HEALTH INSURANCE
POLICY DOCUMENT

KidSmart

Here's all you need to know

accuro
HEALTH INSURANCE

Welcome to Accuro KidSmart

Thank you for choosing KidSmart, Accuro's premier insurance product for *children*, where a *guardian* can take up cover for their children but not take up cover for themselves. KidSmart is the only New Zealand health insurance product designed specifically for children.

We want you to understand the *policy* and be confident in the health cover for your *child* or children, so please read this document carefully. You must provide true, correct, and complete information about yourself and any children 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.

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Tell us about changes

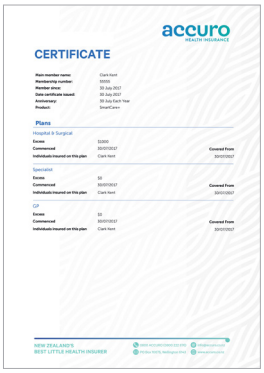
Please make sure that we have your most up-to-date contact details. Contact us if your circumstances change.

WriteMark®
Plain Language Standard

This policy document has achieved the WriteMark Plain Language Standard. We've used plain language to make this policy document easy to understand and for you to see clearly what is and isn't covered under your policy.

KidSmart at a glance

Policy Document



Policy Certificate

This policy document explains what's covered for all children under KidSmart (benefits) and what's not covered (*general exclusions*). Check the *policy certificate* for details that are specific to your child's or children's policy, including *personal exclusions* and the *plans* they have cover under.

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

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

Who KidSmart is for

This KidSmart policy is only for New Zealand citizens, residents, or children who are entitled to funding under New Zealand's public healthcare system. We've designed this policy 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:

Accident Compensation Corporation (ACC) provides comprehensive, no-fault personal injury cover for anyone in New Zealand.

The public health system is subsidised by the government and provides cover for all New Zealand residents. It covers acute treatment (when *surgery* or treatment needs to happen immediately because of a medical emergency) and some elective treatments, which can take years to occur in the public health system.

The private health system gives you control over when and where you're treated, including being able to choose the doctor, specialist or hospital that you prefer. Often people will decide to have elective treatment in the private health system as it's quicker. Treatment is 'elective' when it's scheduled in advance to happen at a later date because it isn't a medical emergency.

Extra care and support

Some customers are more vulnerable to the risk of unfair outcomes or disadvantaged 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.

Start with the base plan and add additional plans

When the policy starts, it begins with the base plan that every child on the policy must have: the Hospital and Surgical base plan. You can choose to add any of the additional plans. You do not need to add the same plans for each child. You can choose which plans you wish to add for each child on the policy.

Check the policy certificate to see which children are covered under this policy, and what plans they hold.

Main benefits of KidSmart

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

Additional plan/product

Specialist plan

Cover for specialist consultations and diagnostic tests.

Day to Day

Cover for everyday costs such as going to the doctor, natural therapist, dentist or optician.

For more details on these plans please see the 'Additional plan' section on page 12.

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 33 to 35. Key terms only appear in italics the first time they are used.

'We' and 'us' means UniMed.

'You' means the guardian (the policy owner) who takes out the KidSmart policy, and may include all other children attached to this policy. As the owner of this policy, you are legally responsible for this policy on behalf of the children insured. The guardian must be a legal guardian for any children listed on the KidSmart policy.

Medical terms in this document are not covered by the WriteMark Plain Language Standard. For explanations of medical terms, please ask your GP or other healthcare provider, or consult the Health Navigator website at www.healthnavigator.org.nz

The KidSmart cover and benefits

This policy document lists what's covered for all KidSmart policy holders (benefits) and what's not covered (general exclusions). A general exclusion could be a medical condition or service that we've decided we won't cover for anyone who has this type of policy.

The policy certificate contains the details that are specific to the policy, such as what plans each child is covered for, as well as any personal exclusions. A personal exclusion is where we've reviewed the medical information you've provided for the child and have decided that a certain condition may pose too great a risk to insure against. Personal exclusions last for different lengths of time (from 1 year to life), depending on the medical condition.

All children on the policy will automatically have the Hospital and Surgical base plan. Please check the policy certificate to see whether any child has cover under any of the additional plans.

To find out what type of prescription drugs are covered under the policy, refer to the 'Conditions of cover for prescription drugs' section on page 24.

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.

Standard benefits:

General surgery — $500,000 for each child in a policy year

If you're wanting to *claim* under this benefit for a child, we strongly recommend you seek pre-approval before the treatment.

This benefit covers the costs of r*easonable and customary 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 in hospital
- Surgeons' fees
- Anaesthetists' fees
- Costs of essential *prostheses* listed in the Accuro schedule
- Pre-operative and post-operative diagnostics, consultations, or tests, if they occur within 2 years before or after the approved surgery

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

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

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

This includes:

Major diagnostic procedures

This benefit covers the costs of reasonable and customary 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 the child is admitted to a hospital.

