HEALTH INSURANCE
POLICY DOCUMENT

# Day to Day

Here's all you need to know

accuro
HEALTH INSURANCE

# Welcome to Accuro Day to Day

Thank you for choosing Day to Day, Accuro's refund policy specially designed to offer basic health cover for everyday services such as GP and nurse visits, prescriptions, physiotherapy, optical and dental treatment.

*We* want you to understand your *policy* and be confident in your health cover, so please read this document carefully. You must provide true, correct, and complete information about yourself and any *participant* when setting up this policy and when making any changes. Accuro is a brand owned, operated and underwritten by Union Medical Benefits Society Limited (UniMed). When you take out a health insurance product with us, you become a Member of UniMed.

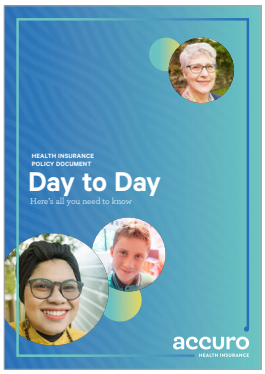
## Contents



## Tell us about changes

Please make sure that we have your most up-to-date contact details. Contact us if your circumstances change.

# Day to Day at a glance




Policy Document

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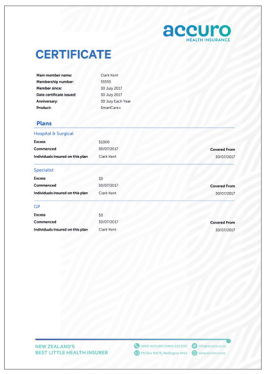



Policy Certificate

This policy document explains what's covered for all Day to Day policy holders (*benefits*) and what's not covered (*general exclusions*).

This document and your *policy certificate* make up your policy. Please make sure you read these documents and keep them in a safe place.

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

## Extra care and support

Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters.

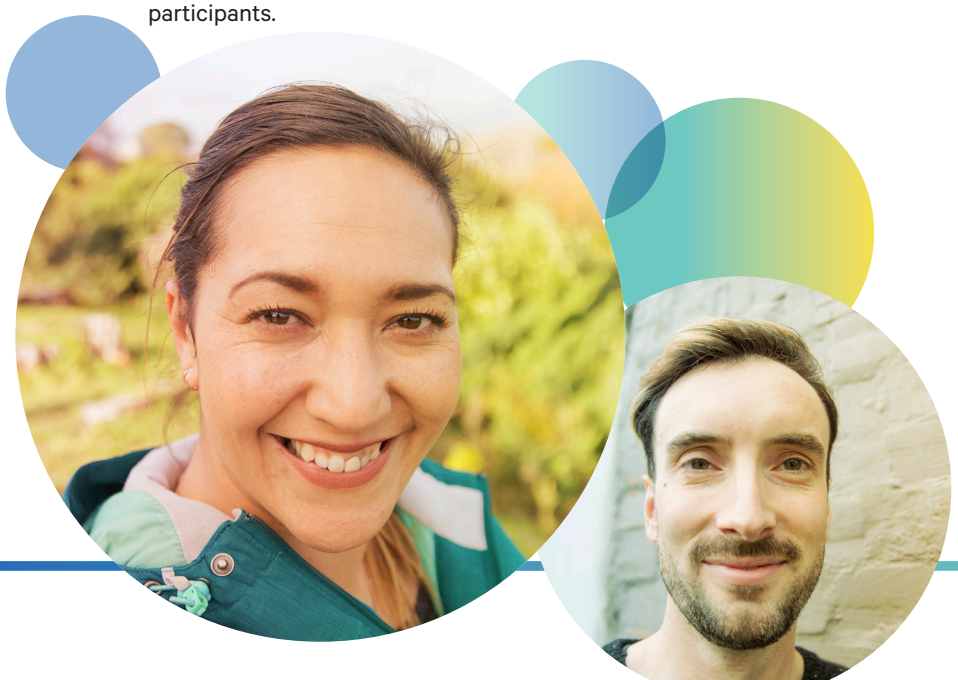
To help us recognise and act with the appropriate level of care please chat to one of our team about your needs so we can take extra care and provide support that fits your needs.

