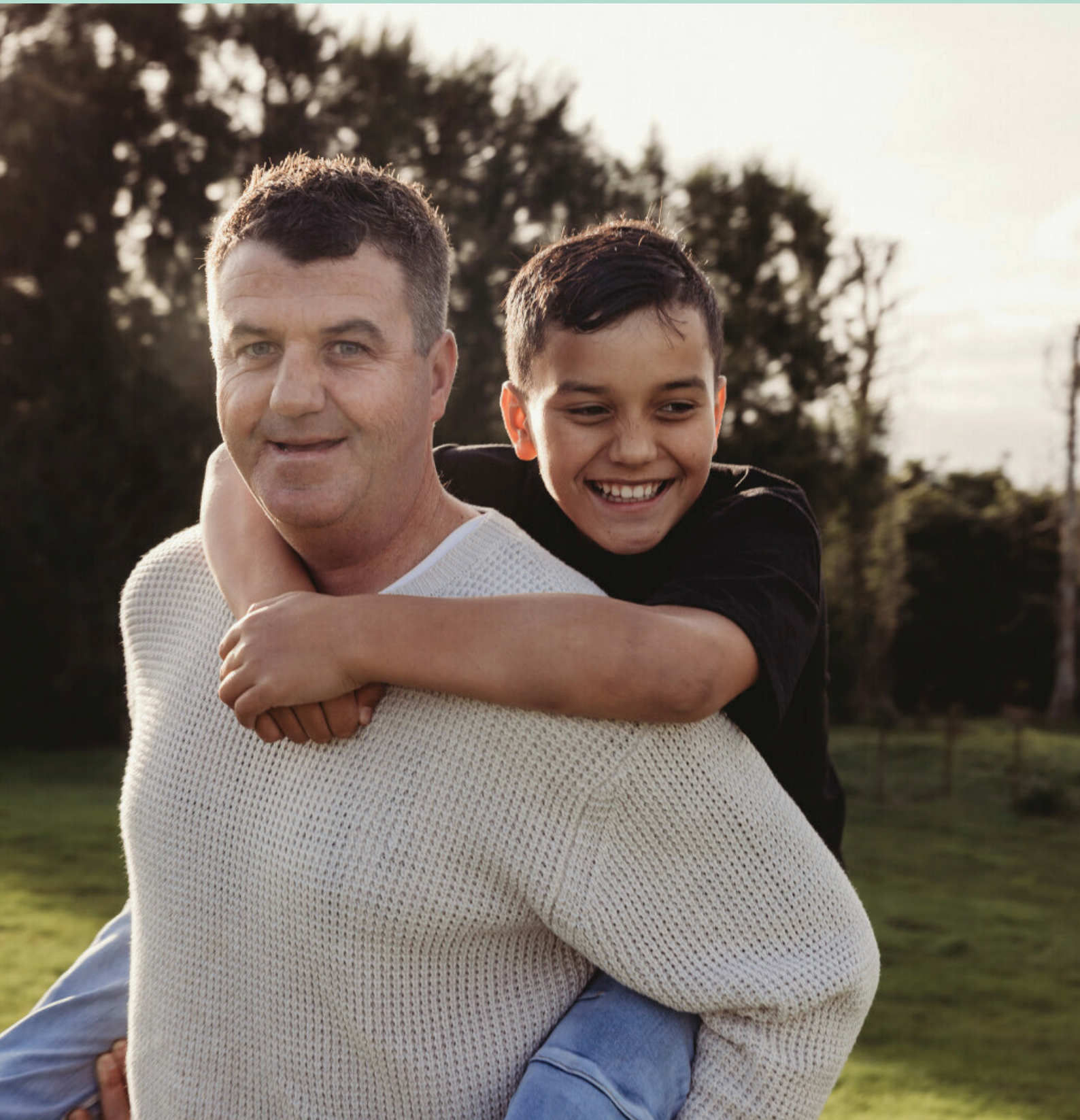
UniMed

SmartCare Health Plan

1 September 2026



Contents

Welcome to SmartCare

Thank you for choosing SmartCare.

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

About us

Who we are

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

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

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

Terms used in this document

Words printed in bold have their own special meanings that are defined in the 'Glossary' section on page 43. For **your** convenience, **we** have included some of the frequently used terms here.