Oral surgery — $300,000 for each child in a policy year

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

- Surgical removal of impacted or unerupted teeth, provided the child has been covered by the policy for 12 months
- Surgical removal of cysts or soft tissue swellings
- Surgical drainage of oral abscesses
- Pre-operative and post-operative diagnostics, consultations or tests if they occur within 2 years before or after the approved surgery

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

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

A registered oral surgeon or registered dentist must perform the surgical removal of unerupted and impacted teeth. They must write to us to confirm the status of the impacted or unerupted teeth.

Private hospital medical admission — $300,000 for each child in a policy year

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

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

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

Non-PHARMAC subsidised drugs

This benefit covers the costs of reasonable and customary charges associated with accessing the most effective treatment available. This is regardless of whether or not the drug qualifies for a government or other subsidy, such as *PHARMAC* funding.

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

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

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

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

Overseas treatments

Treatment outside of New Zealand — **$30,000 for each child in a policy year**

This benefit covers reimbursement of reasonable and customary 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 child must:

- be in New Zealand when they are diagnosed and must not have started an appropriate medical process in New Zealand
- request a surgical procedure that is *medically necessary* and is not experimental or being trialled
- get the procedure or treatment pre-approved by us
- make sure the procedure meets all policy criteria including being subject to all reasonable and customary charges, maximums, and exclusions described elsewhere in this policy.

A New Zealand-registered medical specialist must provide us with written confirmation 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 cost.

Overseas waiting list

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

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

To qualify for this benefit:

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

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

Minor surgery — $3,000 for each claim

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

The procedure must be medically necessary — without it, the physical wellbeing of the child would be affected.

Other benefits

Other benefits that we offer are summarised below.

Public hospital — $3,000 for each child in a policy year

$300 a night.

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

Home nursing — $6,000 for each child in a policy year

$150 a day.

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

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

Guardian accommodation — $3,000 for each child in a policy year

$300 a night for accommodation.

This benefit covers reimbursement of accommodation expenses paid by a guardian accompanying a child. The child must be undergoing medical treatment with overnight admission in a New Zealand private hospital that we've approved under this policy.

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

Transport and accommodation — $3,000 for each child in a policy year

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

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

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the private hospital
- **Rail transport**
  Return train fares and return taxi fare from the station to the private hospital
- **Road transport**
  - Return bus fares and return taxi fare from the station to the private hospital
  - Return private car journey, calculated on the mileage travelled at $0.30 a kilometre

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

This includes:

Support person benefits

This benefit includes cover for the costs of a support person if one is required to accompany the child to the alternative private hospital in New Zealand.

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

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the private hospital
- **Rail transport**
  Return train fares and return taxi fare from the station to the private hospital
- **Road transport**
  - Return bus fares and return taxi fare from the station to the private hospital
  - Return private car journey (if not travelling with the child), calculated on the mileage travelled at $0.30 per km
- **Accommodation expenses** incurred up to $200 per night, for a maximum of 10 nights

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

Ambulance transfer — $200 for each child in a policy year

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. We must have pre-approved the child's initial admission to hospital.

Speech-language therapy — $400 for each child in a policy year

$80 a visit.

This benefit covers the costs of post-operative treatment for a related surgery that we've approved under this policy. The child must be treated by a New Zealand-registered speech-language therapist who is a member of the New Zealand Speech-language Therapists' Association. The treatment must occur and be completed within 6 months after the related surgery.

Physiotherapy — $1,000 for each hospital admission

This benefit covers the costs of post-operative physiotherapy for a related surgery that we've approved under this policy. The child must be treated by a New Zealand-registered physiotherapist with a current practising certificate who is in private practice. The treatment must occur and be completed within 12 months after they have been admitted to hospital for the related surgery.

ACC top-up

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. You must send us a copy of ACC's decision before getting treatment.

These other terms apply.

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

Active Benefits help your child stay healthy

Active Benefits allow your child to use their insurance not just for treatment but to maintain good health.

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

For further information and other Active Benefits, please visit our website www.accuro.co.nz/active-benefits

Accuro Virtual Clinic

Teladoc HEALTH

The Virtual Clinic, powered by Teladoc, is an independent and confidential service that gives access to over 50,000 of the world's leading medical specialists from the comfort of your own home. Accuro will never see any of your communication with or results from the Virtual Clinic unless you choose to send it to us.

If any child on the policy has been diagnosed with an illness, injury or medical condition and you would like a second opinion, you can contact the Virtual Clinic, at no cost, to review their diagnosis and treatment plan.

