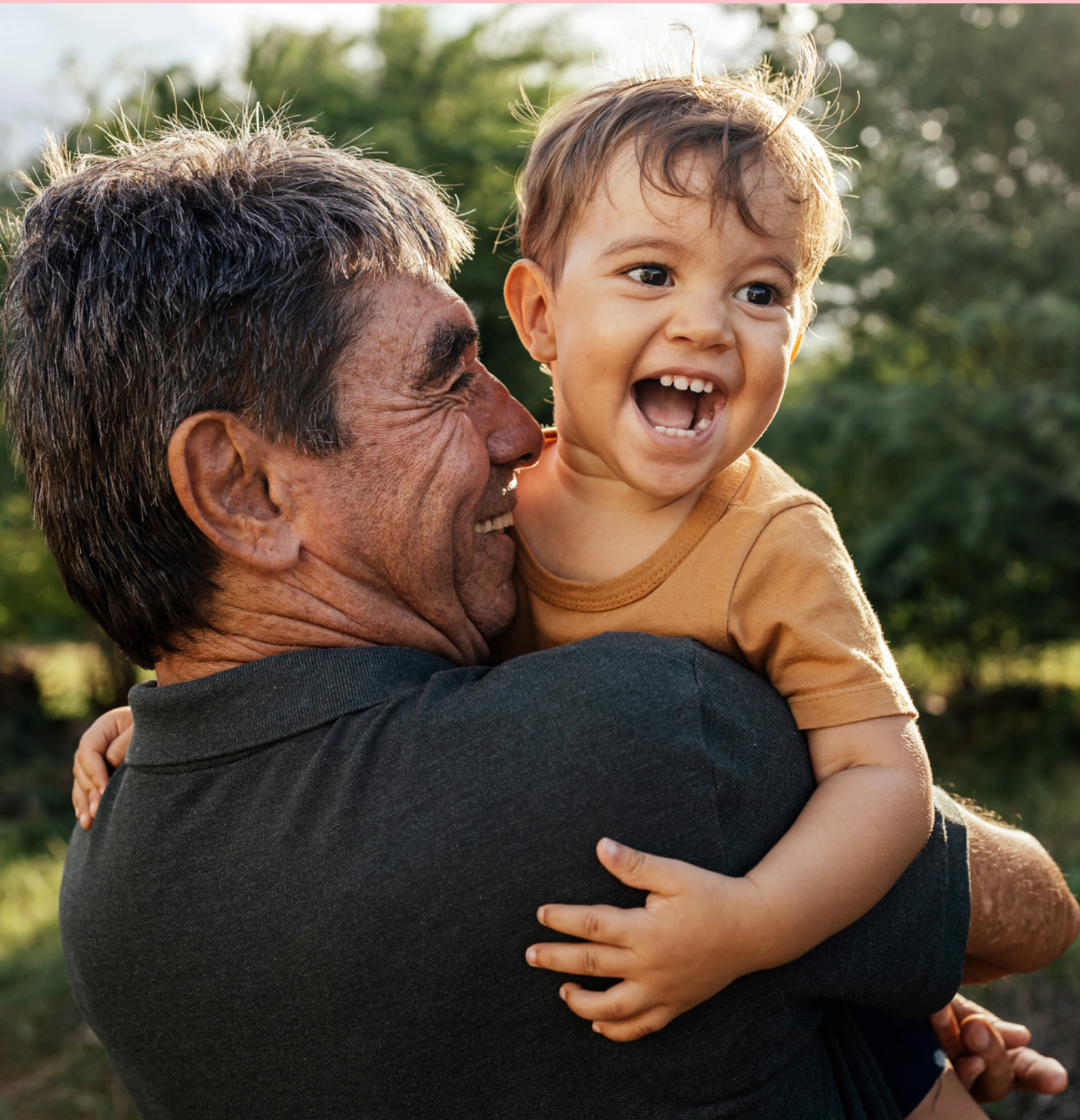
UniMed

KidSmart Health Plan

1 September 2026



Contents

Welcome to KidSmart

Thank you for choosing KidSmart.

We want **you** to understand the **Health Plan** and be confident in the health insurance cover for **your child** or **children**, 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 37. For **your** convenience, **we** have included some of the frequently used terms here.

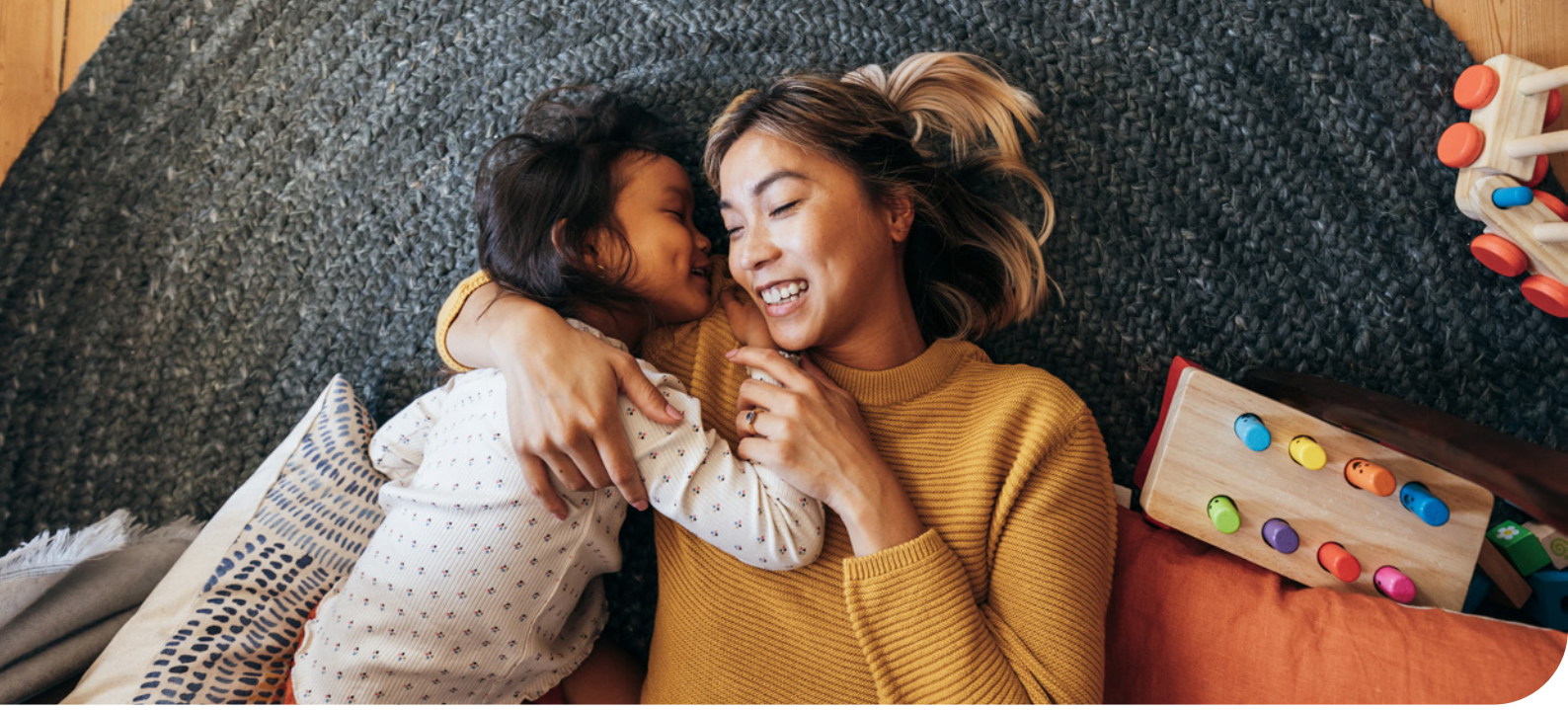
'**We**', '**our**' and '**us**' means **UniMed**.

