure exceed the maximum cover or the *reasonable and customary charges*, the difference will be the *Member's* responsibility.

- 6.1 *Claims* will only be accepted for costs relating to events that occur after the cover start date. For *Primary Plans* *claims* will be accepted after the *no claim period* has passed.
- 6.2 *Claims* will not be paid when *subscriptions* are in arrears, or when Membership has ceased for any reason, irrespective of the date of an *event*.
- 6.3 All *claims* must be received by *Accuro Health Insurance* within 12 months of the date of an *event*. *Claims* made outside the 12 month *claim* period will be declined.
- 6.4 Visits to a medical specialist must be referred by a general practitioner or dentist. A copy of the referral letter must be attached to the *claim* form.
- 6.5 The *Member* will upon request from *Accuro Health Insurance* supply *medical evidence* before *Accuro Health Insurance* agrees to pay any *benefits*. This right of request applies from the prior approval process to the completion of treatment.

On *Accuro Health Insurance's* request the *Member* will also supply *medical evidence* after the medical treatment has been concluded. Medical treatment includes application for diagnostic or screening procedures. Any costs involved in obtaining the above information will be at the *Member's* expense.

- 6.6 Payment is limited to the lesser of the *benefit* levels, or the usual, *reasonable and customary charges* for any approved procedure at the time as solely determined by *Accuro Health Insurance*. This means *Accuro Health Insurance* may negotiate with your nominated service provider, or recommend alternative service providers if the estimated cost received from your chosen provider(s) is above the usual, reasonable and customary levels.
- 6.7 *Benefits* are calculated on the net amount paid after deducting any refunds, subsidies, or entitlements available from other sources for example (without limitation) ACC, other health insurer, government health funder, Work and Income, employer.
- 6.8 No *Member* and/or *Participant* shall receive a *benefit* which, together with any other refunds, subsidies, or entitlements, amounts to more than 100 per cent of the actual costs incurred for any *event*.
- 6.9 Where relevant, the minimum or maximum amount that may be claimed for each *event* is set out in the *Schedule of Benefits*.
- 6.10 A *Member* may request *Accuro Health Insurance* to pay *hospital* and related accounts on his or her behalf, if prior approval has been sought and obtained before entering *hospital*.
- 6.11 *Claims* for *benefits*, as listed in the *Schedule of Benefits*, must be made on the *Accuro Health Insurance claim* form (relevant only for *Primary Plans*). Original receipted accounts only are acceptable in support of *claims*. Photocopies do not qualify unless they have been sent to another source for claiming and the other source must be identified. Together with the photocopies please return remittance advice to *Accuro Health Insurance*.
- 6.12 The minimum *claim* (relevant only for *Primary Plans*) is an aggregation of receipts totalling \$100.
- 6.13 Prescription drugs must be listed on the *PHARMAC schedule* and the *Member* must be eligible to meet *PHARMAC's* funding criteria.
- 6.14 *Claims* may be subject to processing charges as described in the *Schedule of Benefits* relevant to the *Member's Plan(s)*.

7. Claims on Other Insurers

Where another insurer, including but not limited to ACC, may have responsibility in respect of a *claim* the following provisions apply:

- It is the *Member's* responsibility to advise *Accuro Health Insurance* that another insurer is involved in a *claim* that has been submitted to *Accuro Health Insurance*.
- Before *Accuro Health Insurance* accepts a *claim* under this *policy*, the *Member* must firstly make a *claim* to the other insurers for any expense recoverable from a third

party or under any contract of indemnity or insurance. Any expenses recoverable in this way will be deducted from the reimbursement provided by *Accuro Health Insurance* under this *policy*. For the purposes of this *policy*, ACC is defined as another insurer.

For Claims Involving ACC:

Special conditions apply to surgery or treatment covered by ACC. Under the ACC legislation, the *Member* can choose between full payment option (where a provider is fully contracted by ACC to provide your procedure at no cost to you) or partial payment option (where a provider requests elective treatment for you and either does not have a contract with ACC to provide elective services treatment or is a contracted provider who requests elective treatment for you but that treatment is outside the terms of their contract. Under this option, ACC will only partially fund the elective treatment). The full payment option should be the *Member's* first choice as the *Member* will not have to make any contribution towards surgery costs. By comparison, under the partial payment option the *Member* will have to make a contribution towards the cost of the healthcare services.