Services available:

- **Expert Medical Opinion**
  This service allows you to get an independent, expert medical review for your child's illness, injury, or medical condition, including a treatment plan. The review is designed for you to share with your child's treating doctor, to provide certainty and reassurance that you're on the right treatment pathway.
- **Ask a GP**
  Submit a question to an experienced NZ GP. The GP answers your question, with any relevant supporting information, and emails the response to your inbox.

For more information and details on how to register for the Virtual Clinic, visit the Active Benefits section of our website or call the Virtual Clinic on 0800 425 005.

Loyalty benefits

We give your child extra benefits after they have held the policy with Accuro for more than 1 year.

Tongue or lip tie — $400 for each child

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

Screening — $250 for each child every 3 policy years

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

Exercise-based activity contribution — $150 for each child in a policy year

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

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

Additional plan

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

Check the policy certificate to see if your child or children are covered under the Specialist plan. They won't have this plan unless you've asked us to add it to the 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 plans, or would like to add a plan to this policy.

You can also add our Day to Day product

Our Day to Day product provides a mixture of the benefits from our additional plans, up to a maximum of $600 for each person in a policy year.

This product is designed to help cover the everyday costs of staying healthy, such as going to the doctor, dentist or optician. It covers the costs of prescription drugs, the annual flu vaccine and natural therapy treatments to help improve your child's health and wellbeing.

Contact us if you'd like to add Day to Day to this policy.

Specialist plan

The Specialist plan provides access to private tests and specialist consultations to speed up the time to reach a diagnosis. This is an additional plan, so please check the policy certificate to see if any child has cover under this plan.

Specialist consultations

$5,000 for each child in a policy year

This benefit covers the costs of reasonable and customary charges for consultations with a registered medical specialist when referred by a registered medical practitioner, 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

This includes:

Mental health consultations

$1,000 for each child in a policy year

This benefit covers the costs of reasonable and customary charges for consultations with a psychiatrist, psychologist or counsellor when referred by a registered medical practitioner. They must refer the child to a medical professional who is registered either under the psychiatry scope with the Medical Council of New Zealand, as a psychologist with the New Zealand Psychologists Board, or as a counsellor with the New Zealand Association of Counsellors.

Second opinion

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

Diagnostic tests

$5,000 for each child in a policy year

This benefit covers the costs of reasonable and customary 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 & Surgical base plan. These are specifically listed under the General Surgery benefit.

Mental Health Assist

Teladoc HEALTH

This benefit is currently only available to children 18 years and older.

Mental Health Assist, powered by Teladoc, was launched in New Zealand to offer support and guidance when dealing with a mental health issue.

The service will connect your child to a team of health professionals including a nurse, psychologist and psychiatrist. This team will review their condition, make a diagnosis or review an existing diagnosis and treatment plan and make recommendations for future steps. The mental health nurse will continue to support them once they have completed the process.

Your child can expect a consultation within 10 days.

For more information and details on how to register for Mental Health Assist, visit the Active Benefits section of our website or call the Virtual Clinic on 0800 425 005.

Loyalty benefits

We give your child extra benefits after they have held the Specialist plan with Accuro for more than 3 years.

Melanoma — **$200 for each child every 3 policy years**

After 3 years of continuous cover, this benefit covers melanoma investigations.

Speech-language therapy — **$150 for each child in a policy year**

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

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

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

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. Any personal exclusions for the children on the policy will be listed on the policy certificate.

We aim to fully explain what is not covered in this policy. Unless specifically provided for in the plans selected, KidSmart 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.

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

Acute care is covered by the public health system and ACC.

Some conditions

We don't cover these conditions.

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

Obstetrics and gynaecology

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

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

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

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

Treatment for preventative reasons

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

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

Dental or eye treatment or surgery

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

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

Organ failure or donation

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

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

Other treatment or surgery

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

- *Cosmetic procedures* or other enhancement or appearance medicine as defined by us
- Procedures or treatment relating to obesity or weight loss, performed for any reason
- Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary
- Gender reassignment or gender *dysphoria*
- Sleep disturbances, snoring, or sleep apnoea
- Robotic-assisted prostate surgery/treatment.
- 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 his or her scope of practice
- New medical treatments, procedures, and technologies that have not been approved by us

Other costs

We don't cover these costs.

- General practitioners' fees, prescription drugs, or medication (except where this policy specifies otherwise)
- Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*)

- Any medical costs declined by *ACC* if injury is caused by an *accident* outside New Zealand
- Any medical costs incurred outside New Zealand
- Medical mishap or misadventure
- Any personal incidental expenses incurred whilst in hospital - for example, use of phone, family meals, soft drinks, or alcoholic beverages
- Any costs not specifically provided for under a benefit section outlined in the plan

Other expenses and costs we don't cover

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

Appliances and devices

We don't cover the following.

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

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

We don't cover the following.