'**You**', '**your**' and '**yourself**' means the **guardian** (the **policy** owner) who takes out the KidSmart **policy**. As the owner of this **policy**, **you** are legally responsible for this **policy** on behalf of the **children** insured. The **guardian** must be a legal **guardian** for any **children** listed on the KidSmart **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.



KidSmart at a glance

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

This KidSmart **Health Plan** starts from the date on the **Membership Certificate**, or the date specified for each added **child**. Any **children** under this **policy** will be covered until it ends because it's been cancelled or terminated.

Who KidSmart is for

This KidSmart **Health Plan** is only for New Zealand citizens, residents, or **children** who are entitled to funding under New Zealand's public healthcare system. **We've** designed this **Health Plan** to complement the services that are provided by the public health system and the Accident Compensation Corporation (**ACC**).

The New Zealand healthcare system has three main components:

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

Start with the base plan and add an additional module

When the **policy** starts, it begins with the **base plan** that every **child** on the **Health Plan** must have: the Hospital and Surgical base plan. **You** can choose to add the Specialist **module** for each **child** on the **Health Plan**. **You** do not need to add the Specialist **module** for all **children**.

Hospital and Surgical base plan

\+ Specialist module + Specialist module

Main benefits of KidSmart

Hospital and Surgical base plan benefits:	Per child per policy year*
General surgery (including tests such as CT and MRI scans)	$500,000
Oral surgery	$300,000
Private hospital medical admission (including chemotherapy and radiation treatment of $65,000)	$300,000
Multiple overseas treatment benefits	refer to benefit for limit
Non-Pharmac subsidised drugs	refer to benefit for limit

*see 'Hospital and Surgical base plan' from page 6 for full benefit details and where an excess may apply.

Additional module

Specialist module
Cover for specialist consultations and diagnostic tests.

For more detail please see the 'Additional modules' section on page 15.

Extra care and support

Some people 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 the **policy** who can contact **us** on **your** behalf. If **you** have any concerns, please contact **us**.

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

Hospital and Surgical base plan

The following **benefits** apply to the Hospital and Surgical base plan. Please take the time to read over these and ensure **you** understand them. Contact **us** if **you** have any queries about any of **our benefits**.

To find out what type of prescription drugs are covered under this **policy**, refer to the 'Conditions of cover for prescription drugs' section on page 26.

Standard benefits

General surgery

$500,000 per child, per policy year | An excess applies to this benefit

If **you're** wanting to **claim** under this **benefit** for a **child**, please seek prior approval before their treatment.

This **benefit** covers the costs of **reasonable charges** associated with the **surgical** treatment of a non-acute medical **condition**. The **benefit** covers the **procedure(s)** and all subsequent treatment or expenses listed below.

- **Private hospital** or public hospital costs (provided protocols for a **private hospital** set by the Ministry of Health for the treatment of private patients in public hospitals have been followed)
- Physiotherapy while admitted to hospital
- Surgeons' fees
- Anaesthetists' fees
- Costs of essential **prostheses**
- Pre-operative and post-operative diagnostics, consultations, or tests, if they occur within 2 years before or after the approved **surgery**

All costs must be associated with the original diagnosis, including any complications of the initial **surgery**. This **benefit** also includes diagnostic **surgeries** such as a hysteroscopy, cystoscopy, laparoscopy and arthroscopy.

We may consider that an alternative, less invasive **procedure** or **medical treatment** is the most suitable method of treatment instead of the proposed **surgery**. If so, **we'll** cover the costs associated with this rather than paying the **surgical claim**.

Oncology consultations and treatment following **surgery** are covered under the private hospital medical admission **benefit**.

This includes:

Spinal surgery

This **benefit** covers the costs of **reasonable charges** of spinal **surgeries**. This **benefit** can be claimed as needed but the **benefit** is limited to $200,000 for each **child** over their lifetime. A list of all spinal **surgeries** that fall under this **benefit** can be found at unimed.co.nz/important-documents.

General surgery continued

Varicose vein treatment

This **benefit** covers the cost of **reasonable charges** for the **medically necessary** treatment of varicose veins after the **child** has had 3 years of continuous cover.

Major diagnostic procedures

This **benefit** covers the costs of **reasonable charges** for the **child** to have the following diagnostic **procedures**.

- Angiograms
- CT scans
- Dilation and curettage
- Endoscopies, such as a colonoscopy or gastroscopy
- MP scans
- MRI scans
- Myelograms
- PET scans

Cover applies whether or not the **child** is admitted to a hospital

Oral surgery

$300,000 per child, per policy year | An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** associated with oral or maxillofacial **surgery** for the **child** listed below.

- **Surgical** removal of impacted or unerupted teeth provided the **child** has had 3 years of continuous cover
- **Surgical** removal of cysts or soft tissue swellings
- **Surgical** drainage of oral abscesses
- Pre-operative and post-operative diagnostics, consultations or tests if they occur within 2 years before or after the approved **surgery**.

This **benefit** doesn't cover the insertion or removal of dental implants, or the exposure of a tooth.

The **child** must be treated by a New Zealand-registered oral or maxillofacial **specialist**, in an accredited **private hospital** or clinic. A New Zealand-registered medical practitioner, dental surgeon, or dentist must refer the **child** on this **policy**.

A registered oral surgeon or registered dentist must perform the **surgical** removal of unerupted and impacted teeth, and provide confirmation of whether the teeth are impacted or unerupted.

Private hospital medical admission

$300,000 per child, per policy year | An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** for the **child's** admission to a **private hospital** for reasons other than **surgery**, such as cancer treatment. The **child's condition** must have directly resulted from the diagnosis of any non-acute (non-urgent) medical **condition**. The non-surgical hospital treatment must be recommended by an appropriate registered medical practitioner as being necessary to improve the health of the **child**.

This **benefit** covers the following costs that occur during the period of **hospitalisation**.

- **Private hospital** accommodation fees
- Other hospital costs, including intravenous fluids, dressings, and prescription drugs throughout hospital admission
- Chemotherapy drugs administered orally at home that are prescribed by a registered medical **specialist** and to be used during an approved cycle of chemotherapy treatment under this **Health Plan**
- Registered medical **specialist** fees, including fees directly related to the hospital admission and that have occurred within 1 year of the date of admission
- Diagnostic **procedures**, including diagnostic **procedures** directly relating to the hospital admission that occurred within 1 year of the date of admission
- **Claims** under this **benefit** include up to $2,000 per **child** per **policy year** within the **benefit limit** towards personal accessories that are needed during or within 6 months after the cancer **procedure** or **medical treatment**, such as a wig, hat or scarf.

Non-Pharmac subsidised drugs

An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** associated with the **child** accessing the most effective treatment available.

This is regardless of whether or not the drug qualifies for a government or other subsidy, such as **Pharmac** funding.

