Real Value Plan

accuro HEALTH INSURANCE

Standard benefits

General surgery in an accredited private hospital - excess applies

This benefit covers the costs of reasonable and customary charges up to a maximum of $150,000 per claim for the surgical treatment of a non-acute medical condition. A claim is the aggregation of all costs associated with the initial procedure and all subsequent eligible treatment or expenses. The benefit covers the procedure(s) and all subsequent 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
- Surgeon's fees
- Anaesthetist's fees
- Costs of essential prostheses listed in the Accuro schedule
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist benefit below provided they occur within six months of the approved surgery.

All costs must be associated with the original diagnosis, including any complications of the initial surgery. This benefit also includes diagnostic surgeries such as a hysteroscopy, cystoscopy, laparoscopy, culdoscopy and arthroscopy.

Oncology consultations and treatment following surgery are covered under the private hospital medical admission benefit.

This benefit includes:

Major diagnostic procedures

This benefit covers the costs of reasonable and customary charges of diagnostic procedures for angiograms, MRI scans, CT scans, CAT scans, MP scans, PET scans, and myelograms (if general anaesthetic is required), whether or not you're admitted to a private hospital.

Breast reconstruction

This benefit covers the costs of a breast reconstruction of the affected breast only after a mastectomy for the treatment of breast cancer. The reconstruction of the affected breast must occur within 24 months after a mastectomy that we've approved under this plan.

Breast symmetry

This benefit covers the costs of unilateral breast reduction surgery on the unaffected breast in order to achieve breast symmetry after a mastectomy for the treatment of breast cancer. The reduction of the unaffected breast must occur within 24 months after a mastectomy that we've approved under this plan.

Prophylactic surgery - excess applies

This benefit covers up to $60,000 for each person for the costs of prophylactic (preventative) surgery if you have an increased risk of developing cancer because of a high risk status or gene mutation. You can claim this benefit as many times as you need to but it only provides cover up to $60,000 for each person over the lifetime of the policy.

To claim under this benefit, you must meet the requirements listed in the eligibility criteria for Prophylactic surgery.

Specialist – consultations, tests and related costs - excess applies

This benefit covers the costs of reasonable and customary charges up to an aggregated total of $5,000 per person per policy year for specialist consultations, diagnostic tests and investigative procedures provided these are not for preventative and/or screening purposes.

A registered medical specialist must be a member or fellow of the appropriate college of specialists, have Medical Council of New Zealand registration and a current practising certificate for the code of medicine for which the member or participant is being treated.

Where any of these costs relate to or result in a surgical event eligible for cover under the general surgery benefit, they will be included in the aggregated costs of the operation.

This benefit includes:

Diagnostic tests and investigations to a maximum of $4,000 per event.

Diagnostic tests include:

- Allergy testing
- Audiometric tests
- Electrocardiogram (ECG)
- Electromyography (EMG)
- Exercise ECG
- Nuclear scanning
- Urodynamic assessment
- Audiology
- Colposcopy
- Electroencephalography (EEG)
- Endoscopic examinations such as gastroscopy, colonoscopy or cystoscopy
- Mammography
- Ultrasound
- X-ray

Mental health consultations

$1,000 per person per policy year.

This benefit covers the costs of reasonable and customary charges for consultations with a psychiatrist, psychologist or counsellor when a registered medical practitioner refers you.

They must refer you to a medical professional who is registered either under the psychiatry scope with the Medical Council of New Zealand, as a psychologist with the New Zealand Psychologists Board, or as a counsellor with the New Zealand Association of Counsellors.

Private hospital medical admission - excess applies

This benefit covers the costs of reasonable and customary charges associated with admission to a private hospital for reasons other than surgery up to a maximum of $100,000 per person per policy year. Non-surgical cancer treatment is covered to a maximum of $60,000 per person per policy year.

Admissions do not cover convalescence, recovery, obstetrics or psychiatric and/or psychological treatment or counselling, geriatric, senile and recurrent or on-going health conditions.

Please note that any palliative care treatment is not covered as per Accuro's general terms and conditions.

Minor surgery - excess applies

This benefit covers up to a maximum of $200 per event (consultations and materials are not covered) when performed by a New Zealand registered medical practitioner in private practice. The invoice must clearly indicate the procedure.

