HEALTH INSURANCE
POLICY DOCUMENT

SmartCare+

Here's all you need to know

accuro
HEALTH INSURANCE

Welcome to Accuro SmartCare+

Thank you for choosing SmartCare+, Accuro's premier insurance product for people who make their health a top priority. SmartCare+ provides you with our largest range of *benefits* and highest limits.

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.

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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.

SmartCare+ at a glance

Policy Document

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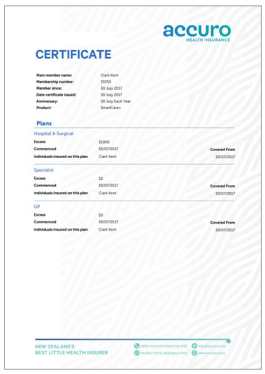


Policy certificate

This policy document explains what's covered for all SmartCare+ policy holders (benefits) and what's not covered (*general exclusions*). Check your *policy certificate* for details that are specific to your policy, including *personal exclusions*, *excesses* and the *plans* you have cover under.

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

Your SmartCare+ 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.

Who SmartCare+ is for

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

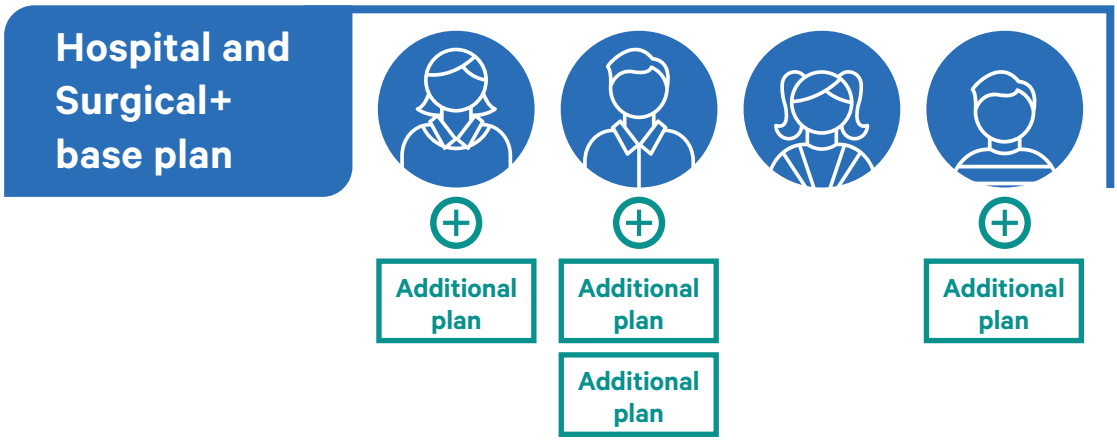
Some customers are more vulnerable to the risk of unfair outcomes or disadvantages due to their personal circumstances. This could be due to, for example, health or disability reasons, life events, financial or personal resilience, knowledge or confidence in managing financial matters.

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.

Start with the base plan and add additional plans

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

Check your policy certificate to see the additional plans and participants on your policy.



Main benefits of SmartCare+

Hospital and Surgical+ base plan benefits:	cover for each person 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 plans/product

Specialist+ plan
Cover for specialist consultations and diagnostic tests.

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

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

Dental and Optical+ plan
Cover for dental treatment and optical consultations and eyewear.

Day to Day product
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 14.

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 39 to 41. 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.

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 SmartCare+ cover and benefits

This policy document lists what's covered for all SmartCare+ 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.

Your policy certificate contains the details that are specific to your policy, such as what plans each person in your family is covered for, as well as any personal exclusions. A personal exclusion is where we've reviewed the medical information you've provided for us 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.

You'll automatically have the Hospital and Surgical+ base plan. Please check your policy certificate to see whether you have cover under any of the additional plans.

Your policy certificate will list any excess under the plans you have. An excess applies to a plan once for each person for each year they have the policy.

To find out what type of prescription drugs are covered under your policy, refer to the 'Conditions of cover for prescription drugs' section on page 29.