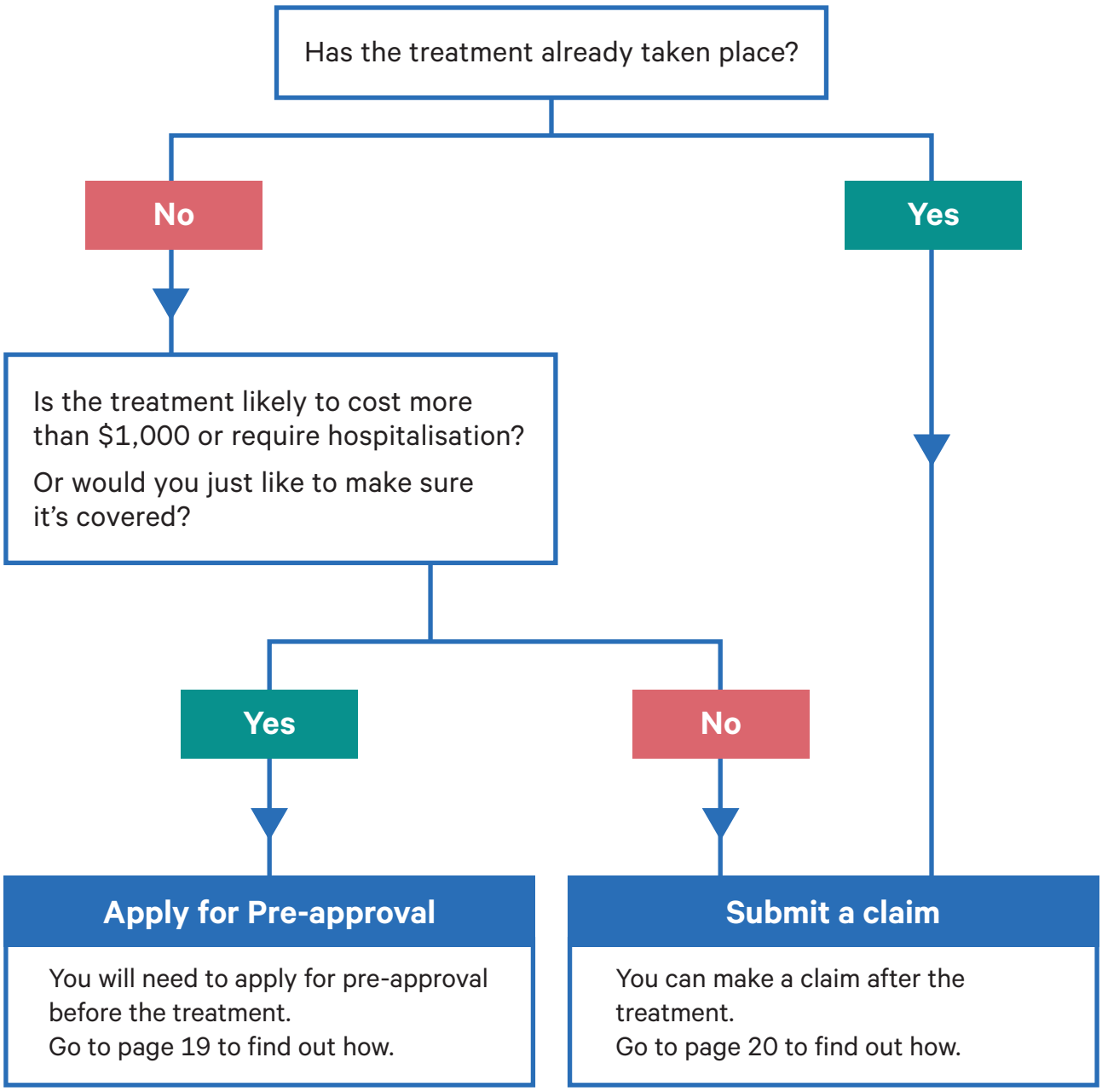
- Disability or illness arising from misuse of alcohol, drugs, participation in a criminal act, or intentional self-injury
- Attempted suicide or suicide within 13 months from the start date of the plan

How to submit a claim

Choose one of two ways to submit a claim for the child's procedure or medical treatment. You can:

1. Get pre-approval for the claim by submitting the details of the child's procedure or medical treatment before it takes place in order to confirm that it is covered under this policy.
2. Submit a claim after the procedure or medical treatment has already taken place.

Use the flow chart below to help you decide whether you need to get pre-approval or if you can make a claim afterwards.



How to apply for pre-approval

Pre-approval is when we confirm cover under the policy before the child's procedure or medical treatment (such as a surgery) happens. We'll also tell you of any conditions that may apply. We need 2 working days to process pre-approvals.

Pre-approval is required:

- for any procedure or medical treatment that is likely to cost $1,000 or more
- if the procedure or medical treatment requires hospitalisation, day-stay, or in-patient care.

