Basic Plan
Advanced Plan

UniMed

Claims year from 1 April to 31 March

The Basic and Advanced Plans are refund only **Health Plans**, meaning that you have to pay for the services first and then submit a **claim** to **us** with the invoices or receipts for reimbursement.

The Basic and Advanced Plan has a 90-day **no-claiming period**. This 90-day period applies to **Members** added to this **Health Plan**, and **claims** cannot be made for any **event** for a **Member** within the 90-day time period after their **start** date on this **Health Plan**. The **Member start** date will be listed on the **Membership Certificate**.

Maximum aggregated refund per year for all benefits on the Health Plan (excluding Special **benefits** and **grants**)	**Basic Plan** **$2,500**	**Advanced Plan** **$3,000**

STANDARD BENEFITS	**Basic Plan** 50% refund up to:	**Advanced Plan** 80% refund up to:
Registered medical practitioner or registered nurse consultations Including laboratory fees for tests.	$55 per visit	$60 per visit
Registered medical specialist consultations. A referral letter is required.	$125 first visit $75 follow-up visit	$150 first visit $100 follow-up visit
Mental health consultations Covers the costs of registered psychiatrist, psychologist, psychotherapist or counsellor consultations.	$1,000 per year	$1,000 per year
Prescription drugs Medicines listed under section A to I of the **Pharmac Schedule** (excluding section H) that are prescribed by a **registered medical practitioner** or designated prescriber nurse.	$20 per item	$25 per item
Physiotherapy treatment (Materials not covered) by a registered physiotherapist.	$80 first visit $40 follow-up visit	$100 first visit $50 follow-up visit
Imaging X-ray and image intensifiers (by a registered radiologist), ultrasound, scintigraphy, CAT or MRI scan. A referral letter is required.	$700 per **event**	$800 per **event**
Private hospital fees Including the **reasonable charges** for **surgical**, medical, ambulance and minor **surgery** at a **surgical** clinic. A referral letter is required.	$1,000 per **event**	$1,250 per **event**

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

OTHER BENEFITS	Basic Plan 50% refund up to:	Advanced Plan 80% refund up to:
Podiatry treatment By a registered podiatrist (materials not covered). Orthotics are not covered.	$100 per year	$125 per year
Chiropractic treatment By a registered chiropractor (materials not covered).	$100 per year	$125 per year
Acupuncture treatment By a registered acupuncturist (materials not covered).	$100 per year	$125 per year
Osteopath treatment By a registered osteopath (materials not covered).	$100 per year	$125 per year

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

For Member offers please visit unimed.co.nz/active-benefits.

Terms and conditions

These are the terms and conditions governing the **benefits** available to **Members** as described in the **Health Plan document**. This **Health Plan** is insured and underwritten by Union Medical Benefits Society Limited. The terms and conditions should be read in conjunction with the **Health Plan document**. **UniMed** reserves the right at all times to vary these terms and conditions, however it deems appropriate. **We** will endeavour to provide reasonable notice (minimum 21 days) prior to such change. All **benefits** relate to private care only (including consultation, **procedure** and/or **medical treatment** or **hospitalisation**), unless public **procedure** and/or **medical treatment** is specified in the **benefit** wording.

Words printed in bold have their own special meanings that are defined in the 'Glossary of key terms' section at the end of this document.

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

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.

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. This **Health Plan document** that sets out the details of **your** cover, including the services and **benefits** available, and the terms and conditions that apply to **your membership**, including what **we** don't cover (general exclusions).
3. Documents and any correspondence you have provided to **us**: i.e. **your** application including any health declaration, medical information and/or **your** medical history.
4. The following documents, which may be updated from time to time:
    - Eligibility criteria for certain **medical treatment** or **procedures**
    - **Rules of UniMed**.

You can access these documents either in **your** welcome pack, through the Member Portal, or via **our** website at unimed.co.nz/important-documents. 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 **your Health Plan document** including terms and conditions.

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.

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 25 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

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**.

Waiver of premium

If the **Primary Member** or **partner** (who is covered under this **Health Plan**) dies, **we** will continue to provide cover for the **Member**-paid **premium** for the remaining **Members** covered under this **Health Plan** for 12 months. Other terms:

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

Appropriate certificates and documentation must be provided.

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.

Applications for membership

- All applications for **membership** and subsequent alterations to a **policy** must be made in writing by completing all sections of **our** application form.
- Full details of the Primary **Member** and all proposed additional **Members** are required.
- All previous medical history must be disclosed in the health declaration on the application form.
- If you have three or more **children** on your **policy**, you only pay **premiums** for the first two **children** as long as the **Health Plans** selected are the same for each **child**. All **children** will remain on **child** rates up to 25 years old. On the anniversary following reaching 25 years, the **premium** payable will be adjusted from a **child** rate to that of a 25-year-old adult and they will remain on your **policy** unless you request their removal.
- **We** reserve the right to exclude any declared or non-declared **pre-existing condition** from the **policy**. This applies to you and any additional **Members** at the time of application and/or during the life of the **policy**.