## Terms used in this document

We've explained some common health insurance terms. Words printed in italics are key terms as defined in the glossary on pages 15 to 16. Key terms only appear in italics the first time they are used.

'We' and 'us' means UniMed.

'You' means the main *member* (the policy holder) and may include all other individuals attached to your policy as participants.



# The Day to Day cover and benefits

The following benefits apply to your Day to Day policy, which provides a maximum limit of $600 per person in a *policy year*. Please take the time to read over the benefits and if you have any queries please get in contact with us.

## General practitioner (GP) and nurse visits — $150 in a year

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

## Specialist consultations — $100 first visit, $40 follow up visit

This benefit covers the costs of a consultation with a *registered medical specialist* when referred by a registered medical practitioner, including mental health consultations.

## Prescription drugs — $100 in a year

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

## Imaging and private hospital fees — $600 in a year

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

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

## Registered health practitioner treatments — $150 in a year

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

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

## Health surveillance test — $100 in a year

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

## Optical and dentistry — $150 in a year

This benefit covers the cost of:

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

## Flu vaccination — $45 in a year

This benefit covers the cost of a flu vaccination.

# What's not covered (exclusions)

We can't cover every kind of medical condition and treatment, so we have to exclude some things. We've listed these general exclusions below. Please contact us if you have any questions.

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

## Health conditions we don't cover

It's important to know which conditions we don't cover. We've listed these below but please ask if you want to know about cover for a different condition that is not listed.

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

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

Below we list the various tests, procedures and treatments we don't cover. This includes any investigations or consultations related to the test, procedure or treatment and any complications that may occur from it.

- *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 reassignment or *gender dysphoria*
- Any investigation or treatment for sleep disturbances, snoring, or sleep apnoea
- Circumcision, except where medically necessary
- 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
- Charges for a treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice
- Any costs not specifically provided for under a benefit section outlined in the policy

## Other expenses and costs we don't cover

Below we list other expenses and costs that we don't cover.

- Any costs not specifically related to the consultation or treatment such as administration costs or statement fees
- 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 policy

# How to make a claim after treatment

When you're submitting a claim, you're asking for payment of a procedure or medical treatment that has already occurred.

You will need to pay for the services and then send us a completed claim form with all the itemised invoices and receipts when you have a minimum aggregated total of $30. Once we have received your claim, we will process your claim and reimburse you directly. Your policy provides cover up to a maximum limit of $600 per person in a policy year.

You can only claim for events that have occurred after your cover under this policy has started.

## Collect a claim form

You'll need to complete a claim form which can be found on our website, in the online member portal, or we can post or email a copy to you. The main member must sign this form and so must the patient if they are over 16 years of age.

## Collect invoices and receipts

Include all invoices and receipts with your claim.

## Submit your claim

To be eligible, a claim must have a minimum aggregation of invoices/receipts totalling $30. All benefits payable under this policy are based on and determined with reference to *reasonable and customary charges* for the services provided.

You can submit your claim by post or email, or through the online member portal . Your member portal also allows you to start a claim and save it, so you can add invoices as you receive them and submit it all together at a later date.

In some cases, we may need to contact you or the health service providers to request additional details so that we assess your claim correctly. We'll contact you if this is the case.



## Things to remember

We can only accept and provide cover for costs:

- for a person who is covered under your policy
- for events that occur after your policy begins
- under a policy that has *premiums* paid up to date
- for benefits listed in the policy you have cover for.

We recommend that you read the next section ('General conditions of your policy'), as things listed here may affect your claim or the amount we're able to pay out for a particular procedure or medical treatment.

# General conditions of your policy

In the next section we explain circumstances that may affect your cover.

## How policy benefit limits affect your claim

Unless specifically stated in this policy document, all benefit limits are for each person 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 participants covered by the policy. The maximum amount for each benefit that you can claim is set out in the 'The Day to Day cover and benefits' section of this policy document.

We won't 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 excess that is applicable for another insurance plan, whether it be another Accuro product, UniMed product or one from another insurer.

**For example, if you had a physiotherapy consultation that cost $110 and ACC agreed to cover $60 of it, we would only be able to assess reimbursement for the remaining $50 under the Registered health practitioner treatments benefit.**

## We don't cover claims covered by ACC

ACC is New Zealand's accident compensation scheme, which provides cover if you're injured. Your Day to Day policy has been set up to complement this and won't cover claims related to accidents that ACC covers. If ACC doesn't cover the full amount for your treatment, we may be able to pay the difference if you have cover for this treatment under your policy.

