ADVISER MANUAL

accuro
HEALTH INSURANCE

Accuro's Adviser Manual

Thank you for putting your trust in New Zealand's best little health insurer and choosing to recommend Accuro's health insurance products to your clients.

This manual has been designed to help you by providing information about our products, services and rules. If you have any questions then please get in contact with your Business Development Manager (BDM) or our helpful Customer Specialists.

Contents

Please note that in the event of any conflict between this document and a member's Policy document or group's Contract, the Policy document or Contract will prevail.

This is a living document so we are always interested to receive feedback or suggestions on the content included. The most up-to-date file for the Adviser manual can be found in the adviser section on our website.

Contacting Accuro

You can contact our Customer Specialists or your Business Development Manager on the below details.
Please note our operating hours are between 8:30am and 5:00pm, Monday to Friday, excluding public holidays.

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

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

Post: Accuro Health Insurance
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Wellington 6143

Our Business Development Managers are:

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Accuro products

For full limits and the terms and conditions for our On-sale products please refer to the relevant Policy document. For our Legacy products please refer to the relevant Policy document as well as Accuro's general policy terms and conditions.

Up-to-date versions of our Policy documents and Accuro's general policy terms and conditions can be found at **http://www.accuro.co.nz/health-insurance-resources/**

On-sale individual products

SmartCare

SmartCare provides comprehensive health cover at a low cost. The Hospital and Surgical base plan provides cover for general, oral and minor surgeries, cancer treatment, major diagnostic tests and the support services following the surgery/treatment, as well as a range of Active Benefits and Loyalty Benefits to help our members stay healthy.

Excess options are $0, $250, $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000.

Additional plans:

- Specialist plan ($0 & $250 excess)
- GP plan (reimbursement plan)
- Natural Health plan (reimbursement plan)
- Dental and Optical plan (reimbursement plan)

SmartCare+

SmartCare+ is Accuro's premier individual product. The Hospital and Surgical+ base plan has higher benefit levels to SmartCare as well as added benefits such as non-PHARMAC subsidised drug cover, medical tourism, overseas waiting list and a screening endoscopy loyalty benefit.

Excess options are $0, $250, $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000.

Additional plans:

- Specialist+ plan ($0 & $250 excess)
- GP+ plan (reimbursement plan)
- Natural Health+ plan (reimbursement plan)
- Dental and Optical+ plan (reimbursement plan)

SmartStay

SmartStay is for non-residents who hold a valid New Zealand work visa or visitor visa for less than two years. The Hospital & Surgical base plan provides cover for people who are not eligible under New Zealand's public healthcare system. This is the only health insurance product in New Zealand for non-residents.

Excess options are $0, $250, $500, $1,000, $2,000 or $4,000.

Additional plans:

- Specialist plan ($0 excess)
- GP plan (reimbursement plan)

KidSmart

KidSmart has been specifically created for babies and children. It allows a guardian to take out health insurance for their children or dependants without having to take out cover for themselves. The Hospital and Surgical base plan has the same benefits as SmartCare+ with loyalty benefits designed just for children and their needs. We are the only New Zealand health insurer that offers a health insurance product designed specifically for children.

Additional plan:

- Specialist plan ($0 excess)

Day to Day

Day to Day is a reimbursement-only product that has been created to provide cover for everyday health costs, up to a total of $600 for each person in a policy year. Please be aware that there are limits on each of the benefits.

It covers costs for GP, dentist or optician consultations. It also provides cover for the costs of prescription medication, the annual flu vaccine, and natural therapy treatments such as physiotherapy or osteopathic treatments.

On-sale group products

Our group products are specifically designed for New Zealand businesses.

StaffCare

StaffCare is the group product designed to deliver quality benefits at a competitive price to group schemes with at least 5 employer-paid members. This product provides pre-existing condition cover for all eligible members who have joined the group scheme within their eligibility period. Please note that group schemes with 5–14 employer-paid members will have a stand-down period of up to three years for pre-existing conditions, as well as a seperate rate card.

The Hospital and Surgical base plan offers comprehensive private hospital and surgical cover as well as a range of Active Benefits and Loyalty Benefits.

Excess options are $0, $250, $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000.

Additional plans:

- Specialist plan ($0 or $250 excess)
- GP plan (reimbursement plan)

StaffCare+

StaffCare+ is the premium group product for group schemes of 15+ employer-paid members. This product provides pre-existing condition cover for all eligible members who have joined the group scheme within their eligibility period.

The Hospital and Surgical+ base plan has higher benefit levels to StaffCare as well as added benefits such as non-PHARMAC subsidised chemotherapy drug cover, ambulance transfer, funeral grant, speech-language therapy and physiotherapy following an approved surgery.

Excess options are $0, $250, $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000.

Additional plans:

- Specialist+ plan ($0 or $250 excess)
- GP+ plan (reimbursement plan)
- Natural Health Care+ plan (reimbursement plan)
- Dental and Optical Care+ plan (reimbursement plan)

StaffStay

StaffStay is a group product for non-residents who hold a valid New Zealand work visa for less than two years. This product is offered as a stand-alone group scheme with at least 5 employer-paid members or to employer-paid members who are part of a company who have a group scheme with Accuro. This product provides pre-existing condition cover for all eligible members who have joined the group scheme within their eligibility period. A stand-down period may apply depending on the number of employer-paid members in the group scheme.

The Hospital & Surgical base plan provides cover for people who are not eligible under New Zealand's public healthcare system.

Excess options of $0, $250, $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000.

Additional plans:

- Specialist plan ($0 excess)
- GP plan (reimbursement plan)

Legacy products

Please note that Accuro's general policy terms and conditions apply to all Legacy products and should be read in conjunction with the Policy document.

Basic plan

A basic reimbursement-only plan designed to give cover across a range of benefits at a 50% refund to the benefit maximum, up to an overall aggregated refund of $2,000 for each person in a policy year.

Advanced plan

A reimbursement-only plan similar to the Basic plan that provides an 80% refund to the benefit maximum, up to an overall aggregated refund of $2,500 for each person in a policy year.

Value Plus plan

A reimbursement-only plan designed to give cover mainly across natural health treatments and the purchase of glasses, dentures and hearing aids at 100% refund to the benefit maximums under the plan.

Major Medical plan

A comprehensive medical plan designed to give cover for private hospital admissions, surgeries, specialist consultations and diagnostic tests.

The Major Medical plan has an excess of 20% of the claim up to the excess level chosen – either $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000 for each person in a policy year.

Major Medical plan hospital cover

A comprehensive medical plan designed to give cover for private hospital admissions and surgeries, but there is no cover for specialist consultations or diagnostic tests unless they relate to an approved surgery and occur within six months of the surgery.

This has the same cover as the Major Medical plan, however the Specialist section has been removed.

The Major Medical plan hospital cover has an excess of 20% of the claim up to the excess level chosen – either $500, $1,000 or $2,000 for each person in a policy year.

Real Value plan

A comprehensive medical plan designed to give cover for private hospital admissions, surgeries, specialist consultations and diagnostic tests with some special benefits for funeral support, birth, sick leave without pay and home support.

The Real Value plan has an excess of 20% of the claim up to the excess level chosen – either $500, $1,000, $2,000, $4,000, $6,000, $8,000 or $10,000 for each person in a policy year.

Real Value plan hospital cover

A comprehensive medical plan designed to give cover for private hospital admissions, surgeries and special benefits, but there is no cover for specialist consultations or diagnostic tests unless they relate to an approved surgery and occur within six months of the surgery.

This has the same cover as the Real Value plan, however the Specialist section has been removed.

The Real Value plan hospital cover has an excess of 20% of the claim up to the excess level chosen – either $500, $1,000 or $2,000 for each person in a policy year.