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 person in a policy year
An excess applies to this benefit

If you're wanting to *claim* under this benefit, we strongly recommend you seek pre-approval before your 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 1 year before or after the approved surgery

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

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

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

This includes:

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 you're admitted to a hospital.

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

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

Prophylactic surgery

$80,000 for each person
An excess applies to this benefit

This benefit covers the costs of prophylactic (preventative) surgery if you have an increased risk of developing cancer because of a high-risk status or gene mutation. You can claim this benefit as many times as you need to but it only provides cover up to $80,000 for each person over the lifetime of the policy.

To claim under this benefit, you must meet the requirements listed in the eligibility criteria for Prophylactic surgery.

Oral surgery

$300,000 for each person in a policy year
An excess applies to this benefit

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
- Surgical removal of cysts or soft tissue swellings
- Surgical drainage of oral abscesses
- Pre-operative and post-operative diagnostics, consultations or tests if they occur within 1 year before or after the approved surgery

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

You must be treated by a New Zealand-registered oral or maxillofacial specialist, in an accredited private hospital or clinic. A New Zealand-*registered medical practitioner*, dental surgeon, or dentist must refer you or the participant on your 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 person in a policy year
An excess applies to this benefit

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. Your condition must have directly resulted from the diagnosis of any non-acute (non-urgent) medical condition. The non-surgical hospital treatment must be recommended by an appropriate registered medical practitioner as being necessary to improve the health of the member or participant.

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 6 months of the date of admission
- Diagnostic procedures, including diagnostic procedures directly relating to the hospital admission that occurred within 6 months of the date of admission
- $2,000 for each person 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, scarf, or mastectomy bra

Non-PHARMAC subsidised drugs

An excess applies to this benefit

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

An excess applies to this benefit

Treatment outside of New Zealand — **$30,000 for each person 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 member or participant 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 excess, 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.

Medical tourism

This benefit covers reimbursement of a surgical procedure or treatment performed at an overseas hospital if you're able to have the procedure in New Zealand within 6 months. If treatment isn't available in New Zealand within 6 months, you can claim under the Overseas waiting list benefit.

We'll reimburse up to 75% of 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 you can travel to for the required medical treatment.

To qualify for this benefit:

- a registered medical specialist must recommend that the member or participant has the medical procedure or medical treatment
- the procedure or treatment must be available in New Zealand within the 6 months after the recommendation
- the member or participant must get pre-approval from us for the procedure or treatment
- the procedure must meet all policy criteria and is subject to all excess, 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.

Overseas treatments (continued)

An excess applies to this benefit

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 you can travel to for the required medical treatment.

To qualify for this benefit:

- a registered medical specialist must recommend that the member or participant 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 member or participant must get pre-approval from us for the procedure or treatment
- the procedure must meet all policy criteria and is subject to all excess, 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.

Cover while in Australia

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

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

The member or participant must meet all policy criteria and is subject to all excess, 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. Services that fall under 'Other benefits' below do not qualify for cover under this benefit.

Minor surgery

$3,000 for each claim
An excess applies to this benefit

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 member or participant would be affected.

Other benefits

Other benefits that we offer are summarised below.

Home nursing

$6,000 for each person in a policy year
No excess applies to this benefit

$150 a day.

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

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

Parent accommodation

$3,000 for each person in a policy year
No excess applies to this benefit

$300 a night for accommodation.

This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. 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 your claim.

Hospice stay

$2,000 for each person in a policy year
No excess applies to this benefit

$50 a night, up to a maximum of 10 nights for each admission.

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

Transport and accommodation

$3,000 for each person in a policy year
No excess applies to this benefit

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

We'll reimburse one of the costs below for the member or participant.

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

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

This includes:

Support person benefits

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

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

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

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

Public hospital

$3,000 for each person in a policy year
No excess applies to this benefit

$300 a night.

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

Health-related appliances

$200 for each person in a policy year
No excess applies to this benefit

This benefit covers the cost of health-related appliances after an approved surgery. Appliances must be purchased or hired within 6 months of the approved surgery. This benefit doesn't cover any bond required to hire appliances.