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

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

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

Tell us about changes

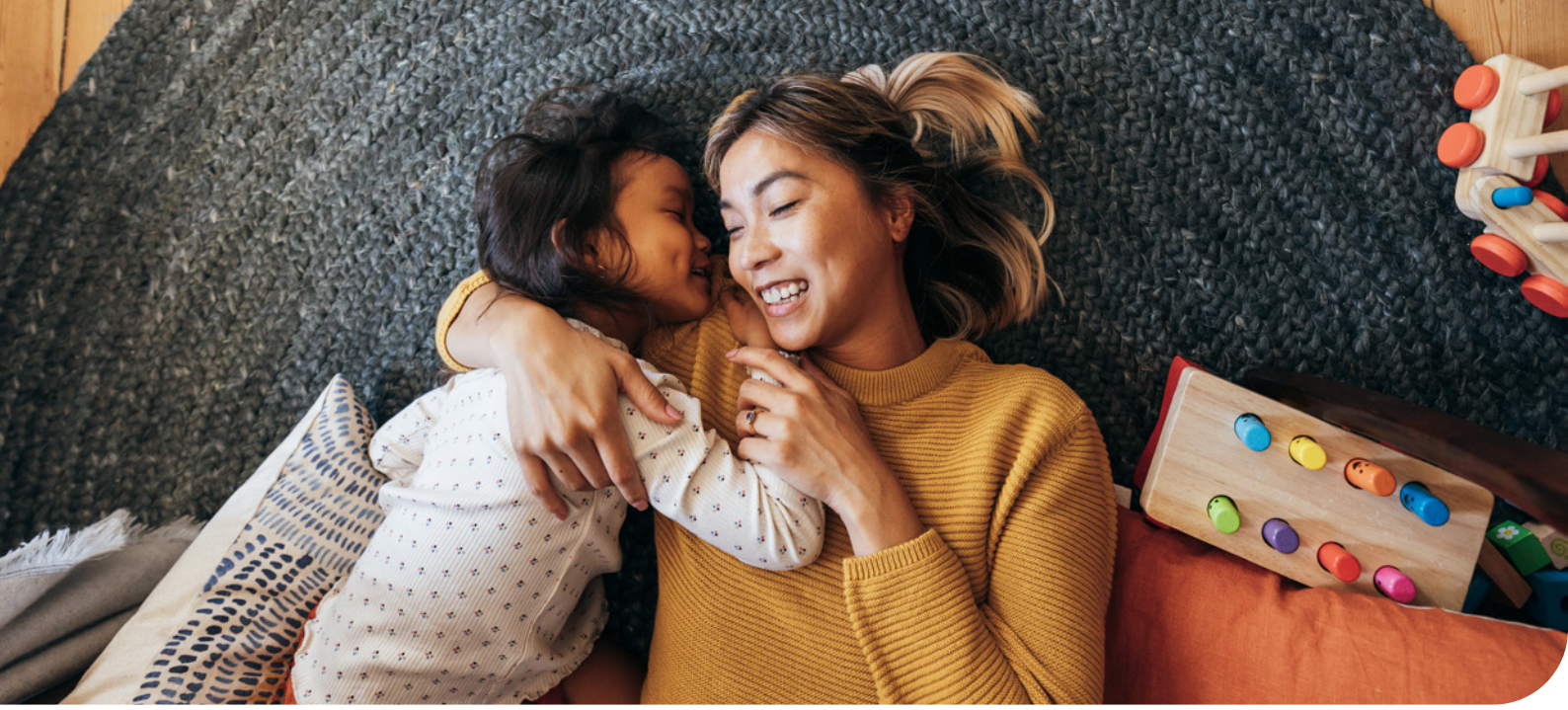
Please make sure that **we** have **your** most up-to-date contact details. Update **your** details in the Member Portal or contact us.

Extra care and support

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

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

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



SmartCare at a glance

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

Your SmartCare **Health Plan** starts from the date on **your Membership Certificate**, or the date specified for each additional **Member**. **You'll** be covered until **your policy** ends because it's been cancelled or terminated.

Who SmartCare is for

This SmartCare **Health Plan** is only for New Zealand citizens, residents, or people 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**).

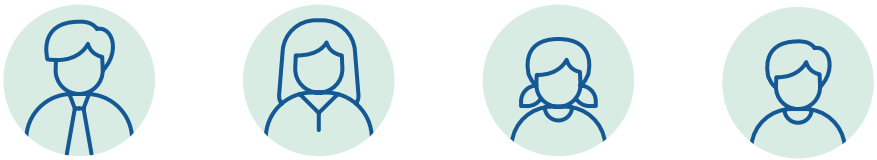
The New Zealand healthcare system has three main components:

- **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 **you** are treated, including being able to choose the doctor, **specialist** or private facility. Often people will decide to have elective treatment in the private health system as it may be quicker.

Start with the base plan and add additional modules

When **your policy** starts, **you** begin with the **base plan** that everyone on the **policy** must have: the Hospital and Surgical base plan. **You** can choose to add any of **our** additional **modules** for **yourself** or any of the other **Members** on the **policy**. They don't need to be the same **modules** for all additional **Members**.

Hospital and Surgical base plan



+ Additional module

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Main benefits of SmartCare

Hospital and Surgical base plan benefits:	Per person per policy year*
General surgery (including tests such as CT and MRI scans)	$300,000
Oral surgery	$300,000
Private hospital medical admission (including chemotherapy and radiation treatment of $65,000)	$200,000
Multiple overseas treatment benefits	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 modules

Specialist module
Cover for specialist consultations and diagnostic tests.

GP module
Cover for GP and nurse consultations, along with prescription drug costs.

Natural Health module
Cover for consultations with chiropractors, physiotherapists, osteopaths and other natural health providers.

Dental and Optical module
Cover for dental treatment and optical consultations and eyewear.

For more detail and benefit limits please see the 'Additional modules' section on page 16.

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 **your policy**, refer to the 'Conditions of cover for prescription drugs' section on page 31.

Standard benefits

General surgery

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

If **you're** wanting to **claim** under this **benefit**, please seek prior approval before **your** 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 1 year 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**. **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.

General surgery continued

Major diagnostic procedures

This **benefit** covers the costs of **reasonable charges** for 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 **you're** admitted to a hospital.

Varicose vein treatment

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

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 **claim** that **we've** approved under this **Health Plan**.

Breast symmetry

This **benefit** covers the costs 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 **claim** that **we've** approved under this **Health Plan**.

Prophylactic surgery

$60,000 per person, per lifetime | An excess applies to this benefit

This **benefit** covers 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.

Oral surgery

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

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

- **Surgical** removal of impacted or unerupted teeth after 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 1 year before or after the approved **surgery**

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

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.

Private hospital medical admission

$200,000 per person, per policy year | An excess applies to this benefit

Non-surgical cancer treatment is limited to a maximum of $65,000 for each person in a **policy year**. This is included within the $200,000 **benefit limit**.

This **benefit** covers the costs of **reasonable charges** for admission to a **private hospital** for reasons other than **surgery**, such as cancer treatment. **Your 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 **Member**.

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 6 months of the date of admission
- Diagnostic **procedures**, including diagnostic **procedures** directly relating to the hospital admission that occurred within 6 months of the date of admission
- **Claims** under this **benefit** include up to $2,000 per person 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, scarf, or mastectomy bra.

Minor surgery

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

This **benefit** covers the costs of **reasonable charges** for minor **surgery** performed 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 **Member** would be affected.

Overseas treatments

An excess applies to this benefit

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

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

To qualify for this **benefit**, the **Member** 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.