Public hospital benefit

This benefit provides $100 per night up to a maximum of $500 per person per policy year for any public hospital stay of a member or participant for three or more consecutive nights. The benefit does not apply to a private fee-paying patient in a public hospital or private wing of a public hospital.

Overseas treatment - excess applies

This benefit covers reimbursement up to $20,000 per person per policy year of reasonable and customary charges for a surgical procedure/treatment performed at an overseas hospital and travel to and from, where the procedure isn't available in New Zealand.

To qualify for this benefit , the member or participant must:

- be in New Zealand when they are diagnosis and they must not have started an appropriate medical process in New Zealand
- request a surgical procedure or treatment that is medically necessary and is not experimental or being trialled
- get the surgical procedure or treatment pre-approved by us
- make sure the procedure meets all plan criteria including being subject to all excess, reasonable and customary charges, maximums and exclusions described elsewhere in this plan or under the general terms and conditions.

A New Zealand-registered medical specialist must provide us with written confirmation that the surgical procedure or medical treatment is necessary and no similar treatment is available in New Zealand. Please also provide the invoices and receipts for travel.

Oral surgery - excess applies

This benefit covers the costs of reasonable and customary charges up to $150,000 per person per policy year for oral or maxillofacial surgery listed below:

- Surgical removal of impacted or unerupted teeth carried out after a member or participant has been covered by the plan for at least 12 months.
- Surgical removal of cysts, soft tissue swellings and other medical (not dental) problems of the mouth that require major surgical intervention.
- Surgical drainage of abscesses.
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist benefit provided they occur within six months of the approved surgery.

This benefit does not cover orthodontic, periodontal, orthognathic or endodontic treatment, as well as crowns, dental plates, root canals, other extractions, tooth exposures or implants.

You must be treated by a New Zealand-registered oral or maxillofacial specialist, in an accredited private hospital or clinic. A New Zealand-registered medical practitioner, dental surgeon, or dentist must refer you or the participant on your policy.

A registered oral surgeon or registered dentist must perform the surgical removal of unerupted and impacted teeth. They must write to us to confirm the status of the impacted or unerupted teeth.

Sterilisation - excess applies

After three years of continuous cover this benefit will cover reimbursement up to a maximum of $3,000 per person per policy year towards the cost of reasonable and customary charges for a sterilisation procedure carried out on a member or participant, where the procedure is necessary in the interest of the physical health of that member or participant.

This procedure must be recommended by a registered medical specialist.

Travel expenses

This benefit covers travel expenses as described below if required and is included in the aggregation for the maximum benefit limit. These costs must directly relate to a private hospitalisation under this plan. Pre-operative and post-operative consultations/treatments do not qualify. Payment will be made by reimbursement on evidence of expenses.

- **Ambulance transfer**
  Where an air or road ambulance transfer to or from a private or public hospital within New Zealand has been authorised by a registered medical specialist, we will reimburse the cost provided the original admission to hospital as a private fee-paying patient was pre-approved by UniMed.
- **Transport costs**
  If the condition cannot be treated locally and the member or participant is required to travel by air, road or rail, we will pay either return public transport costs (economy airfares, bus fares or train fares) or return road travel to the place of hospitalisation within New Zealand. The refund for road travel is calculated on the mileage travelled at $0.30 per km. In addition, a taxi fare from the airport/station to the private hospital and return for the member or participant if required, is also covered.
- **Support person travel and accommodation costs**
  In the above circumstances where the condition cannot be treated locally, similar travel costs will be available for a support person, if this is recommended by a registered specialist, plus accommodation costs not exceeding $100 per night for up to five nights or the period the participant is in hospital, whichever is shorter.