Processing charges

Under some of the Legacy products, there are processing charges. These are being phased out in 2021.

Our processing charges are:

Basic and Advanced plans

These charges have been removed as of March 2021.

A processing charge is applicable to each accepted claim submitted under these plans, and will be dependent on how many claims have been submitted within a policy year, which begins on the 1st of April each year. The processing charge is not applicable to any claim under the specialist benefits and grants section (sick leave without pay benefit, funeral support grant, birth grant and home support benefit). The processing charges are as follows for each policy year:

- First claim – $20 processing charge
- Second claim – $40 processing charge
- Third and subsequent claim – $50 processing charge

Value Plus plan

These charges have been removed as of March 2021.

A processing charge of $20 is applicable to each accepted claim submitted under this plan. The policy year begins on the 1st of April each year. The processing charge is not applicable to any claim under the specialist benefit and grants section (sick leave without pay benefit, funeral support grant, birth grant and home support benefit).

Major Medical and Real Value plans

These charges will be removed later in 2021.

A $100 processing charge is applicable to any accepted claim of $2,000 or more, apart from any claim under the specialist benefit and grants section (sick leave without pay benefit, funeral support grant, birth grant and home support benefit) under the Real Value plan or Real Value Hospital Cover plan.

Excess levels

Excesses work differently under each of Accuro's products so please read the below carefully.

Legacy products

Major Medical plan
- including the Major Medical Hospital Cover plan

The excess under the Major Medical plans is applicable to all benefits apart from the public hospital, travel expenses and Active benefits, and is taken at 20% of the cost of the claim up to the excess level for each person in a policy year.

This means that we will either pay the provider or reimburse the member 80% of the cost of the invoice until the full excess has been taken for the member for the policy year, at which time any further invoices for that policy year will be paid or reimbursed in full.

Real Value plan
- including the Real Value Hospital Cover plan

The excess under the Real Value plans is applicable to all benefits apart from the public hospital, travel expenses, Special benefits and grants and Active benefits, and is taken at 20% of the cost of the claim up to the excess level for each person in a policy year.

This means that we will either pay the provider or reimburse the member 80% of the cost of the invoice until the full excess has been taken for the member for the policy year, at which time any further invoices for that policy year will be paid or reimbursed in full.

On-sale products

SmartCare and SmartCare+

Under SmartCare and SmartCare+, the member can choose to have separate excesses on the Hospital and Surgical base plan and the Specialist plan or to not have any excess. Any excess under these plans is to be taken in full from the first and any subsequent invoices before we will either pay the provider or reimburse the member for any remaining amount.

SmartStay

Under SmartStay, the member can choose to have any excess on the Hospital and Surgical base plan, but there is no excess option on the Specialist plan. Any excess under the base plan is to be taken in full from the first and any subsequent invoices before we will either pay the provider or reimburse the member for any remaining amount.

StaffCare, StaffCare+ and StaffStay

Under StaffCare, StaffCare+ and StaffStay, the employer chooses which excess is applicable for all members under the group on the Hospital and Surgical base plan and also the Specialist plan (if it is employer subsidised). If the employer does not subsidise the Specialist plan, the member can choose to take up this plan. Any excess under these plans is to be taken in full from the first and any subsequent invoices before we will either pay the provider or reimburse the member for any remaining amount.

A buy-out option may be offered to a group scheme on a case by case basis for the employer subsidised base plan that has an excess up to $2,000. This means that the members within the group scheme can choose to pay a portion of their premium to lower the excess applicable under the plan.

Forms, documents and stationery

Up-to-date versions of all our forms and Policy documents can be found on our website under the Resource tab or under the Adviser tab. These can be found in the footer at the very bottom of our website.

You can also order hard copies of the below documents by going to the online Collateral order form or by sending an email request to sales@accuro.co.nz.

- *Main application form*
- *KidSmart application form*
- Policy documents (SmartCare+, SmartCare, SmartStay, KidSmart, Day to Day, StaffCare+, StaffCare and StaffStay)
- Products cards (SmartCare+, SmartCare, SmartStay, KidSmart, Day to Day, StaffCare+ and StaffCare)
- Flyers (Day to Day, Why Accuro, Best Doctors - these may change from time to time)
- Presentation folders

Make sure it's up to date

It is important that the most current forms and documents are used by our members and advisers as we are always making updates throughout the year. If you are not using the correct form or Policy document you could be asking your clients to provide the wrong information or advising them of incorrect information.

Forms

We cannot always accept old forms as they might not meet current legislative requirements and/or could have incorrect information on them. Filling out the correct form initially means your client won't be asked to fill out a second form, saving both you and your client time.

Policy documents

Each year, we review all of our products and release any updates to members on their anniversary date. Because of this, you will need to make sure you are looking at the right Policy document before advising your clients of the information relating to their policy. The date the Policy document was issued can be found on the last page of the policy. For example, ACC7124 09/18 would indicate that this particular document was issued in September 2018.

If you are unsure about what Policy document is relevant to your client, then please get in contact with us.

Our language

Insurance language is fairly consistent across the industry; however, each insurer can have a slightly different meaning for a word. This section will clarify our definition of particular language and phrases. Please note that these do not override any definitions that are set out in the glossary of our Policy documents or under the general terms and conditions.

A full application

A full application is when we require a member's medical history so they can be underwritten.

They can do this by either completing the medical questions in the application form or by providing their full medical history (from date of birth to present).

A short application

A short application is used when no underwriting is required. We only need the member's personal details.

There are a number of short application forms that relate to different products and membership types. These are listed below. However, if you are unsure on which application form to use, please contact us.

- Making changes form (personal) - SmartCare, SmartCare+, SmartStay and any individual Legacy members
- KidSmart making changes form - KidSmart
- Day to Day application (existing members) or Day to Day application (new member) - Day to Day
- Making changes form (business) - StaffCare, StaffCare+, StaffStay and any group Legacy members

A benefit

A benefit is a service or payment that is provided for in a policy. Each benefit will have its own conditions around what can be claimed for, by whom, when and the maximum amount claimable.

Example – the SmartCare+ Hospital & Surgical+ base plan has the below benefits:

- General surgery
- Oral surgery
- Private hospital medical admission
- Minor surgery etc

A plan

A plan is a collection of similar benefits put together and priced independently. Most products have a compulsory base plan and then a range of different additional plans available, allowing members the option to expand their health cover.

Example – SmartCare+ has the below plans:

- Hospital & Surgical+ base plan (obligatory)
- Specialist+ plan
- GP+ plan
- Natural Health+ plan
- Dental and Optical+ plan