With this **benefit**, **we'll** reimburse the costs of all drugs registered by **Medsafe** for use in New Zealand where:

- the treatment is prescribed by a registered medical **specialist** as the appropriate **medical treatment** for the **condition**
- the treatment or **condition** is not excluded elsewhere in this **Health Plan document**
- the drug is being prescribed within the guidelines set by **Medsafe**.

If the drug qualifies for a government or other subsidy, **we'll** reimburse the rest of the cost.

All costs under the non-Pharmac drugs **benefit** are included in the maximum limit of the surgical or non-surgical **benefit**, whichever applies for the relevant treatment under the Hospital and Surgical base plan.

Overseas treatments

An excess applies to this benefit

Treatment outside of New Zealand — $30,000 per child, per policy year

This **benefit** covers reimbursement of **reasonable charges** for a **surgical procedure** or **medical treatment** performed on the **child** at an overseas hospital, where the **procedure** or treatment isn't available in New Zealand.

To qualify for this **benefit**, the **child** must:

- be in New Zealand when they are diagnosed and must not have started an appropriate medical process in New Zealand
- request a **surgical procedure** that is **medically necessary** and is not experimental or being trialled
- get prior approval from **us** for the **procedure** or treatment
- make sure the **procedure** meets all **benefit** criteria including being subject to all **excess**, **reasonable charges**, maximums, and exclusions described elsewhere in this **Health Plan document**.

Written confirmation from a New Zealand-registered medical **specialist** is required to confirm that the **surgical procedure** or **medical treatment** is necessary and no similar treatment is available in New Zealand. **We** don't cover travel and accommodation costs.

Overseas waiting list

This **benefit** covers reimbursement of a **surgical procedure** or treatment performed on the **child** at an overseas hospital if the **procedure** isn't available in New Zealand within 6 months.

We'll reimburse the **reasonable charges** as if it had been undertaken in New Zealand. **We'll** pay **you** in New Zealand dollars. **We'll** decide which country the **child** can travel to for the required **medical treatment**.

To qualify for this **benefit**:

- a registered medical **specialist** must recommend that the **child** has the medical **procedure** or **medical treatment**
- the **procedure** or treatment can be provided privately within New Zealand but can't be provided within 6 months because of insufficient medical resources
- the **child** must get prior approval from **us** for the **procedure** or treatment
- the **procedure** must meet all **policy** criteria and is subject to all **reasonable charges**, maximums, and exclusions described elsewhere in this **policy**.

All costs are included in the maximum limit that applies to the surgical or non-surgical **benefit**, whichever applies for the relevant treatment under the Hospital and Surgical base plan.

Minor surgery

$3,000 per claim | An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** for minor **surgery** performed on the **child** by a New Zealand-registered medical practitioner in private practice. This includes the removal of moles, skin lesions, cysts, and toenails.

The **procedure** must be **medically necessary** — this means that without the **procedure**, the physical wellbeing of the **child** would be affected.

Other benefits

Other **benefits** that **we** offer are summarised below.

Mental health

$1,000 per child, per policy year | No excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** for the **child's** 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 Counselling Association.

Post-operative therapy

$1,500 per event | No excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** associated with the **child's** post-operative therapy provided within 12 months following a related **surgery**, cycle of chemotherapy or radiation treatment that **we've** approved under this **Health Plan**. This includes:

- Occupational therapy
- Physiotherapy
- Speech and language therapy
- Osteopathy
- Chiropractic treatment
- Dietitian/Nutritionist consultations
- Lymphedema physiotherapy

The **child** must be treated by a New Zealand-registered health or medical practitioner with a current practising certificate who is registered with their professional association. The treatment must occur and be completed within 12 months after the **event** date of the **surgery** or treatment. This doesn't include costs for personal items such as food/food substitutes, materials or garments.

Public hospital

$300 per night | $3,000 per child, per policy year
No excess applies to this benefit

This **benefit** is paid only if the **child** is admitted to a public hospital for 4 or more nights in a row.

Home nursing

$150 per day | $6,000 per child, per policy year
No excess applies to this benefit

This **benefit** covers the costs of post-operative home nursing care by a New Zealand-registered nurse. The **child** needs a referral for home nursing by a New Zealand-registered medical **specialist**.

Post-operative nursing care must begin within 6 months after related **surgery**, or after a cycle of chemotherapy or radiation treatment **claim** that has been approved under this **Health Plan**.

Guardian accommodation

$300 per night | $3,000 per child, per policy year
No excess applies to this benefit

This **benefit** covers reimbursement of accommodation expenses paid by a **guardian** accompanying a **child** aged under 18 years, who is listed on the **Membership Certificate**. The **child** must be undergoing **medical treatment** with overnight admission in a New Zealand **private hospital** that **we've** approved under this **Health Plan**.

This **benefit** is for one adult only. **You** must send receipts for reimbursement with the **claim**.

Ambulance transfer

$200 per child, per policy year | No excess applies to this benefit

This **benefit** covers the costs of the **child's** ambulance transfers to or from a public or **private hospital** in New Zealand for necessary treatments and not for personal or social reasons. The transfers must be authorised by a registered medical **specialist**.

This **benefit** is only available to private, fee-paying patients for any non-acute (non-urgent) medical **condition**. The **child** must have prior approval from **us** before their initial admission to hospital.

Transport and accommodation

$3,000 per child, per policy year | No excess applies to this benefit

A registered medical **specialist** must confirm in writing that the **condition** of the **child** cannot be treated at a local private facility. The **specialist** must tell the **child** to travel to an alternative **private hospital** in New Zealand.

We'll reimburse one of the costs below for the **child**.

Air transport

- Return economy airfares and return taxi fare from the airport to the **private hospital**

Rail transport

- Return train fares and return taxi fare from the station to the **private hospital**

Road transport

- Return bus fares and return taxi fare from the station to the **private hospital**
- Return private car journey, calculated on the mileage travelled at $0.30 a kilometre

These costs must directly relate to an overnight admission in a **private hospital** under this **policy**. **You** must send receipts for reimbursement with the **claim**. Pre-operative and post-operative consultations or treatments do not qualify.

This includes:

Support person benefits

This **benefit** includes cover for the costs of a support person. A registered medical **specialist** must confirm in writing that **you** need a support person to accompany the **child** to the alternative **private hospital** in New Zealand.

We'll reimburse one of the transport costs and accommodation below for the support person.

Air transport

- Return economy airfares and return taxi fare from the airport to the **private hospital**

Rail transport

- Return train fares and return taxi fare from the station to the **private hospital**

Road transport

- Return bus fares and return taxi fare from the station to the **private hospital**
- Return private car journey (if not travelling with the patient), calculated on the mileage travelled at $0.30 per km

Accommodation expenses

- Incurred up to $200 per night, for a maximum of 10 nights

These costs must directly relate to an overnight admission in a **private hospital** of the **child** under this **Health Plan**. **You** must send receipts for reimbursement with the **claim**. Pre-operative and post-operative consultations or treatments do not qualify.

ACC top-up

An excess applies to this benefit

We cover any shortfall between what **ACC** pays and the actual costs of the **child's surgical procedure** or **medical treatment** in an approved **private hospital** or facility. **We** deduct the **excess**, which **you** must pay. **You** must send **us** a copy of **ACC's** decision before getting treatment.

These other terms apply.