Cover while in Australia

This **benefit** covers reimbursement of medical costs incurred for non-acute (non-urgent) medical **conditions** that are treated in Australia.

We'll reimburse the **reasonable charges** for the treatment if it had been undertaken in New Zealand. **We'll** pay **you** in New Zealand dollars.

The **Member** must meet all **benefit** criteria and is subject to all **excess**, **reasonable charges**, maximums, and exclusions described elsewhere in this **Health Plan document**.

All costs are included in the maximum limit that applies to the 'General **surgery**' or '**Private hospital** medical admission' **benefits**, whichever applies for the relevant treatment under the Hospital and Surgical base plan. Services that fall under 'Other benefits' below do not qualify for cover under this **benefit**.

Other benefits

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

Mental health

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

This **benefit** covers the costs of **reasonable charges** 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 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 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

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.

Home nursing

$150 per day | $6,000 per person, 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. **You** need 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**.

Parent accommodation

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

This **benefit** covers reimbursement of accommodation expenses paid by a parent 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 **your claim**.

Public hospital

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

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

Hospice stay

$50 per night, maximum 10 nights per admission | $2,000 per person, per policy year
No excess applies to this benefit

This **benefit** covers the cost of **hospice** care for the **Member** if they are admitted to a **hospice** and the admission lasts 4 or more nights in a row. The **hospice** must hold regular or associate service membership with Hospice New Zealand.

Transport and accommodation

$2,000 per person, per policy year | No excess applies to this benefit

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

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

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 **your policy**. **You** must send receipts for reimbursement with **your 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 **Member** 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 **Member** under this **Health Plan**. **You** must send receipts for reimbursement with **your claim**. Pre-operative and post-operative consultations or treatments do not qualify.

Ambulance transfer

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

This **benefit** covers the costs of 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**. **You** must have prior approval from **us** before **your** initial admission to hospital.

Bereavement grant

$2,500 per person | No excess applies to this benefit

We'll pay a bereavement **grant** to the deceased **Member's** estate if a **Member** dies from illness between the ages of 25 to 65 years (inclusive). A copy of the death certificate and proof of the executor, administrator or solicitor acting for the estate must be provided.

Medical misadventure

$30,000 per person, per lifetime | No excess applies to this benefit

We'll pay a medical misadventure **benefit** if the **Member** dies as a direct result of any medical error or mishap by a registered medical provider in a public or **private hospital** in New Zealand.

This **benefit** applies only if:

- the death of the **Member** occurs within 30 days of the medical error or mishap
- the public or **private hospital** accepts a public admission of such an incident and liability
- the instance of medical misadventure is verified and confirmed by the relevant government authority, a court of law, a coroner's inquest, or the Medical Council of New Zealand.

We'll deduct any bereavement **grant** previously paid for a **Member** from the medical misadventure **benefit**.

ACC top-up

An excess applies to this benefit

We cover any shortfall between what **ACC** pays and the actual costs of the **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 **Member** must receive **ACC's** acceptance of their **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 **Member** to apply for a review of **ACC's** decision. **We** may ask for **your** 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 **Member** holds. The **benefit's** maximum limit will apply to all costs paid.

Loyalty benefits

Loyalty benefits allow you to use your insurance not just for treatment but to maintain good health after you've held your SmartCare policy for more than 2 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.

Sterilisation

$3,000 per policy

This is a one-off contribution up to $3,000 toward the total cost of sterilisation **procedures**.

After 2 years of continuous cover, this **benefit** covers the costs of **reasonable charges** of sterilisation including vasectomies and female sterilisation **procedures**. It doesn't include reversals.

GP health check

$150 per person, every 3 policy years

After 3 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 don't qualify for this **benefit**.

Discounts for those with healthy weight

After 3 years of continuous cover and with confirmation from **your GP** that **your** body mass index (BMI) is between 18.5 and 24.99, **your premium** on the Hospital and Surgical base plan will be discounted as follows.

- 5% discount after 3 years of continuous cover
- 10% after 6 years of continuous cover
- 15% after 9 years of continuous cover, and every 3 years following

Children aged 25 years or younger don't qualify for this **benefit**.

Your BMI discount entitlements are assessed on **your** anniversary every 3 years. **We'll** stop this discount if **we** do not receive confirmation of **your** BMI status at **your** 3 yearly anniversary or if **your** BMI falls outside the 18.5 to 24.99 range. Please note this discount doesn't apply to any current or previous **Members** of a **group insurance scheme**.

Bowel screening

One kit for each person every 3 policy years

After 3 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.