  All symptoms and conditions, including **congenital conditions**, will be excluded from cover under the **policy** and must be disclosed at the time of application of the original **policy**. Any such exclusion(s) that you disclose will be clearly stated on the **Membership Certificate** and should be read in conjunction with the **Health Plan document**. **We** reserve the right to exclude any declared or non-declared **pre-existing condition** or **congenital condition** from **your policy** at any time. The exclusion may be backdated to apply from the **start** of **your policy**.

Policy purpose

Your policy is designed to assist you with meeting the financial costs associated with **your** health and wellbeing.

Commencement of membership and cover start date

Membership starts from the date listed on **your Membership Certificate**.

30-day free-look period

We provide a 30-day free-look period that begins from the **start** date on **your Membership Certificate**. This free-look period allows you to review **your** cover 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'll** refund any **premiums** paid, as long as you haven't made a **claim** under the **policy**.

To cancel within the 30-day free-look period, the **Primary Member** must contact **us** and ask to cancel the **policy**.

Extra care and support

Some **Members** are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life **events**, financial or personal resilience, knowledge or confidence in managing financial matters. To help **us** recognise and act with the appropriate level of care please chat to one of **our** team about **your** needs so **we** can take extra care and provide support that fits **your** needs.

Premiums

- **Premiums** must be maintained to ensure continuity of **membership** and eligibility for **benefits**.
- **Claim** payments will be withheld when **premiums** are in arrears until the arrears are cleared.
- **Membership** will be terminated when 90 days of **premiums**, or more, remain unpaid.
- **We** reserve the right to deduct any outstanding **premium** when making payment for an eligible **claim**.

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 make a **claim**, including the documents and information you need to provide, at unimed.co.nz/claims.

When we will cover costs

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 the base plan you have cover for
- for a **medical treatment** or **procedure** provided by a **healthcare provider**
- charged at a reasonable and fair cost
- for services in the private health system (unless listed otherwise in this **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**.

Other information

- Visits to a **registered medical specialist** must be referred by a general practitioner or dentist. A copy of the referral letter must be included with the **claim**.
- Where relevant, the minimum or maximum amount that may be claimed for each **event** is set out in the **Health Plan document**.
- Prescription drugs must be listed under section A to I of the **Pharmac Schedule**, however any drugs listed under section H of the **Pharmac Schedule** will only be covered if used during a **procedure** in a private facility. The **Member** must also be eligible to meet Pharmac's funding criteria. If the prescription drug require special authority from Pharmac to be covered, **we** need confirmation from the **registered medical practitioner** that the **Member** does meet the special authority criteria before **we** can assess cover for the prescription drug cost.

We will cover reasonable charges

A **reasonable charge** is the cost of a **medical treatment** or **procedure** that **we** consider fair, based on regular reviews of what **healthcare providers** charge for the same or similar treatments or **procedures** across New Zealand.

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

The reasonable range helps to ensure that **healthcare providers** are charging fair and consistent prices. Enforcing **reasonable charges** is one strategy **we've** implemented to help reduce the escalating cost of **claims** now and in the future.

Understanding your options:

We always recommend applying for prior approval for **medical treatment** or **procedures** over $1,000. This means **you'll** be aware of the maximum amount **we** can cover before you go ahead.

If the cost is more than the **reasonable charge**, you can choose a different **healthcare provider** or discuss **your** treatment options with **your** provider.

If you choose to proceed, **you'll** 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'll** need to pay this extra amount directly to **your healthcare provider**.

Claims on other insurers

Where another insurer, including but not limited to **ACC**, may have responsibility in respect of a **claim** the following provisions apply:

- It is the **Member's** responsibility to advise **us** that another insurer is involved in a **claim** that has been submitted to **us**.
- Before **we** accepts a **claim** under the **policy**, the **Member** must firstly make a **claim** to the other insurer for any expense recoverable from a third party or under any contract of indemnity or insurance. Any expenses recoverable in this way will be deducted from the reimbursement provided by **us** under the **policy**. For the purposes of the **policy**, **ACC** is defined as another insurer.

Claims involving *ACC*

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

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**.

ACC top-up 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

Your healthcare decisions

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.

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

How we can end your policy

We can end your policy if:

- you fail to pay your **premium** for 90 days 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.

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.

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.

Other important information governing the policy

- **We** reserve the right to review and adjust **premiums** and discounts at **our** discretion to ensure the viability of any **Health Plan** or grouping of **Members** on a **Health Plan**. **We** will endeavour to provide reasonable notice (minimum 21 days) prior to such change.
- In all matters that require interpretation, **UniMed's** decision shall be final.