- The **guardian** or **child** must receive **ACC's** acceptance of the **child's claim** before treatment. They must also give **us** evidence of **ACC's** acceptance and the amount that **ACC** will pay for the treatment.
- **We** may ask the **guardian** or **child** to apply for a review of **ACC's** decision. **We** may ask the **guardian** or **child** for permission to seek legal advice at **our** cost. **You** must reimburse **us** for any cost **ACC** subsequently covers from the review.
- **We** only provide cover if a **claim** is eligible under a **benefit** of the Hospital and Surgical base plan or another additional **module** that the **child** holds. The **benefit's** maximum limit will apply to all costs paid.

Loyalty benefits

Loyalty benefits allow your child to use their insurance not just for treatment but to maintain good health after they have held the KidSmart policy for more than 1 year.

No **personal exclusions** or **excess** applies to these **benefits**: however, some **benefits** have conditions about when they can be claimed, so please read conditions carefully.

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

Tongue or lip tie

$400 per child

After 1 year of continuous cover, this **benefit** covers the costs of **reasonable charges** of the release of the **child's** tongue or lip tie. **You** can **claim** this **benefit** as many times as needed but it only provides cover up to $400 for each **child** over the lifetime of the **policy**.

Screening

$250 per child, every 3 policy years

After 3 years of continuous cover, this **benefit** covers the costs of **reasonable charges** for the **child's** consultation with a New Zealand-registered audiologist, allergist, paediatrician or respiratory **specialist** for screening purposes.

Exercise-based activity contribution

$150 per child, per policy year

After 3 years of continuous cover, this **benefit** provides a contribution towards the **child's** exercise-based activity costs such as school or club sports fees, swimming or dance lessons.

This **benefit** is repayment only. **You** must give **us** evidence of the invoice for the activity, and a receipt showing payment has been made.

Additional module

The following pages cover the benefits under the Specialist module, which is an additional module.

Check **your child's Membership Certificate** to see if they're covered under the Specialist **module**. They won't have this **module** unless **you've** asked us to add it to their **policy**.

We recommend that **you** read over the **benefits** carefully and make sure **you** understand them. Please contact **us** if **you** have any queries about the following **module**, or would like to add it to **your child's policy**.

Specialist module

The Specialist **module** provides access to private tests and **specialist** consultations.

Specialist consultations

$5,000 per child, per policy year | An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** for the **child's** consultations with a registered medical **specialist** when referred by a **healthcare provider**, even when **your child** doesn't require **hospitalisation**. This includes:

- Cardiac surgeons
- Cardiologists
- Ear, nose and throat **specialists**
- Gastroenterologists
- General surgeons
- Gynaecologists
- Neurosurgeons
- Oncologists
- Ophthalmologists
- Orthopaedic surgeons
- Paediatricians
- Urologists

This includes:

Mental health consultations **$1,000 per child, per policy year**

This **benefit** covers the costs of **reasonable charges** for the **child's** 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 Counselling Association.

Second opinion

This **benefit** covers the costs of **reasonable charges** for the **child** to consult a registered medical **specialist** for a second opinion on a diagnosis or a treatment plan that is covered under this **Health Plan**. The **child** must have received their first diagnosis from a registered medical **specialist**.

Diagnostic tests and treatment

$5,000 per child, per policy year | An excess applies to this benefit

This **benefit** covers the costs of **reasonable charges** of diagnostic **procedures** that directly relate to a medical **condition** when the **child** is referred by a registered medical **specialist**. This includes:

- Allergy test
- Ambulatory blood pressure monitoring
- Audiology
- Audiometric test
- Bone density scan
- Cardiovascular ultrasound
- Cardioversion
- Colposcopy
- Dobutamine transoesophageal echocardiography
- Electroencephalography (EEG)
- Electromyography (EMG)
- Exercise electrocardiogram (ECG)
- Holter monitoring
- Laboratory test
- Mammography
- Nerve conduction test
- Nuclear scanning
- Stress echocardiogram
- Ultrasound
- Urodynamic assessment
- X-ray

Please note that some diagnostic tests are covered under the Hospital and Surgical base plan. These are specifically listed under the General surgery **benefit**.

Loyalty benefits

We give your child extra benefits after they've held the Specialist module for more than 3 years

Skin check — $200 per child, every 3 policy years

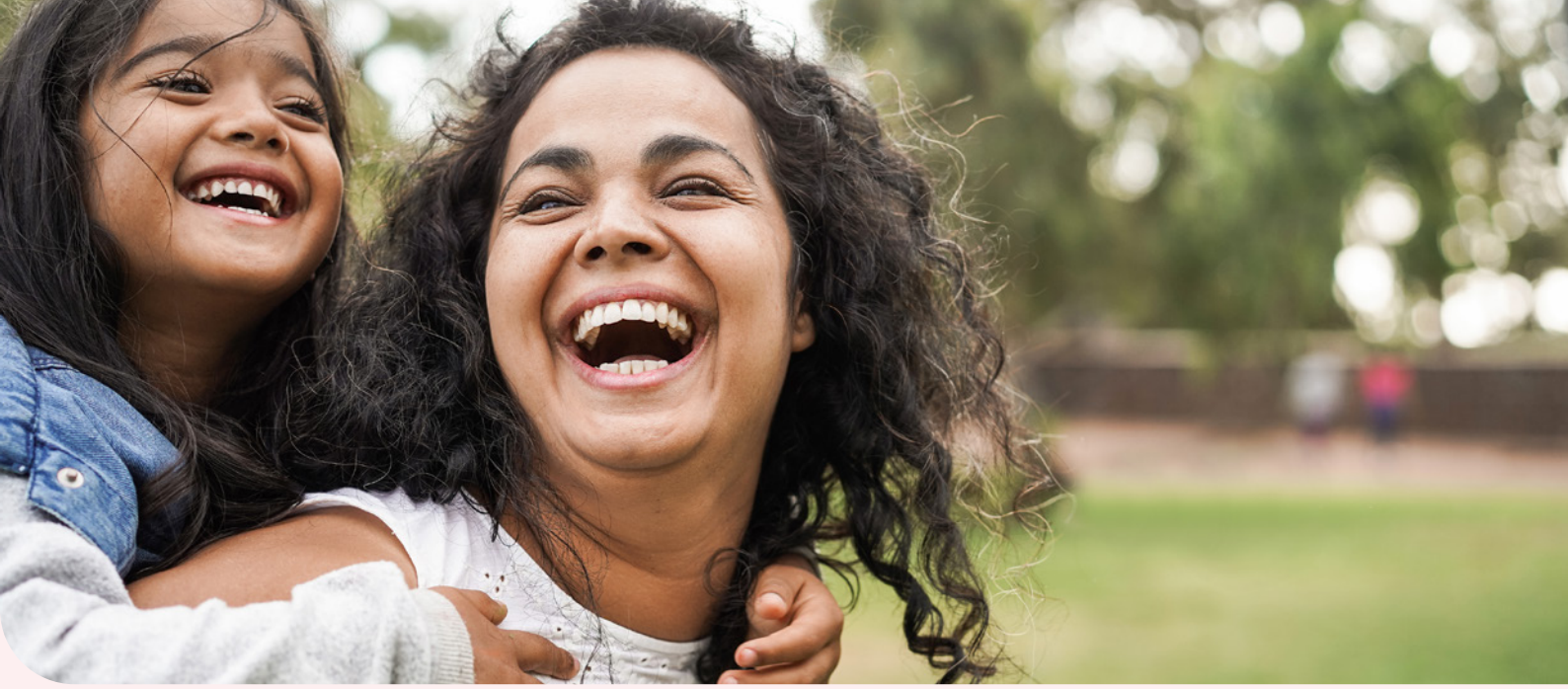
After 3 years of continuous cover, this **benefit** covers the **child**'s consultations and screening skin checks for moles and skin lesions including services, such as mole mapping, provided by a **healthcare provider**.