Ambulance transfer

$200 for each person in a policy year
No excess applies to this benefit

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

This benefit is only available to private, fee-paying patients for any non-acute (non-urgent) medical condition. We must have pre-approved your initial admission to hospital.

Speech-language therapy

$400 for each person in a policy year
No excess applies to this benefit

$80 a visit.

This benefit covers the costs of post-operative treatment for a related surgery that we've approved under this policy. You 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
No excess applies to this benefit

This benefit covers the costs of post-operative physiotherapy for a related surgery that we've approved under this policy. You 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 you have been admitted to hospital for the related surgery.

Medical misadventure

$30,000 for each person
No excess applies to this benefit

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

This benefit applies only if:

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

We'll deduct any funeral support grant previously paid for a member from the medical misadventure benefit.

Funeral support grant

$10,000 for each person
No excess applies to this benefit

$10,000 payable into the bank account of the deceased member or participant's estate.

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

ACC top-up

An excess applies to this benefit

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

These other terms apply.

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

Your Active Benefits help you stay healthy

Active Benefits allow you to use your insurance not just for treatment but to maintain good health. These benefits include screening procedures and access to expert independent advice.

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 you 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 you or any participant on your policy has been diagnosed with an illness, injury or medical condition and would like a second opinion, they 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 illness, injury, or medical condition, including a treatment plan. The review is designed for you to share with your 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 you extra benefits after you've held your policy with Accuro for more than 2 years.

Sterilisation — $5,000 for each policy

This is a one-off contribution up to $5,000 toward the total cost of the procedure.

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

GP health check — $150 for each person every 3 policy years

After 3 years of continuous cover, this benefit covers the costs of a health check performed by a New Zealand-registered medical practitioner (GP).

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

Discounts for those with healthy weight

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

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

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

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

Screening endoscopies — $1,000 for each person every 3 policy years

After 3 years of continuous cover, this benefit covers 80% of the reasonable and customary charges of colonoscopies and gastroscopies. You must use this benefit within 12 months of entitlement.

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

Bowel screening — one kit for each person every 3 policy years

After 3 years of continuous cover, this benefit provides you with a bowel-screening kit. Please contact us if you wish to redeem this benefit and we'll arrange for the kit to be sent to you.

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

Additional plans

You can choose to add any of our additional plans for yourself or any other participant on your policy. These plans include:

- Specialist+ plan
- GP+ plan
- Natural Health+ plan
- Dental and Optical+ plan.

Check your policy certificate to see if you're covered under any of these plans. You won't have these plans unless you've asked us to add them to your policy.

We recommend that you read over the benefits carefully and make sure you understand them. Please contact us if you have any queries about the following plans, or would like to add a plan to your 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 you cover the everyday costs of staying healthy, such as going to the doctor, dentist or optician. It covers the costs of prescription drugs and the annual flu vaccine. You can also enjoy natural therapy treatments to help improve your health and wellbeing.

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

Specialist+ plan

The Specialist+ plan is our most popular additional plan. It provides access to private tests and specialist consultations to speed up the time to reach your diagnosis. This is an additional plan, so please check your policy certificate to see if you're covered and if there is an excess.

Specialist consultations

$5,000 for each person in a policy year
An excess applies to this benefit

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 person in a policy year

This benefit covers the costs of reasonable and customary charges for consultations with a psychiatrist, psychologist or counsellor when a registered medical practitioner refers you. They must refer you 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 you to consult a registered medical specialist for a second opinion on a diagnosis or a treatment plan that is covered under this policy. You must have received your first diagnosis from a registered medical specialist.

Diagnostic tests

$5,000 for each person in a policy year
An excess applies to this benefit

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

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 you to a team of health professionals including a nurse, psychologist and psychiatrist. This team will review your 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 you once you have completed the process.

You can expect a consultation within 10 days.

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

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 you extra benefits after you've held the Specialist+ plan with Accuro for more than 3 years.