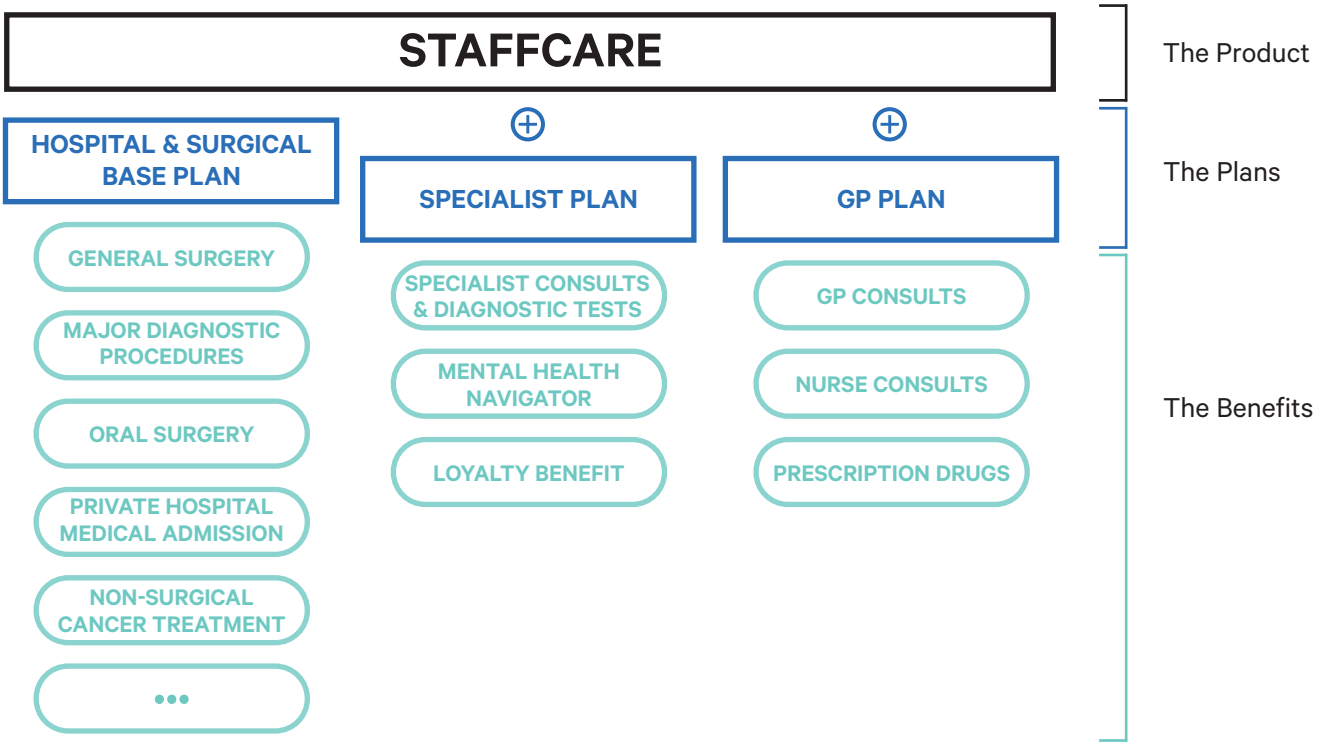
A product

A product is a collection of plans created for certain audiences. As different products are targeted at various audiences, they may have different plans available with varied benefits.

Example – our On-sale products are:

- SmartCare
- SmartCare+
- KidSmart
- SmartStay
- Day to Day

An example of these terms is shown below.



Policy information

Below is a general guide for how different aspects of our policies work. Please check the applicable Policy document for comprehensive policy information.

Dependants

A dependant is a member's child (including any stepchild or adopted child or whāngai) who has been accepted as a participant on the member's policy before the age of 25 years.

This means that a child can stay on their parent or guardian's policy until they reach 25 years of age at a dependant rate. After turning 25, they will be charged at their age rated premium. The member will be advised of this increase in the policy premium notice at their next policy anniversary.

Once the child reaches 25 years of age they can either:

- Remain on the policy. They will now be classified as an adult and so will be charged at their age rated premium.
- Move onto their own policy with the same level of cover. They will be charged at their age rated premium, however they can also add additional participants such as their partner and/or children.
- Move onto their own policy with a different level of cover. Note that this may require further underwriting.

Excess

An excess is the amount the member has to pay when they make a claim, before we pay the rest up to the limit for that benefit.

Excess is connected to a particular plan and is applicable to a number of benefits under that plan. This means that there are certain benefits under the plan that will have excess to pay when claiming on, and others that will not. It will be noted in the Policy document if an excess is applicable to a benefit.

A member can select different excesses on plans, so please check the membership certificate.

All excesses apply for each individual member covered by the plan for each policy year. The policy year begins on the policy's anniversary date.

For example, if a SmartCare+ policy has an anniversary date of the 1st of May, the benefit limits will reset under the policy each year on the 1st of May and so will the excess. If a member under this policy was to make a claim on the 15th of May they would have to pay the full excess applicable under the plan. However if they were to make a further claim under the plan once the excess had been paid in full, they would not have to pay any more towards their excess until the excess reset on the 1st of May the following year – the policy anniversary.

Reasonable and customary charges

Reasonable and customary charges is the cost of a procedure or medical treatment that we judge to be reasonable and within a range of cost charged for the same procedure under similar circumstances. Our reasonable and customary charges make sure that health service providers are fair with the amount they're charging for procedures, and aren't charging more than is required.

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

For example, a hip replacement surgery has an average cost of $22,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $27,000 for this procedure. This means that if a member was to have a standard hip replacement surgery, we'd provide cover up to $27,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $27,000, the member would need to cover any costs over this.

Premium

Premiums are calculated off the age and smoking status of each member for each plan they have chosen. This is required to be paid in advance of cover. If the premiums have not been paid for three months or more, we will cancel the policy.

Please be aware that the initial premium payment for a new policy, plan or member may be more than the quoted amount. This is because the initial premium may include additional days of cover before the first period or cover.

For example, if a new member was added to an existing policy on the 20th of May 2019 and the policy anniversary was the 1st of June, we would take a payment for the first month (1st to the 30th June 2019) as well as the pro rata cost for the additional 11 days beforehand (20th to the 31st of May 2019).

Payment of premium for non-subsidised members or plans on group policies, is the responsibility of the main member on the policy. These are charged at the individual's age rated price from the rate card provided.

Pending report

The pending report is a weekly report sent out to each adviser indicating any policies, plans and lives that are pending and what is required/outstanding for each. All pending policies, plans and lives will remain on the pending report until they have been actioned by Accuro. This will also include any members who have left a group scheme and been sent continuation options, so that you can follow up on any outstanding requirements.

- If an application is in pending status 45 days after it was signed, a *Declaration of health form* will be required.
- If the application is in pending status 90 days after it was signed, we will cancel the policy.

The pending report will also include any clients who are now eligible to claim for a loyalty benefit and the name of the loyalty benefit. This will assist you in helping your clients to make the most of their policy.

Loyalty benefits

There are a range of loyalty benefits under our plans, as we want our members to be able to use their policy even when they are well. Loyalty benefits are valid after the member has had continuous cover under the plan for the noted amount of time.

Unless otherwise stated, there is no timeframe around when they can be claimed so long as the member has passed the period of time under the plan listed on the loyalty benefit.

For example, a member can claim for a GP health check every three years under the loyalty benefit on SmartCare+ once they have had three years of continuous cover. This means that they have from the beginning of their 4th policy year under the end of their 6th policy year to claim for a GP health check, and this benefit would then reset the beginning of their 7th, 10th, 13th policy year etc, as opposed to every three years from the date of claim.

A member is unable to carry over loyalty benefits (or any benefits for that matter) from one policy year to another, or transfer them to another participant on the policy. This means that we are unable to allow members to retrospectively use a loyalty benefit or claim for discounts on their policy that have passed.

Setting up and managing individual policies

Accuro's products have different plans that can be mixed and matched to suit your client's needs and budget while still providing them with a comprehensive level of cover. All participants on the policy must be on the same product as the main member such as SmartCare+, however they can be on different additional plans and can choose different levels of excess including on the base plan.

To qualify for Accuro's SmartCare or SmartCare+ products, a member must be a New Zealand citizen or permanent resident or hold a New Zealand work visa valid for two years or more.

If your client is a non-resident, our specifically designed SmartStay product is for them – only a valid New Zealand work visa or visitor visa is required to be held by the main member on the policy. Immediate family members also in New Zealand can be included on the SmartStay policy. Please see further details on the visa requirements on page 15.

Our online application form offers members the ability to upload their entire medical history or to complete the health questions provided. In most instances automatic underwriting will occur from the health questions with an offer of terms immediately emailed directly to their adviser (providing the member has used the adviser's URL).

Application forms

We have a range of different application forms for different products and different situations.

We have created the below list to show what applications relate to the different products. Please use the following sections to help you decide whether a full application or a short application would be required.