Speech-language therapy — $150 per child, per policy year

After 3 years of continuous cover, this **benefit** covers the cost of speech-language therapy for the **child** when performed by a New Zealand-registered speech-language therapist who is a member of the New Zealand Speech-language Therapists' Association.

Orthodontic treatment — $200 per child in a policy year, for a maximum of 3 years

After 5 years of continuous cover, this **benefit** covers orthodontic treatment for the **child** such as consultations, checks and applying and removing braces. Practitioners providing treatment must belong to their professional body.



Terms and conditions

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

We want you to understand your child's cover

What makes up the policy

We want **you** to understand the **policy** and be confident with **your child's** health insurance, so please read all documents carefully as they are designed to be read together. **You** can always contact **us** to check their cover.

The policy is made up of:

1. **Your child's Membership Certificate** that contains the details that are specific to **your child's policy**, such as the **Health Plan your child** is on, each additional **child** who has cover, any **excess** applicable, as well as any **personal exclusions your child** or **children** may have.
2. This **Health Plan document** that sets out the details of **your child's** cover, including the services and **benefits** available, and the terms and conditions that apply to **your child's membership**, including what **we** don't cover (**general exclusions**).
3. Documents and any correspondence **you** or **your child** have provided to **us**: i.e. **your** application including any health declaration, medical information and/or **your child's** medical history.
4. The following documents, which may be updated from time to time:
    a. Eligibility criteria for certain **medical treatment** or **procedures**
    b. **Rules of UniMed**.

You can access these documents either in **your child's** 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 **policy** documents, the following order of precedence will apply (unless advised otherwise): **Your child's Membership Certificate** takes precedence over all other documents, followed by the **Health Plan document** including terms and conditions.

What's not covered (exclusions)

Personal exclusions

A **personal exclusion** applies to **your child's policy** where **we** have decided that a sign, symptom or **condition** that they 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 **your child** has any **personal exclusions**, they will be listed on their **Membership Certificate**. For more information including how they apply please refer to '"Personal exclusions are listed on your Membership Certificate" on page 27.

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 **children** on the **policy**. 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 child's policy**. Unless specifically provided for in the plans selected, KidSmart doesn't cover any **claims** as described below.

Health conditions we don't cover

Psychiatric, psychological and neurodevelopmental disorders

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

- attention-deficit or 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 (**acute** care is covered by the public health system and **ACC**)
- 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 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

Treatment for preventative reasons

We don't cover any expenses when no symptoms or evidence exist for a **condition** detrimental to **your child's** 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 this **Health Plan**

Other expenses and costs we don't cover

Appliances and devices

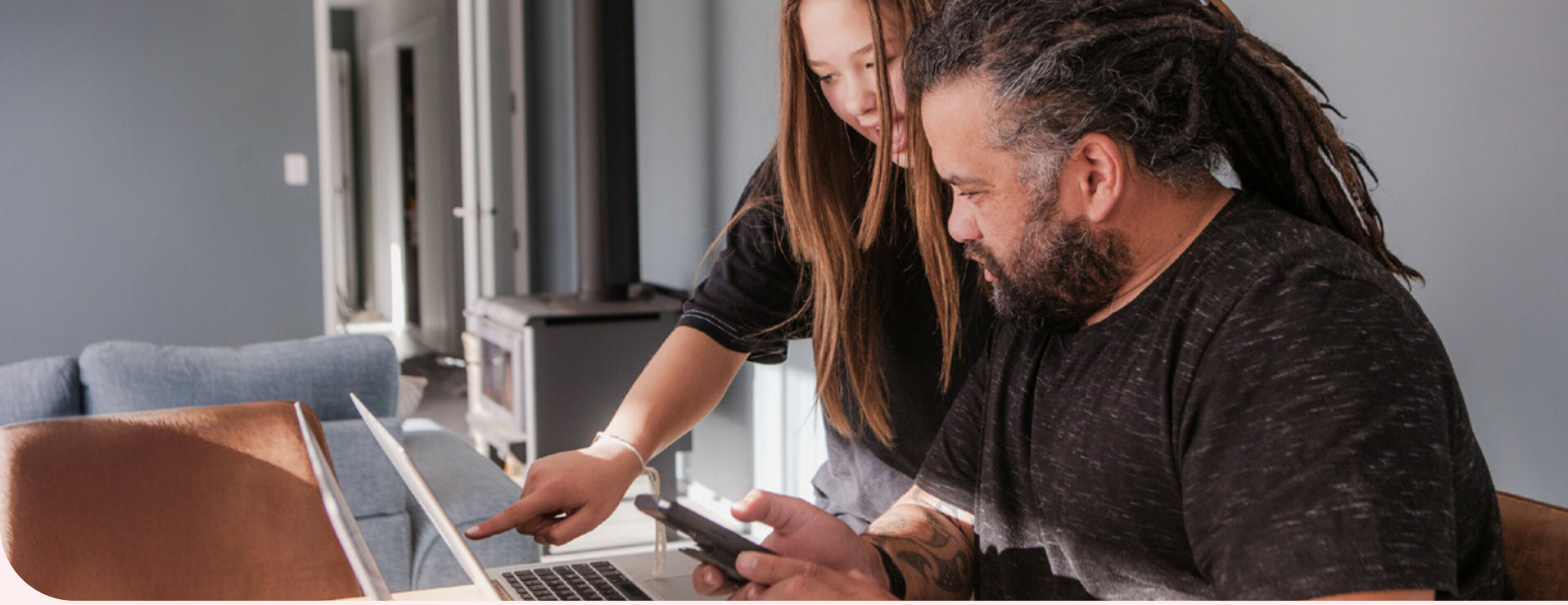
We don't cover the following.

- 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 **Health Plan**



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 child's 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.

If **you** are submitting a **claim** form the **guardian** must sign the form, and so must the **child** if they are over 16 years of age.