Special conditions apply to surgery or treatment covered by ACC. Under the ACC legislation, you can choose between:

- Full payment option — ACC contracts a provider to carry out the procedure or medical treatment and pays the total cost.
- Partial payment option — ACC contracts a provider to carry out the treatment, but only funds a portion of it.

The full payment option should be your first choice, so you don't have to make any contribution towards the cost of surgery or treatment. In this case, you must submit all claims to ACC.

### If ACC agrees to partially pay

Under the ACC partial payment option, you'll have to contribute to the cost of the healthcare services. We'll cover the difference in cost up to the benefit limit in your policy. The treatment or procedure must be covered under your policy.

**For example, if you had an accident and need an x-ray. If ACC agreed to cover $80 of the $100 cost, then we would reimburse the remaining $20 under the Imaging and private hospital fees benefit.**

### If ACC declines cover

If ACC declines cover for treatment that is covered under your policy, we might ask them to review the decision, or submit an appeal. We'd need your support in this — you'd need to give us the ACC decline letter and any other relevant information within 3 months of its issue date. When you give us the decline letter and relevant information, you're giving our legal representative authority to review the case. In cases where ACC reverses its decision to decline the claim, we may seek reimbursement from ACC or you for any related claims that we've already paid.

### If ACC refuses cover or cover stops

You need to make a reasonable effort to secure and maintain cover. If ACC refuses to cover a claim, or stops claim cover because you're not complying with ACC's requirements, you won't be able to claim under your policy.

## We don't cover events during a stand-down period

There is a 30-day *stand-down period* that applies to all members and participants on the policy. You're not covered for any events that happen during this stand-down period.

If you have the Day to Day free cover for 12 months and then carry on with your Day to Day policy after the free cover has finished, the 30-day stand-down period will not apply.

## 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 your responsibility to make sure that your policy is paid up to date for yourself and all participants on your policy. We'll do our best to notify you of any updates to your policy and premiums. 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 won't pay any claims if you owe us premiums on your policy. We don't have to pay until your premiums are up to date. If you miss payments of your premiums, or if your membership has ceased for any reason, we can't provide cover for any services outside the period for which you've paid premiums for. We can only assess cover for a claim when the premium for your policy is up to date for the period when the healthcare services 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'll write to tell you that your policy has fallen into arrears. We'll cancel your policy if you haven't paid your premium for 90 days or longer. Cancellation takes effect from the last date you have paid premiums up to.

### We may increase your premium at any time

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

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

We want to make sure you are covered. If our letters are returned and marked 'no address', we'll continue to make deductions until you tell us otherwise. When you accept this policy, you're authorising us to make deductions.

# Making changes to your policy

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

## 14-day free-look period

We provide a 14-day free-look period that begins from the start date on your policy certificate, or 5 working days after you receive your policy documents (whichever is later). This free-look period allows you to review your policy and make sure it's right for you.

You can make changes to your policy within this 14-day period. If you change your mind and wish to cancel within this 14-day period, we'll refund any premiums paid, as long as you haven't made a claim under the policy.

To cancel within the 14-day free-look period, you must write to us and ask to cancel the policy. The main member must sign the request.

## Adding participants to the policy

You can add your spouse or *partner* and *dependants* or *whāngai* under the age of 25 years, onto your policy at any time. To add a participant to your Day to Day policy, you'll need to complete a Day to Day application form.

Cover for a participant begins from the start date listed on the policy certificate that has the participant listed as covered.

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

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

If you have three or more dependants on your policy, you only pay premiums for the first two dependants as long as the product and plans selected are the same for each dependant. All dependants will remain on dependant rates up to 25 years old.

## How do I remove participants from my policy?

You can remove a participant from your policy at any time by writing to us and signing the request. The main member is responsible for removing participants 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 his or her own right and continue on a separate policy.

