UniMed

Real Value Plan

Where an excess applies, you will pay 20% of the cost of each claim until the selected excess amount for that Member has been reached in the policy year.

All claims and prior approvals are based on reasonable charges for the services provided.

Standard benefits

GENERAL SURGERY IN AN ACCREDITED PRIVATE HOSPITAL — EXCESS APPLIES

This **benefit** covers the costs of **reasonable charges** up to a maximum of $150,000 per **claim** for the **surgical** treatment of a non-acute medical condition. A **claim** is the aggregation of all costs associated with the initial **procedure** and all subsequent eligible treatment or expenses. 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
- Surgeon's fees
- Anaesthetist's fees
- Costs of essential **prostheses**
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist **benefit** below provided they occur within six months of 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, culdoscopy and arthroscopy.

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

This benefit includes:

Spinal surgery

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

Varicose vein treatment

This **benefit** covers the **reasonable charges** for the **medically necessary** treatment of varicose veins after three years of continuous cover.

Major diagnostic procedures

This **benefit** covers the costs of **reasonable charges** of diagnostic **procedures** for angiograms, MRI scans, CT scans, CAT scans, MP scans, PET scans, and myelograms (if general anaesthetic is required), whether or not **you**'re admitted to a **private hospital**.

GENERAL SURGERY IN AN ACCREDITED PRIVATE HOSPITAL — CONTINUED

Breast reconstruction

This **benefit** covers the costs of **reasonable charges** of a breast reconstruction of the affected breast only after a mastectomy for the treatment of breast cancer. The reconstruction of the affected breast must occur within 24 months after a mastectomy that **we've** approved under this **Health Plan**.

Breast symmetry

This **benefit** covers the cost of **reasonable charges** of unilateral breast reduction **surgery** on the unaffected breast in order to achieve breast symmetry after a mastectomy for the treatment of breast cancer. The reduction of the unaffected breast must occur within 24 months after a mastectomy that **we've** approved under this **Health Plan**.

PROPHYLACTIC SURGERY — EXCESS APPLIES

This **benefit** covers up to $60,000 for each person for the costs of **reasonable charges** of prophylactic (**preventative**) **surgery** if **you** have an increased risk of developing cancer because of a high risk status or gene mutation. **You** can **claim** this **benefit** as many times as **you** need to but it only provides cover up to $60,000 for each person over their lifetime.

To **claim** under this **benefit**, **you** must meet the requirements listed in the eligibility criteria for prophylactic **surgery**. This can be found at unimed.co.nz/important-documents.

SPECIALIST — CONSULTATIONS, TESTS AND RELATED COSTS — EXCESS APPLIES

This **benefit** covers the costs of **reasonable charges** up to an aggregated total of $5,000 per person per **policy year** for specialist consultations, diagnostic tests and investigative **procedures** provided these are not for **preventative** and/or screening purposes.

A **registered medical specialist** must be a **member** or fellow of the appropriate college of specialists, have Medical Council of New Zealand registration and a current practising certificate for the code of medicine for which the **Member** is being treated.

Where any of these costs relate to or result in a **surgical event** eligible for cover under the general **surgery benefit**, they will be included in the aggregated costs of the operation.

This benefit includes:

Diagnostic tests and treatment to a maximum of $4,000 per *event*.

Diagnostic tests include but not limited to:

- Allergy testing
- Audiometric tests
- Electrocardiogram (ECG)
- Electromyography (EMG)
- Exercise ECG
- Nuclear scanning
- Urodynamic assessment
- Audiology
- Colposcopy
- Electroencephalography (EEG)
- Endoscopic examinations such as gastroscopy, colonoscopy
- Mammography
- Ultrasound
- X-ray

MENTAL HEALTH

This **benefit** covers the costs of **reasonable charges** up to $1,000 per person per **policy year** for 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.

PRIVATE HOSPITAL MEDICAL ADMISSION — EXCESS APPLIES

This **benefit** covers the costs of **reasonable charges** associated with admission to a **private hospital** for reasons other than **surgery** up to a maximum of $100,000 per person per **policy year**. Non-surgical cancer treatment is covered to a maximum of $60,000 per person per **policy year**.

Admissions do not cover convalescence, recovery, obstetrics or psychiatric and/or psychological treatment or counselling, geriatric, senile and recurrent or on-going health conditions.