If in doubt, get pre-approval. If you don't get pre-approval, we may not be able to approve the claim.

Collect a pre-approval form

You'll need to complete a pre-approval form. You can find the form on our website, in the online member portal, or we can post or email a copy to you. The guardian must sign this form, and so must the child if they are over 16 years of age.

Get an estimate of the cost

Ask the child's health service providers and the hospital for an estimate of the cost for the procedure or medical treatment. Please try to get an estimate of the cost for all parts of the procedure and treatment. Include the number of nights in hospital, theatre fees, and any additional costs such as equipment and physiotherapy. This information allows us to make sure the full cost will be covered. We understand that the information you get will be an estimate and the actual costs may vary.

If the cost is above what we judge to be a reasonable cost for the type of procedure or medical treatment (our reasonable and customary charges), we may ask for further information or we may recommend an alternative treatment or health service provider.

If you choose to continue with the child's procedure or medical treatment at the previous cost, you'll need to pay the difference between the amount we approve and the actual cost of the procedure or medical treatment, regardless of the benefit's maximum limit.

You'll need to let us know if another insurer, including ACC, has a responsibility to pay for all or part of the child's procedure or medical treatment.

Provide medical evidence

You and all children on the policy must give us all the information we reasonably need to assess the pre-approval or claim. We're entitled to ask for information from the pre-approval process, up to and following a claim being made.

You'll need to provide some *medical evidence* for why the procedure or medical treatment is required for the child, so that we can make sure it's covered under the policy. This medical evidence could be either a copy of the GP referral letter or a letter from the specialist that confirms why the treatment is needed.

You may also need to ask the GP who holds the child's medical history to complete Accuro's Medical report.

Please see the 'Why do you need to provide medical evidence' section on page 21 for further information.

You'll need to pay for any costs associated with getting medical evidence.

Submit your pre-approval

You can submit the pre-approval by post or email, or through the online member portal. In some cases, we may need to contact you or the child's health service providers to request additional details to make sure we assess the pre-approval correctly. We'll contact you if this is the case.

Please call or email us if you're unsure about how to apply for pre-approval, including whether or not you need to supply a Medical report with the child's pre-approval.

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.

We'll pay up to the reasonable and customary charges for any necessary medical procedure or treatment that's covered by a benefit as outlined in the policy, up to the specified benefit limit. You can only claim for events that occur after the relevant health insurance cover has started.

Collect a claim form

If you haven't got pre-approval, you'll need to complete a claim form. Find our claim form on our website, in the online member portal, or we can post or email a copy to you. The guardian must sign this form, and so must the child if they are over 16 years of age.

Collect invoices and receipts

Include all invoices with the claim as well as any receipts if you've already paid for the procedure or medical treatment.

Provide medical evidence

You and all children on the policy must give us all the information we reasonably need to assess the pre-approval or claim. We're entitled to request information from the pre-approval process, up to and following a claim being made.

You'll need to provide some medical evidence for why the child needed the procedure or medical treatment so that we can make sure that it is covered under the policy. This medical evidence could be either a copy of the GP referral letter or a letter from the specialist that confirms why the treatment is required.

You may also need to ask the GP who holds the child's medical history to complete Accuro's Medical report.

Please see the 'Why do you need to provide medical evidence' section on page 21 for further information.

We recommend that you read the policy certificate, including any exclusions listed on it, as well as the 'What's not covered' section on pages 15 to 17 to make sure that the child's procedure or medical treatment is covered under the policy. If you're unsure, you can apply for pre-approval beforehand, which confirms whether the procedure or medical treatment will be covered.

Submit your claim

You can submit the claim by post or email, or through the online member portal . The 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 when you have all the information.

We may need to contact you or the child's health service providers to request additional details so that we assess the claim correctly. We'll contact you if this is the case.

What if you already have pre-approval?

If the child has already been approved to have the procedure or medical treatment, you'll just need to send us copies of the invoices and receipts if you've already paid the provider. Please include the membership number and claim number with the invoices.

We'll then assess these and pay the providers directly. If you've already paid the invoices, we'll reimburse you.

Why do you need to provide medical evidence?

We need medical evidence to confirm that the service that your child is claiming for is covered under the policy. We need medical evidence to assess a claim or pre-approval.

Medical evidence could either be a copy of the referral letter, or consultation notes from the GP, dentist or optometrist. We would also accept a copy of the specialist's letter or notes confirming the outcome of the child's consultation or treatment.

The medical evidence must be from the medical professional who saw the child for the condition. It must state why the consultation, procedure or treatment is, or was, required.

When do we need a Medical report?