Screening — **$250 for each person every 3 policy years**

After 3 years of continuous cover, this benefit covers the costs of a mammogram or prostate check performed by a New Zealand-registered medical practitioner.

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

Pregnancy and infertility treatment — **$2,000 for each person in a policy year**

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

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

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

GP+ plan

The GP+ plan provides cover for visits to your doctor, including cover for prescription drugs. This is an additional plan, so please check your policy certificate to see if you have cover under this plan. No excess applies to this plan.

This plan has an initial *stand-down period* of 90 days, which means that you can't make a claim for any benefit on the plan, such as GP visits, in the first 90 days.

General practitioner (GP)

This benefit covers the costs of GP visits, including home and after-hours visits.

Up to $55 for each GP visit.

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

Registered nurse

This benefit covers the costs of practice nurse visits.

Up to $35 for each visit.

Prescription drugs and laboratory tests

This benefit covers the costs of prescription drugs and laboratory tests ordered by a New Zealand-registered medical practitioner or registered medical specialist.

Laboratory tests: $80 each policy year.

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

Loyalty benefit

We give you this extra benefit after you've held the GP+ plan with Accuro for more than 3 years.

Preventative checks **$200 every 3 policy years**

After 3 years of continuous cover, this benefit covers the costs of a preventative mammogram or prostate check performed by a New Zealand-registered medical practitioner.

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

Natural Health+ plan

The Natural Health+ plan provides a diverse approach to keeping well. This is an additional plan so please check your policy certificate to see if you have cover under this plan. No excess applies to this plan.

This plan has an initial stand-down period of 90 days, which means that you can't make a claim for any benefit on the plan, such as physiotherapy treatment, in the first 90 days.

Healthcare practitioners — $800 for each person in a policy year

Osteopath and Chiropractor

This benefit covers the costs of treatment by osteopath and chiropractor health practitioners.

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

Healthcare Practitioners

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

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

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

Loyalty benefits

We give you these extra benefits after you've held the Natural Health+ plan with Accuro for more than 3 years.

Sick leave — $100 each week, up to $500 for each person in a policy year

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

Flu vaccination — $40 for each person in a policy year

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

Dental and Optical+ plan

The Dental and Optical+ plan provides cover for visits to the dentist and optician, as well as the purchase of prescription glasses or contact lenses. This is an additional plan so please check your policy certificate to see if you have cover under this plan. No excess applies to this plan.

This plan has an initial stand-down period of 90 days, which means that you can't make a claim for any benefit on the plan, such as dental treatment, in the first 90 days.

Dental cover

80% of the cost — $500 for each person in a policy year

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

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

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

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

Optical cover

Consultations

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

80% of the cost — up to $60 for each visit, to a maximum of $300 for each person in a policy year.

Glasses or contact lenses

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

80% of the cost — $300 for each person in a policy year.

Loyalty benefit

We give you this extra benefit after you've held the Dental and Optical+ plan with Accuro for more than 3 years.

Orthodontic

80% of the cost — $750 for each person in a policy year

After 3 years of continuous cover, this benefit covers the cost of orthodontic treatment by a registered orthodontist. Practitioners providing assessments must belong to their professional body.

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. Your personal exclusions will be listed on your policy certificate.

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

Health conditions we don't cover

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 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
- 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.