SmartCare/SmartCare+ – *Main application form* or *Making changes form*

SmartStay – *Main application form* or *Making changes form*

KidSmart – *KidSmart application form* or *KidSmart making changes form*

Day to Day – *Day to Day existing member form* or *Day to Day new member form*

A full application will be required for:

- Any new SmartCare, SmartCare+, SmartStay or KidSmart policy.
- Any member over six months of age joining an existing SmartCare, SmartCare+, SmartStay or KidSmart policy.
- Any member joining an existing Major Medical or Real Value policy.
- The addition of a Specialist or Specialist+ plan to an existing policy.
- Decreasing the excess of an existing plan.

For new policies

You can complete a full application (*Main application form*) for SmartCare, SmartCare+, SmartStay and KidSmart on our website, using your individual adviser URL link to link the policy to your agency. If you do not know your individual adviser URL then please contact sales@accuro.co.nz and we will arrange for this to be emailed to you. The client has the ability to upload their entire medical history or complete the health questions.

If the client chooses to upload their entire medical history this must be from their date of birth to present or they will also be required to fill out the health questions.

With our award winning online underwriting system HUGO, we are able to automatically send an offer of terms to those that do not have medical conditions that require extra attention by an underwriter. Meaning that you can present an offer of terms almost instantaneously to the majority of your clients.

A short application will be required for:

- A member transferring policies with the same base level of cover, where the excess may increase.

- A member transferring policies in the event of a partnership separation with the same base level of cover, where the excess may increase.
- A 25-year-old dependant moving to their own policy with the same base level of cover, and the application is received within 30 days of being removed from their parent's policy, where the excess may increase.

A Declaration of health form will be required when:

- A pending application has gone over 45 days from the date of the member's signature on the application. Note: Once it has reached 90 days we will require a full application to be completed again.
- Upgrading from SmartCare to SmartCare+ or from SmartStay to SmartCare+.
- A member cancels their policy and wants to rejoin on the same level of cover within 30 days.
- The addition of a Specialist or Specialist+ plan within the first 30 days of a new policy.

Changing a member's details

A signed request from the main member is required to:

- Cancel a policy.
- Change the main member on the policy.

This must have a physical signature included on it from the main member, even electronic copies. The signed request can be posted, faxed or scanned and emailed to us.

We will accept email confirmation for:

- Changing the member's address or contact details. The email needs to be from the main member or adviser.
- Adding a dependant who is under six months of age to an existing SmartCare, SmartCare+, SmartStay or KidSmart policy. The email needs to include the child's full name, date of birth and gender*.
- Increasing the excess of a plan.
- The removal of a member from the policy*.
- The removal of a plan from the policy*.
- Changing the suffix of bank account the direct debit is taken from*.
- Cancellation of a policy within the 14 day free-look period* or when in pending status.
- Changes to a policy within the 14 day free look period or when in pending status.
- Changing or adding a new adviser to the policy after the 14-day free look period*.
- Suspending the policy. If suspending a policy for more than 12 months due to overseas travel, we will require evidence to be supplied with the email request such as an e-ticket.
- Adding an additional reimbursement plan (Basic, Advanced, Value Plus, GP, Natural Health, Dental and Optical or Day to Day).
- Changing the smoking status for a member*.
- Changing from a SmartStay policy to a SmartCare policy with the same level of cover. We will also require an updated visa to confirm they are now eligible for publicly funded healthcare.
- Giving authority for a member on the policy to make changes to policy information*.

* Email confirmation must be from the main member on the policy.

Payment changes

A member must complete an *Individual payment method form* to make any changes to their premium details for direct debit payments. The *Individual payment method form* is only for individual policy member, not group members.

The only exceptions for not completing this form are in the following situations:

- The main member can pay their premium by credit card over the phone with a Customer Specialist
- The main member can change the suffix of their direct debit bank account by email
- The main member can change the frequency or date of their payments by email with a Customer Specialist

For security reasons, credit card information is never saved to a member's policy.

Applicants on a work or visitor visa

Our SmartStay product has been designed for people who are not citizens or residents of New Zealand, and who are not eligible for publicly funded healthcare in New Zealand. SmartStay provides cover for treatment in both New Zealand's public and private healthcare system, and is the only health insurance product in New Zealand for non-residents.

Any prospective member must hold either:

- A valid New Zealand work visa for less than 24 months, with at least three months still remaining on it, or
- A valid New Zealand visitor visa for at least 12 months, with at least three months still remaining on it.

If they do not have three months remaining on their visa, then we would require confirmation they are applying for an extended work/visitor visa or residency. The main member on the policy is the only one who is required to have one of the above visas for SmartStay, and can add their immediate family members (parents, spouse/partner, children) onto their policy.

If their visa is valid for two years or more (or if they hold visas that accumulate to two years or more) and they are eligible for cover under the public healthcare system, then they are eligible to take up or transfer to the SmartCare product range.

We will not accept a new main member who has a student visa (except PHD students), job seeker visa or guardian visa, but the member's family and dependants can be on any of these visas as long as the main member on the policy holds a valid work or visitor visa.

Requirements for changing plans

Transferring from		Transferring to	Requirements
Basic plan	»	Advanced plan	• Email request from the main member. • Three-month stand-down on any claims. • No underwriting.
Advanced plan	»	Basic plan	• Email request from the main member.
Value Plus plan	»	Basic plan or Advanced plan	• Email request from the main member. • Three-month stand down on any claims. • No underwriting.
Major Medical plan $500 excess	»	Major Medical plan with increased excess	• Email request from the main member with their new excess level.
Major Medical plan or Real Value plan	»	Major Medical or Real Value plan with reduced excess	• New full application – *Main application form*.
Major Medical plan	»	SmartCare or SmartCare+	• New full application – *Main application form*. • Fully underwritten.
Real Value plan	»	SmartCare or SmartCare+	• New full application – *Main application form*. • Fully underwritten.
SmartCare	»	SmartCare+	• *Declaration of health form*. The member only needs to disclose any health issues that have occurred since the policy start date. Members will only be underwritten on the additional benefits that they can claim for under SmartCare+.
SmartStay	»	SmartCare	• Email request from the main member to transfer, along with a copy of the new visa.
SmartStay	»	SmartCare+	• Email request from the main member to transfer, along with a copy of the new visa. • *Declaration of health form*. The member only needs to disclose any health issues that have occurred since the policy start date.
SmartCare or SmartCare+	»	SmartCare or SmartCare+ with reduced excess	• New full application – *Main application form*.
SmartCare or SmartCare+	»	SmartCare or SmartCare+ with increased excess	• Email request from the main member.

Setting up and managing group schemes

What is a group scheme

A group scheme is when an employer pays for health insurance for all eligible employees* of the company. The employer must pay for the entire cost of the premium for each eligible employee for any subsidised plans they have agreed to cover. Our group products provide cover for pre-existing conditions, however, group schemes with 5–14 employer-paid members will have a maximum stand-down period of three years for pre-existing conditions cover.

*Eligibility is defined for each group scheme in the contract between the employer and Accuro.

A full application will be required for:

- Any new policy on StaffCare for a group with 5–14 employer-paid members.
- Any new policy for a staff member or family member outside of the eligibility timeframe.
- Adding a member to an existing group policy outside the eligibility timeframe.
- Adding a child at any age to an existing Major Medical group policy outside the eligibility timeframe.
- Decreasing the excess under an existing plan outside of the eligibility timeframe.
- Adding the Specialist or Specialist+ plan outside of the eligibility timeframe.
- When a buy-out option is taken up outside the eligibility timeframe.

A short application will be required for:

- Any new policy for a member of a group with 15+ employer-paid members within the eligibility timeframe.
- Adding a member to an existing group policy within the eligibility timeframe.