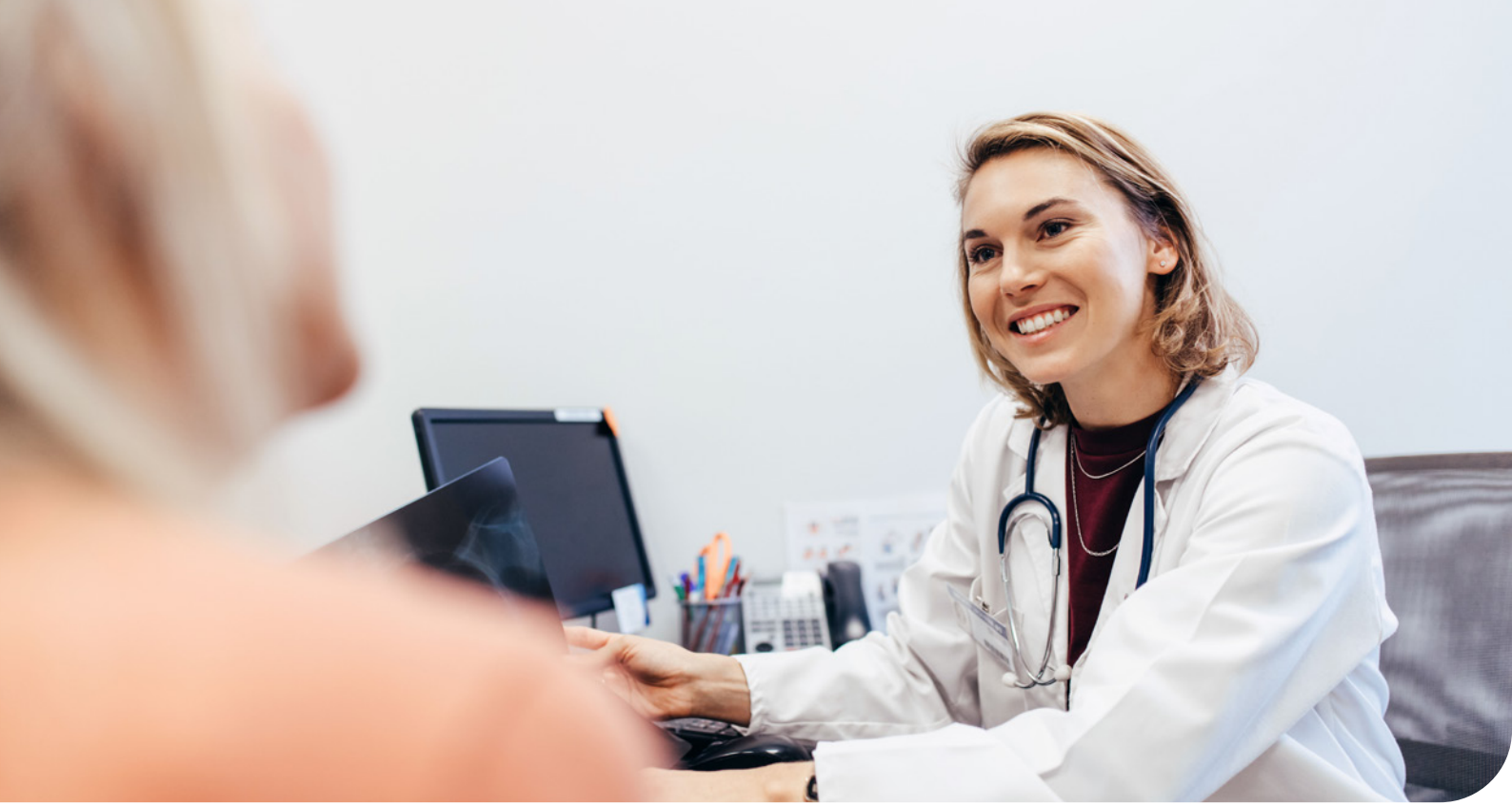
Children aged 25 years or younger don't qualify for this **benefit**.

Weight-loss or breast reduction surgery

$8,000 per person, per lifetime

This is a one-off contribution of 50% of the cost up to $8,000 toward the total cost of weight-loss or breast reduction **surgery**.

After 5 years of continuous cover, this **benefit** covers the costs of **reasonable charges** for **surgery** for weight-loss or breast reduction. For breast reduction **surgery**, an underlying medical **condition** must apply. It doesn't include the removal of implants or cosmetic reduction.



Additional modules

You can choose to add any of our additional modules for yourself or any additional Member on your policy. These modules include:

- Specialist module
- GP module
- Natural Health module
- Dental and Optical module.

Check **your Membership Certificate** to see if **you're** covered under any of these **modules**. **You** won't have these **modules** unless **you've** asked **us** to add them to **your 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 **modules**, or would like to add an additional **module** to **your policy**.

Specialist module

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

Specialist consultations

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

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

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

Mental health consultations — $1,000 per person, per policy year

This **benefit** covers the costs of **reasonable charges** 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 Counselling Association.

Second opinion

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

Diagnostic tests and treatment

$5,000 per person, 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 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 you extra benefits after you've held the Specialist module for more than 3 years

Screening — $250 per person, every 3 policy years

After 3 years of continuous cover, this **benefit** covers the costs of a mammogram or prostate check performed by a **healthcare provider**.

Children aged 25 or younger don't qualify for this **benefit**.

Pregnancy — $1,000 per person, per policy year

After 3 years of continuous cover, this **benefit** covers obstetric care during pregnancy by a registered medical **specialist**. This **benefit** doesn't cover antenatal ultrasounds.

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

After 3 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 **healthcare provider**.

GP module

The GP **module** provides cover for visits to **your** doctor, including cover for prescription drugs. No **excess** applies to this **module**.

This **module** has an initial **no-claiming period** of 90 days, which means that **you** can't make a **claim** for any **benefit** on the **module**, such as **GP** visits, in the first 90 days.

General practitioner (GP)

Covers the costs of **GP** visits, including home and after-hours visits.

Up to $65 for each **GP** visit.
Up to $70 for each home visit or after-hour visit with a **GP**.

Registered nurse

Covers the costs of practice nurse visits.
Up to $55 for each visit.

Prescription drugs and laboratory tests

Covers the costs of prescription drugs and laboratory tests ordered by a **healthcare provider** or registered medical **specialist**.

Laboratory tests: $80 each **policy year**.
Prescription drugs: up to $20 for each item, to a maximum of $400 in a **policy year**.

Loyalty benefit

We give you this extra benefit after you've held the GP module for more than 3 years

Preventative checks **$200 per person, every 3 policy years**

After 3 years of continuous cover, this **benefit** covers the costs of a **preventative** mammogram or prostate check performed by a **healthcare provider**.

Children aged 25 or younger don't qualify for this **benefit**.

Natural Health module

The Natural Health **module** provides a diverse approach to keeping well. No **excess** applies to this **module**.

This **module** has an initial **no-claiming period** of 90 days, which means that **you** can't make a **claim** for any **benefit** on the **module**, such as physiotherapy treatment, in the first 90 days.

Healthcare practitioners

$800 per person, per policy year

Osteopath and chiropractor

This **benefit** covers the costs of treatment by osteopath and chiropractor healthcare practitioner.

Up to $45 for each visit, to a maximum of $240 in a **policy year** for each health practitioner. Materials or supplements are not covered.