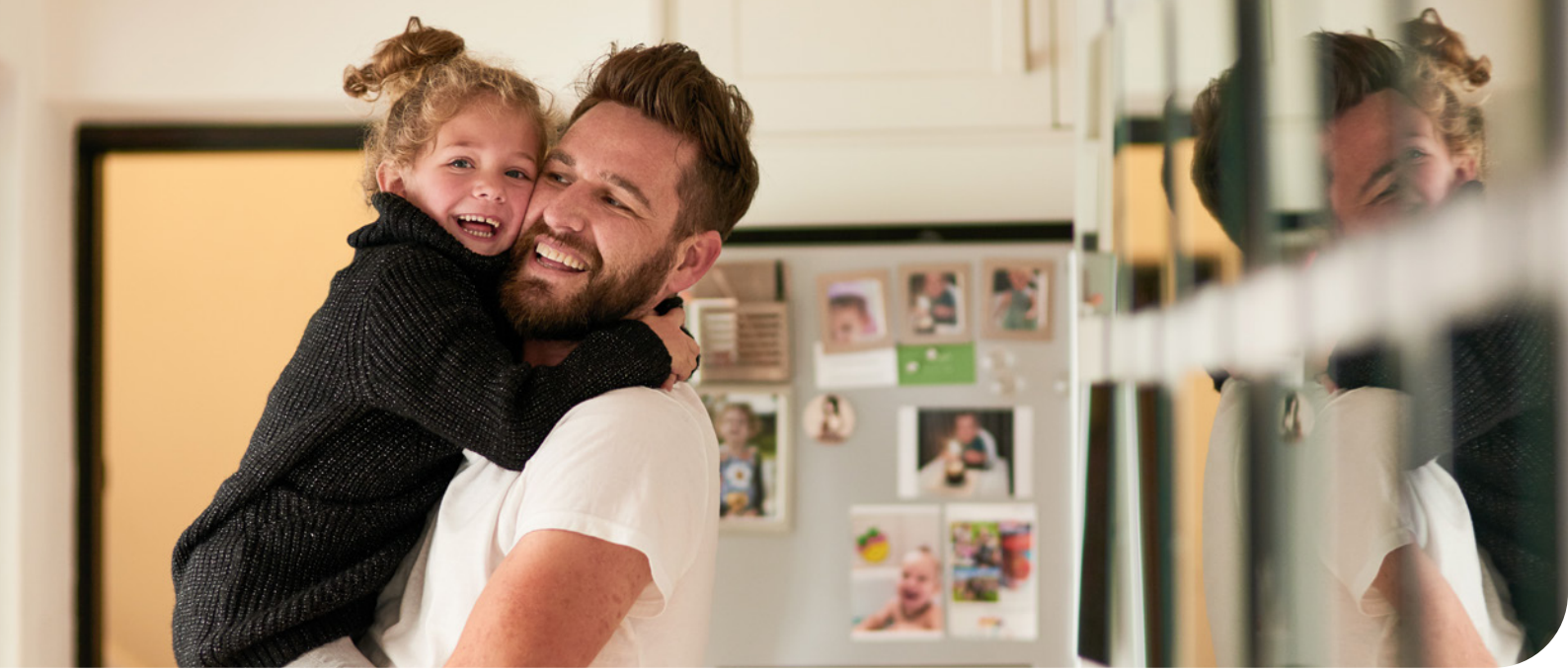
You can find further details on how to make a **claim**, including the documents and information **you** need to provide, at unimed.co.nz/claims.

When we will cover costs

We only accept and provide cover for costs:

- covered by **your child's policy**
- for a **child** who is covered under this **policy**
- for a **medical treatment** or **procedure** that occurs after **your child's policy** begins
- for a **medical treatment** or **procedure** that occurs after the end of any **no-claiming period** that may apply under **your child's policy**
- under a **policy** that is current and has **premium** paid up to date
- for **benefits** listed in the **base plan** or **module your child** has cover for
- for a **medical treatment** or **procedure** provided by a **healthcare provider**
- charged at a reasonable and fair cost (see 'We will cover reasonable charges' section on page 24 for details)
- 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 child's policy**. Each **claim** will be assessed on its own factors and in accordance with the terms in **your child's policy** at the time of the **claim**.



What we will pay

Excesses and limits on your child's policy will affect the amount we can pay.

How an excess under your child's cover affects their claim

Excesses apply to some **benefits**. An **excess** is the amount that must be paid when **your child** has a **claim**, before **we** pay the rest up to the limit for that **benefit**. Different **excesses** may apply to the **base plan** and the Specialist **module**. The **excess** applies to each **child** covered by the **base plan** or Specialist **module** for each **policy year**.

All relevant **excesses** are listed on **your child's Membership Certificate**. If **your child** makes a **claim** for a **benefit** that has an **excess**, **we** take the **excess** off any payment **we** make for their **claim** — off either a reimbursement to **you** or a payment made to **your child's healthcare provider**. **You're** responsible for paying the **excess** amount directly to the **healthcare provider**.

If **your child's claim** is less than their **excess** amount, **we** won't make a payment until further **claims** are received, meaning the full **excess** amount has been reached. This **excess** applies for each **child** and for each **policy year**.

For example, if **your child** has a $250 **excess** under the Hospital and Surgical base plan and **claim** for a $200 minor **surgical procedure** by their **GP**. **You** need to pay the $250 **excess** before **we** can reimburse **you** for anything. The $200 **you've** already paid would go toward **your child's excess**, so **we** wouldn't reimburse **you** for this **claim**.

However, if **your child** needed another $200 minor **surgical procedure** by their **GP** in the same **policy year**, **you'd** only have $50 of the $250 **excess** left to pay and **we'd** reimburse the remaining $150.

When **we** send a prior approval, the **excess** for **your child** will be clearly shown on the approval. **You'll** need to settle this amount directly with **your child's healthcare provider**.

How policy benefit limits affect your child's claim

Unless specifically stated in this **Health Plan document**, all **benefit limits** are for each **child** in each **policy year**. The **benefit limits** reset back to their maximum levels at the start of each **policy year**. **Your child** can't carry over the **benefits** from one **policy year** to the next, or transfer them to other **children** covered by the **policy**. The minimum or maximum amount for each **benefit** that **your child** 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 **your child** from another source first. This includes **ACC**, another health insurer, a government-funded agency, or Work and Income. **We'll** take any reimbursement from them off the total amount before **we** assess the amount against the **benefit** under the **policy**.

Please note that **we** do not cover any excess that is applicable for another insurance plan, whether it be another **UniMed Health Plan** or one from another insurer.

> For example, if **your child** 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 their Specialist **module**.

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

Healthcare providers

You are free to choose **your child's 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 37.

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 child's claim**, **we** will let **you** know. **We** may also decline any future **claims** for **procedures** or **medical treatment** by that **healthcare provider**.

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 going ahead.
- If the cost is more than the **reasonable charge**, **you** can choose a different **healthcare provider** or discuss **your child's** treatment options with their 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 their **healthcare provider**.

For example, a **surgery your child** needs has a reasonable range of $27,000 to $33,000.