When a group member is applying for a new policy within the eligibility period, we do require the *Group short application form* to be completed. However, we are happy to accept an email from the adviser in place of this as long as it states the new member's:

- Full name,
- Date of birth,
- Employment start date,
- Postal address,
- Email address, and
- Phone number.

Any additional non-subsidised plans to be added must be sent with an *Employee payment method form*.

Group payment changes

A member must complete an *Employee payment method form* to make any changes to their premium payments for direct debit payments. The *Employee payment method form* is only for group policy members, not individual members.

Please note that we do not offer any discounts to any group policies, including group members, family additions or left group policies.

Group onboarding process

We have recently made changes to our group process, with a more structured onboarding process and the inclusion of a group contract. We will continue to update and make changes to this process over the next few years as and when required.

Obtain an indicative quote

Once we have received a request, we will provide you with an indicative quote to share with the company based on the information you have provided. We have many different plan and excess options, so please get in contact if you wish to change aspects of the quote. **Please note the quote is valid for 90 days from the date the email is sent.**

Please make sure to read over the email along with the attachments, including the eligibility criteria as this will be personalised for each group scheme.

Application forms

Once you have confirmed with us that the company would like to progress, we will then send you:

- the *Group information form* for the company to complete and sign, and
- the application forms for the staff (and any additional family members) to complete and sign.
  - For groups with under 15 staff, or where full underwriting is required, this will be the *Main application form*.
  - For groups with 15 or more staff, this will be the *Group short application form*.

These need to be completed and returned to Accuro within the 90 day period after the quote has been issued to remain valid, unless negotiated prior.

Offer of terms

Once we have received all the application forms and the *Group information form*, we will review the group and email you the terms that can be offered. This will include the confirmed quote, the group contract, and the *Employer payment method form*. **The contract and payment method form must be completed by the company and returned to Accuro within 30 days of the offer of terms.**

Group scheme goes live

Once we have received the signed contract and payment method form, we will start the upload of the group. The group scheme will be live from the commencement date noted on the contract, unless advised otherwise.

Group policy information changes

A signed request from the main member is required to:

- Cancel a policy when the member is still employed.

This must have a physical signature included on it from the main member, even electronic copies. The signed request can be posted, faxed or scanned and emailed to us.

We will however accept email confirmation for:

- The cancellation of a policy due to the member leaving employment. The email needs to be from the main member, adviser or group and confirm the end date of employment.
- Changing the member's address or contact details. The email needs to be from the main member or adviser.
- Adding a dependant who is under six months of age to a StaffCare, StaffCare+ or StaffStay policy. The email needs to include the child's full name, date of birth and gender*.
- Increasing the excess under a group policy*.

- Increasing the excess of a plan.
- Adding additional reimbursement plans at any time (GP, Natural Health and Dental and Optical plans) or adding the Specialist plan within the eligibility timeframe*.
- The removal of a member from the policy*.
- The removal of a plan from the policy*.
- Changing the suffix of the bank account the direct debit is taken from*.
- Suspending the policy. If suspending a policy for more than 12 months due to overseas travel, we will require evidence to be supplied with the email request such as an e-ticket.
- Adding an additional reimbursement plan (GP, Natural Health, Dental and Optical or Day to Day).
- Giving authority for a member on the policy to make changes to policy information*.

* Email confirmation must be from the main member on the policy.

If there is an incorrect birth date on the policy for a member, we would require confirmation of the correct birth date to change this, such as a copy of a birth certificate, passport, driver's licence etc.

Group members on a work visa

Our StaffStay product has been designed for group members who are not citizens or residents of New Zealand, and who are not eligible for publicly funded healthcare in New Zealand. StaffStay provides cover for treatment in both New Zealand's public and private healthcare system, and is the only group health insurance product offered in New Zealand for non-residents.

Any prospective member must hold a valid New Zealand work visa for less than 24 months with at least three months still remaining on it. If they do not have three months remaining on their visa, then we would require confirmation they are applying for an extended work visa or residency. The main member on the policy is the only one who is required to have a valid work visa, and can add their immediate family members (spouse/partner and children) onto their policy.

If their visa is valid for two years or more (or if they hold visas that accumulate to two years or more) and they are eligible for free cover under the public healthcare system, then they are eligible to take up or transfer to the StaffCare/StaffCare+ product providing that their employer has these products in place and that the member has met any employer eligibility criteria.

We will not accept a new member who has a visitor visa, student visa, job seeker visa or guardian visa, but family members can be on any of these visas as long as the main member on the policy holds a valid work visa.

Transfer off a group scheme

When a member leaves employment and is then transfered out of the group scheme, they will be offered options to carry on their cover with Accuro. The continuation options will depend on how long the member has been with the group scheme and the continuation period selected by the group, which is noted in their contract.

- If the member leaves employment after the continuation period has ended, the member will be able to carry on with the same level of cover without any further underwriting.
- If the member leaves employment before the continuation period has ended, the member will need to be underwritten to continue any cover with Accuro.
- If the member leaves employment before the continuation period has ended but did not get pre-existing condition cover (was fully underwritten), the member will be able to carry on with the same level of cover without any further underwriting.

Please note that we do not offer any discounts to any group policies, including group members, family additions or left group policies.

On a case by case basis, where a member leaves a group scheme before the continuation period has ended due to special circumstances, we may be able to offer pre-existing condition cover.

An example of a case with special circumstance, is when a staff member has had previous cover under a similar health insurance product, with another New Zealand health insurer, prior to joining the group scheme. The staff member continuing would receive pre-existing conditions cover if they had been part of their group scheme with Accuro **and** held their previous cover for over 12 months continuously. All exclusions that were on the staff member's previous health insurance policy would be transferred onto their new personal cover with Accuro.

Please get in contact with us if you have a situation that could be classified as a special circumstance and that you would like us to review.

Group continuation options

A continuation letter will be sent to the member via post or email, outlining their continuation options and will include the application form that the member needs to complete to continue their cover. An email and quote will be sent to the adviser with the continuation letter.

The member has 30 days to complete the application and return this to Accuro to continue their policy.

Any member who has left a group scheme and has been sent continuation options will be listed on the pending report, so you can follow up on any outstanding requirements. When a member leaves an employer who has a group scheme, you will receive renewal commission if you transfer them onto an individual Accuro product, unless another agreement has been made with Accuro.

Non-underwritten group members

A non-underwritten member does not need to provide their complete medical history to Accuro because we have agreed to take on cover for pre-existing conditions. The member will not have any personal exclusions on their policy but general exclusions will apply, so we will still require medical evidence to be provided for a claim or pre-approval, such as a GP referral letter or a letter from the Specialist.

Underwriting

Pre-existing conditions

A pre-existing condition is any sign, symptom, health condition or health event that happened before the policy start date.

Health insurance is set up to provide cover for health conditions or medical issues that arise during the life of the policy and not before the policy begins. This is why a member is asked to either complete the health questions in a full application or provide a copy of their complete medical history.

This information is passed on to our underwriting team who assess the risk that any pre-existing conditions pose to Accuro and then decide whether to accept cover for these conditions or not. Only pre-existing conditions that have been declared on the application form and specifically accepted by Accuro are covered. Any pre-existing conditions that have been deemed too high a risk for Accuro to cover will be listed on your client's membership certificate as an exclusion.

Please make it clear to your clients that they need to include all previous health conditions, events or signs/symptoms no matter how small or irrelevant they think they may be.

If, at any time, we become aware of any sign, symptom, condition or event that wasn't disclosed to us, we will then assess the risk that the condition poses to Accuro. We may apply an exclusion and decline any claims for the pre-existing condition (or any related condition).

What are exclusions?

Under all Accuro policies there are two types of exclusions – personal and general.

