UniMed

Terms and Conditions

Effective 1 April 2026

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Overview

Who we are

Since 1979, **UniMed** has been helping hard-working Kiwis and their families to access and fund the healthcare they need – when they need it. **We've** paid out more than $1.2 billion in **claims**, making a real difference in the lives of **our Members**.

As a mutual society, **we** exist for **our Members** – not shareholders. Guided by **our** values of aspire, care and trust, **we're** here to support **your** health journey every step of the way. Whether **you're** managing an illness, staying on top of preventative care, or making informed choices about **your** wellbeing, **UniMed** is here for **you**.

How to contact us

Phone: 0800 600 666 (see unimed.co.nz/contact for available hours)

Web: unimed.co.nz

Post: UniMed, PO Box 1721, Christchurch 8140

We aim to provide excellent customer service, care, and support to **our Members**. However, occasionally things can go wrong, or **you** may have concerns about a **claim** or prior approval decision. If that is the case, then please get in contact with **us**. **You** can find further information on this under the *'Contact us if you have any concerns'* section on page 24.

You can download a copy of **our** annual report at unimed.co.nz/important-documents or contact **us** for a copy of **our** financial statements for the last reported year.

Terms used in this document

Words printed in bold have their own special meanings that are defined in the *'Glossary'* on pages 26 - *28*. For **your** convenience, **we** have included some of the frequently used terms here.

'**We**', '**our**' and '**us**' means **UniMed**.

'**You**', '**your**' and '**yourself**' means the **Primary Member** and any additional **Members** on **your policy**.

For explanations of medical terms, please ask **your GP** or other **healthcare provider**, or consult Healthify at healthify.nz.

We want you to understand your cover

What makes up your policy

We want **you** to understand **your policy** and be confident with **your** health insurance, so please read all documents carefully as they are designed to be read together. **You** can always contact **us** to check **your** cover. **Our** contact details are on page 3.

Your policy is made up of:

1. **Your Membership Certificate** that contains the details that are specific to **your** own **policy**, such as the **Health Plan you** are on, each additional **Member** who has cover, any **excess** applicable, as well as any **personal exclusions you** or **your** family member may have.
2. These **Terms and Conditions** (previously referred to as Conditions of Membership) that explain the terms and conditions of **your** cover and **your Membership** with **us**, including what **we** don't cover (**general exclusions**).
3. **Your Special Joining Concessions** that apply if **you** are part of a **group insurance scheme**. This will explain the specific terms, conditions and exclusions of **your group insurance scheme** provided through **your** employer.
4. **Your Health Plan**, which is the specific type of health insurance cover **you** have. What **you** are covered for under **your Health Plan** such as services and **benefits** is set out in the **Health Plan document** as well as any compulsory **excess**. All **Members** on **your policy** will have the same **Health Plan**.
5. Documents and any correspondence **you** have provided to **us**: i.e. **your** application including any health declaration, medical information and/or **your** medical history.
6. The following documents, which may be updated from time to time:
    a. The List of Approved Healthcare Services (previously referred to as Approved and Unapproved Surgical Procedures)
    b. The List of Unapproved Healthcare Services (previously referred to as Unapproved Medical Services; Approved and Unapproved Surgical Procedures)
    c. Eligibility criteria for certain **medical treatment or procedures**
    d. **Rules of UniMed** (previously referred to as Rules of the Society).

You can access these documents either in **your** welcome pack, through the **Member Portal**, via **our** website at unimed.co.nz/important-documents, or via **your group insurance scheme** webpage. If a document is not available through these channels, please contact **us** to request a copy.

If there is any inconsistency or contradiction between **your policy** documents, the following order of precedence will apply (unless advised otherwise):

Your Membership Certificate takes precedence over all other documents, followed by these **Terms and Conditions**, then **your Special Joining Concessions** (where applicable) and finally **your Health Plan document**.

When and how we may update your policy

At **our** discretion, **we** may make changes from time to time to these **Terms and Conditions**, to **our Health Plans**, and to other documents that may affect **your policy**. Changes may be needed to keep **your membership** and insurance cover relevant, suitable for **Members**, in line with current trends and regulations, and financially sustainable.

If **we** make changes to these **Terms and Conditions**, **Health Plan documents** or **your premium**, **we** will notify **you** at least 30 days before these changes take effect. Other documents may be updated from time to time, and the most recent version will be available on **our** website at unimed.co.nz/important-documents.

If **you** are not happy with any change **we** make to **your policy**, please contact **us** to discuss **your** options, or **you** can choose to cancel **your policy**.

Extra care and support

Some **Members** are more at risk of harm because their personal circumstances make them especially vulnerable.

To help **us** recognise and act with the appropriate level of care, please talk to one of **our** team about **your** needs so **we** can take extra care and provide support. **We** can also help **you** appoint a family member or friend as an 'authorised person' on **your policy** who can contact **us** on **your** behalf. If **you** have any concerns, please contact **us**.

You can see more about how **we** support vulnerable **Members** at unimed.co.nz/vulnerablemembers.

When cover under your policy starts

Your policy starts from the **start date** (also known as the Member since date) listed on **your Membership Certificate**.

Cover for any additional **Members** will start from the **start date** specified against each person on the **Membership Certificate**.

We provide a 30-day free-look period that begins from the **start date**. This free-look period allows **you** to review **your policy** and make sure it is right for **you**.

You can make changes to **your policy** within this 30-day period. If **you** change **your** mind and wish to cancel within this 30-day period, **we** will refund any **premium** paid, provided **you** have not made a **claim** under the **policy**. If **you** have made a **claim** that **we** have accepted, then **we** will not refund **your premium**.

Who is eligible to be a Member

Only New Zealand citizens, residents, or people who are entitled to funding under New Zealand's public health system can apply for a **policy** and be a **Member**.

We have designed **our Health Plans** to complement the services provided by the New Zealand public health system and the Accident Compensation Corporation (**ACC**).

The New Zealand healthcare system

The New Zealand healthcare system has three main components:

- Accident Compensation Corporation (**ACC**) provides **personal injury** cover in accordance with the Accident Compensation Act 2001. More information about **ACC** is available at acc.co.nz.
- The public health system provides government-funded hospital and medical care for all New Zealand residents and citizens. It delivers acute, emergency treatment and some elective treatment through public hospitals. Treatment is 'elective' when it's scheduled to happen later because it is not a medical emergency.
- The private health system includes hospitals, **specialists**, and other **healthcare providers** that operate independently of government funding. Services are paid for by individuals, so gives more control over when and where **you** are treated, including being able to choose the doctor, **specialist** or private facility. Often people will decide to have elective treatment in the private health system as it may be quicker.

Other important information

We are not liable or responsible for determining or delivering the quality, standard, or effectiveness of the **healthcare services**, **medical treatment or procedures you** receive that are covered by **your policy**. **Your healthcare providers** are solely responsible for **your healthcare services**, **medical treatment or procedures**. **You** are responsible for obtaining **your** own advice about the suitability of the particular **Health Plan** for **you**.

What we do not cover

Personal exclusions

A **personal exclusion** applies to **your policy** where **we** have decided that a sign, symptom or **condition** that **you** have disclosed is:

1. not covered at all;
2. not covered for a specified length of time; and/or
3. subject to a lower limit of what **we** may pay in the event of a **claim**.

