UniMed

Day to Day Health Plan

1 September 2026

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Welcome to Day to Day

Thank you for choosing Day to Day.

We want **you** to understand **your Health Plan** and be confident in **your** health insurance cover, so please read this document carefully.

About us

Who we are

Since 1979, **UniMed** has been helping 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**.

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' section on page 20. 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.

Tell us about changes

Please make sure that **we** have **your** most up-to-date contact details. Update **your** details in the Member Portal or contact us.

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.

Day to Day at a glance

This Health Plan document explains what's covered for all Day to Day Members (benefits) and what's not covered (general exclusions). Check your Membership Certificate for details that are specific to your policy, including personal exclusions, excesses and the modules you have cover under.

Day to Day is a refund only **Health Plan**, meaning that **you** have to pay for the services first and then submit a **claim** to **us** with the invoices or receipts for reimbursement. **Your** Day to Day **Health Plan** starts from the date on **your Membership Certificate**, or the date specified for each additional **Member**. **You'll** be covered until **your policy** ends because it's been cancelled or terminated.

There is a 30-day **no-claiming period** that applies to all **Members** on the Day to Day **Health Plan**.

Day to Day cover and benefits

The following benefits apply to your Day to Day Health Plan, which provides a maximum limit of $600 per person in a policy year.

Please take the time to read over the **benefits** and if **you** have any queries please get in contact with **us**.

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

General practitioner (GP) and nurse visits

$150 per person, per policy year

This **benefit** covers the costs of registered medical practitioner (**GP**) and practice nurse visits.

Specialist consultations

$100 first visit | $40 follow up visit

This **benefit** covers the costs of a consultation with a registered medical **specialist** when referred by a **healthcare provider**.

Mental Health consultations

$100 first visit | $40 follow up visit

This **benefit** covers the costs of consultations with a psychiatrist, psychologist, psychotherapist or counsellor. They must be registered either under the psychiatry scope with the Medical Council of New Zealand, as a psychologist with the New Zealand Psychologists Board, as a psychotherapist with the Psychotherapists Board of Aotearoa New Zealand, or as a counsellor with the New Zealand Association of Counsellors or New Zealand Christian Counsellors Association.

Prescription drugs

$100 per person, per policy year

This **benefit** covers the costs of drugs prescribed by a **healthcare provider** or registered medical **specialist** which are listed under section A to I of the **Pharmac schedule** (excluding section H).

Imaging and private hospital fees

$600 per person, per policy year

Imaging – X-ray and image intensifiers, ultrasound, scintigraphies, CAT scans, MRI scans.

Private hospital fees – including all **surgical**, medical and other fees as well as **surgery** performed by a **healthcare provider** at a **surgical** clinic.

Registered health practitioner treatments

$150 per person, per policy year

This **benefit** covers the costs of **procedures** and/or **medical treatments** performed by the following New Zealand **healthcare providers**. Materials or supplements are not covered.

- Physiotherapists
- Podiatrists
- Chiropractors
- Acupuncturists
- Osteopaths
- Naturopaths
- Homeopaths
- Herbalists
- Dietitians
- Reflexologists
- Nutritionists
- Remedial massage therapists
- Traditional Chinese medicine practitioner

Health surveillance test

$100 per person, per policy year

This **benefit** covers the cost of a mammogram, smear test, mole mapping and/or a prostate check.

Flu vaccination

$45 per person, per policy year

This **benefit** covers the cost of a flu vaccination.

Optical and dentistry

$150 per person, per policy year

This **benefit** covers the cost of:

- optometrist or orthoptist consultations and/or prescription glasses or contact lenses
- dental treatment by a registered dental practitioner including dental check, cleaning, scaling, teeth removal, x-rays and fillings

Terms and conditions

The following sections contain the terms and conditions that apply to your cover and membership.

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.

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:
    a. Eligibility criteria for certain **medical treatments** or **procedures**
    b. **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.

What's not covered (exclusions)

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 **Members**. They cannot be overridden unless **we** have specifically said otherwise in this **Health Plan document**.