- 7.1 It is the *Member's* responsibility to submit all *claims* to ACC in the first instance. Where surgery is indicated, the *Member* must seek or obtain prior approval from ACC for *private hospital* costs.
- 7.2 If, due to the *Member's* failure to comply with ACC's requirements, and ACC refuses to cover the *claim* or ceases *claim* cover, the *Member* will be deemed by *Accuro Health Insurance* to not have made a reasonable effort to secure cover or maintain cover and will therefore be ineligible to *claim* under this *policy*.
- 7.3 If ACC declines ACC cover or declines to pay in full for *private hospital* surgery, treatment or any other relevant entitlement, for whatever reason, *Accuro Health Insurance* reserves the right to insist that the *Member* or *Participant* applies to ACC for a review of that decision before *Accuro Health Insurance* accepts any *claim*. The *Member* must co-operate fully with *Accuro Health Insurance* in pursuing the review or appeal. Where ACC reverses a decision for a previously declined *claim*, *Accuro Health Insurance* reserves the right to seek reimbursement from ACC or the *Member* for any related *claims* paid by *Accuro Health Insurance*.
- 7.4 Where ACC agrees to contribute to the *Member's* *private hospital* costs, *Accuro Health Insurance* will cover the difference in cost between the ACC contribution and the usual *reasonable and customary charges* or as specified in the *Schedule of Benefits*. Copies of appropriate acceptance documentation from ACC must be provided to *Accuro Health Insurance* prior to *Accuro Health Insurance* acceptance of the procedure.

8. Termination of Membership

- 8.1 A *Member* may terminate Membership at any time upon giving notice in writing to *Accuro Health Insurance*.
- 8.2 A *Member* wishing to remove a *Participant* from the *Member's* *Plan* must advise *Accuro Health Insurance* in writing.
- 8.3 *Accuro Health Insurance* will acknowledge all requests for termination of Membership on receipt of the written request.
- 8.4 *Subscriptions* received in good faith may be retained by the *Society* irrespective of the date of termination of Membership.
- 8.5 Membership will not be reinstated following the termination. This does not prevent a *Member* from applying to rejoin at a later date but a new application must be made on the *Accuro Health Insurance* application form.

9. Other Important Information Governing the Policy

- 9.1 Untrue statements - any information the *Member* gives *Accuro Health Insurance*, or which is given to *Accuro Health Insurance* on the *Member's* behalf, when making a *claim* must be true, correct and complete. If any information given to *Accuro Health Insurance* is untrue, or incorrect, or incomplete;
 - or if the *Member* or *Participant*, or *Member's* doctor(s), or *Participant's* doctor(s) or others have not told *Accuro Health Insurance* about anything else that the *Member* or they know;
 - or a reasonable person in the circumstances would be expected to know it was relevant to *Accuro Health Insurance's* decision to accept a *claim*;in these instances *Accuro Health Insurance* may not pay a *claim* and *Accuro Health Insurance* may void all or part of the policy, or cancel it. If *Accuro Health Insurance* has already paid the claim, it can recover from the *Member* the amounts paid.
- 9.2 All *Members* are bound by and subject to the *Constitution* and the Terms and Conditions and *Schedule of Benefits* of *Accuro Health Insurance*.
- 9.3 The *Constitution* may change from time to time in accordance with the powers of amendment it contains.
- 9.4 A copy of the current *Constitution* is available from the *Society* on application.
- 9.5 The Terms and Conditions of Membership and the *Schedule of Benefits* are subject to change in accordance with prevailing conditions and at the discretion of the *Board*. *Accuro Health Insurance* will endeavour to provide reasonable notice (minimum three months) prior to such change.
- 9.6 *Accuro Health Insurance* reserves the right to review and adjust *subscriptions* at its discretion to ensure the viability of any *Plan*, or grouping of *Members* and/or *Participants* within a *Plan*. *Accuro Health Insurance* will endeavour to provide reasonable notice (minimum 21 days) prior to such change.
- 9.7 In all matters that require interpretation, the *Board's* decision shall be final.

10. Complaints

Accuro Health Insurance aims to provide all *Members* with efficient and courteous service. In the event that a *Member* is unhappy with our service or a decision in respect to a *claim*, the *Member* should write in the first instance to:

The Claims Manager
Accuro Health Insurance
P O Box 10075
Wellington 6143

Accuro will investigate and reply to you as soon as practically possible. If you are unhappy with the response from the Claims Manager, then write to the Chief Executive Officer at the same address. The Chief Executive Officer will respond to you as soon as practically possible.