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

## How can a policy end?

Cover for your Day to Day policy ends when any one of these things happen:

- you ask us to cancel your policy — the request must be from the main member or designated financial adviser (if applicable)
- you fail to pay your premium for 90 days or longer
- you or any participant breach the terms of this policy
- the last member covered by this policy dies
- if this is a group policy through your employer, then your policy can also end if you leave employment with the employer, your employer writes asking us to remove you from the group scheme, the group scheme comes to an end or if your premium is not paid by your employer for 3 months or more.

# Suspending your policy

You may ask us to suspend your cover for a period of time, ranging from 2 to 24 calendar months. You must write to us when applying to suspend cover.

We'll consider an application to suspend cover for the following reasons.

- Travelling overseas for a period longer than 2 months (maximum length of suspension is 24 months)
- Taking maternity leave (maximum length of suspension is 12 months)
- Being registered as unemployed for a period longer than 2 months (maximum length of suspension is 6 months)
- Being made redundant or suffering financial hardship (maximum length of suspension is 6 months)

Please contact us if you wish to apply to suspend your policy for any of the reasons above. We'll tell you if we need any further documentation or evidence. Please remember that we won't pay any benefits under the policy to you or any participant on your policy who is suspended at the time an event occurs.

The main member or participant must have continuous cover under this policy for a 12-month period before they can apply for suspension. There must be a 12-month period between the previous suspension and the start date of the next suspension.

Please note that if you suspend your policy, the period your policy is suspended for won't be deducted from the timeframe for any personal exclusions you or any participants have on the policy.

# Cancelling your policy

If you cancel your Day to Day policy within your 14-day free-look period, we'll refund all premiums paid, as long as no claims have been made by a person covered by your policy.

You can cancel your policy at any time. After the 14-day free-look period, we can keep any premiums we've received, irrespective of the date you cancelled the policy. You must pay all premiums due up to the date of the cancellation.

In all cases, cancellation must be requested by the main member or designated financial advisor (if applicable). We'll acknowledge your request to cancel your policy when we receive it.

We won't reinstate membership after you cancel your policy. This doesn't prevent you from applying to rejoin at a later date but you must make a new application.

When you cancel the policy or cover for a participant, the date of cancellation depends on the frequency of your premium payments.

- If you pay premiums at a frequency of monthly or less, the date of cancellation is the next due date for premium payments after we have acknowledged receiving the cancellation request
- If you pay premiums at a frequency greater than monthly, the date of cancellation is the expiry of the month in which we receive the cancellation request. We may refund a pro-rata amount of the premiums paid, depending on the circumstances

# Other important information

This section outlines other important information about your policy.

## Your insurer

Accuro is a brand owned, operated and underwritten by UniMed (Union Medical Benefits Society Ltd).

## Your policy document

This policy document may change from time to time according to prevailing conditions and policies, and at the discretion of the *Board of Directors*. 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 'How can a policy end?' on page 9).

For more information about discounts and eligibility, visit www.accuro.co.nz/about/discounts

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

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

## Privacy statement — we respect your right to privacy

We make sure that our privacy practices comply with the Privacy Act 2020, the Health Information Privacy Code 2020 and industry best practice. By applying for membership under the terms of this policy, you agree that we can collect and use your information in accordance with this privacy statement.

### When and how we collect information

We collect information from you when you become a member, sign up for information, or provide us with information when making an application or a claim under a policy. We also collect information from you when you use our website, including using cookies.

Some examples of personal information we may collect from you are:

- your name, contact details, date of birth and gender
- payment information, such as your credit card and bank account number
- alternative contact information
- health information such as medical records
- claims information and information relating to any other insurance you've applied for or held or claims you've previously made
- website information, such your IP address and browser type.

We may also collect personal information about you from third parties such as your GP or a hospital. We'll only do this if we've told you first or where we're allowed to by law.

### How we use personal information collected

We'll only disclose your personal information according to this privacy statement, the Privacy Act 2020, or after notifying you at the time of collection.

We may use personal information for matters relating to any policy you've taken out, including:

- confirming your identity
- evaluating and assessing your application for a policy and any claims under your policies
- providing client service and information

- managing a relationship with you, including contacting you about our products and services
- recovering any unpaid debts or other monies owing
- producing reports and summary data.

We can also use personal information to:

- improve and better understand our business, including our website
- improve our range of products, services and promotions (including assessing trends and customer interests or preferences)
- manage and monitor our business risks
- comply with our legal and regulatory obligations.