You need to provide a Medical report form with a child's claim or pre-approval if:

- the child was added to the policy after 6 months of age, and
- the child's complete medical history was not supplied at the time of submitting their application (that's all of the child's medical notes from birth to the date health insurance with us was applied for), and
- the child is claiming within the first 5 years of their Hospital & Surgical base plan or Specialist plan, and
- the child has not claimed for this condition before.

The Medical report form needs to be completed by the GP (or dentist or optometrist) who holds the child's medical history. We need this form to give us the history of the condition, its symptoms, and when it first became apparent. Often the GP referral or specialist letter will not give us a comprehensive history of the condition, which is why we ask for the Medical report form to be completed.

Where a child is over the age of 16 years, we may require the child to provide authorisation to access their medical records so we can process the claim.

You must pay any costs involved in getting any of the information above.

Things to remember

We can only accept and provide cover for costs:

- for a child who is covered under the policy
- for events that occur after the policy begins
- under a policy that has premiums paid up to date
- for benefits listed in the plans that the child has cover for
- charged at a reasonable and fair cost (within our reasonable and customary charges)
- for services only in the private sector (unless listed otherwise in this policy document).

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

Please call or email us if you're unsure about anything, including whether you need to send a Medical report with your child's claim.

What we will pay

Limits on the policy will affect the amount we can pay.

How policy benefit limits affect a claim

Unless specifically stated in this policy document, all benefit limits are for each child in each policy year. The benefit limits reset back to their maximum levels at the start of each policy year. You can't carry over the benefits from one policy year to the next, or transfer them to other children covered by the policy. The minimum or maximum amount for each benefit that you can claim for an event is set out in the 'The KidSmart cover and benefits' section of this policy 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 the child 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 the 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 your child had an x-ray that cost $110 and ACC agreed to cover $60 of it, we would only be able to assess reimbursement of the remaining $50 under the Specialist plan.

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

We will cover reasonable and customary charges

'Reasonable and customary charges' is the cost for a procedure or medical treatment that we judge to be reasonable and within a range of cost charged for the same procedure under similar circumstances. Our reasonable and customary charges make sure that health service providers are fair with the amount they're charging for procedures and aren't charging more than is required.

For procedures that have a reasonable and customary charge applied to them, we look at the average cost of the same procedure done throughout New Zealand. Once we have the average cost, we add an extra amount on top to set the reasonable and customary charge for this type of procedure. We understand that some health service providers charge more than others, which is why we add the extra amount as a buffer.

For example, a hip replacement surgery has an average cost of $27,500 throughout New Zealand. Once we add a buffer of 20%, we have a reasonable and customary charge of $33,000 for this procedure. This means that if a member were to have a standard hip replacement surgery, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000 the member would need to cover any costs over this.

Maximum cost we will pay

We'll pay the cost for a procedure or medical treatment that falls under the policy, up to the relevant benefit limit or the reasonable and customary charge for this procedure, whichever is less. If the cost for a child's procedure exceeds the maximum limit or the reasonable and customary charges, we can't pay the exceeded amount. The extra cost will be your responsibility.

For example, if your child had surgery done by a 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.

If the cost is above what we judge to be a reasonable cost for this type of procedure or medical treatment, we may ask for further information or we may recommend an alternative treatment or health service provider.

If you choose to accept the cost, you'll need to pay the difference between the amount we approve and the actual cost for the child's procedure or medical treatment, regardless of the benefit's maximum limit. You'll need to pay this extra amount directly to your child's health service provider. If you apply for pre-approval, our approval letter will advise you of this and the maximum amount we can cover for the child's procedure or medical treatment.

General conditions of the policy

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

We don't cover claims covered by ACC

ACC is New Zealand's accident compensation scheme, which provides cover if your child is injured. Our KidSmart 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 child's treatment, we may be able to pay the difference if they have cover for this treatment under the 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 your child's 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 child's healthcare services. We'll cover the difference in cost up to the reasonable and customary charges for this procedure or treatment, or up to the benefit limit in the policy, whichever is less. The treatment or procedure must be covered under the policy for the applicable child.

For example, your child has had an accident and needs an x-ray. If ACC agreed to cover 80% of the cost, and the child has the Specialist plan, we'd pay the remaining 20%.

If ACC declines cover

If ACC declines cover for a child's treatment that is covered under the 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 child's 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 and/or the child need to make a reasonable effort to secure and maintain cover. If ACC refuses to cover a claim for the child, or stops claim cover because you're not complying with ACC's requirements, you won't be able to claim under the policy.

Conditions of cover for prescription drugs

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

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

Unless outlined differently in the policy, 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 procedure in a private facility
- PHARMAC-approved
- medically necessary
- prescribed by a registered medical practitioner.

The child must also meet PHARMAC's funding criteria and the drugs must be funded for the relevant claim. If the prescription drugs require special authority from PHARMAC to be covered, we need confirmation from the registered medical practitioner that you do meet the special authority criteria before we can assess cover for the prescription drug cost.