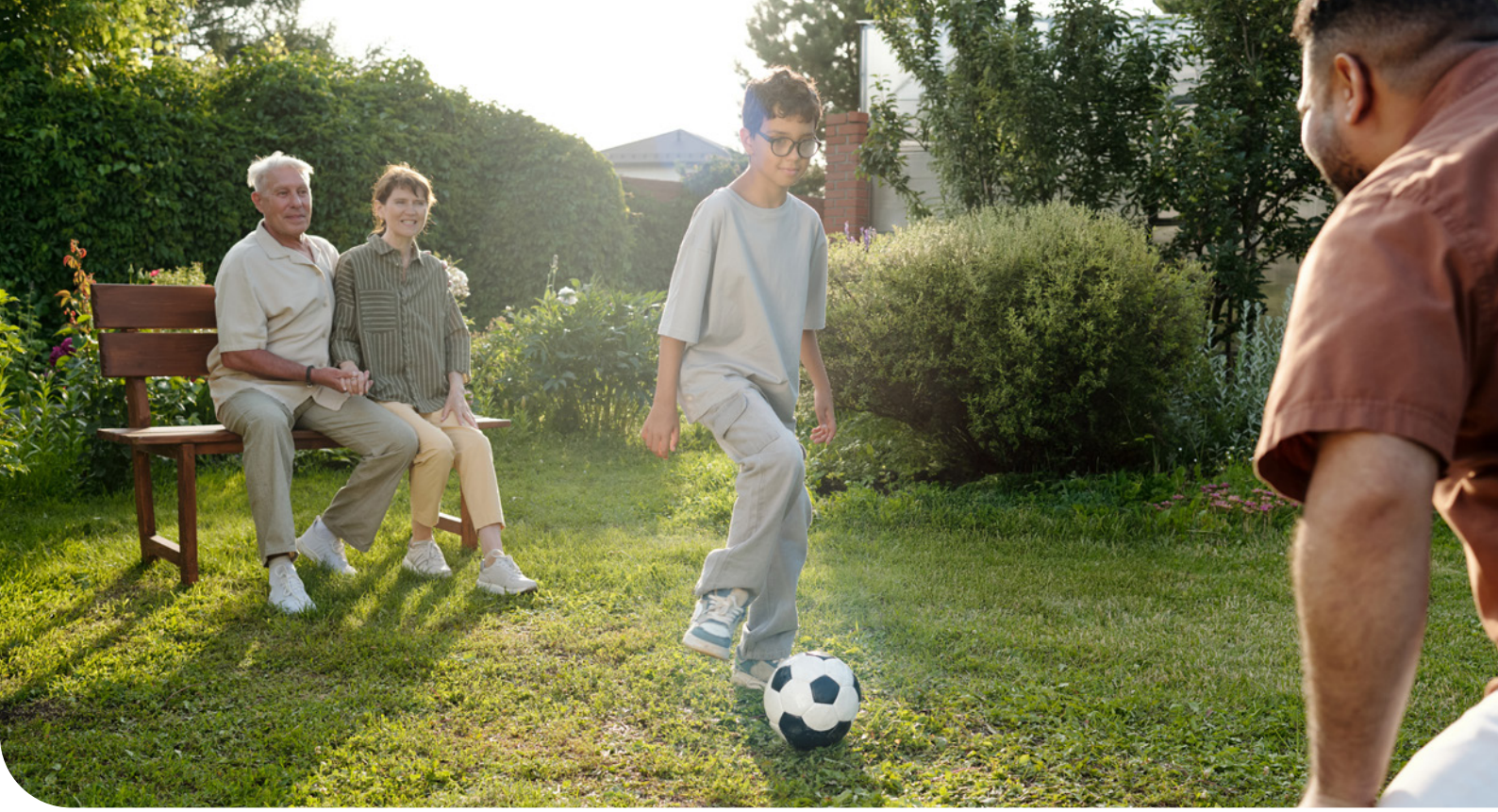
This means that **we** will pay up to $33,000 (the upper limit).

In the unlikely **event** that their **surgery** costs more than $33,000 and if **you** choose to proceed with that **healthcare provider**, **you'll** need to pay the difference directly to the **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 child's procedure** exceeds the **benefit limit** or the **reasonable charge**, **we** can't pay the exceeded amount. The extra cost will be **your** responsibility.

For example, if **your child** had **surgery** done by their **GP** under the Minor surgery **benefit** and it came to $4,500, **we** would only be able to provide reimbursement of $3,000. The remaining $1,500 would be **your** responsibility. This is because the **benefit limit** for Minor Surgery is $3,000 for each **claim**, so **we** are unable to provide cover for costs above this amount.



General conditions of your policy

ACC and injury-related claims

This **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 and **your child** must do everything **you** reasonably can to have **ACC** cover and **ACC**-funded treatment for **your child's** injury. If **you** need more information, please get in contact with **us** or with **ACC**.

ACC top-up benefit

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

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

If ACC declines your claim

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

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

Conditions of cover for prescription drugs

Your child's policy offers different cover for prescription drugs, depending on what type of **healthcare services** they relate to.

- Drugs prescribed and administered in hospital are covered as part of hospital charges related to **surgical** treatment, or to non-surgical **hospitalisation** under the Hospital and Surgical base plan.
- Chemotherapy drugs taken as part of a course of chemotherapy treatment are covered as part of the private hospital medical admission **benefit** under the Hospital and Surgical base plan.

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.

The **child** 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 **your child** does meet the special authority criteria before **we** can assess cover for the prescription drug cost.

As part of the Hospital and Surgical base plan, the non-Pharmac drugs **benefit** covers **Medsafe**-registered prescription drugs.

Under this **benefit**:

- prescription drugs must be registered by **Medsafe** for use in New Zealand
- the treatment is prescribed by a registered medical **specialist** as being the appropriate **medical treatment** for the **condition**
- the treatment or **condition** is not excluded elsewhere in this **Health Plan document**
- the drug being prescribed is within the guidelines set by **Medsafe**.

All costs under the non-Pharmac drugs **benefit** are included in the maximum limit of the **surgical** or non-surgical **benefit**, whichever applies for the relevant treatment under the Hospital and Surgical base plan. The non-Pharmac drugs **benefit** is not able to be used with any **benefit** on an additional **module**.

Your responsibilities

You must disclose pre-existing conditions

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

If **you** or **your child** provide information that is untrue or misleading, including failing to provide **us** with information, this may affect **your child's** cover and any **claims** they make. Full details are in the 'You must be truthful with us' section on page 28.

A **pre-existing condition** is:

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

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

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

If **you** or **your child** provide untrue or misleading information or fail to tell **us** about **pre-existing conditions** for any **children** on the **policy**, or fail to provide information **we** have reasonably requested about the **condition**, **we** may decline any **claim** related to those **conditions**, and/or apply additional **personal exclusions**. The **personal exclusion** may be backdated to apply from the start of the **policy**. If **we** have already paid any **claims** relating to the **condition**, **we** may recover those amounts from **you**. Full details are in the 'You must be truthful with us' section on page 28.

Personal exclusions are listed on your Membership Certificate

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

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

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

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

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

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

If a **pre-existing condition** is listed under the 'What's not covered (exclusions)' section on page 18, this **condition** is excluded from cover and will not be covered under the **policy**. It does not need to be listed on the **Membership Certificate** as it is a **general exclusion** that applies to all **children** covered by the **policy**.

You must be truthful with us

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

You and **your child** 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** or **your child** have not omitted any information.

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

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

- If **you** or **your child** knowingly give **us** information that is untrue or misleading (or did not care whether it was), **we** may:
  - terminate the **policy** with effect from the time when untrue or misleading information was provided,
  - refuse to pay any **claims**, and/or
  - keep any **premiums** paid.
- If information turns out to be untrue or misleading because **you** or **your child** did not take reasonable care, **we** may:
  - apply different terms to the **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 the **policy** from the beginning and return any **premiums** paid.

If **we** identify fraudulent behaviour, **we** may take legal action against **you** or anyone 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 the **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 **children** on the **policy**, such as any changes or information relating to the **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 the policy's premium

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

Your children are only covered when you've paid the premium

We may not accept a **claim** if the **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 the **policy** is up to date for the period when the **medical treatment** or **procedure** took place.

We'll cancel the policy if you haven't paid the premium for 90 days

If **you** don't pay the **premium** on the **policy**, **we** will contact **you** to tell **you** that the **Health Plan** has overdue **premium**. **We** may cancel the **policy** if **you** haven't paid the **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 this KidSmart **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 **premium**.

We'll continue to make deductions if your contact details change

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

Unacceptable behaviour

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

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

Sometimes people 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 **you** or **your child's** behaviour is unacceptable:

- **We** will contact **you** in writing (by email or letter) advising **you** that the behaviour is unacceptable.
- **We** may limit how **you** or **your child** can contact **us** (for example, requiring written communication only or using a representative).
- **We** may issue **you** or **your child** with a warning explaining possible consequences should the unacceptable behaviour continue.
- **We** may terminate **your child's policy**. **We** reserve the right to unilaterally cancel the **policy** for unacceptable behaviour by **you** or anyone else on the **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 child or children's 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 the **Membership Certificate**. This free-look period allows **you** to review **your child's** cover and make sure it is right for them.

