Accuro Policy and Premium changes

September 2022

Health Insurance premiums generally go up annually due to a number of factors such as the increasing age of members on the policy and the rising claim costs that come with advancements in medical procedures, technology and treatments. In addition, due to current inflationary pressures impacting wages and operating costs, we are forecasting increased treatment costs from hospitals and providers which will impact directly on the cost of claims. To cover the collective impact these factors have on the cost of claims we need to increase our premiums accordingly.

To help manage our premium increases, we have kept policy changes to a minimum with most of the changes that have been made designed to help make our policy wording clearer and easier to understand. We have however taken the opportunity to increase our mental health consultation benefit to double what it was previously (from $500 to $1,000) to help support our members in this area. We have listed out the more significant changes that have been made to each Accuro policy below. Unless specifically stated, these changes take effect at your next anniversary date from 1 September 2022.

If you have any questions please do not hesitate to contact us.

Policy changes

NEW ZEALAND'S
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Basic and Advanced plan

Mental health benefit			
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations. You can now also claim for consultations with a counsellor.		
New policy wording:	**Mental health consultations** Covers the costs of registered psychiatric, psychologist or counsellor consultations.	**Basic plan** $1,000 per year	**Advanced plan** $1,000 per year
Member impact:	You will now be able to claim for counsellor consultations as well as twice as much under this benefit as previous years, however the overall plan limits will still remain. This change is effective from 1 September 2022 for all members.		

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	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.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	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.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

Terms and condition changes:

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3rd and subsequent dependants	
Policy change:	We have added and updated our wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	2.5 If you have three or more *dependants/whāngai* on your policy, you only pay *premiums* for the first two *dependants/whāngai* as long as the product and *plans* selected are the same for each *dependant*. All *dependants/whāngai* will remain on *dependant* rates up to 25 years old. On the anniversary following reaching 25 years, the *premium* payable will be adjusted from a *dependant* rate to that of a 25-year-old adult and they will remain on your *policy* unless you request their removal.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into the Terms and Conditions to reflect this.
New policy wording:	5. Extra care and support 5.1 Some members are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

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Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

Cancellation	
Policy change:	We have updated the wording to reflect the current process, in particular around refunding premiums after cancellation and no longer requiring the cancellation request in writing. Please note, we still require this request from the main member or financial adviser (if applicable). We have also changed the wording from terminate to cancel to match the terminology across our documents.
New policy wording:	9. Cancellation of membership 9.1 Cancellation of a policy, *plan* or *participant* must be requested by the main *member* or designated financial advisor (if applicable). 9.2 *Accuro Health Insurance* will acknowledge all requests for cancellation of membership on receipt of the request. 9.3 The date of cancellation depends on the frequency of the *premium* payments. • If *premiums* are paid at a frequency of monthly or less, the date of cancellation is the next due date for *premium* payments after we have acknowledged receiving the cancellation request • If *premiums* are paid at a frequency greater than monthly, the date of cancellation is the expiry of the month in which we receive the cancellation request. *We* may refund a pro-rata amount of the *premiums* paid, depending on the circumstances 9.4 Membership will not be reinstated following the cancellation. 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.
Member impact:	This now reflects our current process, in particular where we may refund a pro-rata amount of premium if paid in advance on the cancellation of a policy rather than retaining it.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from the Terms and Conditions.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*

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Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by *Accuro Health Insurance* • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary* • Gender reassignment or *gender dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by *Accuro Health Insurance* • Circumcision, except where *medically necessary* • Additional *surgery* performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this *policy* • A treatment or procedure that is provided by a *registered medical practitioner* practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by *Accuro Health Insurance* **Other costs**

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	We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this *policy* specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a *benefit* section outlined in the *plan*
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

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Value Plus plan

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	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.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

Terms and condition changes:

3rd and subsequent dependants	
Policy change:	We have added and updated our wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy that premium is being paid for.
New policy wording:	2.5 If you have three or more *dependants/whāngai* on your policy, you only pay *premiums* for the first two *dependants/whāngai* as long as the product and *plans* selected are the same for each *dependant*. All *dependants/whāngai* will remain on *dependant* rates up to 25 years old. On the anniversary following reaching 25 years, the *premium* payable will be adjusted from a *dependant* rate to that of a 25-year-old adult and they will remain on your *policy* unless you request their removal.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into the Terms and Conditions to reflect this.
New policy wording:	5. Extra care and support 5.1 Some members are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.