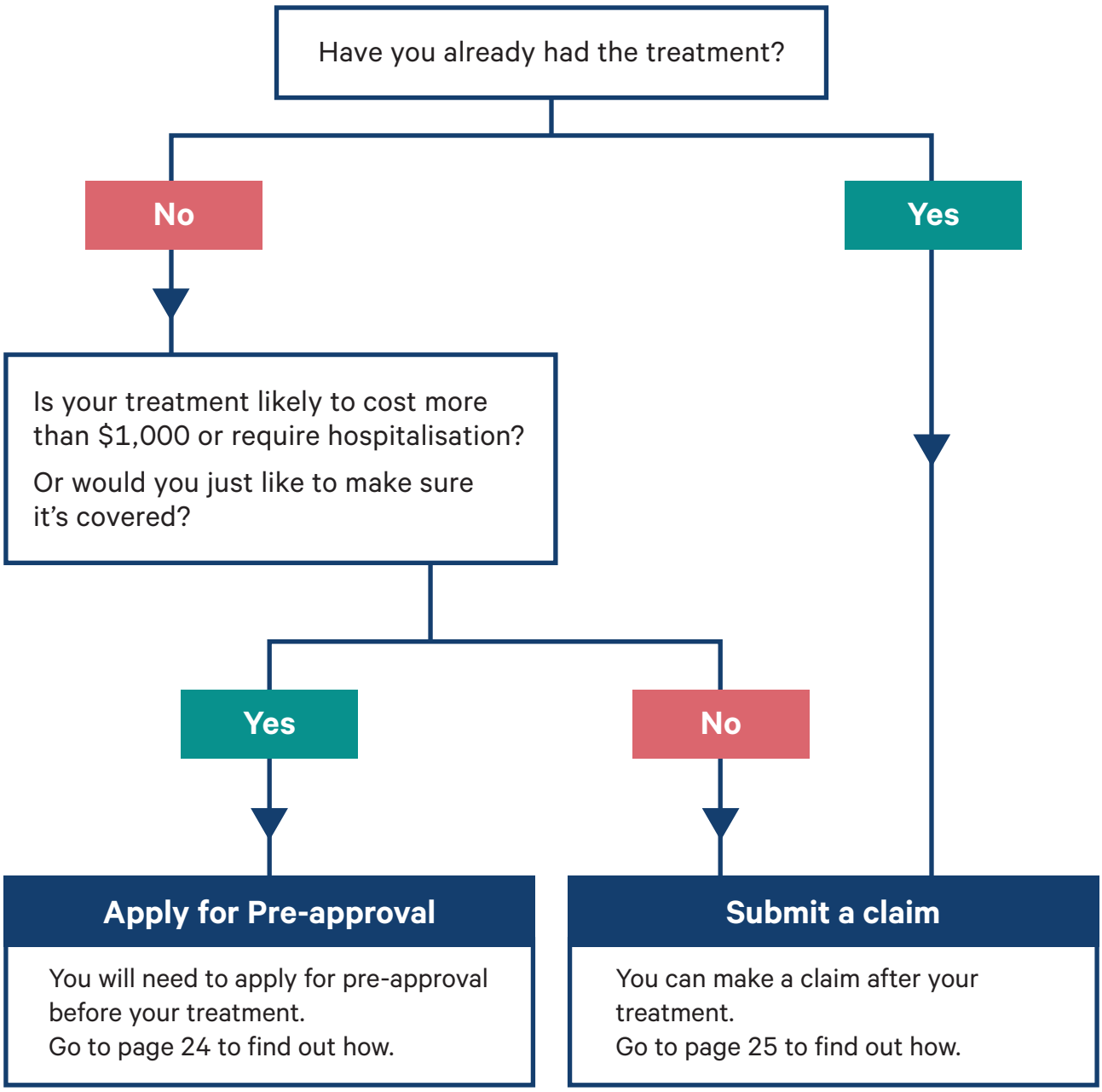
- Disability or illness arising from misuse of alcohol, drugs, participation in a criminal act, or intentional self-injury
- Attempted suicide or suicide within 13 months from the start date of the plan

How to submit a claim

Choose one of two ways to submit a claim for your procedure or medical treatment. You can:

1. Get pre-approval for your claim by submitting the details of your procedure or medical treatment before it takes place in order to confirm that it is covered under your 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 your policy before your procedure or medical treatment (such as a surgery) happens. We'll also tell you of any conditions or excess 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 your 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 your 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 main member must sign this form, and so must the patient if they are over 16 years of age.

Get an estimate of the cost

Ask your 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 your 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 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 procedure or medical treatment.