If **you** have any **personal exclusions**, they will be listed on **your Membership Certificate**.

For more information including how they apply please refer to *'Personal exclusions are listed on your Membership Certificate'* section on page 18.

General exclusions

We do not provide cover for any costs related to, or incurred as a consequence of, the health **conditions**, **healthcare services** or situations described in this section.

These are **general exclusions** and apply to all **our Members**. These are standard across all **our** policies and cannot be overridden unless **we** have specifically said otherwise in **your Health Plan document** or in **your Special Joining Concessions** (please note, **Special Joining Concessions** only apply if **you** are part of a **group insurance scheme**).

Please also refer to the **List of Unapproved Healthcare Services** as this details **medical treatment or procedures** that are unapproved by **us** and no cover is provided.

We aim to fully explain what is not covered in **your policy**. Unless specifically provided for in a **benefit** in **your Health Plan**, **we** do not cover any **claims** in relation to the **general exclusions** listed below.

Health conditions we do not cover

Pre-existing conditions

We don't cover any costs related to, or incurred as a consequence of, any **pre-existing conditions**, unless accepted by **us**.

If **you** are part of a **group insurance scheme**, please check **your Special Joining Concessions** as changes to **pre-existing condition** cover will be noted there.

Congenital conditions

We don't cover any costs related to, or incurred as a consequence of, a **congenital condition**.

Chronic conditions

We don't cover any costs related to, or incurred as a consequence of, the following chronic **conditions**:

- Diabetes
- Ischaemic heart disease
- Chronic obstructive pulmonary disease
- Chronic renal failure
- Macular degeneration
- Scoliosis.

Degenerative neurological disorders

We don't cover any costs related to, or incurred as a consequence of, degenerative neurological disorders. This includes:

- Huntington's disease
- Friedreich's ataxia
- Spinocerebellar ataxias (various subtypes)
- Parkinson's disease
- Dementia related disorders
- Motor neuron disorders.

Developmental conditions

We don't cover any costs related to, or incurred as a consequence of, **developmental conditions**. This includes:

- Marfan syndrome
- Pectus excavatum
- Pectus carinatum
- Spina bifida
- Cystic fibrosis
- Polycystic kidney disease
- Facial structural deformities
- Muscular dystrophies.

Psychiatric, psychological and neurodevelopmental disorders

We don't cover any costs related to, or incurred as a consequence of, any psychiatric, psychological and neurodevelopmental disorders. This includes:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Geriatric care including geriatric hospitalisation
- Pre-senile dementia
- Senile illnesses including dementia and Alzheimer's disease.

AIDS, HIV or sexually transmitted diseases

We don't cover any costs related to, or incurred as a consequence of, AIDS or HIV infection or any **condition** arising from the presence of AIDS, HIV infection or sexually transmitted diseases.

Breast reduction and gynaecomastia

We don't cover any costs related to, or incurred as a consequence of, breast reduction or treatment of gynaecomastia, regardless of whether it is medically necessary.

Snoring or sleep disturbances

We don't cover any costs related to, or incurred as a consequence of, sleep disturbances, snoring or obstructive sleep apnoea.

Injury or illness from war, active duty or terrorism

We don't cover any costs related to, or incurred as a consequence of, war, act of war (whether declared or not), active duty in the military of any country or international authority, or terrorism.

Illness or injury from substance abuse or self-harm

We don't cover any costs related to, or incurred as a consequence of:

- misuse of alcohol or drugs whether prescribed, non-prescription or recreational
- participation in a criminal act
- intentional self-injury.

Overseas injuries

We don't cover any costs related to, or incurred as a consequence of, an injury caused by an **accident** outside New Zealand.

Healthcare services we do not cover

Services not covered under your policy

We don't cover any costs related to, or incurred as a consequence of, **medical treatment or procedures**, drugs or other **healthcare services** not covered under **your policy**. This includes:

- **medical treatment or procedures** and technologies that have not been approved by **us**, including any that are new, experimental, unorthodox or not widely accepted as effective, appropriate or essential according to the recognised standards of the medical specialty involved
- additional surgery performed during any operation that is not directly related to any **condition** or treatment covered under the terms of **your policy**
- any costs not specifically provided for under a **benefit** section outlined in **your Health Plan document**
- any **healthcare service** listed in **our List of Unapproved Healthcare Services**
- **medical treatment or procedures** and drugs for **conditions** or **healthcare services** that are excluded under **your policy**.

Services provided at a public facility

We don't cover any costs or expenses incurred whilst using or receiving **healthcare services** in the public health system.

Services provided outside of New Zealand

We don't cover any costs related to, or incurred as a consequence of, **healthcare services** provided outside New Zealand.

ACC services

We don't cover any costs related to, or incurred as a consequence of any **accident**, treatment injury, or work-related gradual process injury, except for what **you** are entitled to under the '**ACC** top-up' **benefit** in **your Health Plan document**.

Pregnancy or childbirth

We don't cover any costs related to, or incurred as a consequence of, pregnancy, childbirth, or miscarriage.

Pregnancy termination

We don't cover any costs related to, or incurred as a consequence of, termination of a pregnancy.

Infertility or assisted reproduction

We don't cover any costs related to, or incurred as a consequence of, the investigation, diagnosis or treatment of infertility, sub fertility or assisted reproduction, including assisted reproductive technology.

Sterilisation and contraception

We don't cover any costs related to, or incurred as a consequence of:

- sterilisation, including reversals
- contraception of any kind including intrauterine devices (except when used for medical reasons).

Gender affirmation

We don't cover any costs related to, or incurred as a consequence of, gender affirmation.

Cosmetic

We don't cover any costs related to, or incurred as a consequence of, any surgery, procedure, or treatment that primarily changes, improves, or enhances appearance, regardless of whether it is undertaken for medical, physical, functional, psychological or emotional reasons.

Weight loss treatment

We don't cover any costs related to, or incurred as a consequence of, weight loss or bariatric investigations or treatment, including when such treatment is intended to manage, treat, or improve other health **conditions** (for example: diabetes, cardiovascular or gastrointestinal **conditions**).

Correction of refractive errors or astigmatism

We don't cover any costs related to, or incurred as a consequence of, the correction of visual errors or astigmatism, including surgery or laser treatment, surgically implanted intraocular lens(es), intraocular injections, radial keratotomy, photo-reactive keratectomy, or any related complications.

Dental care

We don't cover any costs related to, or incurred as a consequence of, dental care, including **conditions** associated with dental health. This includes orthodontic, endodontic, orthognathic (jaw correction) and periodontal treatment, tooth extractions and exposures.

Dental implants

We don't cover any costs related to, or incurred as a consequence of, the implantation of teeth, including dental implants.

Transplants, transfusions and dialysis

We don't cover any costs related to, or incurred as a consequence of, any of the following, for either the donor or recipient:

- organ transplantation
- transfusion or infusion of blood or blood products, excluding routine peri-operative transfusions
- renal dialysis
- faecal transplantation
- stem cell transplantation.

Robotically assisted surgery

We don't cover any costs related to, or incurred as a consequence of, robotically assisted surgery. **We** may, at **our** sole discretion, contribute toward the cost of a robotically assisted procedure up to the **reasonable charge** for the equivalent non-robotic surgery.

