Basic Plan
Advanced Plan

accuro HEALTH INSURANCE

Claims year from the 1 April to 31 March

Maximum aggregated refund per year for all benefits on the plan (excluding Specialist benefits and grants)	Basic plan $2,000	Advanced plan $2,500

Standard benefits	Basic plan 50% refund up to:	Advanced plan 80% refund up to:
Registered medical practitioner or **registered nurse consultations** - including laboratory fees for tests.	$30 per visit	$38 per visit
Registered medical specialist consultations. A referral letter is required.	$125 first visit $50 follow-up visit	$150 first visit $65 follow-up visit
Mental health consultations – covers the costs of registered psychiatric, psychologist or counsellor consultations.	$1,000 per year	$1,000 per year
Prescription drugs – medicines listed under section A to I of the PHARMAC Schedule (excluding section H) that are prescribed by a registered medical practitioner or designated prescriber nurse.	$20 per item	$25 per item
Physiotherapy treatment (materials not covered) by a registered physiotherapist.	$80 first visit $40 follow-up visit	$100 first visit $50 follow-up visit
Imaging – X-ray and image intensifiers (by a registered radiologist), ultrasound, scintigraphy, CAT or MRI scan. A referral letter is required.	$625 per event	$700 per event
Private hospital fees, including surgical, medical, ambulance and minor surgery at a surgical clinic. A referral letter is required.	$850 per event	$1,000 per event

Special benefits and grants	Basic plan 100% refund up to:	Advanced plan 100% refund up to:
Sick leave without pay Member or partner (who is covered by the plan) may claim. Before you are eligible to claim under this benefit, you will need to be sick for at least five consecutive working days and have exhausted your sick leave entitlement at your current employment. A medical certificate and written confirmation that there is no sick leave with pay left from your employer are required to support every claim.	$100 per week, to a maximum of $400 per year	$100 per week, to a maximum of $400 per year
Funeral support Grant payable on the death of any participant into the bank account of the deceased participant's estate. A copy of the full death certificate and proof of the executor, administrator or solicitor acting for the estate must be provided.	$1,500	$1,500
Birth Benefit is payable after the member has contributed continuously for 12 months prior to the birth. One grant is claimable on the birth, adoption or stillbirth of a child to a member or partner on the plan. Members aged 24 years or younger do not qualify for this benefit. A copy of the full birth certificate to clearly identify parents must be provided. Adoption of a participant's child from a previous relationship does not qualify.	$400 per birth	$400 per birth
Home support Member or partner (who is covered by the plan) may claim $20 per day up to $100 per week. A medical certificate and written confirmation of payment to the domestic assistance supplier is required. Payable where daily domestic assistance is essential after illness or accident.	$20 per day, up to $100 per week, to a maximum of $400 per year	$20 per day, up to per week, to a maximum of $400 per year
Hospital cover excess – refund Excess refundable only if a member or participant has Tower Hospital Cover plan, NZNO Real Value plan (RVP) or Major Medical plan (MMP).	$500 per member per year	$500 per member per year

Other benefits	**Basic plan** 50% refund up to:	**Advanced plan** 80% refund up to:
Podiatry treatment By a registered podiatrist (materials not covered). Orthotics are not covered.	$100 per year	$125 per year
Chiropractic treatment By a registered chiropractor (materials not covered).	$100 per year	$125 per year
Acupuncture treatment By a registered acupuncturist (materials not covered).	$100 per year	$125 per year
Osteopath treatment By a registered osteopath (materials not covered).	$100 per year	$125 per year
Traditional Chinese medicine Includes treatment and consultations provided by a registered Chinese Medicine practitioner (materials or supplements not covered).	$100 per year	$125 per year
Natural therapies treatment Provided by naturopaths, homoeopaths, herbalists and remedial body therapists. Covers the cost of consultations performed by New Zealand health practitioners or New Zealand registered medical practitioners with a current annual practising certificate who are registered members of their professional bodies (materials not covered).	$100 per year	$125 per year
Health surveillance tests Mammogram, smear test, mole mapping and prostate check only.	$100 per year	$125 per year
Hearing aids Repair and/or purchase of hearing aids through a registered audiologist.	$250 per year	$312 per year
Orthodontic Corrective orthodontic appliances when an orthodontic plate or brace has been fitted by a registered orthodontic specialist to a participant under 25 years of age.	$300 per year Maximum of $900 per event	$375 per year Maximum of $1,125 per event
Oral surgery Surgery/consultation performed by a registered oral surgeon including the removal of impacted wisdom teeth. A referral letter or written confirmation of the status of teeth from the oral surgeon is required. (Other extractions, conservation dentistry, periodontic treatment, root canal and normal repair to teeth are excluded.)	$500 per year	$650 per year
Denture Repair by or purchase of dental plates from a registered dental technician or registered dental surgeon.	$100 per year	$125 per year
Occupational therapy By an occupational therapist holding a current annual practising certificate.	$100 per year	$125 per year
Optical This benefit is only payable when glasses or contact lenses are purchased. A certified account that details charges for the cost of lenses, frames and so on is required. There is no refund for a consultation, examination, case, sundry charges, or contact lenses or glasses purchased outside New Zealand.	$200 per year	$250 per year