Healthcare practitioners

This **benefit** covers the costs of treatment by the following health practitioners:

- Acupuncturist
- Dietitian
- Homeopath
- Medical herbalist
- Naturopath
- Nutritionist
- Physiotherapist
- Podiatrist
- Reflexology treatment
- Remedial body therapist
- Traditional Chinese medicine practitioner

Up to $45 for each visit, to a maximum of $200 in a **policy year** for each health practitioner. Materials or supplements are not covered.

Loyalty benefits

We give you these extra benefits after you've held the Natural Health module for more than 3 years

Sick leave — $100 each week, up to $500 per person, per policy year

After 3 years of continuous cover, this **benefit** provides income during sick leave without pay. To qualify for this **benefit**, the **Primary Member** or their **partner** (who is covered under this **module**) must present a certificate from their employer confirming unpaid sick leave. **You** must also send **us** a medical certificate from a **healthcare provider**.

Flu vaccination — $40 per person, per policy year

After 3 years of continuous cover, this **benefit** covers the flu vaccination.

Dental and Optical module

The Dental and Optical **module** provides cover for visits to the dentist and optician as well as the purchase of prescription glasses or contact lenses. No **excess** applies to this **module**.

This **module** has an initial **no-claiming period** of 90 days, which means that **you** can't make a **claim** for any **benefit** on the **module**, such as dental treatment, in the first 90 days.

Dental cover

80% of the cost — $500 per person, per policy year

This **benefit** covers the costs of dental treatment by a registered dental practitioner, including:

- Cleaning
- Dental check
- Fillings
- Scaling
- Teeth removal
- X-rays

Your dental practitioner must be registered with the Dental Council of New Zealand and hold a current annual practising certificate.

This **benefit** excludes orthodontic, periodontal, or orthognathic (jaw-correcting) treatments unless specified.

Optical cover

80% of the cost up to the benefit limit

Consultations — $60 per visit | $300 per person, per policy year

This **benefit** covers the costs of optometrist or orthoptist consultations. Practitioners providing assessments must belong to their professional body.

Glasses or contact lenses — $300 per person, per policy year

This **benefit** covers the costs of prescription glasses or contact lenses.

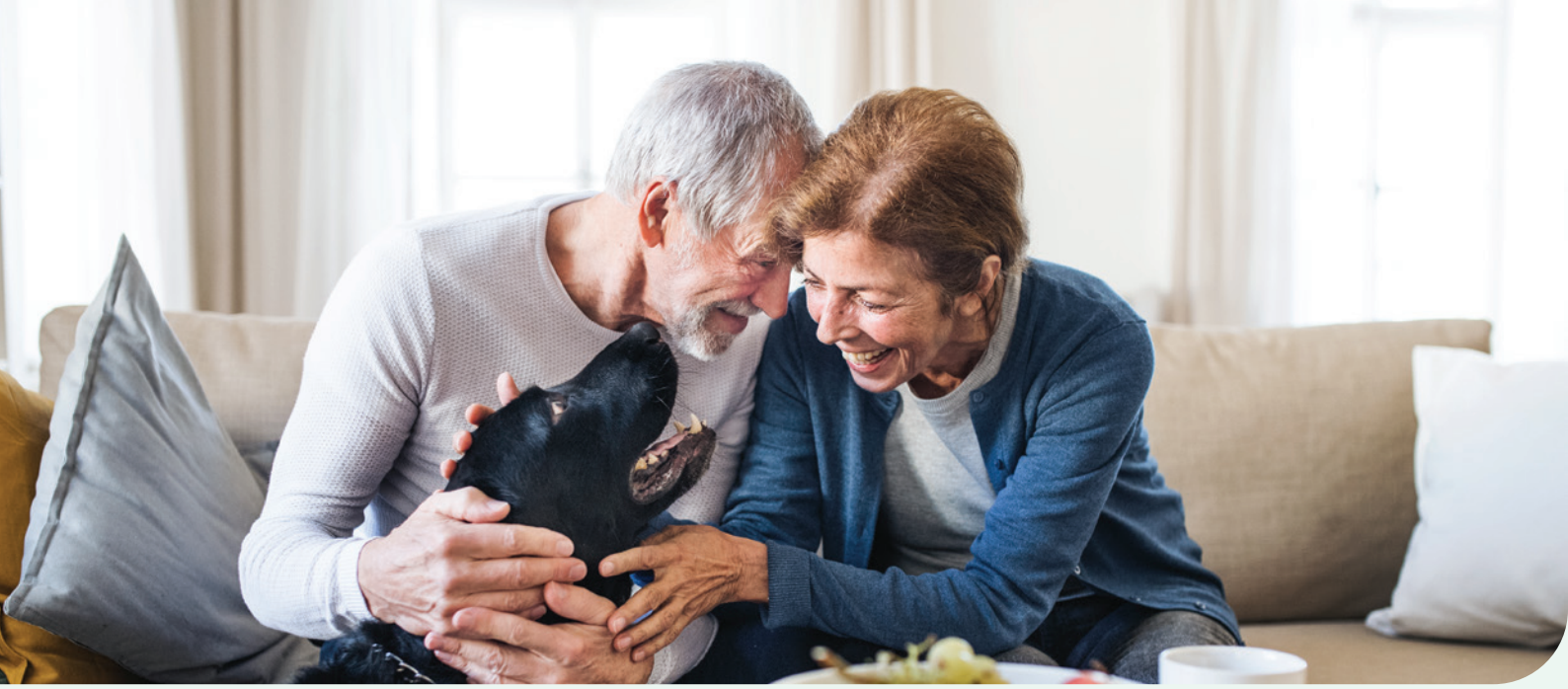
Loyalty benefit

We give you this extra benefit after you've held the Dental and Optical module for more than 3 years

Orthodontic — 80% of the cost | $750 per person, per policy year

After 3 years of continuous cover, this **benefit** covers the cost of orthodontic treatment by a registered orthodontist.

Practitioners providing assessments must belong to their professional body.