Special benefits and grants - 100% refund

- ### Sick leave without pay benefit
  $100 per week to a maximum of $600 per policy year
  Before you are eligible to claim under this benefit, you (the member) would need to be sick for 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 valid sick leave with pay left from your employer are required to support every claim.
- ### Funeral support grant
  $2,500 payment
  We will pay a funeral support grant on the death of any participant covered under the plan 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.
- ### Birth grant
  $400 payment
  We will pay a birth grant 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 participant 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 parent(s) must be provided. Adoption of a member's child from a previous relationship does not qualify.
- ### Home support benefit
  Up to $100 per week to a maximum of $600 per policy year
  The member or participant may claim $20 per day up to $100 per week. A medical certificate and confirmation of payment to the domestic assistance supplier is required. The benefit is payable where daily domestic assistance is essential after illness or accident.

Active benefits

Active Benefits allow you to use your insurance not just for treatment but to maintain good health. These benefits include screening procedures and access to expert independent advice.

No personal exclusions or excess applies to these benefits; however, some benefits have conditions about when they can be claimed, so please read the conditions carefully.

For further information and other Active Benefits, please visit our website www.accuro.co.nz/active-benefits

Accuro Virtual Clinic

The Virtual Clinic, powered by Teladoc, is an independent and confidential service that gives you access to over 50,000 of the world's leading medical specialists from the comfort of your own home. Accuro will never see any of your communication with or results from the Virtual Clinic unless you choose to send it to us.

If you or any participant on your policy has been diagnosed with an illness, injury or medical condition and would like a second opinion, they can contact the Virtual Clinic, at no cost, to review their diagnosis and treatment plan.

Services available:

- **Expert Medical Opinion**
  This service allows you to get an independent, expert medical review for your illness, injury, or medical condition, including a treatment plan. The review is designed for you to share with your treating doctor, to provide certainty and reassurance that you're on the right treatment pathway.
- **Ask a GP**
  Submit a question to an experienced NZ GP. The GP answers your question, with any relevant supporting information, and emails the response to your inbox.

For more information and details on how to register for the Virtual Clinic, visit the Active Benefits section of our website or call the Virtual Clinic on 0800 425 005.

Mental Health Assist

Mental Health Assist, powered by Teladoc, was launched in New Zealand to offer support and guidance when dealing with a mental health issue.

The service will connect you to a team of health professionals including a nurse, psychologist and psychiatrist. This team will review your condition, make a diagnosis or review an existing diagnosis and treatment plan and make recommendations for future steps. The mental health nurse will continue to support you once you have completed the process.

You can expect a consultation within 10 days.

This benefit is currently only available to members 18 years and older.

For more information and details on how to register for Mental Health Assist, visit the Active Benefits section of our website or call the Virtual Clinic on 0800 425 005.

Loyalty benefit – GP 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 (GP).

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

Loyalty benefit – melanoma

$200 per person every three policy years.

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

Loyalty benefit – bowel screening

A bowel screening kit per person, every three continuous policy years.

After 3 years of continuous cover, this benefit covers the cost of a Bowel screening kit. Please contact us if you wish to redeem this benefit and we'll arrange for a kit to be sent to you.

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

General information

Acceptance into the Real Value plan entitles a participant to full cover as described in this schedule of benefits, less the specified excess and in accordance with any special conditions stated in the policy certificate issued at the time of acceptance. Membership commences from the date on which the first subscription is received by UniMed.

- All claims are subject to an excess of 20% of costs to a maximum of the plan excess per participant per policy year.
- All claims and pre-approvals are based on reasonable and customary charges for the services provided.

On receipt of the confirmation of membership from UniMed, 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 Accuro general policy terms and conditions 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.

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.

Pre-existing health conditions

Only pre-existing health conditions that have been declared on the application form and accepted by UniMed will be covered.

General exclusions

Some situations are not covered (unless specifically provided for in the Real Value 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.

Procedure for pre-approval

Pre-approval is required for any event over $1,000 or where the procedure and/or medical treatment involves any hospitalisation, day-stay or in-patient care regardless of the cost. Failure to do so will prejudice the ability to claim for the treatment costs at a later date.

A minimum of two working days' notice is required to

give UniMed time to do any necessary checks and send out confirmation before the procedure and/or medical treatment takes place. However,to ensure that the procedure and/or medical treatment 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.

We will pay your account(s) directly to the provider. All claims and pre-approvals are based on reasonable and customary charges for the services provided.

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 payments for all remaining participants will be the responsibility of the policy's main member

Appropriate certificates and documentation must be provided.

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