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Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	7.11 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* must also be eligible to meet *PHARMAC's* funding criteria. If the prescription drug require special authority from *PHARMAC* to be covered, we need confirmation from the *registered medical practitioner* that the *member* does meet the special authority criteria before we can assess cover for the prescription drug cost.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

Cancellation	
Policy change:	We have updated the wording to reflect the current process, in particular around refunding premiums after cancellation and no longer requiring the cancellation request in writing. Please note, we still require this request from the main member or financial adviser (if applicable). We have also changed the wording from terminate to cancel to match the terminology across our documents.
New policy wording:	**9. Cancellation of membership** 9.1 Cancellation of a policy, *plan* or *participant* must be requested by the main *member* or designated financial advisor (if applicable). 9.2 *Accuro Health Insurance* will acknowledge all requests for cancellation of membership on receipt of the request. 9.3 The date of cancellation depends on the frequency of the *premium* payments. • If *premiums* are paid at a frequency of monthly or less, the date of cancellation is the next due date for *premium* payments after we have acknowledged receiving the cancellation request • If *premiums* are paid at a frequency greater than monthly, the date of cancellation is the expiry of the month in which we receive the cancellation request. *We* may refund a pro-rata amount of the *premiums* paid, depending on the circumstances 9.4 Membership will not be reinstated following the cancellation. 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.

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Member impact:	This now reflects our current process, in particular where we may refund a pro-rata amount of premium if paid in advance on the cancellation of a policy rather than retaining it.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from the Terms and Conditions.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by *Accuro Health Insurance* • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary* • Gender reassignment or *gender dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by *Accuro Health Insurance* • Circumcision, except where *medically necessary*

	• Additional *surgery* performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this *policy* • A treatment or procedure that is provided by a *registered medical practitioner* practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by *Accuro Health Insurance* Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this *policy* specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a *benefit* section outlined in the *plan*
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

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Real Value plan or Real Value Hospital cover

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Real Value plan.
New policy wording:	**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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Real Value plan - Please have a look at page 5 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 5 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator). Real Value Hospital cover - Please have a look at page 4 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors). Note that the Mental Health Assist benefit is not available on this plan.
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	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.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

Waiver of premium	
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General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	Other treatment or surgery We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by *Accuro Health Insurance* • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary* • Gender reassignment or *gender dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by *Accuro Health Insurance* • Circumcision, except where *medically necessary*

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Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

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Major Medical plan or Major Medical Hospital cover

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Major Medical plan.
New policy wording:	**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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Major Medical plan - Please have a look at page 4 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 5 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator). Major Medical Hospital cover - Please have a look at page 4 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors). Note that the Mental Health Assist benefit is not available on this plan.
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	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.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

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Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	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.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

Terms and condition changes:

3rd and subsequent dependants	
Policy change:	We have added and updated our wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy that premium is being paid for.
New policy wording:	2.5 If you have three or more *dependants/whāngai* on your policy, you only pay *premiums* for the first two *dependants/whāngai* as long as the product and *plans* selected are the same for each *dependant*. All *dependants/whāngai* will remain on *dependant* rates up to 25 years old. On the anniversary following reaching 25 years, the *premium* payable will be adjusted from a *dependant* rate to that of a 25-year-old adult and they will remain on your *policy* unless you request their removal.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into the Terms and Conditions to reflect this.
New policy wording:	5. Extra care and support 5.1 Some members are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.

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Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	7.11 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* must also be eligible to meet *PHARMAC's* funding criteria. If the prescription drug require special authority from *PHARMAC* to be covered, we need confirmation from the *registered medical practitioner* that the *member* does meet the special authority criteria before we can assess cover for the prescription drug cost.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

Cancellation	
Policy change:	We have updated the wording to reflect the current process, in particular around refunding premiums after cancellation and no longer requiring the cancellation request in writing. Please note, we still require this request from the main member or financial adviser (if applicable). We have also changed the wording from terminate to cancel to match the terminology across our documents.
New policy wording:	**9. Cancellation of membership** 9.1 Cancellation of a policy, *plan* or *participant* must be requested by the main *member* or designated financial advisor (if applicable). 9.2 *Accuro Health Insurance* will acknowledge all requests for cancellation of membership on receipt of the request. 9.3 The date of cancellation depends on the frequency of the *premium* payments. • If *premiums* are paid at a frequency of monthly or less, the date of cancellation is the next due date for *premium* payments after we have acknowledged receiving the cancellation request • If *premiums* are paid at a frequency greater than monthly, the date of cancellation is the expiry of the month in which we receive the cancellation request. *We* may refund a pro-rata amount of the *premiums* paid, depending on the circumstances 9.4 Membership will not be reinstated following the cancellation. 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.