Preventative and maintenance services

We don't cover any costs for investigations, monitoring or treatment when **you** are asymptomatic and there is no evidence the **condition** is harmful to **your** health. This includes:

- preventative or prophylactic care and health surveillance testing, such as mole mapping and genetic tests
- screening or tests performed for administrative or non-clinical purposes, for example for employment, travel, study or licensing reasons
- **healthcare services** which, in **our** opinion, are not **medically necessary**
- vaccinations/immunisations
- convalescence.

Other expenses and costs we don't cover

Health related appliances, equipment or devices

We don't cover any costs for:

- personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, shower stools, mouthguards, and artificial limbs, medicine sachets or blister packs
- medical devices; for example, cardiac pacemakers, nerve appliances, cochlear implants, or penile implants
- surgical or medical appliances; for example, glucometers, oxygen machines, respiratory machines, diabetic monitoring equipment, or blood pressure monitoring equipment.

Acute care

We don't cover any costs related to, or incurred as a consequence of, **acute** care.

Long-term care

We don't cover any cost related to, or incurred as a consequence of, **long-term care**, including aged or geriatric care and hospitalisation, **hospice**, respite, or convalescence.

Recoverable expenses

We don't cover any costs or expenses recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, **ACC**).

Personal costs related to hospital stay

We don't cover any personal expenses incurred while in hospital. This includes charges for family meals, soft drinks, alcohol, travel costs, or accommodation for family.

Costs not in relation to a service

We don't cover any costs not specifically related to a consultation, **medical treatment or procedure**, such as administration costs (courier fees, charges for medical notes etc), charges for cancellation or non-attendance, or statement fees.

How to claim

There are two ways to submit a **claim**. **You** can:

1. Get prior approval for a **claim** over $1,000 to confirm that it is covered under **your policy** by submitting the details of the **medical treatment or procedure** before it takes place. The fastest way to request prior approval is through the **Member Portal**.
2. Submit a **claim** after the **medical treatment or procedure** has already taken place. Do this through the **Member Portal** for faster **claim** processing.

You can find further details on how to **claim**, including the documents and information **you** need to provide, at unimed.co.nz/claims.

We only accept and provide cover for costs:

- covered by **your policy**
- for a person who is covered under **your policy**
- for a **medical treatment or procedure** that occurs after **your policy** begins
- for a **medical treatment or procedure** that occurs after the end of any **no-claiming period** that may apply under **your policy**
- under a **policy** that is current and has **premium** paid up to date
- for **benefits** listed in **your Health Plan document**
- for a **medical treatment or procedure** provided by a **healthcare provider**
- charged at a reasonable and fair cost (see *'Reasonable charges'* section on page 13 for details)
- for services in the private health system (unless listed otherwise in **your Health Plan document**).

Any past payment or acceptance of a **claim** does not necessarily mean that **we** are required to cover similar **claims** in the future, particularly if they fall outside of the terms of **your policy**. Each **claim** will be assessed on its own factors and in accordance with the terms in **your policy** at the time of the **claim**.

The next section ('*What we will pay*') also lists things that may affect **your claim** or the amount **we** will pay for a particular **medical treatment or procedure**.

What we will pay

Policy benefit limits

- Unless specifically stated in the **Health Plan document**, all **benefit limits** are the most **we** will pay for each **Member** in each **policy year**.
- The **benefit limits** reset back to their maximum levels at the start of each **policy year**.
- **Benefit limits** cannot be carried over from one **policy year** to the next, accumulated, or transferred to anyone else covered by the **policy**.
- There are some **benefits** that have a lifetime limit or are a one-off lump sum, meaning once a **claim** has been paid up to that sum, the **benefit limit** reduces to zero. These are stated in **your Health Plan document**.
- The minimum or maximum amount for each **benefit** that **you** can **claim** for an **event** is set out in **your Health Plan document**.
- **You** can only **claim your** costs of **medical treatment or procedures** once up to the **benefit limit** under **your Health Plan**. **We** do not pay **your** costs across multiple **benefit limits**.
- **We** will not pay or reimburse any costs that are more than the actual costs incurred, or that are outside of **reasonable charges**.

Loyalty benefits

Under some **Health Plans we** offer loyalty **benefits** which **you** can **claim** after **you** have had the same **Health Plan** for a continuous period of cover. Each **Health Plan** has different loyalty **benefits** and conditions. Please check **your Health Plan document** for details.

No-claiming period

Some **Health Plans** or additional **modules** have a **no-claiming period**. This means that **we** will not pay a **claim** for an **event** that occurred during that specified period. If a **no-claiming period** applies, this will be stated in **your Health Plan document**. If a **Member** is added to **your policy** later, then the **no-claiming period** for them will begin from their **start date**.

Claims with other sources

- **You** must **claim** any other refunds, subsidies, or entitlements available to **you** from another source first. This includes **ACC**, another health insurer, a government-funded agency, or **your** employer. **We** will take any reimbursement from them off the total amount before **we** assess the amount against the **benefit** under **your Health Plan**.
- **We** do not provide cover for an **excess** that is applicable for another insurance plan, whether it be another of **our Health Plans** or one from another insurer, unless specifically advised in **your Health Plan document**.

Unless specifically stated in **your Health Plan document** or accepted in writing before the **event**, **we** do not cover any **medical treatment or procedure you** receive in the public health system. This means a **medical treatment or procedure** in a public hospital or facility that is controlled directly or indirectly by **Health New Zealand | Te Whatu Ora** (or its successor).

Maximum cost we will pay

We will pay the cost for a **medical treatment or procedure** that falls under **your policy**, up to the relevant **benefit limit** or the **reasonable charge** for the **medical treatment or procedure**, whichever is less. If the cost for **your medical treatment or procedure** exceeds the **benefit limit** or the **reasonable charge**, **we** will not pay the exceeded amount. The extra cost will be **your** responsibility and cannot be claimed under another **benefit** or **policy you** have with **us**.

For example, if **your GP** carried out surgery on **you** and the minor surgery **benefit** applies, then the **benefit limit** is $500. If the **claim** was for $1,500, **we** would only reimburse $500 (less any **excess**) and the remaining $1,000 would be **your** responsibility. This is because the **benefit limit** is $500 for each **claim**.

Reasonable charges

'**Reasonable charges**' is the cost for a **medical treatment or procedure** that **we** judge to be reasonable and within a range of cost charged for the same **medical treatment or procedure** under similar circumstances. **Our reasonable charges** make sure that **healthcare providers** are fair with the amount charged, and within a reasonable range, for similar **medical treatments or procedures**.

For **medical treatments or procedures** that have a **reasonable charge** applied to them, **we** look at the average cost as well as the range of charges of the same, or similar, **medical treatments or procedures** throughout New Zealand. The **reasonable charge** that is set represents the cost that is within what **we** consider to be a reasonable range for that, or a similar, **medical treatment or procedure**.

We understand that some **healthcare providers** charge more than others, which is why **we** set an upper limit, while maintaining costs within a reasonable range.

For example, if a surgery has an average cost of $27,500 throughout New Zealand, **we** may determine that the **reasonable charge** of $33,000 applies to the surgery. This means that if **you** were to have a surgery of this type that is covered by **your policy**, **we** would provide cover up to $33,000 as it's unlikely that the surgery would cost above that. However, if it did cost over $33,000, **you** would need to pay any costs over this. If it costs less than that, **we** only pay the actual amount charged.