Personal exclusions are when a certain condition is not covered for a particular member. Personal exclusions are based on the medical history each member has provided and can be for different lengths of time (from 1 year to life) depending on the risk that the specific condition poses. Once the exclusion timeframe has passed and the exclusion has automatically "dropped off", the member can then claim for treatment or services that have occurred **after** the exclusion period, even if the member was still experiencing symptoms of the condition during the exclusion period.

These personal exclusions can be found on the membership certificate for the policy, and will be broken down to show who the exclusion is for, what plan it is on and the exclusion period.

General exclusions are when a specific medical condition or service is not covered for anyone with the same type of policy. Most general exclusions are the same across all of Accuro's products.

For our On-sale products these general exclusions are listed in the Policy document under the 'What's not covered' section. For our Legacy products (Basic, Advanced, Value Plus, Major Medical and Real Value plans) these are listed in Accuro's general policy terms and conditions.

How exclusions and review criteria work

Once a member's medical information has been assessed, if the underwriter believes that a particular condition poses a risk to Accuro, they will place an exclusion on the policy for a period of time, which will apply to that particular condition and any related conditions. An exclusion can be placed for a timeframe ranging from one year to the life of the policy. Our standard timeframes are three years, five years, ten years and the life of the policy.

If the exclusion is reviewable, with the possibility of the exclusion to be reduced or removed, the review criteria will be noted in the exclusion, which will advise the member of the process and what is required to allow it to be reviewed.

If an exclusion does not have review criteria, this means it is very unlikely that we will remove or reduce the exclusion due to the nature of the condition.

Once an exclusion has expired, it 'drops off' the policy. This means that, while it will still show under the member's policy and on their membership certificate, as the exclusion timeframe has expired, the member will then be able to submit a claim or pre-approval in relation to the condition after the expiry date of the exclusion.

Providing a medical history when applying

When applying for health insurance with Accuro, your client can either:

- Apply online through the online application with our award-winning underwriting system or
- Fill out a *Main application form* (or *KidSmart application form*) including answering all of the health questions.

The benefits of providing a complete medical history are that:

- It contains all current and previous medical conditions, which reduces the risk of non-disclosure.
- At claims time, we will not require a medical report from the member (which is normal practice for policies that have been in place for less than five years).

Please note that for us to accept the member's medical history notes instead of the health questions with a full application, the complete medical history needs to be provided from the member's date of birth until the present. We will not accept partial medical history in place of answering the health questions. If a member only provides a partial history, the full application will need to be completed, and the member will be required to obtain medical reports at the time of claiming.

If asked, we are sometimes able to request a member's medical information from another insurer such as their previous health or life insurer. To do this we require:

- Their policy number at the insurer, and
- Authority given by the member to the insurer for Accuro to request this information.

Any cost associated with the request of this information is at the member's expense.

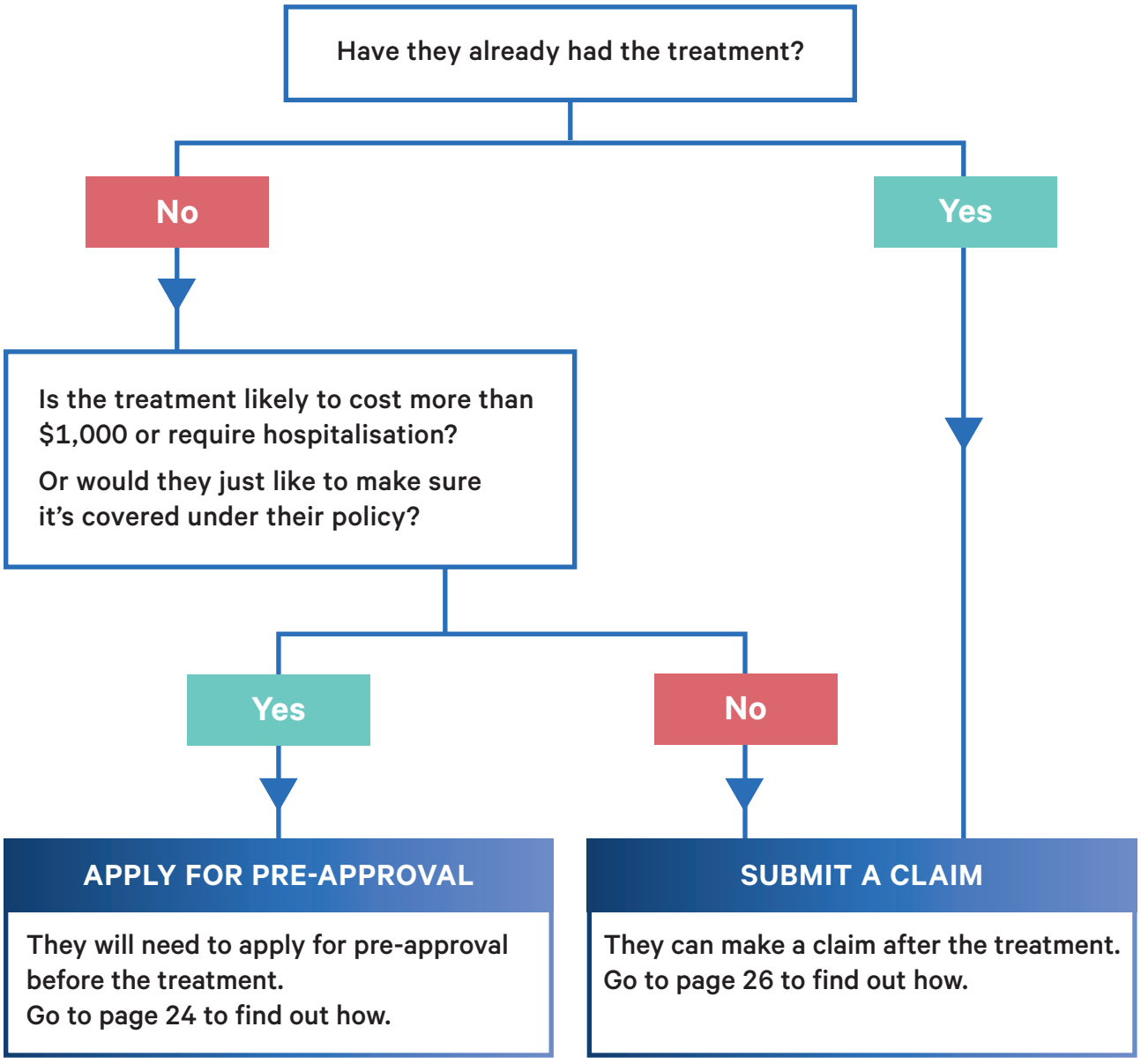
Pre-approvals and claims

The claiming process

There are two ways to submit a claim for your client's procedure or medical treatment.

1. Get pre-approval for the claim by submitting the details of your client's procedure or medical treatment before it takes place in order to confirm that it is covered under their policy.
2. Submit a claim after the procedure or medical treatment has already taken place.

Use the flow chart below to help you decide whether your client needs to get pre-approval or if they can make a claim afterwards.



Please note we are unable to give pre-approval for any of the below plans as these are reimbursement-only plans:

- Basic plan
- Advanced plan
- Value Plus plan
- Any GP plans (including GP+ plans)
- Any Natural Health plans (including Natural Health+ plans)
- Any Dental and Optical plans (including Dental and Optical+ plans)
- Day to Day product

How to apply for pre-approval

Pre-approval is when we confirm cover under the policy before the procedure or medical treatment (such as a surgery) happens. We'll also tell the member of any conditions or excess that may apply. On average we need two working days to process pre-approvals.

Pre-approval is required:

- for any procedure or medical treatment that is likely to cost $1,000 or more
- if the procedure or medical treatment requires hospitalisation, day-stay, or in-patient care.