Please note that any **palliative care** treatment is not covered as per the Real Value Plan's terms and conditions.

POST-OPERATIVE THERAPY

This **benefit** covers up to $1,000 per **event** towards costs associated with post-operative therapy that is provided within 12 months following a related **surgery**, cycle of chemotherapy or radiation treatment that **we've** approved under this **policy**. This includes:

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

You 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 **your surgery** or treatment. This doesn't include costs for personal items such as food/food substitutes, materials or garments.

MINOR SURGERY — EXCESS APPLIES

This **benefit** covers up to a maximum of $200 per **event** (consultations and materials are not covered) when performed by a New Zealand **registered medical practitioner** in private practice. The invoice must clearly indicate the **procedure**.

PUBLIC HOSPITAL BENEFIT

This **benefit** provides $100 per night up to a maximum of $500 per person per **policy year** for any **public hospital** stay of a **Member** or for three or more consecutive nights. The **benefit** does not apply to a private fee-paying patient in a **public hospital** or private wing of a **public hospital**.

OVERSEAS TREATMENT — EXCESS APPLIES

This **benefit** covers reimbursement up to $20,000 per person per **policy year** of **reasonable charges** for a **surgical procedure**/treatment performed at an overseas hospital and travel to and from, where the **procedure** isn't available in New Zealand.

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

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

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. Please also provide the invoices and receipts for travel.

ORAL SURGERY — EXCESS APPLIES

This **benefit** covers the costs of **reasonable charges** up to $150,000 per person per **policy year** for oral or maxillofacial **surgery** listed below:

- **Surgical** removal of impacted or unerupted teeth after three years of continuous cover.
- **Surgical** removal of cysts, soft tissue swellings and other medical (not dental) problems of the mouth that require major **surgical** intervention.
- **Surgical** drainage of abscesses.
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist **benefit** provided they occur within six months of the approved **surgery**.

This **benefit** does not cover orthodontic, periodontal, orthognathic or endodontic treatment, as well as crowns, dental plates, root canals, other extractions, tooth exposures or implants.

You 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 **you** or the additional **Member** on **your 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.

STERILISATION — EXCESS APPLIES

After three years of continuous cover this **benefit** will cover reimbursement up to a maximum of $3,000 per person per **policy year** towards the cost of **reasonable charges** for a sterilisation **procedure** carried out on a **Member**, where the **procedure** is necessary in the interest of the physical health of that **Member**.

This **procedure** must be recommended by a **registered medical specialist**.

TRAVEL EXPENSES

This **benefit** covers travel expenses as described below if required and is included in the aggregation for the maximum **benefit** limit. These costs must directly relate to a private **hospitalisation** under this **Health Plan**. Pre-operative and post-operative consultations/treatments do not qualify. Payment will be made by reimbursement on evidence of expenses.

Ambulance transfer

Where an air or road ambulance transfer to or from a private or **public hospital** within New Zealand has been authorised by a **registered medical specialist**, **we** will reimburse the cost provided the original admission to hospital as a private fee-paying patient was pre-approved by **UniMed**.

Transport costs

If the condition cannot be treated locally and the **Member** is required to travel by air, road or rail, **we** will pay either return public transport costs (economy airfares, bus fares or train fares) or return road travel to the place of **hospitalisation** within New Zealand. The refund for road travel is calculated on the mileage travelled at $0.30 per km. In addition, a taxi fare from the airport/station to the **private hospital** and return for the **Member** if required, is also covered.

Support person travel and accommodation costs

In the above circumstances where the condition cannot be treated locally, similar travel costs will be available for a support person, if this is recommended by a registered specialist, plus accommodation costs not exceeding $100 per night for up to five nights or the period the **Member** is in hospital, whichever is shorter.

Special benefits and grants – 100% refund

SICK LEAVE WITHOUT PAY BENEFIT

$100 per week to a maximum of $600 per *policy year*

Before **you** are eligible to **claim** under this **benefit**, **you** (the **Member**) would need to be sick for five consecutive working days and have exhausted **your** sick leave entitlement at **your** current employment. A medical certificate and written confirmation that there is no valid sick leave with pay left from **your** employer are required to support every **claim**.

BEREAVEMENT GRANT

$2,500 payment

We will pay a bereavement **grant** on the death of any **Member** covered under the **policy** into the bank account of the deceased **Member's** estate. A copy of the full death certificate and proof of the executor, administrator or solicitor acting for the estate must be provided.