If the cost for **your medical treatment or procedure** is above what **we** judge to be a **reasonable charge**, **we** may ask for further information, or **you** may want to consider an alternative **medical treatment or procedure** or **healthcare provider**.

If **you** choose to proceed, then **you** will need to pay the difference between the amount **we** approve and the actual cost for the **medical treatment or procedure**, regardless of the **benefit limit**. **You** will need to pay this extra amount directly to **your healthcare provider**. If **you** apply for prior approval, **our** approval will advise **you** of this and the maximum amount **we** can cover.

How an excess works

Excesses apply to some **benefits**. An **excess** is the amount **you** must pay when **you** have a **claim**, before **we** pay the rest (up to the **benefit limit**). The **excess** applies to each **Member** covered by the **Health Plan** for each **claim**, unless advised otherwise in **your Health Plan document**.

All compulsory **excesses** are listed in **your Health Plan**, if applicable. If **you**, or **your** employer through **your group insurance scheme**, have selected a different **excess**, then this **excess** will be shown on **your Membership Certificate**. If the **excess** shown on **your Membership Certificate** is higher, it will override the **excess** stated in the **Health Plan document**.

If **you** make a **claim** for a **benefit** that has an **excess**, **we** will pay the difference between the **excess** and the actual cost or **reasonable charge** for the **medical treatment or procedure** or the **benefit limit**, whichever is lower. **You** are responsible for paying the **excess** amount directly to the **healthcare provider**, unless **your Health Plan** specifies that the **excess** will be deducted from **your** reimbursement. If **you** apply for prior approval, the **excess** amount will be shown on the approval.

For example, **you** have a $1,000 **excess** under **your Health Plan** and make a **claim** for a wisdom tooth extraction that cost $1,500. **You** are responsible for paying the **excess** amount of $1,000, and **we** will pay the remaining $500.

Conditions of cover for prescription drugs

Unless outlined differently in the **Health Plan**, all prescription drugs covered under **your policy** 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 **medical treatment or procedure** in a private facility;
- **Pharmac**-approved;
- **medically necessary**; and
- prescribed by a **healthcare provider**.

You must also meet **Pharmac**'s funding criteria, and the drug(s) must be funded for the relevant **claim**. If the prescription drug(s) require special authority from **Pharmac** to be covered, **we** need confirmation from the **healthcare provider** that **you** meet the special authority criteria before **we** can assess cover for the prescription drug cost.

Your Health Plan may offer varying coverage for prescription drugs, depending on what type of **medical treatment or procedure** they relate to.

- Drugs prescribed and administered in hospital are covered as part of hospital charges related to surgical treatment, or to non-surgical hospitalisation.
- Drugs taken as part of a course of chemotherapy or radiation treatment are covered as part of the chemotherapy or radiation **benefits**.
- Drugs prescribed and taken as part of a course of cancer treatment under the **Medsafe** Approved or Cancer Care Plus **modules**, both of which are additional **modules** and will appear on **your Membership Certificate** if applicable.
- Any other drugs are only covered under the prescription drugs and laboratory tests **benefits**, which could be part of **your Health Plan**.

Non-Pharmac drugs

As part of some **Health Plans**, there is cover for non-**Pharmac** drugs which are **Medsafe**-registered. Under this **benefit**:

- the prescription drug must be registered by **Medsafe** for use in New Zealand;
- the prescription drug must be prescribed by a **specialist** as being an appropriate medical treatment for the **condition**;
- the **condition** or **healthcare service** the prescribed drug is for is not otherwise excluded in the **Health Plan document** or these **Terms and Conditions**; and
- the prescribed drug is within the guidelines set by **Medsafe**.

ACC and injury-related claims

Your Health Plan is designed to work alongside **ACC**. **We** don't cover **medical treatment or procedures** for injuries that **ACC** covers, including injuries caused by an accident, treatment, or a work-related gradual process.

You must do everything **you** reasonably can to have **ACC** cover and **ACC**-funded treatment for **your** injury.

If **you** need more information, please get in contact with **us** or with **ACC**.

ACC top-up benefit

If **ACC** doesn't fully cover the cost of **your medical treatment or procedure**, **you** can make a **claim** with **us** for the rest if it is covered by **your policy**.

The **ACC** top-up **benefit** is subject to the other terms of **your policy**, including any **personal exclusions** or **general exclusions** and **benefit limits**. Injuries that occurred before **your policy** commenced may not be covered by **your policy**.

If ACC declines your claim

If **ACC** declines **your claim**, then **we** may consider covering it under **your policy**.

If **we** believe that **ACC**'s decision to decline **your claim** may be wrong, **we** may ask **you** to challenge **ACC**'s decision. The process would require **your** cooperation, including **you** giving **us** or **our** legal representative the authority to act for **you** in challenging **ACC**'s decision.

Healthcare providers

You are free to choose **your** own **healthcare provider** provided they meet the eligibility criteria in **your Health Plan** (including appropriate registration) and the definitions set out in the *'Glossary'* on page 26.

We may not accept **claims** for **medical treatment or procedures** from **healthcare providers** if **we** believe they have acted dishonestly, misrepresented information, engaged in fraudulent behaviour, or practised outside their recognised medical scope or specialty.

If this affects **your claim**, **we** will let **you** know. **We** may also decline any future **claims** for **medical treatment or procedures** by that **healthcare provider**.

Your responsibilities

You must be truthful with us

When **you**, or anyone else covered under **your policy**, apply for cover, request a change, make a **claim**, or otherwise communicate with **us**, **you** have to always be truthful.

You must take reasonable care not to misrepresent any information. This means checking that everything **you** give **us** is true, correct, complete, not misleading and **you** have not omitted any information.

You must answer **our** questions carefully, honestly, and to the best of **your** knowledge, and provide **us** all information **we** ask for.

If **you** are not truthful with **us**, **your** cover may be affected in the following ways:

- If **you** knowingly give **us** information that is untrue or misleading (or if **you** did not care whether it was), **we** may:
    - terminate **your policy** with effect from the time when **you** provided untrue or misleading information,
    - refuse to pay any **claims**, and/or
    - keep any **premiums you** have paid.
- If information turns out to be untrue or misleading because **you** did not take reasonable care, **we** may:
    - apply different terms to **your policy**, for example, by adding **personal exclusions** or adjusting **premium**, **excess**, or co-payment terms, and assess any **claim** as if those adjusted terms had been in place from the start
    - if **we** determine that **we** would not have provided cover on any terms without the misrepresentation, **we** may cancel **your policy** from the beginning and return any **premiums you** have paid.

If **we** identify fraudulent behaviour, **we** may take legal action against **you** or the additional **Member** involved, as well as notifying enforcement agencies such as the New Zealand Police.

Keeping contact details up to date

You need to let **us** know immediately if **your** contact details such as email address, contact number, or postal address change to make sure **we** have **your** most up to date details.

We will send all communication regarding **your policy** to the last known email address for **you**. If **we** do not have a current email address, **we** will use **your** last known postal address. **We** treat **our** correspondence to **you** as delivered once **we** have sent it.

You are responsible for passing on any information to additional **Members** on the **policy**, such as any changes or information relating to **your policy**.