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

Health conditions we don't cover

Some conditions

We don't cover these **conditions**.

- 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

Obstetrics and gynaecology

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

- Pregnancy, childbirth, miscarriage, or any associated **conditions** or complications for the mother, or foetus or **child**
- 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

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
- Circumcision, except where **medically necessary**
- A treatment or **procedure** that is provided by a registered medical practitioner practising outside their scope of practice

Other costs

We don't cover these costs.

- 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 costs not specifically provided for under a **benefit** section outlined in this **Health Plan**.

Other expenses and costs we don't cover

- 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 **Health Plan**

How to claim

Day to Day is a refund only Health Plan, meaning that you pay for the services first and then submit a claim to us with the invoices or receipts for reimbursement. 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** or **modules you** have cover for
- for a **medical treatment** or **procedure** provided by a **healthcare provider**

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**.

What we will pay

How policy benefit limits affect your claim

Unless specifically stated in this **Health Plan document**, all **benefit limits** are for each **Member** in each **policy year**. The **benefit limits** reset back to their maximum levels at the start of each **policy year**. **You** can't carry over **your benefits** from one **policy year** to the next, or transfer them to other **Members** covered by the **policy**. The minimum or maximum amount for each **benefit** that **you** can **claim** for an **event** is set out in this **Health Plan document**.

We won't pay or reimburse any costs that amount to more than 100% of the actual costs incurred. As such **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, Work and Income, or **your** employer. **We'll** take any reimbursement from them off the total amount before **we** assess the amount against the **benefit** under **your policy**.

For example, if **you** had an x-ray that cost $110 and **ACC** agreed to cover $60 of it, **we** would only be able to assess reimbursement of the remaining $50 under imaging and private hospital fees **benefit**.

Healthcare providers

You are free to choose **your** own **healthcare provider** provided they meet the eligibility criteria for the provider (including appropriate registration) and the definitions set out in the 'Glossary' section on page 20.

We may not accept **claims** for **procedures** or **medical treatment** 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 **procedures** or **medical treatment** by that **healthcare provider**.

Maximum cost we will pay

We'll pay the cost for a **procedure** or **medical treatment** up to the relevant **benefit limit** or the **reasonable charges** for this **procedure**, whichever is less. If the cost for **your procedure** exceeds the **benefit limit** or the **reasonable charge**, **we** can't pay the exceeded amount. The extra cost will be **your** responsibility.

General conditions of your policy

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

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.

We don't cover events during a no-claiming period

There is a 30-day **no-claiming period** that applies to all **Members** on the **Health Plan**. **You're** not covered for any **events** that happen during this **no-claiming period**.

Conditions of cover for prescription drugs

Unless outlined differently in the Health Plan, prescription drugs must be:

- listed under section A to I of the **Pharmac Schedule**, note that section H is only applicable if the drug is used during a **medical treatment** or **procedure** in a private facility;
- **Pharmac**-approved;
- **medically necessary** and;
- prescribed by a registered medical practitioner.

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

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**.

You must pay your policy's premium

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

You're only covered when you've 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'll cancel your policy if you haven't paid your premium for 90 days

If **you** don't pay **your premium** on **your policy**, **we** will contact **you** to tell **you** that **your Health Plan** 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 90 days 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 **premiums** and discounts for **your** Day to Day **policy** are not guaranteed. **We** reserve the right to review and adjust **premiums** and discounts at **our** discretion. **We'll** give **you** a minimum of 21 days' notice of a change in **your premium**.

We'll continue to make 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.

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.

Making changes to your policy

This section explains what you can do with your policy — from start to finish.

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**.

Adding children and additional Members to your policy

You can add **your** spouse or **partner** and **children** under the age of 25 years, onto **your policy** at any time. To add an additional **Member** to **your** Day to Day **policy**, **you'll** need to complete an application for each additional **Member**.

Cover for an additional **Member** begins from the **start date** listed on the **Membership Certificate** that has the additional **Member** listed as covered.