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Member impact:	This now reflects our current process, in particular where we may refund a pro-rata amount of premium if paid in advance on the cancellation of a policy rather than retaining it.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from the Terms and Conditions.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by *Accuro Health Insurance* • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary* • Gender reassignment or *gender dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by *Accuro Health Insurance* • Circumcision, except where *medically necessary*

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	• Additional *surgery* performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this *policy* • A treatment or procedure that is provided by a *registered medical practitioner* practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by *Accuro Health Insurance* Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this *policy* specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a *benefit* section outlined in the *plan*
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

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SmartCare

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	Extra care and support Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Hospice stay benefit	
Policy change:	We have updated the wording under this benefit to clarify that it now will be applicable to all nights during a hospice stay of at least 4 nights.
New policy wording:	This benefit covers the cost of hospice care for the member or participant if they are admitted to a hospice and the admission lasts 4 or more nights in a row. The hospice must hold regular or associate service membership with Hospice New Zealand.
Member impact:	Members will now be paid out more under this benefit as we will now include the first 3 nights when calculating the total number of nights.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 11 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 15 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).

Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each person in a 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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	**Diagnostic tests** This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the General Surgery benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Diagnostic test benefit limit of $5,000 will still remain.

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$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the Natural health plan, GP plan and Dental and Optical plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	Other treatment or surgery We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment.

	• Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.

New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. **Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends, the premium payments for all remaining participants will be the responsibility of the policy's main member.**
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a private facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 31 – **How can a policy end?** Cover for your SmartCare policy ends when any one of these things happen:

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	• you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you fail to pay your premium for 90 days or longer • you or any participant breach the terms of this policy • the last member covered by this policy dies. Page 32 - Cancelling your policy In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

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SmartCare+

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	Extra care and support Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Hospice stay benefit	
Policy change:	We have updated the wording under this benefit to clarify that it now will be applicable to all nights during a hospice stay of at least 4 nights.
New policy wording:	This benefit covers the cost of hospice care for the member or participant if they are admitted to a hospice and the admission lasts 4 or more nights in a row. The hospice must hold regular or associate service membership with Hospice New Zealand.
Member impact:	Members will now be paid out more under this benefit as we will now include the first 3 nights when calculating the total number of nights.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 12 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 16 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).

Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each person in a 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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	**Diagnostic tests** This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical+ base plan. These are specifically listed under the General Surgery benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Diagnostic test benefit limit of $5,000 will still remain.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the Natural health+ plan, GP+ plan and Dental and Optical+ plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	Other treatment or surgery We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Chelation therapy or similar treatment as defined by Accuro Health Insurance

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	• Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the

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	member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends, the premium payments for all remaining participants will be the responsibility of the policy's main member.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a private facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 33 – **How can a policy end?** Cover for your SmartCare+ policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable)

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	• you fail to pay your premium for 90 days or longer • you or any participant breach the terms of this policy • the last member covered by this policy dies. Page 34 - **Cancelling your policy** In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

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SmartStay

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	**Extra care and support** Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand public or private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 10 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 12 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each person in a 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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultations and diagnostic tests benefit limit of $4,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	**Diagnostic tests** This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Endoscopy • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the Major diagnostic procedures benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Specialist consultations and diagnostic tests benefit limit of $4,000 will still remain.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the GP plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.

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Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance

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	Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends,

	the premium payments for all remaining participants will be the responsibility of the policy's main member.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a public or private hospital/facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy that premium is being paid for.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 26 – **How can a policy end?** Cover for your SmartStay policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you fail to pay your premium for 90 days or longer • you or any participant breach the terms of this policy • the last member covered by this policy dies • when you tell us that you now have cover under New Zealand's public health system. At this time, we would transfer you onto one of Accuro's other policies, which will have more appropriate cover for you and your family. Page 27 - **Cancelling your policy**

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	In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a sign request, this can be done over the phone or via email.