If **we** can't contact **you** using **your** last known email or postal address, **we** will stop sending communication until **you** have updated **your** contact details. If this happens, **you** acknowledge and agree that **we** have met all **our** obligations to send communications to **you**.

Premiums

You must pay your policy's premium

You must continue to pay **your premium** to make sure **you** are a **Member** and are eligible for **benefits**. It's the responsibility of the **Primary Member** to make sure that the **premium** is up to date for **you** and additional **Members** on **your policy**. **We** will notify **you** of any updates to **your policy** including **your premium**. **You** must pay **us** the **premium** in advance at one of the frequencies **we** offer.

You are only covered when you have paid your premium

We may not accept a **claim** if **your premium** is not up to date, or **we** may deduct any **premium you** owe from any **claim** reimbursement **we** provide to **you**. **We** do not provide cover for any **medical treatment or procedure** that occurs outside the period for which the **premium** has been paid. **We** can only assess cover for a **claim** when the **premium** for **your policy** is up to date for the period when the **medical treatment or procedure** took place.

We will cancel your policy if you haven't paid your premium for 3 months

If **you** don't pay **your premium** on **your policy**, **we** will contact **you** to tell **you** that **your policy** has overdue **premium**. **We** may cancel **your policy**, or **Member**-paid cover if **you** are part of a **group insurance scheme**, if **you** haven't paid **your premium** for 3 months or longer. Cancellation takes effect from the last date **you** have paid **premium** up to.

We may increase your premium at any time

We may apply a general **premium** increase and other changes to **premiums** at any time. The **premium** for **your Health Plan** is not guaranteed. **We** reserve the right to review and adjust **premiums** at **our** discretion. **We** will give **you** a minimum of 30 days' notice of a change in **your premium**.

We will continue to make premium deductions if your contact details change

We want to make sure **you** are covered. If **our** communications are returned and marked 'no address' or **your** email address fails, **we** will continue to make deductions for **your premium** until **you** tell **us** otherwise. When **you** accept **your policy**, **you** authorise **us** to make **premium** deductions.

Pre-existing conditions

You must disclose pre-existing conditions

Our Health Plans are designed to cover treatment for signs, symptoms or **conditions** that develop after the **policy** starts. When **you** apply for cover it's important that **you** are truthful and take reasonable care to provide accurate health information about **yourself** and any additional **Members**, including about **pre-existing conditions**.

If **you** provide information that is untrue or misleading, including if **you** fail to provide **us** with information, this may affect **your** cover and any **claims you** make. Full details are in the *'You must be truthful with us'* section on page 16.

If **you** are part of a **group insurance scheme**, then **you** may have cover for **conditions** that were present before **your policy** started (see **your Special Joining Concessions** for whether this applies to **you** or not). *'General exclusions'* listed on page 7 of this document will still apply, unless a **condition** is specifically advised otherwise in the **Special Joining Concessions**.

A **pre-existing condition** is:

- any health or medical **condition you** are aware of, or any signs or symptoms that **you** are currently experiencing or have experienced in the past, that occurred before the start of **your policy**, or
- a medical **event** that occurred before the start of **your policy**.

We need to know about all previous and current signs, symptoms and **conditions** so **we** can fully assess **your** application.

We may decline claims related to pre-existing conditions you have not told us about

If **you** provide untrue or misleading information or fail to tell **us** about **pre-existing conditions** for **you** or any additional **Member** on **your policy**, or fail to provide information **we** have reasonably requested about the **condition**, **we** may decline any **claim** related to those **conditions**, and/or apply additional **personal exclusions**. The **personal exclusion** may be backdated to apply from the start of **your policy**. If **we** have already paid any **claims** relating to the **condition**, **we** may recover those amounts from **you**. Full details are in the *'You must be truthful with us'* section on page 16.

Personal exclusions are listed on your Membership Certificate

Any **personal exclusions** or **conditions** limited in cover for each **Member** will be shown on **your Membership Certificate**.

A **personal exclusion** or **condition** limited in cover applies to **your policy** where **we** have determined that a sign, symptom or **condition** is:

- not covered at all;
- not covered for a specified length of time; and/or
- is subject to a lower limit of what **we** may pay in the **event** of a **claim**.

You are required to read this information and let **us** know if anything is missing or incorrect.

Make sure **you** check how long each **personal exclusion** applies for or the limit in cover. If there is a time period listed with the **personal exclusion**, once this time period has passed, **you** can then **claim** for that **condition**.

> For example, if **we** placed a **personal exclusion** for a period of 3 years for a **condition you** had prior to joining, **we** will not pay a **claim** in relation to the **condition** within the first 3 years of **your policy**. However, once **you** have had the **policy** for 3 years, the **personal exclusion** no longer applies, and **we** may then pay **claims** in relation to the **condition**.

If a **pre-existing condition** is listed under the *'General exclusions'* listed on page 7, this **condition** is excluded from cover and will not be covered under **your policy**. It does not need to be listed on **your Membership Certificate** as it is a **general exclusion** that applies to all **Members**. Please also refer to any scheme-specific exclusions in **your Special Joining Concessions** if **you** are part of a **group insurance scheme**.

Unacceptable Member behaviour

We want to maintain respectful, helpful, and constructive interactions with **our Members**, and to provide a safe and supportive environment for **our** staff.

We understand that issues with **your policy** can be frustrating, and **we** are committed to listening and resolving matters fairly and in a timely manner.

Sometimes **Members** can behave in ways that are unreasonable or unacceptable, which can affect **our** ability to serve others and keep **our** workplace safe. If interactions become abusive or unreasonably demanding, **we** may need to take action to protect **our** staff and other **Members**.

Types of unacceptable behaviour

Unacceptable behaviour includes, but is not limited to:

- Unreasonable persistence or demands: including excessive contact, repeated requests, or demands for decisions that have already been finalised.
- Unwillingness to cooperate: including withholding information, making dishonest arguments, or refusing to accept reasonable explanations.
- Aggression or abusive conduct: including any verbal or physical abuse, bullying, threats, or discriminatory or derogatory comments toward **our** staff.

How we assess unacceptable behaviour

We consider behaviour unacceptable when it:

- compromises the mental or physical health, safety, or security of **our** staff; and/or
- disrupts **our** ability to operate effectively for **our Members**.

Possible actions

If **we** consider that **your** behaviour is unacceptable:

- **We** will contact **you** in writing (by email or letter) advising **you** that **your** behaviour is unacceptable.
- **We** may limit how **you** can contact **us** (for example, requiring written communication only or using a representative).
- **We** may issue **you** with a warning explaining possible consequences should **your** unacceptable behaviour continue.
- **We** may terminate **your policy**. **We** reserve the right to unilaterally cancel **your policy** for unacceptable behaviour by **you** or another **Member** on **your policy** if **we** determine that is appropriate. **We** will give **you** up to 30 days' notice of the termination.

Changing your policy

Making changes to your policy

You can contact **us** to request changes to **your policy** at any time.

Making changes to **your policy** can affect things like **your excess**, **benefit limits**, continuous cover, **pre-existing condition** cover, **general** and **personal exclusions**, and **premium**. **We** recommend that **you** talk to **us** or **your** Adviser so **you** can fully understand the implications of any proposed changes.

Increasing your cover

Depending on the type of increase, **you** may be required to fill out a new application or health declaration in relation to the increase in cover. New **personal exclusions** or **conditions** subject to a lower limit may be placed on **your policy** due to the increase in cover, and these will be shown on **your** new **Membership Certificate**.