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're 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

Exclusions

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**.

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**.

We aim to fully explain what is not covered in **your policy**. Unless specifically provided for in the **Health Plan** you select, **we** don't cover any **claims** as described below.

Health conditions *we* don't cover

Psychiatric, psychological and/or neurodevelopmental disorders

We don't cover treatment or counselling for any psychiatric, psychological and/or neurodevelopmental disorders. This includes but isn't limited to:

- attention-deficit/hyperactivity disorder
- autism spectrum disorder
- dyslexia
- geriatric care including geriatric **hospitalisation**
- intellectual disability (intellectual developmental disorder)
- motor disorders (including but not limited to Tourette's disorder)
- pre-senile dementia
- senile illness or dementia
- specific learning disorders.

Certain types of care

We don't cover these types of care.

- Any **acute** care
- Any **long-term care**
- **Palliative care** as defined by **us** (except where this **policy** specifies otherwise).

Some conditions

We don't cover these conditions.

- Any **pre-existing conditions**, unless accepted by **us**
- Any condition connected with the use of non-prescription drugs
- AIDS or HIV infection or any condition arising from the presence of AIDS, HIV infection or sexually transmitted diseases
- **Congenital conditions** diagnosed within 3 months of birth; this includes but is not limited to the investigation, treatment, or complications of any residual issues
- Any health condition as a consequence of war, invasion, act of foreign enemy, terrorism, hostilities (whether war is declared or not), civil war, rebellion, revolution, or military or usurped power.

Obstetrics and gynaecology

We don't cover any expenses arising from these obstetric or gynaecological conditions.

- Pregnancy, childbirth, miscarriage, or any associated conditions and/or complications for the mother or foetus/child, and all normal effects of pregnancy.
- Treatment, investigation, and diagnosis of infertility and assisted reproduction
- Sterilisation or contraception of any kind, or intrauterine devices (except a Mirena when used for medical reasons)
- Termination of pregnancy.

Tests, diagnostic procedures and treatments that *we* don't cover

Below **we** list the various tests, **procedures** and treatments **we** don't cover.

Treatment for *preventative* reasons

We don't cover any expenses when no symptoms or evidence exist for a condition detrimental to **your** health; for example:

- **preventative** healthcare services and treatments, maintenance or health surveillance testing, genetic testing, employment-related examinations or screening
- vaccination against any disease or condition
- convalescence.

Dental or eye treatment or *surgery*

We don't cover these **procedures** including any treatment, investigations or consultations related to a **procedure** or any complications that may occur from one.

- Dental care: orthodontic, endodontic, orthognathic (jaw correction), periodontal treatment, implants, or tooth exposure
- Correction of visual errors or astigmatism - for example, consultations, **surgery** or laser treatment, surgically implanted intraocular lens(es), radial keratotomy, photo-reactive keratectomy, or any related complications.

Organ failure or donation

We don't cover these **procedures** including any treatment, investigations or consultations related to a **procedure** or any complications that may occur from one.

- Specialised transfusion of blood, blood products, or treatment for renal failure or renal dialysis
- Organ donation and receipt
- Specialised tertiary treatments such as transplants. This includes but is not limited to heart, lung, kidney, liver, bone marrow and stem cell transplants.

Other treatment or *surgery*

We don't cover these **procedures** including any treatment, investigations or consultations related to a **procedure** or any complications that may occur from one.

- **Cosmetic procedures** or other enhancement or appearance medicine as defined by **us**
- **Procedures** or treatment relating to obesity or weight loss, performed for any reason
- Breast reduction or treatment of gynaecomastia, regardless of whether **medically necessary**
- Gender affirmation **surgery**/treatment or **gender dysphoria**
- Sleep disturbances, snoring, or sleep apnoea
- Robotically assisted **surgery**
- Chelation therapy or similar treatment as defined by **us**
- Circumcision, except where **medically necessary**
- Additional **surgery** performed during any operation that is not directly related to any medical condition or treatment covered under the terms of this **policy**
- A treatment or **procedure** that is provided by a **registered medical practitioner** practising outside their scope of practice
- New medical treatments, **procedures**, and technologies that have not been approved by **us**.

Other costs

We don't cover these costs.

- General practitioners' fees, prescription drugs, or medication (except where this **policy** specifies otherwise)
- Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, **ACC**)
- Any medical costs declined by **ACC** if injury is caused by an **accident** outside New Zealand
- Any medical costs incurred outside New Zealand
- Medical mishap or misadventure
- Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages
- Any costs not specifically provided for under a **benefit** section outlined in the plan.

Other expenses and costs *we* don't cover

Appliances and devices

We don't cover the following.

- Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs
- 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
- Any costs not specifically related to the consultation or treatment such as administration costs or statement fees.