Once an additional **Member** has been added to **your policy**, they will remain on it until the **Primary Member** tells **us** otherwise. The **Primary Member** is responsible for keeping additional **Members** updated about all matters related to the **policy**, and any changes to the **policy** or the additional **Member's** cover.

Premiums for added additional **Members** will be charged from the **start date** for the additional **Member**, as shown on **your policy premium** notice as part of the normal billing cycle.

If **you** have three or more **children** on **your policy**, **you** only pay **premiums** for the first two **children** as long as the **Health Plan** selected are the same for each **child**. All **children** will remain on **child** rates up to 25 years old.

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'll need to complete a new application and go through the full application process.

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** is then considered the **Primary Member**.

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.

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 the terms and conditions 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

Your Health Plan document

This **Health Plan document** may change from time to time according to prevailing conditions and policies, and at the discretion of **UniMed**. This is to make sure that the cover provided reflects current trends and is commercially sustainable.

We'll do **our** best to give reasonable notice (at least 21 days) before any changes. **You** may cancel the **policy** at any time (see 'Ending your policy' section on page 16).

This **Health Plan document** provides information of a factual nature only, and is not an opinion or recommendation in relation to Day to Day.

This **policy** has no surrender value. **We** are not liable for the standard or effectiveness of the **procedures** and **medical treatment** that this **policy** covers.

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 this **Health Plan document** 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 the terms and conditions in **your Health Plan document** and the **Rules of UniMed**, **your Health Plan document** takes 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.

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**.

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 this **Health Plan document**) 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 **Health Plan 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 this **Health Plan document**.

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**, whāngai, 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 in relation to a **benefit** under their **base plan** or **module** refunded as described in this **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 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 an amount specified in this **Health Plan document** or on **your Membership Certificate** that is excluded from a **claim** 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.

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.

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 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**.

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, **medical treatment** or **procedure** 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.

Hospitalisation means admission to **private hospital** for treatment.

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

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 (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**.

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 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 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**
- **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 on **your policy** anniversary 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**.

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** is 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**.

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**.

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.

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

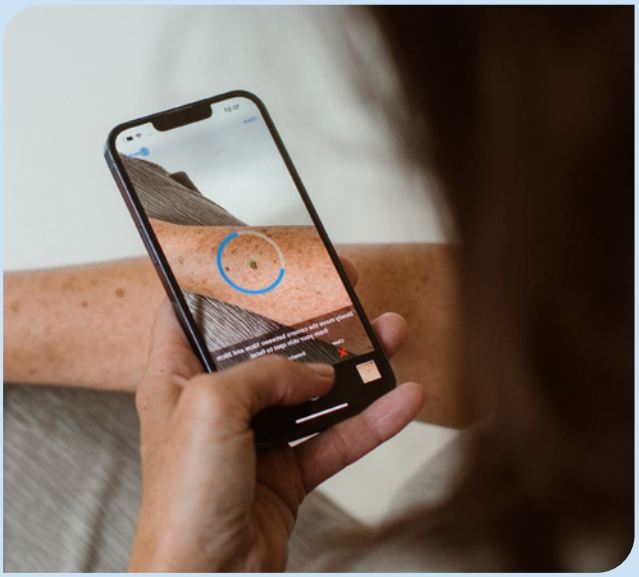
Surgery or **surgical** means an operation or **surgical procedure** used to treat disease, injury or deformity.

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

We don't just cover you for illness we actively help you avoid it.



At UniMed, we believe that health insurance should do more than just react when something goes wrong. That's why we offer a growing range of benefits to help you stay well — mentally and physically — every day.

These services are included in your cover and are designed to help prevent illness, boost energy, and support lifelong wellbeing.

FIND OUT MORE unimed.co.nz/active-benefits

UniMed

Union Medical Benefits Society Limited
165 Gloucester Street, Christchurch
PO Box 1721, Christchurch 8140

0800 600 666 | unimed.co.nz