Product movement	
Policy change:	We are updating our conditions to give us the ability to transfer members to a more appropriate level of cover should we have reason to believe that they are eligible and where attempts to contact them have not been successful.
New policy wording:	Cover may change to suit your needs People who come to New Zealand may become eligible for publicly funded healthcare at a later stage. This may happen, for example, if you obtain a work visa that allows you to stay in New Zealand for two years or more. In order to deliver the best possible outcomes to our members, we will contact you after the end of your second policy year to see whether another policy may better suit your needs. In the rare situations after a reasonable period of time, we may consider automatically transferring you to a SmartCare policy. If that occurs, we will provide you with no less than 21 days' notice of that change, including any change in premiums. When we contact you, we will use the contact details you have most recently provided to us, so it's important to make sure you update us if they change.
Member impact:	This will allow us to transfer members, at no risk to their level of cover, onto a product that may be better suited to their needs.

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KidSmart

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	**Extra care and support** Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Guardian accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clearer that the child must be admitted overnight for medical treatment for this benefit to applicable.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a guardian accompanying a child. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with the claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 11 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 14 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so members can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each child in a policy year. This benefit covers the costs of reasonable and customary charges for consultations with a psychiatrist, psychologist or counsellor when referred by a

	registered medical practitioner. They must refer the child 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.
Member impact:	Members will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	**Diagnostic tests** This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the General Surgery benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Diagnostic test benefit limit of $5,000 will still remain.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

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Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance **Other costs** We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*)

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	• Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if a member were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 the member would need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a private facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	If there are three or more dependants on this policy, you only pay premiums for the first two dependants as long as the product and plans selected are the

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	same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 27 – **How can a policy end?** Cover for this KidSmart policy ends when any one of these things happen: • you ask us to cancel this policy — the request must be from the guardian or designated financial adviser (if applicable) • you fail to pay the premium for 90 days or longer • you or any child (if relevant) breach the terms of this policy • in respect to a particular child, when the child is removed from this policy • when a child reaches the age of 25 years, at which time they will be transferred to their own SmartCare+ policy • the last child covered by this policy dies. Page 27 - **Cancelling the policy** In all cases, cancellation must be requested by the guardian or designated financial advisor (if applicable). We'll acknowledge your request to cancel the policy when we receive it.
Member impact:	A guardian can now cancel the policy without having to send in a signed request, this can be done over the phone or via email.

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Day to Day

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	Extra care and support Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Prescription drugs benefit	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered under this benefit.
New policy wording:	This benefit covers the costs of drugs prescribed by *a registered medical practitioner or registered medical specialist* which are listed under section A to I of the *PHARMAC schedule* (excluding section H).
Member impact:	There is no member impact as we are just providing further clarification around which section of the PHARMAC schedule prescription drugs need to be under to be covered.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy that premium is being paid for.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 9 – **How can a policy end?** Cover for your Day to Day policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you fail to pay your premium for 90 days or longer • you or any participant breach the terms of this policy • the last member covered by this policy dies • if this is a group policy through your employer, then your policy can also end if you leave employment with the employer, your employer writes asking us to remove you from the group scheme, the group scheme comes to an end or if your premium is not paid by your employer for 3 months or more. Page 10 - **Cancelling your policy** In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

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Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	Extra care and support Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 10 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 14 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	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

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	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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation and diagnostic tests benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	**Diagnostic tests** This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Endoscopy • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the Major diagnostic procedures benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Specialist consultations and diagnostic tests benefit limit of $5,000 will still remain.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the GP plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.

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Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance

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	Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends,

	the premium payments for all remaining participants will be the responsibility of the policy's main member.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a private facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 29 – **How can a policy end?** Cover for your StaffCare policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you leave employment with the employer who has an agreement with us to provide cover under this policy; you may qualify to transfer to your own individual policy without completing a full application form — contact us or your adviser to confirm • your employer writes asking us to remove you from the group scheme, or the group scheme comes to an end • you or your employer fail to pay your premium or part of your premium for 90 days or longer • you or any participant breach the terms of this policy

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	• the last member covered by this policy dies. Page 30 - Cancelling your policy In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

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StaffCare+

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	**Extra care and support** Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 11 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 14 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each person in a 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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation benefit limit of $5,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	Diagnostic tests This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical+ base plan. These are specifically listed under the General Surgery benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Diagnostic test benefit limit of $5,000 will still remain.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the Natural health+ plan, GP+ plan and Dental and Optical+ plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.
Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*

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Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance **Other costs**

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	We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends, the premium payments for all remaining participants will be the responsibility of the policy's main member.