Terms and conditions

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

We want you to understand your cover

What makes up your policy

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

Your policy is made up of:

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

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

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

What's not covered (exclusions)

Personal exclusions

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

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

If **you** have any **personal exclusions**, they will be listed on **your Membership Certificate**. For more information including how they apply please refer to "Personal exclusions are listed on your Membership Certificate" on page 33.

General exclusions

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

These are **general exclusions** and apply to all **Members**. They cannot be overridden unless **we** have specifically said otherwise in this **Health Plan document**.

We aim to fully explain what is not covered in **your policy**. Unless specifically provided for in the plans **you** select, SmartCare 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 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** 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

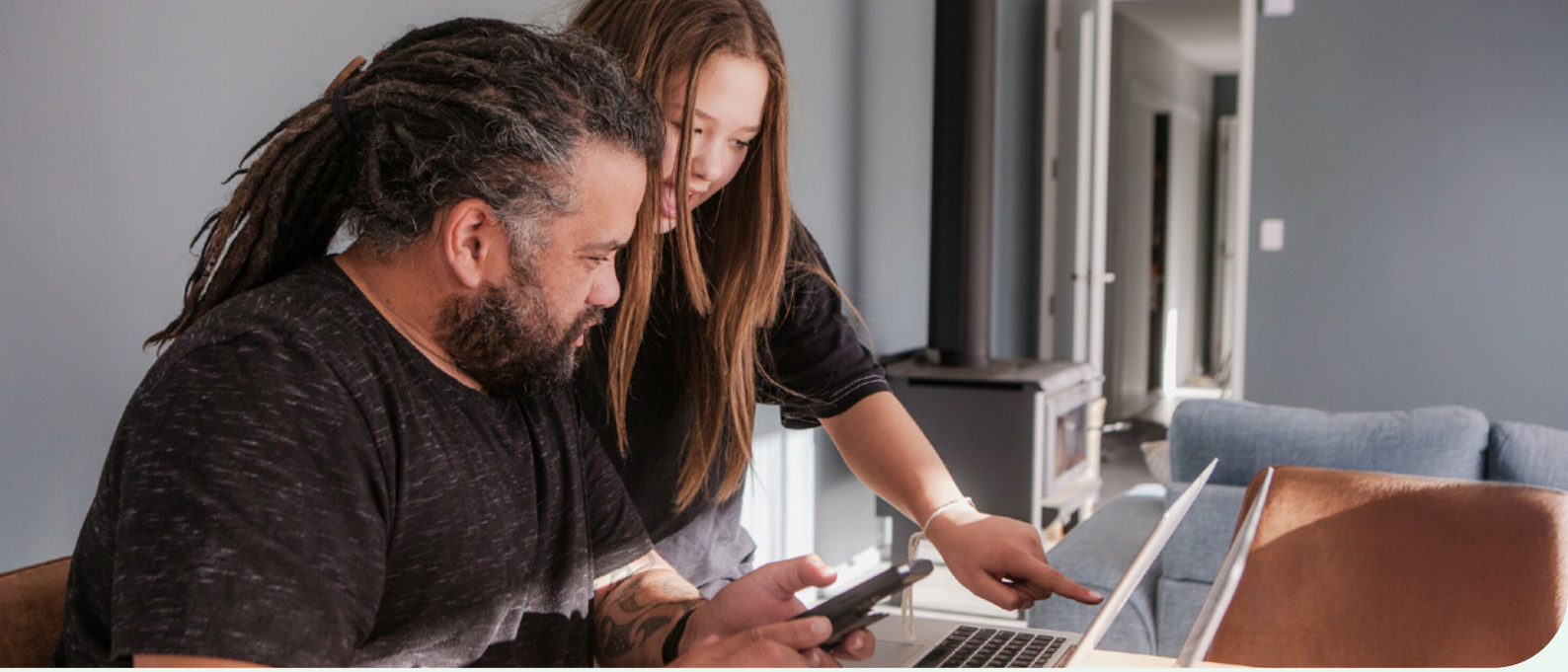
We don't cover the following.

- 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 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** or **modules you** have 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 29 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 policy**. Each **claim** will be assessed on its own factors and in accordance with the terms in **your policy** at the time of the **claim**.

What we will pay

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

How an excess under your cover affects your claim

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

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

If **your claim** is less than **your 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 **Member** and for each **policy year**.

For example, if **your excess** is $1,000 and **your** first **claim** is $950, **you** won't be reimbursed because **you** haven't met **your excess** yet.

That $950 counts toward **your excess**.

If **you** make another $950 **claim** in the same **policy year**, **you'll** only need to pay the remaining $50 of **your excess**, and **we'll** reimburse the remaining $900.

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

How policy benefit limits affect your claim

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

We won't pay or reimburse any costs that amount to more than 100% of the actual costs incurred. As such **you** must **claim** any other refunds, subsidies, or entitlements available to **you** from another source first. This includes **ACC**, another health insurer, a government-funded agency, Work and Income, or **your** employer. **We'll** take any reimbursement from them off the total amount before **we** assess the amount against the **benefit** under **your policy**.

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 **you** had an x-ray that cost $110 and **ACC** agreed to cover $60 of it, **we** would only be able to assess reimbursement of the remaining $50 under **your** Specialist **module**.

Unless specifically stated in this **Health Plan document** or accepted in writing before the **event**, **we** do not cover any healthcare **you** receive 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** own **healthcare provider** provided they meet the eligibility criteria for the provider (including appropriate registration) and the definitions set out in the 'Glossary' section on page 43.

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

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

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**.

For example, a **surgery you** need 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 **your 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 **your healthcare provider**.

Maximum cost we will pay

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

For example, if **you** had **surgery** done by **your 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

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

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

ACC top-up benefit

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

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

If ACC declines your claim

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

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

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

Some **modules** have a 90-day **no-claiming period** that applies to all **Members** on the **module**. **You're** not covered for any **events** that happen during this **no-claiming period**.