If in doubt, get pre-approval. If the member doesn't get pre-approval, we may not be able to approve the claim.

Complete a Pre-approval form

The form can be found on our website, or we can post or email a copy. The member can also complete the pre-approval process through the online member portal. The main member must sign this form, and so must the patient if they are over 16 years of age.

Get an estimate of the cost

Obtain an estimate of the cost for the procedure or medical treatment from the health service providers including the hospital. Please try to get an estimate of the cost for all parts of the procedure and treatment, including the number of nights in hospital, theatre fees, and any additional costs such as equipment and physiotherapy. This information allows us to make sure the full cost will be covered. We understand that the information provided will be an estimate and the actual costs may vary.

If the cost is above what we judge to be a reasonable cost for the type of procedure or medical treatment (our reasonable and customary charges), we may ask for further information or we may recommend an alternative treatment or health service provider.

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

Provide medical evidence

The member will need to provide some medical evidence for why the procedure or medical treatment is required. This medical evidence could be either a copy of the GP referral letter or a letter from the specialist that confirms why the treatment is needed.

We may also need the patient's GP (or dentist/optometrist) who holds their medical history to complete Accuro's *Medical report form*. We'll need this report if:

- the patient having the procedure or medical treatment was underwritten and is within the first five years of the applicable plan, and
- this is the first time the patient is claiming for this medical condition.

Any costs associated with getting medical evidence is at the member's expense.

Submit the pre-approval

Submit the pre-approval by post or email, or through the online member portal. In some cases, we may need to contact the member or the health service providers to request additional details to make sure we assess the pre-approval correctly.

Once the assessment has been completed

At the completion of the assessment, the member will receive confirmation of cover via post as well as by email (if there is an email address on their policy). If a pre-approval is declined for any reason, the member will receive a letter advising of this, including why this decision has been made and how to seek a review if they wish.

We will include the adviser in any email correspondance as long as the member has given authorisation for this on the *Pre-approval form*.

If pre-approval has been given, the member needs to make sure that all invoices in relation to the consultation or treatment are sent to Accuro to allow us to assess cover and make payment. These invoices need to clearly state whether Accuro is to pay the provider directly or reimburse the member (receipts showing proof of payment are required).

How to make a claim after treatment

When submitting a claim, the member's asking for payment of a procedure or medical treatment that has already occurred.

We recommend checking your client's plans and products under the Accuro Product section on page 3 as different products and plans have different processing charges and the excess can work differently.

We'll pay up to the reasonable and customary charges for any necessary medical procedure or treatment that's covered by a benefit as outlined in the policy, up to the specified benefit limit. We can only assess claims for events that occur after the relevant health insurance cover has started.

Complete a Claim form

If the member hasn't got pre-approval, they will need to complete a *Claim form*. The form can be found on our website, in the online member portal, or we can post or email a copy. The main member must sign this form, and so must the patient if they are over 16 years of age.

Collect invoices and receipts

Include all invoices with the claim as well as any receipts for the procedure or medical treatment.

Provide medical evidence

The member will need to provide some medical evidence for why the procedure or medical treatment was required so that we can make sure that it is covered under their policy. This medical evidence could be either a copy of the GP referral letter or a letter from the specialist that confirms why the treatment is required. Medical evidence is required when claiming under the below plans (this includes under group policies):

- Major Medical plan.
- Real Value plan.
- Any Hospital and Surgical base plans (including Hospital and Surgical+ base plans).
- Any Specialist plans (including Specialist+ plans).

We may also need the patient's GP (or dentist/optometrist) who holds their medical history to complete Accuro's *Medical report form*. We'll need this report if:

- the patient having the procedure or medical treatment was underwritten and is within the first five years of the applicable plan, and
- this is the first time the patient is claiming for this medical condition.

Any costs associated with getting medical evidence is at the member's expense.

Submit the claim

Submit the claim by post or email, or through the online member portal . In some cases may need to contact the member or the health service providers to request additional details so that we assess the claim correctly.

Once the assessment has been completed

Once all applicable documents have been received, the claims team will start assessment, which on average takes two working days. We will include the adviser in email correspondance with the member regarding the claim as long as the member has given authorisation for this on the *Claim form*.

If a claim is declined for any reason, the member will receive an official letter, including why this decision has been made and how to seek a review, if they wish.

Claims that involve ACC

If a member's health condition or injury is the result of an accident, we ask that the member goes through Accident Compensation Corporation (ACC) in the first instance.

If ACC agrees to provide cover for the full cost of the consultation or treatment, we will not provide cover.

If ACC agrees to provide cover for part of the consultation or treatment, we will assess cover for the remainder of the consultation or treatment as long as it falls under a benefit on the member's policy.

If for some reason ACC declines to cover the consultation or treatment in full, we will assess cover for the cost as long as it falls under a benefit on the member's policy. We would require a copy of the ACC decline letter and an authority form to be completed by the member, which allows us to challenge ACC's decision. Please note that by completing the authority form it will in no way affect the outcome of the request, or the time frame to have the consultation or treatment assessed.

Medical evidence and medical reports

Medical evidence is required to confirm that the service is covered under the member's policy. We require this to assess a claim or pre-approval.

Medical evidence could either be a copy of the referral letter or consultation notes from the GP, dentist or optometrist. We would also accept a copy of the Specialist's letter or notes confirming the outcome of the consultation or treatment. The medical evidence must be from the medical professional who saw the patient for the condition and state why the consultation, procedure or treatment was/is required.

Unless the client provided their complete medical history at the time of application, if they claim within the first five years of their policy and have not claimed for the condition before, then we will require Accuro's *Medical report form* to be completed by the GP (or dentist/optometrist) who holds the patient's medical history. This is required to give us the history of the condition, the symptoms and when it first became apparent. Often the GP referral or Specialist letter will not provide a comprehensive history of the condition, which is why we ask for the *Medical report form* to be completed. A history of the condition informs us if this is a new condition or pre-existing and therefore subject to exclusion.

Any costs associated with obtaining any of the above are at the member's own expense.

Can advisers access a member's pre-approval/claim info?