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Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a private facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy that premium is being paid for.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 32 – **How can a policy end?** Cover for your StaffCare+ policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you leave employment with the employer who has an agreement with us to provide cover under this policy; you may qualify to transfer to your own individual policy without completing a full application form — contact us or your adviser to confirm • your employer writes asking us to remove you from the group scheme, or the group scheme comes to an end • you or your employer fail to pay your premium or part of your premium for 90 days or longer • you or any participant breach the terms of this policy • the last member covered by this policy dies. Page 33 -

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	Cancelling your policy In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

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StaffStay

Extra care and support	
Policy change:	We know that some of our customers do require extra care and support due to their personal circumstances and we are here to provide this for them. As such we have included some wording into our policy documents to reflect this.
New policy wording:	**Extra care and support** Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters. To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.
Member impact:	There is no member impact as we are already providing extra care and support to members who need it and will continue to do so.

Parent accommodation benefit	
Policy change:	We have updated the wording under this benefit to make it clear that the child must be admitted overnight for medical treatment for this benefit to apply.
New policy wording:	This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand public or private hospital that we've approved under this policy. This benefit is for one adult only. You must send receipts for reimbursement with your claim.
Member impact:	There is no member impact as we are just clarifying what is required to be able to claim under this benefit.

Active benefits	
Policy change:	We have refreshed the wording of our Active benefits to make it clearer what they are and how to use them. We have also included a link to the website where you can access other active benefits. www.accuro.co.nz/active-benefits
New policy wording:	Please have a look at page 10 for the refreshed Accuro Virtual Clinic benefit (previously Best Doctors) and page 13 for the refreshed Mental Health Assist benefit (previously Mental Health Navigator).
Member impact:	There is no member impact as we are just providing more clarity around these benefits, however there are additional Active benefits that are listed on our website for members to use.

Mental health benefit	
Policy change:	We have doubled the limit for this benefit so you can now claim $1,000 per person per year for mental health consultations under the Specialist plan.
New policy wording:	**Mental health consultations** $1,000 for each person in a 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.
Member impact:	You will now be able to claim twice as much under this benefit as previous years, however the overall Specialist consultation benefit limit of $4,000 will still remain. This change is effective from 1 September 2022 for all members.

Diagnostic tests benefit	
Policy change:	We have removed the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning for the Diagnostic tests benefit under the Specialist plan.
New policy wording:	Diagnostic tests This benefit covers the costs of reasonable and customary charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes: • Allergy test • Ambulatory blood pressure monitoring • Audiology • Audiometric test • Bone density scan • Cardiovascular ultrasound • Cardioversion • Colposcopy • Dobutamine transoesophageal echocardiography • Electroencephalography (EEG) • Electromyography (EMG) • Endoscopy • Exercise electrocardiogram (ECG) • Holter monitoring • Laboratory test • Mammography • Nerve conduction test • Nuclear scanning • Stress echocardiogram • Ultrasound • Urodynamic assessment • X-ray Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the Major diagnostic procedures benefit.
Member impact:	There will now no longer be the $1,500 limit for Cardioversion, Endoscopy and Nuclear Scanning under the diagnostic tests benefit, however the cost still needs to be reasonable and the overall Diagnostic tests benefit limit of $4,000 will still remain.

$100 claim wording	
Policy change:	We have removed the wording that advises you need invoices totalling $100 or more to submit a claim under the GP plan as this has not been a requirement for a number of years.
Member impact:	If members have invoices that they have not submitted, they should send them to us to assess.

Pandemic exclusion	
Policy change:	We have removed the pandemic exclusion listed below from all of our policy documents.

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Removed policy exclusion:	*Avian influenza infection or any condition arising from the presence of avian influenza infection or any other identified pandemic*
Member impact:	Pandemic related claims or treatment should go through the public healthcare system as they are set up to manage the pandemic response and cover these costs, however we can now assess additional costs in relation to a pandemic disease (e.g. Covid-19) under your policy. This change is effective from 1 September 2022 for all members.

Personal health-related appliances exclusion	
Policy change:	We have updated the exclusion wording to include mouthguards, which are classified as a personal health-related appliance and are excluded from cover.
New policy wording:	*Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs*
Member impact:	There is no member impact as mouthguards were already excluded from cover, we have just made it clearer by including it in the exclusion wording.