After a *Member* has followed *Accuro Health Insurance's* internal process outlined above, if your complaint relates to a *claim* and deadlock has been reached, you can write to the Insurance and Savings Ombudsman 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 original complaint.

You can obtain more information on the Ombudsman from the website www.iombudsman.org.nz.

The Ombudsman's address is:
Insurance and Savings Ombudsman
P O Box 10845
Wellington 6143

11. Industry Standards

Accuro Health Insurance is a member of the Health Funds Association of New Zealand and the Insurance and Savings Ombudsman scheme. We are bound by the Code of Practice as laid down by the Health Funds Association of New Zealand.

Under the Insurance Companies Act 1994, *Accuro Health Insurance* is not required to have a rating because it provides health insurance only and accordingly has elected not to be rated.

12. Legal

12.1 The *Society* conducts all its business in accordance with the laws of New Zealand.

12.2 All currency quoted in all of the *Society's* material is in New Zealand dollars. All *benefits* and *subscriptions* are GST inclusive.

12.3 The rights and obligations of the *Member* and the *Society* are set out in the composite set comprising:

Item 1: The individual *Member's* Application Form and all material provided by, or on behalf of the *Member* in support of the application.

Item 2: The individual *Member's* *Membership Certificate*.

Item 3: The terms of the *Plan* as specified in the *Schedule of Benefits* and current at the time of *claim*.

Item 4: General Policy Terms and Conditions current at the time of *claim*.

Item 5: The *Constitution*.

12.4 A *Member* can obtain a copy of the *Constitution* of *Accuro Health Insurance* by calling 0800 222 876.

13. Exclusions

No *claim* will be accepted for, or in association with, the following conditions, or events unless specifically provided for in the *Accuro Health Insurance Schedule of Benefits*;

- 13.1 General practitioners fees, drugs and medication;
- 13.2 Conditions that to the knowledge of the *Member* existed prior to the start of eligibility for benefits, unless declared in *Member's* application and accepted by *Accuro Health Insurance*, including a known *congenital condition*;
- 13.3 *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;
- 13.4 *Surgery* or laser treatment for the correction of visual errors, astigmatism; surgically implanted intraocular lens(es);
- 13.5 Breast reduction and gynaecomastia;
- 13.6 Medical mishap, or misadventure;
- 13.7 Chelation therapy, or similar treatment as defined by *Accuro Health Insurance*;
- 13.8 Sclerotherapy treatment unless the vascular condition is at the stage of requiring surgical treatment and a Specialist Vascular Surgeon advises that sclerotherapy is a viable alternative treatment to a surgical intervention; Sclerotherapy/Endovenous laser therapy.
- 13.9 A condition in connection with the use of non-prescription drugs;
- 13.10 Palliative care;
- 13.11 Contraception of any kind; treatment, or diagnosis of infertility; all the normal effects of pregnancy, childbirth, or abortion; (this exclusion is only relevant to Basic, Advanced, Value Plus, Major Medical and Real Value *Plan*);
- 13.12 Contraception of any kind; treatment, or diagnosis of infertility; pregnancy, childbirth or abortion; (this exclusion is only relevant to SmartCare range of *Plans*);
- 13.13 Dental care; orthodontic, endodontic, orthognathic and periodontal treatment;
- 13.14 Psychiatric and/or psychological treatment or counselling; pre-senile dementia, senile illness or dementia, geriatric care including geriatric hospitalisation;
- 13.15 *Any long term care*;
- 13.16 Any health condition as a consequence of war, invasion, act of foreign enemy, terrorist insurrection, hostilities (whether war is declared or not), civil war, rebellion, revolution, military, or usurped power;
- 13.17 *Preventative healthcare treatments and services*, maintenance, and/or health surveillance testing; employment-related examinations, or screening; vaccination against any disease, or condition; convalescence; or any expense where there are no symptoms, or evidence of a condition detrimental to health;
- 13.18 AIDS, or HIV infection, or any condition arising from the presence of AIDS, or HIV infection; sexually transmitted diseases;