BIRTH GRANT

$400 payment

We will pay a birth **grant** after the **Member** has contributed continuously for 12 months prior to the birth. One **grant** is claimable on the birth, adoption or stillbirth of a child to a **Member** on the **policy**. **Members** aged 24 years or younger do not qualify for this **benefit**. A copy of the full birth certificate to clearly identify **parent(s)** must be provided. Adoption of a **Member's** child from a previous relationship does not qualify.

HOME SUPPORT BENEFIT

Up to $100 per week to a maximum of $600 per *policy year*

The **Member** may **claim** $20 per day up to $100 per week. A medical certificate and confirmation of payment to the domestic assistance supplier is required. The **benefit** is payable where daily domestic assistance is essential after illness or **accident**.

Loyalty Benefits

Loyalty **benefits** allow **you** to use **your** insurance not just for treatment but to maintain good health after **you've** held **your** Real Value Plan for more than three years.

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.

GP HEALTH CHECK

$150 per person every three *policy* years.

After three years of continuous cover, this **benefit** covers the costs of a health check performed by a New Zealand **registered medical practitioner** (GP).

Children aged 25 years or younger do not qualify for this **benefit**.

SKIN CHECK

$200 per person every three *policy* years.

After three years of continuous cover, this **benefit** covers consultations and screening skin checks for moles and skin lesions including services such as mole mapping, provided by a **registered medical practitioner**.

BOWEL SCREENING

A bowel screening kit per person, every three continuous *policy* years.

After three years of continuous cover, this **benefit** enables **you** to request one free bowel screening kit. Visit unimed.co.nz/members for terms of the **benefit** and information on how to request the kit.

Children aged 25 years or younger do not qualify for this **benefit**.

Terms and conditions

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

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

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

What makes up your policy

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

Your policy is made up of:

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

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

If there is any inconsistency or contradiction between **your policy** documents, the following order of precedence will apply (unless advised otherwise): **Your Membership Certificate** takes precedence over all other documents, followed by **your Health Plan document** including terms and conditions.

Membership of the Society

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

UniMed membership

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

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

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

By applying for cover, directly or through **your** employer, **you** have applied for **membership** of **UniMed** for **yourself** and any other person covered under **your policy**. When **we** accept **your** application, **you** and any other person covered

under **your policy** is automatically granted **membership** of **UniMed**. This means that throughout **our** documents, **we** may refer to **you** as the **Primary Member** and all other individuals on **your policy** as additional **Members**.

By becoming a **Member** of **UniMed**, and being aged 16 years or older, **you** are deemed to have accepted and are bound to comply with the **Rules of UniMed**. The **Rules of UniMed** may change from time to time. A copy of the **Rules of UniMed** is available at unimed.co.nz/important-documents.

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

Removing additional Members from your policy

You can remove an additional **Member** from **your policy** at any time by contacting **us**.

The **Primary Member** is responsible for removing additional **Members** from the **policy** if circumstances change — for example, following a marital separation.

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

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

Options after being removed from a policy

Any additional **Member** aged 25 years and over who has been included on **your policy**, may apply to have their own **policy**. If the additional **Member** applies within 30 days of leaving **your policy**, they will not need to go through the full application process, and any **pre-existing condition** cover will remain the same if retaining the same **Health Plan** and **policy** terms.

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

Death of the Primary Member

If the **Primary Member** of the **policy** dies, the **partner** who has been included on the **policy** may retain the **policy** and continue paying the appropriate **premium**. The **partner** will then take over the role of the **Primary Member**.

Waiver of premium

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

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

Appropriate certificates and documentation must be provided.

Suspending your policy

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

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

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

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

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

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

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

Applications for membership

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

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

Policy purpose

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

Commencement of membership and cover start date

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

30-day free-look period

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

You can make changes to **your policy** within this 30-day period. If **you** change **your** mind and wish to cancel within this 30-day period, **we'll** refund any **premiums** paid, as long as **you** haven't made a **claim** under the **policy**.

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

Extra care and support

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

Premiums

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

How to claim

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

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

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

When we will cover costs

We only accept and provide cover for costs:

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

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

Other information

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

We will cover reasonable charges

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

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

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

Understanding your options:

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

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

If **you** choose to proceed, **you'll** need to pay the difference between the amount **we** approve and the actual cost for the **medical treatment** or **procedure**, regardless of the **benefit** limit. **You'll** need to pay this extra amount directly to **your healthcare provider**.