Provide medical evidence

You and all participants on your policy must give us all the information we reasonably need to assess your 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, so that we can make sure it's covered under your 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 patient's medical history to complete Accuro's Medical report. We'll need this report if:

- the patient having the procedure or medical treatment is within the first 5 years of their policy, and
- this is the first time the patient is claiming for this medical condition.

Please see the 'Why do you need to provide medical evidence' section on page 26 for further information.

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

Submit your pre-approval

You can submit your pre-approval by post or email, or through the online member portal. In some cases, we may need to contact you or the health service providers to request additional details to make sure we assess your 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.

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

Provide medical evidence

You and all participants on your policy must give us all the information we reasonably need to assess your 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 you need the procedure or medical treatment so that we can make sure that it is covered under your 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 patient's medical history to complete Accuro's Medical report.

Please see the 'Why do you need to provide medical evidence' section on page 26 for further information.

We recommend that you read your policy certificate, including any exclusions listed on it, as well as the 'What's not covered' section on pages 20 to 22 to make sure that the procedure or medical treatment is covered under your 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 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 when you have all the information.

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

What if you already have pre-approval?

If you have 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 your 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 you are claiming for is covered under your 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 your consultation or treatment.

The medical evidence must be from the medical professional who saw the patient 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 your claim or pre-approval if:

- you did not provide your complete medical history at the time of submitting your application (that's all your medical notes from birth to the date you applied for health insurance with us), and
- you're claiming within the first 5 years of your Hospital & Surgical+ base plan or Specialist+ plan, and
- you have not claimed for this condition before.

The Medical report form needs to be completed by the GP (or dentist or optometrist) who holds your 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.

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 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 plans you have 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 your policy document).

We recommend that you read the next section ('What we will pay'), as things listed here may affect your 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 claim.

What we will pay

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

How an excess under your cover affects your claim

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

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

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

For example, you have a $1,000 excess under the Hospital and Surgical+ base plan and claim for a $950 MRI scan. You need to pay the $1,000 excess before we can reimburse you for anything. The $950 you've already paid would go toward your excess, so we wouldn't reimburse you for this claim. However, if you needed another $950 MRI scan in the same policy year, you'd only have $50 of the $1,000 excess left to pay and we'd reimburse the remaining $900.

When we send you a pre-approval, your excess will be clearly shown on the approval letter. You'll need to settle this amount directly with your health service provider.

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 minimum or maximum amount for each benefit that you can claim for an event is set out in the 'The SmartCare+ 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 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 an x-ray that cost $110 and ACC agreed to cover $60 of it, we would only be able to assess reimbursement of the remaining $50 under your Specialist+ plan.

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

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 you 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 you'd 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 your policy, up to the relevant benefit limit or the reasonable and customary charge for this procedure, whichever is less. If the cost for your 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 you had surgery done by your GP under the Minor Surgery benefit and it came to $4,500, we would only be able to provide reimbursement of $3,000. The remaining $1,500 would be your responsibility. This is because the benefit limit for Minor Surgery is $3,000 for each claim, so we are unable to provide cover for costs above this amount.

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

General conditions of your policy

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

We don't cover claims covered by ACC

ACC is New Zealand's accident compensation scheme, which provides cover if you're injured. Your SmartCare+ 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 reasonable and customary charges for this procedure or treatment, or up to the benefit limit in your policy, whichever is less. The treatment or procedure must be covered under your policy.

For example, you have an accident and need an x-ray. If ACC agreed to cover 80% of the cost, and you have the Specialist+ plan, we'd pay the remaining 20%.

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

Some plans have a 90-day stand-down period that applies to all members and participants on the plan. You're not covered for any events that happen during this stand-down period. We state the stand-down periods under the relevant plans in the 'The SmartCare+ cover and benefits' section.

We waive the premium on death or terminal illness

If the main member or the partner on this policy dies or is diagnosed with a *terminal illness* up to the age of 70, we'll continue to provide cover for the member-paid premium for the remaining participants who are covered under this policy for whichever of these is earlier:

- 36 months

  or
- until the oldest surviving person on the policy reaches the age of 70.