General information

Acceptance into the Basic plan or Advanced plan entitles a member or participant to full cover as described in this schedule of benefits and in accordance with any special conditions stated in the policy certificate issued at the time of acceptance. Membership commences from the date listed on your policy certificate and for which the first premium is received for by Accuro.

On receipt of the confirmation of membership from Accuro, you have a free-look period of 14 days in which the plan may be cancelled. Any premiums paid will be refunded if the plan is cancelled within the free-look period, provided that, during this period, no claim has been made in respect of any person covered by this application. All benefits described in this schedule of benefits are subject to the provisions described in the general policy terms and conditions of Accuro as amended from time to time and should be read in conjunction with your policy certificate

UniMed

Accuro is a brand owned, operated and underwritten by Union Medical Benefits Society Limited (UniMed). UniMed is the trading name for the Union Medical Health Benefits Society Limited, which is incorporated under the Industrial and Provident Societies Act 1908. Like all societies, it has rules that will bind you. The rules govern the way the Society is run and the health benefit plans it administers. The rules are subject to change. If you want a copy of the current rules before making your application, please feel free to ask us for a copy.

Accident, treatment injuries or employment-related conditions

Accidental injury can happen at any time. In New Zealand, the Accident Compensation Corporation (ACC) covers accidents, treatment injuries and employment-related injuries, amongst other situations. Prior to any treatment costs being incurred, ACC must have first been approached and a copy of their letter of acceptance, in full or part, or declination provided to UniMed. In instances where ACC has declined a claim or only accepted part payment for injury, UniMed will, at its sole discretion, either assist with full or part payment if the treatment is covered under the plan or require the participant to apply for a review and, if necessary, an appeal of the decision.

Cover start date

The Basic plan and Advanced plan has a 90-day stand down period. This 90-day period applies to participants added to this plan, and claims cannot be made for any event for a member or participant within the 90-day time period after their start date on this plan. The member or participant's start date will be listed on the policy certificate.

Six months' free cover for children

A dependant who is under 6 months of age is eligible to receive cover free of premiums for the first 6 months after birth. We will charge the relevant premium once the child has reached 6 months of age. Exclusions listed under Accuro's general policy terms and conditions will still apply.

General exclusions

Some situations are not covered (unless specifically provided for in the Basic and Advanced plan schedule of benefits), for example (without limitation), general practitioners' fees; drugs and medication; cosmetic procedures and/or other enhancement/ appearance medicine; medical mishap; palliative care; contraception of any kind; dental care; orthodontic, endodontic, orthognathic and periodontal treatment; psychiatric and/or psychological treatment or counselling; disability or illness arising from the misuse of alcohol or drugs; preventative healthcare treatments and services; AIDS or HIV infection; any expense recoverable from a third party under any contract of indemnity or insurance; any acute care; breast reduction; chelation therapy; long-term care; surgery or laser treatment for the correction of visual errors and astigmatism; personal health-related appliances; any medical cost incurred outside New Zealand; and any cost not specifically provided for under a benefit section contained in the plan selected. Exclusions are subject to change. For a full list of exclusions, please see Accuro's general policy terms and conditions.

Prescription drugs

Prescription drugs must be listed under section A to I of the PHARMAC Schedule, however any drugs listed under section H of the PHARMAC Schedule will only be covered if used during a procedure in a private facility. The member or participant must also be eligible to meet PHARMAC's funding criteria.

Waiver of premium

If the main member or partner (who is covered under this plan) dies, we will continue to provide cover for the member-paid premium for the remaining participants covered under this plan for 12 months. Other terms:

- Once notified, the waiver of premium will start from the date of death
- Any changes made to your policy during the waiver of premium like the addition of a new member or increase in cover will not be eligible for the waiver of premium
- Once the waiver of premium benefit ends, the premium for all remaining participants will be the responsibility of the policy's main member to pay

Appropriate certificates and documentation must be provided.

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