General exclusions	
Policy change:	We have rearranged how some of our exclusions are listed under "Tests, diagnostic procedures and treatments that we don't cover", removing the "Cosmetic and body image" and "Other conditions" headings, and combining these exclusions under "Other treatment or surgery" and "Other costs" headings. We have not removed or added any new exclusions apart from the pandemic exclusion as listed above.
New policy wording:	**Other treatment or surgery** We don't cover these procedures including any treatment, investigations or consultations related to a procedure or any complications that may occur from one. • *Cosmetic procedures* or other enhancement or appearance medicine as defined by Accuro Health Insurance • Procedures or treatment relating to obesity or weight loss, performed for any reason • Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary • Gender reassignment or gender *dysphoria* • Sleep disturbances, snoring, or sleep apnoea • Robotic-assisted prostate surgery/treatment. • Chelation therapy or similar treatment as defined by Accuro Health Insurance • Circumcision, except where medically necessary • Additional surgery performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this policy • A treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice • New medical treatments, procedures, and technologies that have not been approved by Accuro Health Insurance

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	Other costs We don't cover these costs. • General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise) • Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*) • Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand • Any medical costs incurred outside New Zealand • Medical mishap or misadventure • Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages • Any costs not specifically provided for under a benefit section outlined in the plan
Member impact:	This is no member impact as no exclusions in this list have been added or removed, we have just removed any confusion that may have been caused by having the cosmetic and body issue heading.

Reasonable and Customary charges	
Policy change:	We have updated the figures in the hip replacement example under Reasonable and customary charges to reflect our current figures for this type of procedure.
New policy wording:	For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if you were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 you'd need to cover any costs over this.
Member impact:	This is no member impact as we have not change anything, we have just updated the figures to the current reasonable and customary change for hip replacements.

Waiver of premium	
Policy change:	We have updated the wording to reflect how this benefit works for remaining members on the policy and when the waiver of premium will start.
New policy wording:	If the main member or the partner on this policy dies or is diagnosed with a terminal illness up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier: • 36 months or • until the oldest surviving person on the policy reaches the age of 70. Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. 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 ends,

	the premium payments for all remaining participants will be the responsibility of the policy's main member.
Member impact:	There is no member impact as we are just updating the wording to clarify our current process.

PHARMAC schedule	
Policy change:	We have updated the wording in relation to the PHARMAC schedule to advise which sections a drug needs to fall under to be covered.
New policy wording:	Unless outlined differently in the policy, prescription drugs must be: • listed under section A to I of the *PHARMAC Schedule*, note that section H is only applicable if the drug is used during a procedure in a public or private hospital/facility • *PHARMAC*-approved • medically necessary • prescribed by a registered medical practitioner.
Member impact:	There is no member impact, we are providing further clarification around which section of the PHARMAC schedule drugs need to be under to be covered.

3rd and subsequent dependants	
Policy change:	We have added wording to make it clear that any 3rd and subsequent dependants on the policy will be free as long as they have the same product and plans as the two dependants on the policy for which premium is being paid.
New policy wording:	If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.
Member impact:	There is no member impact as we are providing clarification around how this discount applies to a member's policy.

Cancellation	
Policy change:	We have updated the wording so that we no longer require a cancellation request in writing. Please note we still require this request from the main member or financial adviser if applicable.
New policy wording:	Page 28 – **How can a policy end?** Cover for your StaffStay policy ends when any one of these things happen: • you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable) • you leave employment with the employer who has an agreement with us to provide cover under this policy; you may qualify to transfer to your own individual policy without completing a full application form — contact us or your adviser to confirm • your employer writes asking us to remove you from the group scheme, or the group scheme comes to an end • you or your employer fail to pay your premium or part of your premium for 90 days or more • you or any participant breach the terms of this policy

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	• the last member covered by this policy dies • when you tell us that you now have cover under New Zealand's public health system. At this time, we would transfer you onto one of Accuro's other group policies, which will have more appropriate cover for you and your family. Page 29 - **Cancelling your policy** In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.
Member impact:	A main member can now cancel their policy without having to send in a signed request, this can be done over the phone or via email.

Product movement	
Policy change:	We are updating our conditions to give us the ability to transfer members to a more appropriate level of cover should we have reason to believe that they are eligible and where attempts to contact them have not been successful.
New policy wording:	**Cover may change to suit your needs** People who come to New Zealand may become eligible for publicly funded healthcare at a later stage. This may happen, for example, if you obtain a work visa that allows you to stay in New Zealand for two years or more. In order to deliver the best possible outcomes to our members, we will contact you after the end of your second policy year to see whether another policy may better suit your needs. In rare situations, after a reasonable period of time, we may consider automatically transferring you to an equivalent Staff policy. If that occurs, we will provide you with no less than 21 days' notice of that change, including any change in premiums. When we contact you, we will use the contact details you have most recently provided to us, so it's important to make sure you update us if they change.
Member impact:	This will allow us to transfer members, at no risk to their level of cover, onto a product that may be better suited to their needs.

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