Decreasing your cover

Decreasing **your** cover does not require a health declaration, however if **you** decide to decrease **your** cover and then wish to increase it again in the future, **you** may be required to complete a new application or health declaration and **personal exclusions** may be added.

Removing additional modules

If **you** add an additional **module** to **your policy** and then want to remove it, **you** can only remove it from the start of **your** next **policy year**.

Exclusions will continue to apply with changes

Any **personal exclusions** on **your policy** for **pre-existing conditions** will continue to apply to **your policy** after changes have been made if **we** deem them still necessary. These will be listed on **your** new **Membership Certificate** issued after the changes have been made.

We can decline to change your cover

We have the right to decline **your** request for a change of cover at **our** discretion, for example, **we** may decline **your** request if it appears **you** are trying to manipulate **your** cover or take advantage of **us** by making the change.

Adding additional Members to your policy

You can add **your partner**, or **children** 18 years and younger, onto **your policy** at any time. To be eligible they need to be a New Zealand citizen, resident, or entitled to funding under New Zealand's public health system.

- To add an additional **Member** to **your policy you** may need to complete a full application for each additional **Member** and answer the health questions or provide their full medical history.
- **We** will assess each application and decide whether the additional **Member** can be added and under which terms, based on the health information **we** receive.
- Cover for an additional **Member** starts from their **start date** on the **Membership Certificate**, which is provided with the confirmation of their coverage.
- Once an additional **Member** has been added to **your policy**, they will remain on it until the **Primary Member** tells **us** otherwise.

- **Premium** for additional **Members** will be charged from the date cover starts for the additional **Member**, as part of the normal billing cycle.

Adding children to your policy

Adding a baby who is under 3 months old

You can add a baby who is under 3 months old to **your policy**. The baby will have no **personal exclusions**. **You** can do this in the **Member Portal**, or contact **us** with the **child**'s full name, date of birth and their sex at birth, and they will be added to **your policy**.

The *'General exclusions'* listed on page 7 will still apply, including **congenital conditions**.

Adding a child who is older than 3 months

If **you** wish to add a **child** who is 3 months of age or older to **your policy**, **you** will need to complete a full application. **We** will assess the application, considering any **pre-existing conditions** the **child** may have and apply any necessary **personal exclusions**.

Children remaining on your policy

Children can remain on **your policy** until the end of the **policy year** after they reach 19 years of age. After the end of the **policy year**, **we** will classify them as an adult and the associated **premium** will apply.

If **you** are part of a **group insurance scheme**, there may be different rules applicable around the **child**'s age and whether they can remain on **your policy** as an adult. Please see **your Special Joining Concessions** for further details or contact **us**.

Removing additional Members from your policy

You can remove an additional **Member** from **your policy** at any time by contacting **us**.
The **Primary Member** is responsible for removing additional **Members** from the **policy** if circumstances change — for example, following a marital separation.

When a family arrangement changes, a separated **partner** may apply to become a **Member** in their own right and continue on a separate **policy**.

If **you** remove an additional **Member** from **your policy** and wish to add them again in the future, they may need to complete an application and health declaration.

Options after being removed from a policy

Any additional **Member** aged 18 years and over who has been included on **your policy**, may apply to have their own **policy**. If the additional **Member** applies within 30 days of leaving **your policy**, they will not need to go through the full application process, and any **pre-existing condition** cover will remain the same if retaining the same **Health Plan** and **policy** terms.

If they apply outside of the 30-day period or are requesting a change in cover, then they may need to complete an application and health declaration, and further **personal exclusions** or **conditions** subject to lower limits may apply.

If **you** are part of a **group insurance scheme**, please refer to **your Special Joining Concessions** for information about continuing cover as specific terms and conditions may apply, or contact **us** to find out more.

Death of the Primary Member

If the **Primary Member** of the **policy** dies, the **partner** who has been included on the **policy** may retain the **policy** and continue paying the appropriate **premium**. The **partner** will then take over the role of the **Primary Member**. **Group insurance scheme Members** may not be eligible to retain the existing **policy**.

Suspending your policy

You may ask **us** to suspend **your policy** (put it on hold and not pay **premium**) for a period of time. **You** must provide the reason(s) for **your** request, and **we** will advise if **we** need supporting information.

We will not pay any **claims** for **you** or any additional **Members** for **medical treatment or procedures** that occur while **your policy** is suspended. **You** are unable to access Active Benefits/Care while **your policy** is suspended.

You must be a **Member** for a minimum of 12 months before **your policy** can be suspended.

There is a minimum of 12 months between suspension periods. This 12-month period starts from the end date of the last suspension.

Reasons to request a **policy** suspension may include:

- taking parental leave
- suffering financial hardship
- travelling overseas for an extended period
- being seconded overseas for work if **you** are part of a **group insurance scheme**.

There are specific terms and conditions for each suspension type, such as minimum and maximum periods. These terms and conditions, and further information about suspension options are on **our** website at unimed.co.nz/important-documents.

Ending your policy

Any **medical treatment or procedures** after the date of cancellation, regardless of the reason why **your policy** has been cancelled, will not be covered under **your policy**, including those **you** may have prior approval for.

Cancelling your policy

You can ask **us** to cancel **your policy** at any time. Cancellation must be requested by the **Primary Member**, Adviser or an authorised person on **your policy**.

Reinstatement of **membership** within 30 days of **you** cancelling **your policy** is at **our** discretion. If **you** apply to rejoin more than 30 days after cancelling, **you** may need to submit a new application and health declaration.

Leaving a group insurance scheme

If **you** have a **policy** that is provided by **your** employer and **you** become ineligible for reasons such as leaving employment or a change in employment, once **we** are notified **we** will cancel **your policy**. The cancellation date of **your policy** will be the date **your** employment ends or the date **your** employer has paid **your premium** up to.

Confirmation of the cancellation will be sent to **you** along with options to continue **your policy** with **us**. If **you** wish to continue **your policy**, **you** will need to confirm this within 30 days to ensure continuous cover.

If **you** apply outside of this 30-day continuation period, **you** will not receive continuous cover and may need to submit a new application and health declaration.

Your Special Joining Concessions explain the conditions for continuation after leaving **your** employer, so please refer to these for more information.

How we can end your policy

We can end **your policy** if:

- **you** fail to pay **your premium** for 3 months or longer;
- **you** or any additional **Member** breaches these **Terms and Conditions**, the terms of the **Health Plan** or the **Rules of UniMed**;
- there is unacceptable behaviour by **you** or a **Member** on **your policy**; or
- the last **Member** covered by the **policy** dies.

Other important information

Our Terms and Conditions provide information of a factual nature only and is not an opinion or recommendation.

A **policy** has no surrender value.

Membership of the Society

UniMed is the trading name for Union Medical Benefits Society Limited, which is incorporated under the Industrial and Provident Societies Act 1908. This legislation governs the way **UniMed** is run, and the health benefit plans it administers. Like all legislation, it can change from time to time.

UniMed membership

Everyone insured by **us** is referred to in these **Terms and Conditions** as a **Member** for the purposes of describing insurance cover under a **policy**.