As part of the Hospital and Surgical base plan, the non-PHARMAC drugs benefit covers Medsafe-registered prescription drugs. Under this benefit:

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

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

What you need to do

Your responsibilities are explained in the next section.

You must disclose pre-existing conditions

Our policies are set up to cover treatment of signs, symptoms and conditions that arise after this policy has started. This means that when you apply for cover for any children under the policy, you must disclose all pre-existing conditions for all children, including congenital conditions.

A pre-existing condition is:

- any health or medical condition that you or any child was aware of, or were experiencing signs or symptoms of, before the start of the policy
- a medical event that occurred before the start of the policy.

Our underwriters need to know about all previous and current signs, symptoms and conditions so they can fully assess the application.

We'll list any excluded conditions on the policy certificate. Personal exclusions may be placed on the policy because of your child's pre-existing conditions. We don't place personal exclusions on policies for all pre-existing conditions. Make sure you check how long each exclusion applies for. After the time period listed with the exclusion has passed, the child can then claim for that condition.

We may decline a claim if a child needs a procedure or medical treatment for, or related to, a pre-existing condition that was not included on the application form, and that you or the child knew about or should have known about. We reserve the right to exclude any declared or non-declared pre-existing condition or congenital condition from your policy at any time. The exclusion may be backdated to apply from the start of your policy.

Your duty of disclosure

Every child seeking insurance under this policy has a legal duty to disclose everything they and you knew (or ought to have known) that would have influenced our decision to provide cover.

All information given to us must be true, correct and complete. If the information given is untrue, incorrect or incomplete, we don't have to pay a claim. We may also treat all or any part of this policy as if it did not exist, cancel it, or amend the terms applying to you or any child.

We can take any of these actions immediately if:

- any information given to us is untrue, incorrect or incomplete
- you or any child has not told us about something else that is relevant to our decision to accept a claim, and any reasonable person in the circumstance would have known that information.

If we've already paid the claim, we will recover the amounts paid from you.

If, at any time, we become aware of any pre-existing condition that you or the child haven't disclosed, we'll add this to the policy certificate, and it will be recorded as an excluded condition.

In some circumstances, where we identify fraudulent behaviour, we may take legal action against you or the child involved.

You must pay the policy's premium

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

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

We won't pay any claims if you owe us premiums on the policy. We don't have to pay until the premiums are up to date. If you miss payments of the premiums, or if any child's membership has ceased for any reason, we can't provide cover for any services outside the period for which premiums have been paid. We can only assess cover for a claim when the premium for the policy is up to date for the period when the healthcare services took place.

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

If you don't pay the premium on the policy, we'll send you letters to tell you that the policy has fallen into arrears. We'll cancel the policy if you haven't paid the premium for 90 days or longer. Cancellation takes effect from the last date you have paid premiums up to.

We may increase the premium at any time

We may apply a general premium increase and other changes to premiums at any time. The premiums and discounts for this KidSmart policy are not guaranteed. We reserve the right to review and adjust premiums and discounts at our discretion 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 your child or children 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 the policy

This section explains what you can do with the 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 the policy certificate, or 5 working days after you receive the policy documents (whichever is later). This free-look period allows you to review the plans that your child or children have and make sure they are correct.

You can make changes to the 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 a claim hasn't been made under this policy.

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

Adding children to the policy

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

You can only add a child that you are legally responsible for onto the policy.

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

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

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

If there are three or more dependants on this 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.

Adding a child who is under 6 months old

You can add a child who is under 6 months of age to the policy by completing a Making Changes form with no personal exclusions placed due to their medical history. The exclusions listed on pages 15 to 17 will still apply, including congenital conditions.

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

How long can a child stay on the policy?

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

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

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

How do I remove a child from the policy?

You can remove a child from the policy at any time by writing to us and signing the request. The guardian is responsible for removing a child from the policy if circumstances change.

If you remove a child from the policy and wish to add them again in the future, they'll need to complete a new application form and go through the full application process. A child must be under 18 years to be added back onto a KidSmart policy.

How can a policy end?

Cover for this KidSmart policy ends when any one of these things happen:

- you ask us to cancel this policy — the request must be from the guardian or designated financial adviser (if applicable)
- you fail to pay the premium for 90 days or longer
- you or any child (if relevant) breach the terms of this policy
- in respect to a particular child, when the child is removed from this policy
- when a child reaches the age of 25 years, at which time they will be transferred to their own SmartCare+ policy
- the last child covered by this policy dies.

Suspending the policy

You may ask us to suspend a child's 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)
- The guardian being registered as unemployed for a period longer than 2 months (maximum length of suspension is 6 months)
- The guardian being made redundant or suffering financial hardship (maximum length of suspension is 6 months)

Please contact us if you wish to apply to suspend the 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 for any child on the policy who is suspended at the time an event occurs.