Expenses arising from drugs, criminal activity, or self-harm

We don't cover the following.

- Disability or illness arising from misuse of alcohol, drugs, participation in a criminal act, or intentional self-injury
- Attempted suicide or suicide within 13 months from the **start** date of the plan.

Glossary of key terms

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 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 condition or disease that warrants immediate care within 48 hours by a doctor or hospital admission for treatment or monitoring.

Benefit means the reimbursement available for **Members** for specific types of expenses as specified in this **Health Plan document**, including **grants**.

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 25 years of age.

Claim means the request by a **Member** to have their costs under their chosen **Health Plan** refunded as described in the **Health Plan document**, providing the **Member** is eligible.

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 3 months of life, or where signs or symptoms were present before **your policy** began – regardless of when it was formally diagnosed.

Cosmetic procedure means any **procedure**, **surgery** or treatment that is carried out to improve or enhance appearance, whether or not undertaken for physical, psychological or emotional reasons.

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 any amount specified on **your** current **Membership Certificate** that is excluded from payment, and you are responsible for.

Gender dysphoria is a condition that causes discomfort or distress because of the conflict between biological sex and gender identity.

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

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**.

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 this document that outlines the terms and conditions of **your policy**, the **benefits** provided by the base plan and any additional modules, and any changes made to the **Health Plan** in accordance with the terms of **your policy**. Terms and conditions include general conditions and requirements, eligibility, exclusions and limitations, **claims** and payment conditions and the responsibilities of **UniMed** and the **Members** on the **policy**.

Hospice means a healthcare facility that holds regular or associate service **membership** with **Hospice** New Zealand and that provides **palliative care** services for patients with a **terminal illness**. It doesn't include the word '**Hospice**' used as part of the name of a **hospice** or the umbrella organisation.

Hospitalisation means admission to hospital for treatment.

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**.

Medically necessary means healthcare services that, in **our** opinion, are necessary for the care or 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** and for whom **premiums** for are currently being paid to **UniMed**. This could be the **Primary Member** or their **partner**, 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 (previously referred to as **policy 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**.

No-claiming period means the period of 90 days after the **start** date or, in the case of a **Member** added to a **policy**, 90 days after the date on which that **Member** is added during which **events** are not claimable.

Palliative care means care given to patients with life-limiting illnesses that has the primary aim of improving the quality or quantity of life until the death of that patient. **Palliative care** may also positively influence the course of the illness. A life-limiting illness is one that cannot be cured and may at some time result in the person dying (whether that is years, months, weeks or days away).

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**

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

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

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

- your **Membership Certificate**
- 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
- eligibility criteria for certain **medical treatment** or **procedures**
- **Rules of UniMed**.

Policy year means the 12-month period that starts from midnight on the **policy** annual renewal date and ends at midnight on the next annual renewal date. Each subsequent **policy year** begins at midnight on the annual renewal date and continues for a 12-month period.

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 or on behalf of a **Member** to maintain **membership** and eligibility for **benefits**.

Preventative means to seek to reduce or prevent the risk of an illness, disease or medical condition from developing in the future.

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

Private hospital means a privately owned hospital that is licensed as a **private hospital** in accordance with the Health and Disability Services (Safety) Act 2001. Mobile treatment facilities are not recognised as private hospitals.

Procedure and/or **medical treatment** means a particular course of action required to manage a health condition, including but not limited to diagnosis, medical screening, **surgical procedures**, therapeutics or rehabilitation.

Prostheses means an artificial extension that replaces a missing or malfunctioning part of the body, such as artificial replacement of hips or knees.

Public hospital means a hospital service or institution licensed in accordance with the Health and Disability Services (Safety) Act 2001 directly or indirectly owned or funded by the New Zealand Government or any of its agencies.

Reasonable 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**.

Registered medical practitioner means a healthcare practitioner, other than you or any **member** of **your** immediate family, who holds a current annual practising certificate issued by the Medical Council of New Zealand, and who is practising as a medical practitioner in New Zealand.

Registered medical specialist means a health service provider who is:

- a **member** or fellow of an appropriately recognised specialist medical college
- 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 Medical Council of New Zealand registration for:

- **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 **registered medical specialist** may be amended by **us** from time to time at **our** sole discretion.

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

Society means Union Medical Benefits Society Limited incorporated under the Industrial and Provident Societies Act 1908.

Start means the date on which **membership** begins, as specified in the **Membership Certificate**.

Surgery or **surgical** means an operation or **surgical procedure** used to treat disease, injury or deformity.

UniMed means Union Medical Benefits Society Limited incorporated under the Industrial and Provident Societies Act 1908.

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

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

Get in touch

The team at UniMed are available to discuss your plan, and answer any questions you may have.

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UniMed

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