You can make changes to the **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 no **claim** has been made under the **policy**.

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

Adding children to the policy

You can add a **child** under the age of 18 years, onto the **policy** at any time. To add a **child** to this KidSmart **policy**, **you'll** need to complete a full application for each **child** and answer the health questions, or provide their full medical history.

We'll assess each application and decide whether the **child** can be added on the basis of the health information **we** receive. Cover for a **child** begins from the **start date** listed on the **Membership Certificate** that has the **child** listed as covered.

Once a **child** has been added to the **policy**, they will remain on it until the **guardian** tells **us** otherwise. The **guardian** is responsible for keeping **children** updated about all matters related to the **policy**, and any changes to the **policy** or the **child's** cover.

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

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

Adding a child who is under 6 months old

You can add a **child** who is under 6 months of age to the **policy** with no **personal exclusions** placed due to their medical history. The **general exclusions** listed on pages 18 to 20 will still apply, including **congenital conditions**.

A **child** who is under 6 months of age is eligible to receive cover free of **premiums** for the first 6 months after birth. **We** will charge the relevant **premium** once the **child** has reached 6 months of age.

How long can children stay on the policy?

Any **children** who have been added to the **policy** will be charged at a **child** rate until they reach 25 years old.

Once they reach 25 years of age, they'll be transferred onto a SmartCare+ **policy** and charged an age-related **premium**.

Any **child** aged 18 years and over who has been included on the **policy**, may apply to have their own **policy** at any point. If they do so within 30 days of leaving the **policy**, they will not need to go through the full application and approval process.

Removing a child from the policy

You can remove a **child** from the **policy** at any time by contacting **us**. The **guardian** is responsible for removing a **child** from the **policy** if circumstances change.

If **you** remove a **child** from the **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. A **child** must be under 18 years to be added back onto a KidSmart **policy**.

Suspending the policy

You may ask **us** to suspend **your child's 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 **medical treatment** or **procedures** that occur while the **policy** is suspended. **Your child** is unable to access Active Benefits/Care while the **policy** is suspended.

Your child or **children** must be a **Member** for a minimum of 12 months before the **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 if **you** or **your child**:

- are taking parental leave
- are suffering financial hardship
- are travelling overseas for an extended period

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 child's policy

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

Cancelling your policy

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

Reinstatement of cover within 30 days of **you** cancelling **your child's policy** is at **our** discretion. If **your child** applies to rejoin more than 30 days after cancelling, they 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 **child** breaches the terms and conditions of the **Health Plan** or the **Rules of UniMed**;
- there is unacceptable behaviour by **you** or a **child** on the **policy**;
- the last **child** covered by the **policy** dies; or
- when the last **child** remaining on the **policy** reaches the age of 25 years, at which time they will be transferred to their own SmartCare+ **policy**.

Other important information

This 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 child's policy' section on page 33).

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

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 **child** for the purposes of describing insurance cover under a KidSmart **policy**.

However, for the purposes of **membership** of Union Medical Benefits Society Limited under the Industrial and Provident Societies Act 1908, only insured 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, **you** have applied for **membership** of **UniMed** for any person covered under the **policy**. When **we** accept the application, any **child** aged 16 and above covered under the **policy** is automatically granted **membership** of **UniMed**.

By becoming a **Member** of **UniMed**, and being aged 16 years or older, **you** are deemed to have accepted and are bount to comply with the **Rules of UniMed**. Any **child** who is insured by **us** before they turn 16 automatically becomes a **Member** upon turning 16 if they continue to be insured by **us**.

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. **Membership** automatically ends if the **policy** is cancelled or terminated, or in the **event** of a **Member's** 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 your child** receives that are covered by the **policy**. **Your healthcare providers** are solely responsible for **your child's healthcare services**, **medical treatment** or **procedures**. **You** and **your child** are responsible for obtaining advice about the suitability of the particular **Health Plan** for **your child**.

Contact us if you have any concerns

We pride ourselves on providing great customer service, care, and support to **our Members**, so if **you** or **your child** 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** or **your child** can provide feedback to **us** via **our** website unimed.co.nz.

Complaints

If **you** or **your child** are unhappy with a **claim** or prior approval decision, or 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 the complaint to **your** satisfaction or **we** can't reach an agreement 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 or **your child** can contact the IFSO if **we** haven't been able to reach an agreement. **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 the 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** and **your child's** information, as well as how **you** can access and correct 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** and **your child**'s 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 **guardians** or **children** for specific types of expenses as specified in this **Health Plan document** and for which the **child** is eligible for, including grants.

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

Child/Children means a person under the age of 25 years on a KidSmart **policy**.

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

Condition means any illness, injury, disease, ailment, sickness, disorder, or disability, whether diagnosed or undiagnosed, that affects 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 the **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 the **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 anyone covered under the **policy** as listed in the 'General exclusions' section in this document.

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

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

Guardian means an adult who is legally responsible for any **children** on this **policy**. The **guardian** is the **policy** owner who takes out this **policy** on the behalf of a **child** and who is legally responsible for this **policy**, including paying **premiums**.

Health Plan means the specific **UniMed** health insurance plan that a **child** is covered under, which includes a **base plan** and additional **modules** if chosen.

Health Plan document means this document that outlines the terms and conditions of the **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 the **policy**. Terms and conditions include general conditions and requirements, eligibility, exclusions and limitations, **claims** and payment conditions and the responsibilities of **UniMed** and the **guardian** and **children**.

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.

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

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

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

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

Member means a person who has been accepted as a **Member** of **UniMed**, who is named on the **Membership Certificate** for whom **premium** is currently being paid to **UniMed**. This could be any **child** aged over 16 on the **policy**. **Guardians** are not **Members**. 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, **you** have applied for membership of **UniMed** for any **children** aged 16 and older covered under the **policy**. When **we** accept **your** application for cover, any **children** aged over 16 covered under the **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 **guardian** that confirms initial acceptance of **membership** or subsequent alterations to the **policy** for all **children** on the **policy**.

Member Portal means the secure online platform where **you** can log in to view and manage **your child's** 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 **children** to the **policy**, and view the **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 a **child** added to the **policy**, the period after the date on which that **child** is added. **You** cannot **claim** for **events** that happen during the **no-claiming period**.

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).

Personal exclusion means signs, symptoms, medical **conditions** or body parts that **we** do not cover for a particular **child**, as specified on the **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 the insurance contract with **us** that is made up of:

- the **Membership Certificate**
- the **Health Plan document**(s)
- documents and any correspondence **you** or **your child** have provided to **us**: i.e. **your** application including any health declaration, medical information and/or **your child's** medical history
- eligibility criteria for certain **medical treatment** or **procedures**
- **Rules of UniMed**.

Policy year means the 12-month period that starts on the **policy** anniversary date, and every 12-month period after that.

Pre-existing condition means:

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

Premium means the amount paid to **us** by or on behalf of a **child**, 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.

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**.

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

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 the **policy** starts or **membership** begins, as shown on **your child's 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 **guardian** (the **policy** owner) who takes out the KidSmart **policy**.

UniMed

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

0800 600 666 | unimed.co.nz