Claims on other insurers

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

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

Claims involving *ACC*

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

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

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

ACC top-up

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

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

If ACC declines your claim

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

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

Your healthcare decisions

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

Ending your policy

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

Cancelling your policy

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

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

How we can end your policy

We can end your policy if:

- you fail to pay your **premium** for 90 days or longer;
- you or any additional **Member** breaches these Terms and Conditions, the terms of the **Health Plan** or the **Rules of UniMed**;
- there is unacceptable behaviour by you or a **Member** on your **policy**; or
- the last **Member** covered by the **policy** dies.

Unacceptable Member behaviour

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

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

Sometimes **Members** can behave in ways that are unreasonable or unacceptable, which can affect **our** ability to serve others and keep **our**

workplace safe. If interactions become abusive or unreasonably demanding, **we** may need to take action to protect **our** staff and other **Members**.

Types of unacceptable behaviour

Unacceptable behaviour includes, but is not limited to:

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

How we assess unacceptable behaviour

We consider behaviour unacceptable when it:

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

Possible actions

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

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

You must be truthful with us

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

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

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

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

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

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

Other important information governing the policy

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

Contact us if you have any concerns

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

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

Complaints

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

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

Insurance & Financial Services Ombudsman (IFSO)

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

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

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

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

- Phone: 0800 888 202
- Mail: Insurance & Financial Services Ombudsman, PO Box 10845, Wellington 6143

Financial Services Council

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

Privacy Statement — we're committed to respecting your privacy

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

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

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

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

New Zealand law and currency apply

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

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

Exclusions

Personal exclusions

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

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

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

General exclusions

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

These are general exclusions and apply to all **our Members**. These are standard across all **our** policies and cannot be overridden unless **we** have specifically said otherwise in **your Health Plan document**.

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

Health conditions *we* don't cover

Psychiatric, psychological and/or neurodevelopmental disorders

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

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

Certain types of care

We don't cover these types of care.

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

Some conditions

We don't cover these conditions.

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

Obstetrics and gynaecology

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

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

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

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

Treatment for *preventative* reasons

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

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

Dental or eye treatment or *surgery*

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

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

Organ failure or donation

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

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

Other treatment or *surgery*

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

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

Other costs

We don't cover these costs.

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

Other expenses and costs *we* don't cover

Appliances and devices

We don't cover the following.

- Personal health-related appliances; for example, hearing aids, personal alarms, orthotic shoes, crutches, wheelchairs, toilet seats, mouthguards, and artificial limbs
- Medical devices; for example, cardiac pacemakers, nerve appliances, cochlear implants, or penile implants
- **Surgical** or medical appliances; for example, glucometers, oxygen machines, respiratory machines, diabetic monitoring equipment, or blood pressure monitoring equipment
- Any costs not specifically related to the consultation or treatment such as administration costs or statement fees.

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

We don't cover the following.

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

Glossary of key terms

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

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

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

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

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

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

Child/Children means a **Member's** child, including any stepchild, adopted child, or child for whom the **Member** has legal guardianship or primary caregiving responsibility, who has been accepted as an additional **Member** on the **policy** before the child turns 25 years of age.

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

Congenital condition means a health abnormality or defect that is present at birth (whether it is inherited or due to external factors such as drugs or alcohol or any other cause). This includes any conditions present at birth and diagnosed within the first 3 months of life, or where signs or symptoms were present before **your policy** began – regardless of when it was formally diagnosed.

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

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

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

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

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

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

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

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

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

Hospitalisation means admission to hospital for treatment.

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

Medically necessary means healthcare services that, in **our** opinion, are necessary for the care or treatment of a nominated health condition.

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

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

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

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

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

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

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

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

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

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

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

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

Pre-existing condition means:

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

Premium means the amount paid to **us** by or on behalf of a **Member** to maintain **membership** and eligibility for **benefits**.

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

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

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

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

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

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

Reasonable charges means charges for a **medical treatment** or **procedure** that is determined by **us** in **our** sole discretion to be both:

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

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

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

Registered medical specialist means a health service provider who is:

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

This does not include those holding Medical Council of New Zealand registration for:

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

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

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

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

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

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

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

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

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

Get in touch

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

0800 600 666 | unimed.co.nz

UniMed

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