We treat any personal information as confidential. Sometimes we may disclose information to third parties, including trusted service providers, for the purposes listed above and for reporting, summary or statistical purposes.

If you, or any person covered by your policy, give us incomplete or inaccurate information, we may decline your claim, void or cancel your policy, or amend the terms applying to you or a participant as allowed by law.

## Storage and security of your personal information

The intended recipient of the information is UniMed. That information is held physically or digitally at UniMed's offices, or with our trusted data storage providers. Personal information may also be stored in third party storage facilities and in cloud storage located inside and outside New Zealand.

We take all reasonable steps to make sure that the personal information we hold is protected against loss, unauthorised use, unauthorised access, unauthorised modification, unauthorised disclosure, and any other misuse.

We retain your personal information only for as long as it is required for lawful purposes. We'll take all reasonable steps to ensure that the personal information is securely destroyed when it is no longer required.

## Accessing and correcting your personal information

Under the Privacy Act 2020, you're entitled to ask us to confirm whether we hold personal information about you or not. You're entitled to have access to that personal information. You're also entitled to ask us to correct any of your personal information if you believe it's inaccurate.

You can request a copy of, or ask us to correct, your personal information by writing to us at info@accuro.co.nz or Accuro Health Insurance, PO Box 10075, Wellington 6140.

## Our current Privacy Statement is on our website

We may update our privacy statement. We recommend that you refer to the Accuro website for changes.

# Financial Services Council

UniMed is a member of the Financial Services Council (FSC).

UniMed is authorised to collect, use and disclose personal information and health information about you and other individuals covered by your policy to help detect and prevent fraud and other serious probity concerns. You authorise disclosure of personal and health information to FSC or its agents and FSC members for the above purpose.

## Code of practice

This policy complies with the Financial Services Council Code of Conduct. You can get a copy of our financial statements for the last reported year by writing to us at:

Accuro Health Insurance
PO Box 10075
Wellington 6140

Or you can download a copy of our annual report from the Accuro website.

# Membership of the Society

Accuro is a brand owned, operated and underwritten by Union Medical Benefits Society Limited (UniMed). When you take out an Accuro policy, you become a Member of the UniMed 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 the Society is run and the health benefit plans it administers. Like all legislation, it can change from time to time.

Membership is available to anyone who UniMed accepts for membership and is permitted to become a member under the rules of the Society. As a policy holder with UniMed, you're now a member of UniMed. This means that, throughout this policy document, we may refer to you as the main member and all other individuals attached to your policy as participants. Only a person insured under a UniMed policy may be a Member of the Society.

UniMed is a member of the Financial Services Council and the Insurance & Financial Services Ombudsman Scheme.

## UniMed membership

To apply for membership and subsequent alterations to a policy, you must complete all sections of our application form. You must include full details of the member and all proposed participants. You must disclose all previous medical history in the health declaration on the application form. The main member must sign the form, as well as any participants aged 16 years and older.

The rights and obligations of the member and UniMed are set out in the documents listed below:

- the individual member's application form and all material provided by or on behalf of the member in support of the application and any claim
- the individual member's policy certificate
- the terms of the policy as specified in this policy document and current at the time of claim
- the rules of the Society.

All members are bound by and subject to the rules of the UniMed Society and this policy document.

The rules of the UniMed Society may change from time to time according to the powers of amendment they contain. A copy of UniMed's rules are available on the UniMed website.

# New Zealand law and currency apply

UniMed conducts all its business according to the laws of New Zealand.

All monetary amounts in all our material (including this policy document) are in New Zealand dollars. All benefits and premiums include GST.

# How to contact us

You can contact us if you have any questions or concerns. We can help you apply for pre-approval, make a claim, or make changes to your policy.


Phone: 0800 ACCURO (0800 222 876)
Fax: 04 473 6187
Email: info@accuro.co.nz
Web: www.accuro.co.nz
Post: Accuro Health Insurance
PO Box 10075
Wellington 6140


You can use the member portal on the Accuro website www.accuro.co.nz to:

- update or make changes to your personal details
- submit a pre-approval or claim
- save invoices to submit with a claim at a later date.

## Contact us if you have any concerns

We pride ourselves on providing great service to all our members, so if you have a concern, please let us know. We'll work with you to resolve your concerns as quickly as we can.