The child 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 the policy, the period the policy is suspended for won't be deducted from the timeframe for any personal exclusions that the child has on the policy.

For example, a child has a 5-year personal exclusion for a hernia, and you suspend their cover for 12 months after 1 year of cover. You won't be able to claim for treatment relating to the hernia for the child for the first year of cover, while suspended, or for the 4 years following suspension.

Cancelling the policy

If you cancel this KidSmart policy within the 14-day free-look period, we'll refund all premiums paid, as long as no claims have been made by a child covered by the policy.

You can cancel the 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 guardian or designated financial advisor (if applicable). We'll acknowledge your request to cancel the policy when we receive it.

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

When you cancel the policy or cover for a child, the date of cancellation depends on the frequency of the 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 the policy.

Your insurer

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

This 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 27).

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 KidSmart.

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

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 and any child's information in accordance with this privacy statement.

When and how we collect information

We collect information from you and any child when becoming 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 and any child when you use our website, including using cookies.

Some examples of personal information we may collect from you and any child 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 your children's medical records
- claims information and information relating to any other insurance applied for or held or claims previously made by you or any child
- website information, such your IP address and browser type.

We may also collect personal information about you and any child from third parties such as your child's 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 and your children's 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 you or your child's identity
- evaluating and assessing any application for a policy and any claims under the policies
- providing client service and information

- managing a relationship with you and any covered children, 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 child covered by the policy, give us incomplete or inaccurate information, we may decline your claim, void or cancel the policy, or amend the terms applying to you or a child as allowed by law.

Storage and security of 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 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 personal information

Under the Privacy Act 2020, you're entitled to ask us to confirm whether we hold your or your child's personal information, or not. You're entitled to have access to that personal information. You're also entitled to ask us to correct any of your or your child's 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 children covered by this 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. 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.

As the guardian of a child insured under this policy and having applied for cover for the child you shall be deemed a Member of the Society in your capacity as guardian. Your Membership ceases when the last child covered by the policy turns 18 years old or the policy comes to an end.

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 your full details as the guardian and full contact and medical details for all proposed children. You must disclose all previous medical history for all children in the health declaration on the application form. The guardian must sign the form, as well as any children aged 16 years and older.

The rights and obligations of the guardian, child and UniMed are set out in the documents listed below:

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

All guardians and children are bound by and subject to the rules of the 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 this 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 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.

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

benefit means the reimbursement available for guardians for specific types of expenses as specified in this policy document and for which the child is eligible, including grants.

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

child means a person under the age of 25 years on a KidSmart policy.

children has a corresponding meaning.

claim means the request by a guardian to have costs under the child's chosen plan refunded as described in this policy document, providing the child is eligible.

congenital condition means a health anomaly 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) and is recognised at birth or diagnosed within the first 3 months of life.

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.

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

grant means a payment of a fixed amount as listed in this policy document or that may be made at our discretion.

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

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

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

hospitalisation means admission to hospital for treatment.

long-term care means either public or private hospital-based services provided on an on-going basis where a health condition, as determined by us, has been or is likely to be present for more than 6 months.

medical evidence means (without limitation) medical records, medical history and correspondence or supportive screening information for the treatable condition.

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.

Medsafe means the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the Ministry of Health and is the authority responsible for the regulation of therapeutic products in New Zealand. Medsafe administers the Medicines Act 1981 and Medicines Regulations 1984.

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. A person who is a member only because they are a guardian of this policy is not insured under this policy for their personal health. It doesn't include generic use of the word 'member' or 'members' when referring to members of families, associations, or our member portal.

palliative care means care given to patients with life-limiting illnesses that has the primary aim of improving the quality or quantity of life until the death of that patient. Palliative care may also positively influence the course of the illness. A life-limiting

illness is one that cannot be cured and may at some time result in the person dying (whether that is years, months, weeks or days away).

personal exclusion means a medical condition (current or previous) or body part that is not covered for a particular child under the plan for a period of time.

PHARMAC is the New Zealand Pharmaceutical Management Agency, 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 the Pharmaceutical Management Agency.

plan means a specified range of benefits. It doesn't include the use of 'plan' in 'treatment plan'.

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 that confirms initial acceptance or subsequent alteration to a plan. 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.

pre-existing condition means:

- any health or medical condition that you or any child was aware of, or were experiencing signs or symptoms of, before the start of the policy
- a medical event that occurred before the start of the policy.

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

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

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

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.

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

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

reasonable 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.

start means the date on which membership in relation to a child begins, as specified in the policy certificate.

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

underwriting means to assess the information provided by the applicant on the application form. Depending on this information, the underwriter may request additional information about medical history that relates to pre-existing conditions.

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. .

accuro
HEALTH INSURANCE