- 13.19 Charges for a treatment or procedure not provided by a registered medical practitioner practicing within his or her scope of practice;
- 13.20 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 implant, penile implant; surgical, or medical appliances, for example (without limitation) glucometers, oxygen machines, respiratory machines, diabetic monitoring equipment, blood pressure monitoring equipment and/or any personal incidental expenses incurred whilst in hospital for example (without limitation) use of phone, family meals, soft drinks or alcoholic beverages etc;
- 13.21 Any expense recoverable from a third party under any contract of indemnity or insurance, or any statutory scheme, or any government funded scheme/agent;
- 13.22 Any medical costs incurred outside New Zealand;
- 13.23 Any investigation and/or treatment for sleep disturbances, snoring, or obstructive sleep apnoea;
- 13.24 Any *acute care*;
- 13.25 Disability, or illness arising from misuse of alcohol, or drugs; participation in a criminal act; intentional self-injury or attempted suicide;
- 13.26 Specialised transfusion of blood, blood products, treatment for renal failure and renal dialysis as provided by government funded agencies, organ donation and receipt;
- 13.27 Specialised tertiary treatments such as heart, lung, kidney, liver and bone marrow transplants as provided by government funded agencies;
- 13.28 Chronic conditions, includes but not limited to Marfan's Syndrome, Cystic Fibrosis, Spina Bifida, Polycystic Kidney Disease, Kyphoscoliosis and Pectus Excavatum;
- 13.29 Radial keratotomy or photo-reactive keratectomy or any related complications;
- 13.30 Circumcision, except where medically necessary;
- 13.31 Avian Influenza infection or any condition arising from the presence of Avian Influenza infection or any other nominated pandemic;
- 13.32 New medical treatments, procedures and technologies that have not been approved by *Accuro Health Insurance*;
- 13.33 Any costs not specifically provided for under a benefit section contained in the *Plan*;
- 13.34 Additional surgery performed during any operation, which is not directly related to any medical condition or treatment covered under the terms of this *policy*.

Glossary of Key Terms

Words printed in ***italics*** are key terms as defined in this glossary.

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

ACC means the Accident Compensation Corporation of New Zealand.

Accident means an accident as defined in the Injury Prevention, Rehabilitation and Compensation Insurance Act 2001.

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.

Benefits mean the reimbursements available for Members for specific types of expenses and specified in the Schedule of Benefits 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 the Schedule of Benefits appropriate to the Member's chosen Plan and for which the Member is eligible.

Commencement means the date on which Membership begins, as specified in the Membership Certificate.

Congenital Condition(s) means condition(s) which are present at birth as a congenital anomaly or diagnosed as congenital prior to application for Accuro Health Insurance Membership.

Constitution means the Rules of the Society in force from time to time.

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 stepchildren or adopted children) who has been accepted as a Participant in the Member's Plan.

Event means (without limitation) the date of birth, death, visit, consultation, test, surgery, repair, treatment, supply of 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 the Schedule of Benefits, or which may be made at the discretion of Accuro Health Insurance.

Hospital means either a hospital or licensed hospital as defined in the Hospital Act 1957, or any amendments. It does not include 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 ongoing 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.

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 subscriptions 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.

No Claim Period means the period of three months after the commencement date, or in the case of a Participant added to a Plan, three months after the date on which that Participant is added, during which events are not claimable.

Participant means partner, or dependant accepted by Accuro Health Insurance who is named on the Member's Membership Certificate and for whom subscriptions are current at the time of application for any benefit.

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

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

Plan means a specified range of Accuro Health Insurance benefits described in the Schedule of Benefits.

Policy means your contract with Accuro Health Insurance and includes the Membership Certificate, General Policy Terms and Conditions and the Schedule of Benefits applicable to your chosen Plan.

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 is from anniversary date to anniversary date.

Pre-existing Condition means any sign, symptom, health condition or health event that occurred or existed prior to the commencement date of the policy.

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.

Primary Plans means (without limitation) Basic, Advanced, Value Plus, SmartCare 3, SmartCare 4 and SmartCare 5 Plans.

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.

Procedure and/or Medical Treatment means a particular course of action(s) required to manage a health condition, including and not limited to diagnosis, medical screening, surgical process, therapeutics or rehabilitation.

Prosthesis means 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 are 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 practicing certificate issued by the Medical Council of New Zealand and practicing as a medical practitioner in New Zealand.

Registered Medical Specialist means a health provider who is a member or Fellow of an appropriately recognised specialist medical college and must have Medical Council of New Zealand registration and current annual practicing certificate in that specialty.

Schedule of Benefits means the list and terms of benefits current at the time when a member lodges a claim.

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

Subscription means the amount paid to Accuro Health Insurance by or on behalf of a Member to maintain Membership and eligibility for benefits.

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

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Accuro Health Insurance is the trading name for
The Health Service Welfare Society Limited which is
incorporated under the Industrial and Provident Societies Act 1908