If you're unhappy with a claim or pre-approval decision, or you wish to write to us about your concern, please contact our customer team manager.

Email: info@accuro.co.nz

Mail:
Accuro Health Insurance
PO Box 10075
Wellington 6140

When we receive a request to review a claim or pre-approval decision, we'll investigate and reply as soon as possible. Sometimes we may need to ask for additional medical information for our review, which may cause a delay. If you're unhappy with the reply from the customer team manager, you can write to the Chief Executive Officer at the same address.

If we can't reach an agreement with you about a claim or pre-approval decision after you've taken the steps above, you can choose to take your concern to the Insurance & Financial Services Ombudsman.

A full copy of our complaints resolution process is available on request and on our website.

## Insurance & Financial Services Ombudsman (IFSO)

UniMed is a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008. UniMed is 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 using Accuro's internal complaints process.

You can write to the IFSO if your concern relates to a claim, you've followed the internal process outlined above, and we haven't been able to reach agreement with you. You must write to the IFSO:

- within 2 months of us telling you, in writing, that we won't change our decision on the claim or pre-approval
- within 3 months of the date of your initial complaint if we don't write to tell you what we have decided.

You can get more information on the IFSO from its website or by writing to them.

Website: www.ifso.nz

Mail:
Insurance & Financial Services Ombudsman
PO Box 10845
Wellington 6143

# Glossary

**ACC** means the Accident Compensation Corporation of New Zealand.

**accident** means an accident as defined in the Accident Compensation Act 2001.

**Accuro Health Insurance** or **Accuro** is a brand owned, operated and underwritten by UniMed or Union Medical Benefits Society Ltd who is incorporated under the Industrial and Provident Societies Act 1908.

**benefit** means the reimbursement available for members for specific types of expenses as specified in this policy document, including grants.

**Board of Directors** means the current board of directors of the Society.

**claim** means the request by a member to have their costs refunded as described in this policy document, providing the member is eligible.

**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.

**dependant** means a member's child (including any stepchild, adopted child or whāngai) who has been accepted as a participant on the member's policy before the age of 25 years.

**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.

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

**general exclusion** means a medical condition or service that is not covered for any member or participant on this type of policy.

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

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

**Member** means a person who has been accepted as a member of UniMed and by whom or on whose behalf premiums are currently being paid to UniMed. It doesn't include generic use of the word 'member' or 'members' when referring to members of families, associations, or our member portal.

**participant** means a partner, parent, child, dependant or whāngai accepted by us who is named on the policy certificate and for whom premiums are current at the time of claim for any benefit.

**partner** means the spouse or de facto partner of a member where the parties are living together in a relationship in the nature of a marriage or civil union.

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

**policy** means your contract with us and includes the policy certificate, this policy document and any alterations.

**policy certificate** means the most recent policy certificate issued to a member that confirms initial acceptance or subsequent alteration to a policy. This may also be called a membership certificate

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

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

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

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

**reasonable and customary charges** means charges for medical treatment that are determined by us in our sole discretion to be both:

- reasonable and
- within a range of fees charged under similar circumstances by persons of equivalent experience and professional status in the area in which the medical treatment is provided.

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

**registered medical specialist** means a health service provider who is:
- a member or fellow of an appropriately recognised specialist medical college
- registered with the Medical Council of New Zealand and holds a current annual practising certificate in that specialty.

This does not include those holding Medical Council of New Zealand registration for:
- emergency medicine
- family planning and reproductive health
- general practice
- medical administration
- public health medicine
- sexual health medicine
- urgent care.

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

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

**stand-down period** means the period of 30 days after the start date or, in the case of a participant added to a policy, 30 days after the date on which that participant is added. You cannot claim on events that happen during the stand-down period.

**start** means the date on which membership begins, as specified in the policy certificate.

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

**UniMed** means Union Medical Benefits Society Ltd who is incorporated under the Industrial and Provident Societies Act 1908.

**we, us, our,** means UniMed or Union Medical Benefits Society Ltd.

**whāngai** means a child from your extended whānau who you raise or bring up within your family and who has been accepted as a participant in the member's policy. A whāngai is considered a dependant under this policy.

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HEALTH INSURANCE