We waive the premium on death or terminal illness

If the **Primary Member** or their **partner** dies or is diagnosed with a **terminal illness** up to the age of 70, **we'll** continue to provide cover for the **Member**-paid **premium** for the remaining additional **Members** on the **policy** for whichever of these is earlier:

- 36 months, or
- until the oldest surviving **Member** on the **policy** reaches the age of 70.

Once notified, the waiver of **premium** will start from the date of death or diagnosis of a **terminal illness**. 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** ends, the **premium** payments for all remaining **Members** will be the responsibility of the **policy's Primary Member**.

Conditions of cover for prescription drugs

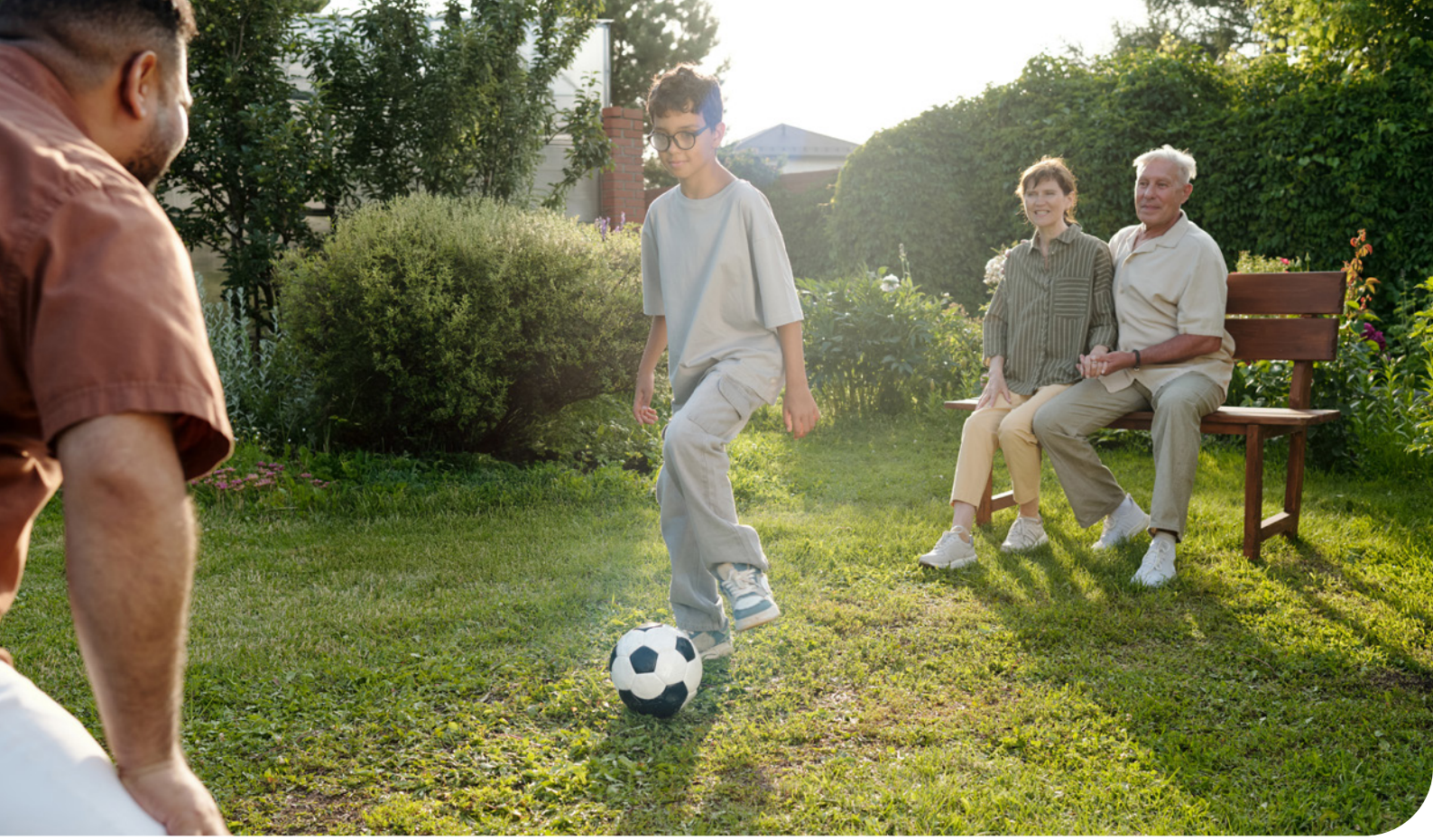
Your policy offers different cover for prescription drugs, depending on what type of **healthcare services** they relate to.

- 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.
- Any other drugs are only covered under the prescription drugs and laboratory tests **benefit** in the GP **module**, which is an additional **module**.

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

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

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



Your responsibilities

You must disclose pre-existing conditions

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

If **you** provide information that is untrue or misleading, including if **you** fail to provide **us** with information, this may affect **your** cover and any **claims you** make. Full details are in the 'You must be truthful with us' section on page 34.

A **pre-existing condition** is:

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

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

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

If **you** provide untrue or misleading information or fail to tell **us** about **pre-existing conditions** for **you** or any additional **Member** on **your policy**, or fail to provide information **we** have reasonably requested about the **condition**, **we** may decline any **claim** related to those **conditions**, and/or apply additional **personal exclusions**. The **personal exclusion** may be backdated to apply from the start of **your policy**. If **we** have already paid any **claims** relating to the **condition**, **we** may recover those amounts from **you**. Full details are in the 'You must be truthful with us' section on page 34.

Personal exclusions are listed on your Membership Certificate

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

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

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

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

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

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

If a **pre-existing condition** is listed under the 'What's not covered (exclusions)' section on page 23, this **condition** is excluded from cover and will not be covered under **your policy**. It does not need to be listed on **your Membership Certificate** as it is a **general exclusion** that applies to all **Members**.