Once notified, the waiver of premium will start from the date of death or diagnosis of a terminal illness. Any changes made to your policy during the waiver of premium like the addition of a new member or increase in cover will not be eligible for the waiver of premium. Once the waiver of premium ends, the premium payments for all remaining participants will be the responsibility of the policy's main member.

Conditions of cover for prescription drugs

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

- Drugs prescribed and administered in hospital are covered as part of hospital charges related to surgical treatment, or to non-surgical hospitalisation under the Hospital and Surgical+ base plan.
- Chemotherapy drugs taken as part of a course of chemotherapy treatment are covered as part of the private hospital medical admission benefit under the Hospital and Surgical+ base plan.
- Any other drugs are only covered under the prescription drugs and laboratory tests benefit in the GP+ plan, which is an additional 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.

You must also meet PHARMAC's funding criteria and the drugs must be funded for the relevant claim. If the prescription drugs require special authority from PHARMAC to be covered, we need confirmation from the 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 your policy has started. This means that when you apply for your policy, you must disclose all pre-existing conditions for all participants, including congenital conditions.

A pre-existing condition is:

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

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

We'll list any excluded conditions on your policy certificate. Personal exclusions may be placed on your policy because of pre-existing conditions or any other participant'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, you can then claim for that condition.

For example, if you had a hernia at the start of your policy, we'd place a personal exclusion for this condition for a period of 5 years. You'd be unable to claim for anything relating to your hernia within the first 5 years of your policy. However, once you'd had the policy for 5 years, the exclusion would drop off and you could then claim for services relating to your hernia.

We may decline your claim if you need a procedure or medical treatment for, or related to, a pre-existing condition that you didn't include on your application form, and that you or the participant 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

Everyone seeking insurance under this policy has a legal duty to disclose everything they 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 your policy as if it did not exist, cancel it, or amend the terms applying to you or a participant.

We can take any of these actions immediately if:

- any information given to us is untrue, incorrect or incomplete
- you or any participant 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 haven't disclosed, we'll add this to your 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 participant involved.

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 send you letters 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 SmartCare+ 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 plans and make sure they are 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 dependants and 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 SmartCare+ policy, you'll need to complete a full application form for each participant and answer the health questions, or provide their full medical history.

We'll assess each application and decide whether the participant can be added on the basis of the health information we receive. 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.

Adding a dependant who is under 6 months old

You can add a dependant who is under 6 months of age to your policy by completing a Making Changes form with no personal exclusions placed due to their medical history. The exclusions listed on pages 20 to 22 will still apply, including congenital conditions.

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

Adding a dependant who is older than 6 months

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

How long can dependants or whāngai stay on my policy?

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

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

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

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 full application process.

Death of the main member

If the main member of the policy dies, the partner who has been included on the policy may retain the policy and continue paying the appropriate premium. The partner is then considered the main member. The 'We waive the premium on death or terminal illness' section on page 29 has more information about whether the waiver of premium applies.

How can a policy end?

Cover for your SmartCare+ 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.

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.

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

Cancelling your policy

If you cancel your SmartCare+ 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 on our application form.

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 33).

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

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

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

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, www.accuro.co.nz.

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 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.

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

benefit means the reimbursement available for members for specific types of expenses as specified in this 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 under their chosen plan refunded as described in this policy document, providing the member 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.

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.

excess means any amount specified on your current policy certificate that is excluded from payment.

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 member or participant on this type of policy.

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

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

hospitalisation means admission to hospital for treatment.

long-term care means 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. 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).

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.

personal exclusion means a medical condition (current or previous) or body part that is not covered for a particular member or participant 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 to a member 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 you're aware of, or were experiencing signs or symptoms of, before the start of your policy, or
- a medical event that occurred before the start of your policy.

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

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

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

stand-down period means the period of 90 days after the start date or, in the case of a participant added to a plan, 90 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.

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

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

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.

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 plan. A whāngai is considered a dependant under this policy.

accuro
HEALTH INSURANCE