However, for the purposes of **membership** of Union Medical Benefits Society Limited under the Industrial and Provident Societies Act 1908, only individuals aged 16 years and over are eligible to be voting **UniMed** members under the **Rules of UniMed**.

Where a person under the age of 16 is insured under a **policy**, they are covered as an insured person of that **policy** but are not a member of Union Medical Benefits Society Limited for statutory purposes.

By applying for cover, directly or through **your** employer, **you** have applied for **membership** of **UniMed** for **yourself** and any other person covered under **your policy**. When **we** accept **your** application, **you** and any other person covered under **your policy** is automatically granted **membership** of **UniMed**. This means that throughout **our** documents, **we** may refer to **you** as the **Primary Member** and all other individuals on **your policy** as additional **Members**.

By becoming a **Member** of **UniMed**, and being aged 16 years or older, **you** are deemed to have accepted and are bound to comply with the **Rules of UniMed**.

The **Rules of UniMed** may change from time to time. A copy of the **Rules of UniMed** is available at unimed.co.nz/important-documents.

In the event of a discrepancy between these **Terms and Conditions** and the **Rules of UniMed**, these **Terms and Conditions** take precedence in regard to **your** insurance cover. **Your membership** automatically ends if **your policy** is cancelled or terminated, or in the **event** of **your** death.

Contact us if you have any concerns

We pride ourselves on providing great customer service, care, and support to **our Members**, so if **you** have a concern, please let **us** know. **We** will work with **you** to resolve **your** concerns as quickly as **we** can.

We are always working on ways to improve **your** customer experience. **You** can provide **your** feedback to **us** via **our** website unimed.co.nz.

Complaints

If **you** are unhappy with a **claim** or prior approval decision, or **you** wish to make a complaint, please follow **our** complaints process available at unimed.co.nz/complaints-process, or **you** can request a copy from **us**.

If **we** have not resolved **your** complaint to **your** satisfaction or **we** can't reach an agreement with **you** about a **claim** or prior approval decision after the steps detailed in **our** complaints process, **you** can choose to take **your** concern to a free and independent dispute resolution service, the Insurance & Financial Services Ombudsman (IFSO).

Insurance & Financial Services Ombudsman (IFSO)

We are a member of an approved free and independent dispute resolution scheme operated by the Insurance and Financial Services Ombudsman (IFSO) which may help investigate and resolve a complaint if it is not resolved to **your** satisfaction.

You can contact the IFSO if **we** haven't been able to reach an agreement with **you**. **You** must contact the IFSO within 3 months of **us** telling **you**, in writing, that **we** won't change **our** decision and providing **you** with a letter of deadlock.

If **we** do not notify **you** what **we** have decided, then 2 months after the date of **your** initial complaint **you** can contact the IFSO.

You can get more information on the IFSO at ifso.nz or by contacting them directly:

Phone: 0800 888 202

Mail: Insurance & Financial Services Ombudsman, PO Box 10845, Wellington 6143

Financial Services Council

We are a member of the Financial Services Council (FSC), which is a non-profit member organisation with a vision to grow the financial confidence and wellbeing of New Zealanders. FSC members commit to delivering strong consumer outcomes from a professional and sustainable financial services sector and members are required to comply with the FSC Code of Conduct. **You** can find more at fsc.org.nz.

Privacy Statement — we are committed to respecting your privacy

Personal and health information is collected and held by **us** in accordance with the Privacy Act 2020 and Health Information Privacy Code 2020 (or their successors).

We value the trust **you** place in **us** to protect, use and disclose this information appropriately.

Please see unimed.co.nz/privacy for **our** full Privacy Statement which sets out how **we** collect, store and share **your** information, as well as how **you** can access and correct **your** personal information.

We may update **our** Privacy Statement from time to time to reflect changes in **our** practices or legal requirements. **We** encourage **you** to review it periodically to stay informed about how **we** manage **your** information.

New Zealand law and currency apply

We conduct all **our** business according to the laws of New Zealand and any disputes regarding the **policy** are to be determined by New Zealand law.

All monetary amounts in all **our** material (including any **Health Plan documents**) are in New Zealand dollars. All **benefit** and **premium** amounts include GST.

Glossary

This section explains the specific meaning of words and phrases that appear in bold throughout this document. Singular words in this section can also be taken to mean the plural and vice versa.

The definitions in this Glossary are specific to this **Terms and Conditions** document. They might be different from standard medical or other common definitions. If there's ever a difference, the meanings in this Glossary are the ones that apply.

ACC is the Accident Compensation Corporation of New Zealand referred to in the Accident Compensation Act 2001 (or its successor), or any organisation providing third party injury management pursuant to the Accident Compensation Act 2001. More information about **ACC** can be found at acc.co.nz.

Accident is as defined in the Accident Compensation Act 2001 (or its successor).

Acute means a sign, symptom, or **condition** that warrants care within 48 hours by a doctor or hospital admission for treatment or monitoring.

Base plan and **module** means a specified range of **benefits** grouped together and offered under a **Health Plan**.

Benefit means the reimbursement available for **Members** for a specified **medical treatment or procedure** as outlined in the **base plan** or **module** within the **Health Plan document**, including grants.

Benefit limit means the maximum amount that **we** will pay under a **benefit**, less **your excess**.

Child/Children means a **Member**'s **child**, including any stepchild, adopted **child**, or **child** for whom the **Member** has legal guardianship or primary caregiving responsibility, who has been accepted as an additional **Member** on the **policy** before the **child** turns 19 years of age.

Claim means the request by a **Member** to have their costs in relation to a **benefit** under their **base plan** or **module** refunded as described in a **Health Plan document**, providing the **Member** is eligible.

Condition means any illness, injury, disease, ailment, sickness, disorder, or disability, whether diagnosed or undiagnosed, that affects **your** physical or mental health.

Congenital condition means a health abnormality or defect that is present at birth (whether it is inherited or due to external factors such as drugs or alcohol or any other cause). This includes any **conditions** present at birth and diagnosed within the first 12 months of life, or where signs or symptoms were present before **your policy** began – regardless of when it was formally diagnosed.

Developmental condition means a health abnormality or defect that is present at birth but does not show any signs or symptoms until later in life. This includes **conditions** that may not be diagnosed until childhood, adolescence, or adulthood.

Event means (without limitation) the date of birth, death, visit, consultation, test, surgery, repair, treatment or supply, or the period of absence from work, duration of treatment or time in hospital.

Excess means an amount specified in **your Health Plan document** or on **your Membership Certificate** that is excluded from a **claim** payment, and **you** are responsible for.

General exclusion means a **condition**, treatment, or situation that **we** do not cover for any **Member** as listed in the *'General exclusions'* section in this document.

General Practitioner/GP means a medical practitioner who is vocationally registered in general practice, holds a current annual practising certificate issued by the Medical Council of New Zealand and is operating within their scope.

Grant means a payment of a fixed amount as listed in a **Health Plan document** or that may be made at **our** discretion.

Group insurance scheme means a scheme of cover offered by **us** on particular terms and conditions to a group in respect of the officers, employees, or contractors of the group.

Health Plan means the specific **UniMed** health insurance plan that a **Member** is covered under, which includes a **base plan** and additional **modules** if chosen. The **Health Plan** could either be selected by the **Member** or provided to them through a **group insurance scheme**.