You must be truthful with us

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

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

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

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

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

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

Keeping contact details up to date

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

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

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

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

You must pay your policy's premium

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

You're only covered when you've paid your premium

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

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

If **you** don't pay **your premium** on **your policy**, **we** will contact **you** to tell **you** that **your Health Plan** has overdue **premium**. **We** may cancel **your policy**, or **Member**-paid cover if **you** are part of a **group insurance scheme**, if **you** haven't paid **your premium** for 90 days or longer. Cancellation takes effect from the last date **you** have paid **premium** up to.

We may increase your premium at any time

We may apply a general **premium** increase and other changes to **premiums** at any time. The **premiums** and discounts for **your** SmartCare **policy** are not guaranteed. **We** reserve the right to review and adjust **premiums** and discounts at **our** discretion. **We'll** give **you** a minimum of 21 days' notice of a change in **your premium**.

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

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

Unacceptable Member behaviour

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

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

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

Types of unacceptable behaviour

Unacceptable behaviour includes, but is not limited to:

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

How we assess unacceptable behaviour

We consider behaviour unacceptable when it:

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

Possible actions

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

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

Making changes to your policy

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

30-day free-look period

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

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

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

Adding children and additional Members to your policy

You can add **your** spouse or **partner** and **children** under the age of 25 years, onto **your policy** at any time. To add an additional **Member** to **your** SmartCare **policy**, **you'll** need to complete a full application for each additional **Member** and answer the health questions, or provide their full medical history.

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

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

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

If **you** have three or more **children** on **your policy**, **you** only pay **premiums** for the first two **children** as long as the **Health Plan** 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 **your policy** with no **personal exclusions** placed due to their medical history. The **general exclusions** listed on pages 23 to 25 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.

Adding a child who is older than 6 months

If **you** wish to add a **child** who is 6 months of age or older to **your policy**, **you'll** need to complete a full application. **Our** underwriting team will assess the application, taking into account any **pre-existing conditions** the **child** may have and apply any necessary **personal exclusions**.

How long can children stay on my policy?

Any **children** who have been added to **your policy** before they reach 25 years of age will be classified as a **child** and charged at a **child** rate.

Once they reach 25 years of age, they'll remain on **your policy** but will be charged an age-related **premium**, unless **you** ask **us** to remove them from **your policy**.

Any additional **Member** aged 25 years and over who has been included on **your policy**, may apply to have their own **policy**. If they do so within 30 days of leaving **your policy**, they will not need to go through the full application and approval process.

Removing additional Members from your policy

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

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

If **you** remove an additional **Member** from **your policy** and wish to add them again in the future, they'll need to complete a new application and go through the full application process.

Death of the Primary Member

If the **Primary Member** of the **policy** dies, the **partner** who has been included on the **policy** may retain the **policy** and continue paying the appropriate **premium**. The **partner** is then considered the **Primary Member**. The 'We waive the premium on death or terminal illness' section on page 30 has more information about whether the waiver of **premium** applies.

Suspending your policy

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

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

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

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

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

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

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

Ending your policy

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

Cancelling your policy

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

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

How we can end your policy

We can end **your policy** if:

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

Other important information

Your Health Plan document

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

We'll do **our** best to give reasonable notice (at least 21 days) before any changes. **You** may cancel the **policy** at any time (see 'Ending your policy' section on page 39).

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

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

Membership of the Society

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

UniMed membership

Everyone insured by **us** is referred to in this **Health Plan document** as a **Member** for the purposes of describing insurance cover under a **policy**.

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

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

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

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

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

In the **event** of a discrepancy between the terms and conditions in **your Health Plan document** and the **Rules of UniMed**, **your Health Plan document** takes precedence in regard to **your** insurance cover. **Your membership** automatically ends if **your policy** is cancelled or terminated, or in the **event** of **your** death.

Your healthcare decisions

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

Contact us if you have any concerns

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

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

Complaints

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

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

Insurance & Financial Services Ombudsman (IFSO)

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

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

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

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

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

Financial Services Council

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

Privacy Statement — we're committed to respecting your privacy

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

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

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

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

New Zealand law and currency apply

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

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

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 the **Primary Member**, their **partner** or **child** or any additional **Member** on the **policy**. It doesn't include generic use of the word 'member' or 'members' when referring to members of families, associations, or **our Member Portal**.

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

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

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

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

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

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**.

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

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

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

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

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

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

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

Pre-existing condition means:

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

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

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

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

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

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

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

Terminal illness means that **your** life expectancy, due to sickness and regardless of any available **procedure** and/or **medical treatment**, is not greater than 12 months. This must be:

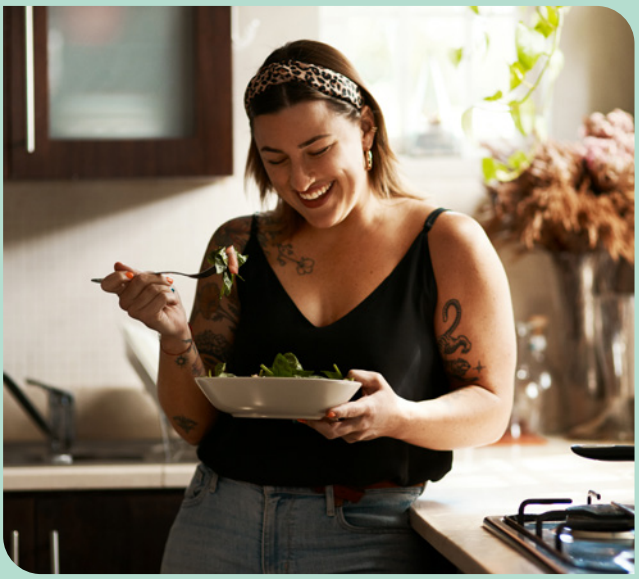
- in the opinion of a registered medical **specialist** and, if **we** require, in the opinion of an independent medical **specialist** elected by **us** and
- in **our** assessment, having considered medical or other evidence **we** may require.

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

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

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

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



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

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

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


Helping
New Zealanders
stay in lifelong
good health.
UniMed

UniMed

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