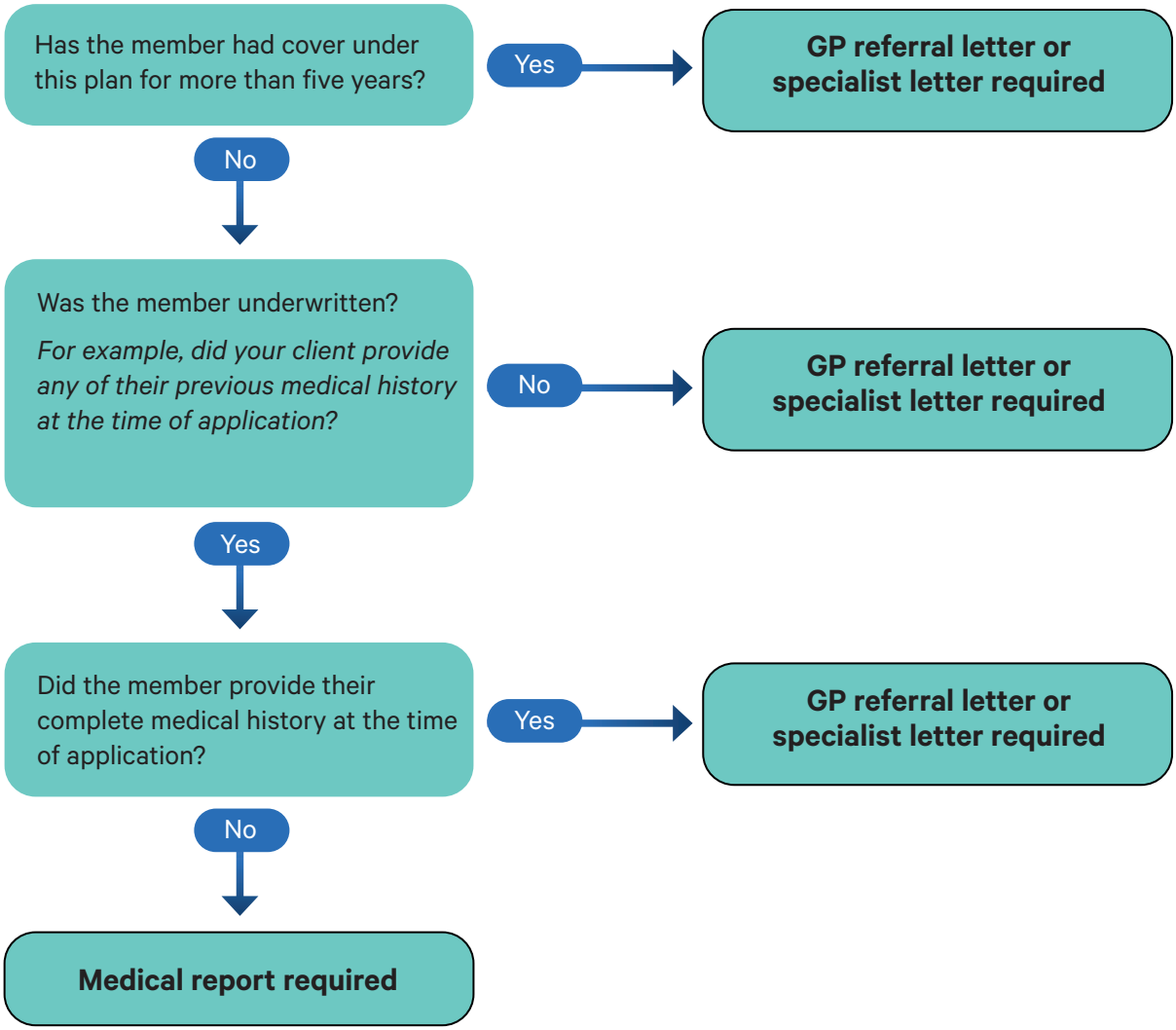
If you wish to obtain information about a particular pre-approval or claim for a member, you need authorisation from the member. The member is able to provide this at the time of submitting the pre-approval or claim.

If you have submitted a claim or pre-approval on behalf of a member, or a member has submitted a claim or pre-approval and ticked 'I authorise information about the details of this claim to be provided to my adviser', you will have access to all information about that particular pre-approval or claim, including whether it has been approved or declined. If the pre-approval has been approved, you will be included in the email to the member.

If a member has submitted a claim or pre-approval without giving the adviser authorisation, you can still obtain limited information about that particular pre-approval or claim, such as whether the claim/pre-approval has been submitted and whether the payment has been made.

Does my client need a Medical report form completed?

Please use the below flowchart to help you decide whether your client will need a *Medical report form* when applying for pre-approval or claiming under their policy.



Confirmation of cover for a procedure

Please do not confirm directly to a member that a procedure is covered under their policy. While a procedure may be a benefit under the member's policy, other factors can impact our assessment of whether a procedure is covered under the policy or not.

Reasons why we may decline cover are:

- The procedure does not fall under any benefit under the member's policy.
- The medical information provided shows that the condition existed prior to the member's policy start date, and should be excluded as pre-existing.
- The procedure is related to a general exclusion under the member's policy (for instance, the procedure is for a screening or preventative measure).
- The procedure is related to a personal exclusion for that particular member under their policy (for instance, they have a current exclusion for skin lesions and the claim is for the removal of a skin lesion).

If a member wants confirmation beforehand that a procedure is covered, advise them to apply for pre-approval.

Member portal

Accuro has a member portal where the main member on a policy can see details, make changes to and submit claims and pre-approvals.

To register, the main member will need to go to our website www.accuro.co.nz, click on “Login” in the top right corner of the home page, then click on “Register” and follow the process. The email used to register for the portal must be the one loaded in our system against the main member of the policy.

Once the main member is registered they can:

- See who is covered under their policy and what plans they hold.
- See a high-level summary of the benefits under each plan.
- Access the latest copy of their membership certificate.
- Access the latest copy of their policy premium notice, as well as any policy enhancements made at their last anniversary.
- View and make changes to certain payment details.
- Request to suspend their policy or suspend a particular member.
- View claims which have been paid.
- Submit a claim or pre-approval.
- Start and save a claim, including adding supporting documentation such as invoices or receipt, to be submitted at a later date.

Commission structure

Commission structure

On-sale plans

Individual	Up front	Renewal
SmartCare, SmartCare+ and KidSmart		
Hospital and Surgical base plan	30%	15%
Specialist plan	30%	15%
GP plan	15%	8%
Natural Health plan	15%	8%
Dental and Optical plan	15%	8%
SmartStay	0%	10%*
Day to Day	0%	0%

* Pro rata payable on receipt of premium for membership duration

Group	Up front	Renewal
StaffCare, StaffCare+ and StaffStay		
- Subsidised members	25% for initial securing of a Group scheme** 10% for every additional subsidised person added thereafter	10%
- Non subsidised members	25%	10%

** Or the commission rate negotiated by the adviser with Accuro

Left group continuation	Up front	Renewal
StaffCare, StaffCare+, StaffStay, SmartCare, SmartCare+	10%	10%

Legacy plans

Plans	Up front	Renewal
Basic plan	0%	10%
Advanced plan	0%	10%
Value Plus plan	0%	10%
Major Medical plan	0%	10%
Real Value plan	0%	10%

Clawbacks

If a policy is discontinued, Accuro will recover commissions paid in accordance with the commission schedule in your agency agreement.

Policy discontinued	% of commission repayable
0 to 6 months	100%
7 to 9 months	50%
10 to 12 months	25%

Financial strength rating

Financial Strength Ratings play a useful role in regulating the financial services sector and can be helpful when making decisions on insurance.

Accuro has a B+ Financial Strength Rating with AM Best. While this rating may be lower than the ratings of some other New Zealand health insurers, there is reasoning behind this.

The key financial considerations in choosing health insurance is the value offered (quality and price) and assurance of the payment of claims.

Value

Quality relates to the breadth and depth of risks covered and the performance of customer service. The higher the level of quality on these dimensions, the greater the cost of delivery. Additional factors that impact price are profit margins and overhead costs. Balanced between quality and cost, is value.

Accuro is regularly assessed by independent experts as offering top quality products at prices that are at the lower end of the market. As a member owned, not-for-profit, we do not have to set aside a margin to pay out to shareholders, which reduces our costs. Additionally, we have much smaller advertising budgets and work hard to keep overheads low.

Assurance of payment of claims

Accuro has been in business since 1971 and every month we have paid out the claims owing. Building and maintaining reserves at a level that ensures that we can always pay out claims is the first financial consideration of Accuro's board and management. Accuro carefully evaluates what level is required based on independent actuarial advice, Reserve Bank licensing specifications and close analysis of trends and patterns in claims and premium. We use a formula that calculates the dynamic value needed to ensure a secure and prudent margin of protection against any extreme adverse financial scenario Accuro could face.

We don't build reserves unduly above that value as this would mean taking money from our members that will not be directly reinvested to them. Accuro's ability to meet members' claims is robust, tested and well proven.

Accuro's history has shown that bigger is not always better. While bankers and rating agencies like to see large amounts of money sitting idly in reserve, Accuro believes it is in the best interests of its members to set its premiums at levels that are affordable and maintain reserves above the regulatory requirement but not to excess. This does mean that we are unlikely to ever achieve an A rating. However, we will confidently continue to pay out claims each month and provide quality product, service and value.

We believe this is the right way to operate a member owned health insurance cooperative.