Health Plan document means the document that outlines the range of **benefits** provided by the **base plan** and any additional **modules** under a **UniMed Health Plan**, and any changes made to the **Health Plan** in accordance with the terms of **your policy**.

Healthcare provider means a **general practitioner**, **specialist**, or registered practising member who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its successor), is a member of the appropriate registration body, and who is recognised by **us**.

Healthcare service means any procedure, treatment, surgery, investigation, diagnostic test, consultation, prescription drug cost, therapeutic, rehabilitation, hospitalisation, or other private **healthcare service** provided by a **healthcare provider** in a private facility.

Health New Zealand | Te Whatu Ora (or its successor) means the entity responsible for managing all public health services and systems across New Zealand.

Hospice means a healthcare facility that holds regular or associate service membership with Hospice New Zealand and provides palliative care services for patients with a terminal illness.

List of Approved Healthcare Services means the list published on **our** website at unimed.co.nz/important-documents containing **healthcare services** approved by **UniMed**. It was previously referred to as Approved and Unapproved Surgical Procedures.

List of Unapproved Healthcare Services means the list published on **our** website at unimed.co.nz/important-documents containing the **healthcare services** not approved by **UniMed**, and for which there is no cover. It was previously referred to as Unapproved Medical Services; Approved and Unapproved Surgical Procedures.

Long-term care means ongoing care or support required for a health **condition**, disability, or loss of functional ability that is not expected to improve in the short-term. It may include personal care, residential care, or other support services focused on day-to-day living rather than **acute** or medical treatment.

Medical treatment or procedure means any procedure, treatment, private surgery, investigation, diagnostic test, consultation, therapeutic, rehabilitation, hospitalisation, or other private **healthcare service** provided by a **healthcare provider** or a private facility.

Medically necessary means any **healthcare service** that, in **our** opinion, is necessary for the care and treatment of a nominated health **condition**.

Medsafe is the New Zealand Medicines and Medical Devices Safety Authority (or its successor), a division of the Ministry of Health, responsible for the regulation of therapeutic products in New Zealand.

Member means a person who has been accepted as a **Member** of **UniMed**, who is named on the **Membership Certificate** for whom **premium** is currently being paid to **UniMed**. This could be the **Primary Member**, their **partner** or **child** or any additional **Member** on the **policy**. It doesn't include generic use of the word 'member' or 'members' when referring to members of families, associations, or **our Member Portal**.

Membership means **membership** of **UniMed**. Everyone insured by **us** is a **Member** of **UniMed**. By applying for cover, directly or through **your** employer, **you** have applied for **membership** of **UniMed** for **yourself** and any other person covered under **your policy**. When **we** accept **your** application for cover, **you** and any other person covered under **your policy** is automatically granted **membership** of **UniMed**.

Membership Certificate means the most recent **Membership Certificate** issued by **us** to a **Primary Member** that confirms initial acceptance of **membership** or subsequent alterations to the **policy** for all **Members** on the **policy**.

Member Portal means the secure online platform where **you** can log in to view and manage **your** health insurance **policy**. Through the **Member Portal**, **you** can do things like submit and track **claims**, request prior approval, update **your** details, request to add family to **your policy**, and view **your Health Plan document** and other important documents.

Module and **base plan** means a specified range of **benefits** grouped together and offered under a **UniMed Health Plan**.

No-claiming period (previously referred to as stand-down period) means the period as defined in the **Health Plan document** after the **start date** or, in the case of an additional **Member** added to the **policy**, the period after the date on which that additional **Member** is added. **You** cannot **claim** for **events** that happen during the **No-claiming period**.

Partner means the spouse or de facto **partner** of the **Primary Member** where the parties are living together in a relationship in the nature of a marriage or civil union, and who is listed on the **Membership Certificate**.

Personal exclusion (previously referred to as an endorsement) means signs, symptoms, medical **conditions** or body parts that **we** do not cover for a particular **Member**, as specified on **your Membership Certificate**.

Personal injury has the meaning given in section 26 of the Accident Compensation Act 2001 (or its successor).

Pharmac is the New Zealand Pharmaceutical Management Agency (or its successor), a Crown entity that decides which medicines and pharmaceutical products are subsidised for use in the community and public hospitals.

Pharmac Schedule means the list of pharmaceuticals that are approved for public prescription in New Zealand and funded by **Pharmac**.

Policy means **your** insurance contract with **us** that is made up of:

- **your Membership Certificate**
- these **Terms and Conditions**
- **your Special Joining Concessions**, if applicable
- **your Health Plan document**(s)
- documents and any correspondence **you** have provided to **us**: i.e. **your** application including any health declaration, medical information and/or **your** medical history
- the List of Approved Healthcare Services
- the List of Unapproved Healthcare Services
- eligibility criteria for certain **medical treatment or procedures**
- **Rules of UniMed**.

Policy year means the 12-month period that starts on **your membership** commencement date or **policy start date**, and every 12-month period after that.

Pre-existing condition means:

- any health or medical **condition you** are aware of, or any signs or symptoms that **you** are currently experiencing or have experienced in the past, that occurred before the start of **your policy**, or
- a medical **event** that occurred before the start of **your policy**.

Premium means the amount paid to **us** by **you**, or by **your** employer if **you** are in a **group insurance scheme**, on behalf of a **Member** to maintain **membership** and eligibility for **benefits**.

Primary Member means the person in whose name the **policy** is issued and who is responsible for the payment of **premium**.

Reasonable charges (previously referred to as Usual and customary charges) means charges for a **medical treatment or procedure** that is determined by **us** in **our** sole discretion to be both:

- reasonable, and
- within a range of fees charged for the same or similar **medical treatment or procedure**.

We do not pay more than what **we** determine to be the **reasonable charge**.

Rules of UniMed (previously referred to as Rules of the Society) means the Rules of Union Medical Benefits Society.

Specialist means a medical practitioner who:

- is a member or fellow of an appropriately recognised **specialist** medical college
- is registered with the Medical Council of New Zealand and holds a current annual practising certificate in that specialty
- holds a vocational scope of practice.

This does not include those holding vocational registration in:

- accident and medical practice
- emergency medicine
- family planning and reproductive health
- general practice
- medical administration
- public health medicine
- sexual health medicine
- urgent care.

The list of specialties excluded in the definition of **specialist** may be amended by **us** from time to time at **our** sole discretion.

Special Joining Concessions means the document provided that sets out the terms that apply to a **Member** who joins as part of a **group insurance scheme**. These concessions may include specific joining terms, conditions, or exclusions that are different from what's normally set out in the **Health Plan document** or these **Terms and Conditions**.

Start date is the date **your policy** starts as shown on **your Membership Certificate**. May also be referred to as 'Member since date' on the **Membership Certificate**.

Terms and Conditions means this document that sets out the general conditions and requirements that apply to **your policy** with **UniMed**. This includes eligibility, exclusions and limitations, **claims** and payment conditions and the responsibilities of **UniMed** and the **Members** on the **policy**. These **Terms and Conditions** apply to all **Health Plans** unless stated otherwise in the relevant **Health Plan document**.

UniMed means Union Medical Benefits Society Limited incorporated under the Industrial and Provident Societies Act 1908 (or its successor).

We, **us**, and **our** means **UniMed** or Union Medical Benefits Society Limited, or **our** authorised agents.

You, **your** and **yourself** means the **Primary Member** and any additional **Members** on **your policy**.

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