Primary Care

Your insurance policy

HealthCare

It's good to belong

Effective from 1 January 2019


TEU
TE HAUTŪ
KAHURANGI
TERTIARY EDUCATION UNION


PSA


NZEI
TE RIU ROA


TIASA


PPTA
Te Wehengarua


isea
Independent Schools
Education Association

Welcome to Primary Care a HealthCarePlus product underwritten by Union Medical Benefits Society Ltd (UniMed)

Thank you for choosing Primary Care from HealthCarePlus. We are sure that you will find that it's good to belong.

This is your insurance policy document. Please take the time to read your insurance policy document carefully and if you have any questions please call **0800 600 666** Monday – Friday 8 am – 5 pm.

What is Primary Care?

This product covers day-to-day health care costs. This includes a wide range of health care treatment and other benefits from optical and GP visits to complementary medical provider visits and health care screening.

Primary Care is exclusively available to members of a participating union[1] and their families.[2] It's one of the key benefits of belonging to these unions. Primary Care is underwritten by UniMed.

HealthCarePlus also offers access to a range of other insurance products for you to choose from including Hospital Cover, Risk Insurance including; life insurance, income/mortgage protection, trauma insurance and a home loans solution. To find out more about the benefits of these products, please call **0800 268 3763** Monday – Friday 8 am – 5 pm.

Hospital Cover and Risk Insurance may be underwritten by a range of New Zealand insurers. The Home Loans Solution is arranged through a range of New Zealand registered banks. These products are distributed by HealthCarePlus Representatives who are financial advisers employed by or contracted to Monument Insurance Limited, a division of Crombie Lockwood.

1 Members of: NZEI, PPTA, ISEA, TIASA, PSA and Tertiary Education Union.
2 See definition of "Family/Whanau" on page 15.

Who is HealthCarePlus?

HealthCarePlus is the trading name for The Education Benevolent Society Incorporated ("EBS"). EBS was started in 1963 to enable teachers, education sector members, and their families to access competitive insurance products to support their families' health and provide financial protection for unforeseen events.

In 2018 the Board of EBS conducted a fundamental review of the business and decided to enter a strategic partnership with UniMed whereby UniMed underwrites all HealthCarePlus health insurance products, and EBS focusses on providing members with a range of competitively priced health insurance products underwritten by UniMed.

Who is UniMed?

UniMed is the trading name for Union Medical Benefits Society Limited established in 1979. UniMed provides a comprehensive range of health insurance plans. Like HealthCarePlus, UniMed was established by Unions to provide its members with health insurance benefits. UniMed is a New Zealand licensed insurer.

UniMed is a not-for-profit incorporated society. This means UniMed is owned by you, its members, and any profits (called surpluses) are applied for the benefit of those members. Unlike a company, there are no dividends paid to shareholders.

Financial Strength

UniMed has been given an A (Excellent) insurer financial rating by AM Best.

A

(Excellent) Rating

AM Best's ratings are as follows:

Secure Ratings						Vulnerable Ratings						
A++	A+	A	A-	B++	B+	B	B-	C++	C+	C	C-	D
Superior		Excellent		Good		Fair		Marginal		Weak		Poor

Contents

Primary Care Coverage Table

The following tables describe the benefits covered by your Primary Care policy. It includes the health care service or benefit covered, reimbursement level, Benefit Maximums, Waiting Periods and other terms and conditions applicable to the cover. The Benefit Maximums apply as a total (i.e. aggregate) sum for all of the services outlined in the Benefit Section (unless otherwise indicated i.e. where Sub-limits apply).

The Board reserves the right to interpret, alter or amend the conditions for payment of benefits generally as it deems necessary. Further details about the terms and conditions of Membership are outlined in this policy document within UniMed / HealthCarePlus Conditions of Membership and on the HealthCarePlus website.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
OPTICAL			
OPTOMETRIST EYE EXAMINATIONS AND GLASSES, CONTACT LENSES	50% reimbursement of actual costs incurred up to $250 per Calendar Year for each Insured Adult or for all Insured Children collectively.	6 months	Covers the cost, up to the maximum cover for this benefit, of: · Optometrist eye examinations · Prescription glasses or contact lenses where there has been a change in vision Documentation specifying the date of the eye examination must be provided to claim for prescription glasses or contact lenses. Receipted itemised accounts must be provided, clearly stating the date of the prescribing eye examination. The effective date for the claim is the date of the prescribing eye examination and not the date of purchase or supply of the prescription glasses or contact lenses. Optical coatings, eye drops, solutions, cases and prescribed medicines are not included.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
MEDICAL, SPECIALISTS & TESTS (including health screening)			
GENERAL PRACTITIONER FEES, PRESCRIPTION MEDICINES, LABORATORY TESTS, SPECIALIST CONSULTATIONS, DIAGNOSTIC TESTS AND HEALTH SCREENING, AMBULANCE FEES	50% reimbursement of actual costs incurred up to $750 per Calendar Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of: · Registered Medical Practitioner consultations, · Registered Medical Specialist consultations, · Medicines or laboratory tests prescribed or referred by a Registered Medical Practitioner or Registered Medical Specialist up to a maximum of $10 per prescription item or laboratory test. · Flu vaccinations (all other vaccinations excluded) · Diagnostic tests*, x-rays and ultrasound (non obstetric) on referral from a Registered Medical Practitioner or Registered Medical Specialist. This benefit excludes treatment covered by the Complementary Medical Benefit even if this treatment is provided by a Registered Medical Practitioner. * This includes health screening tests including mammography, prostate checks and skin checks (excluding mole mapping - dermatologist consultations only). If you have an Approved Hospital Cover policy, please refer to the note at the end of this table.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
COMPLEMENTARY MEDICAL			
PHYSIOTHERAPY, CHIROPRACTIC, OSTEOPATHY, PODIATRY, ACUPUNCTURE, NATUROPATHY, HOMEOPATHY, PSYCHOLOGY, PSYCHOTHERAPY, COUNSELLING, DRUG AND ALCOHOL THERAPY, DIETITIAN AND NUTRITIONIST, LYMPHOEDEMA THERAPY, ALLERGY TESTING AND CHELATION THERAPY, AUDIOLOGY, OCCUPATIONAL THERAPY, SPEECH-LANGUAGE THERAPY, INFERTILITY/ STERILISATION	50% reimbursement of actual costs incurred up to $400 per Calendar Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of treatment and consultations provided by/ or x-rays on referral from persons registered with: · The Physiotherapy Board of New Zealand; · New Zealand Chiropractic Board; · Osteopathic Council of New Zealand; · Podiatrists Board of New Zealand; · Acupuncture NZ; · New Zealand Acupuncture Standards Authority Inc (NZASA); · The Physiotherapy Acupuncture Association of New Zealand Inc (PAANZ); · Naturopaths & Medical Herbalists of New Zealand Inc – **Naturopaths only**; · New Zealand Council of Homeopaths Inc (NZCH); · New Zealand Psychologists Board; · The Psychotherapists Board of Aotearoa New Zealand; · The New Zealand Association of Psychotherapists (NZAP); · NZ Association of Counsellors (NZAC); · The Addiction Practitioners Association of Aotearoa – New Zealand Inc (DAPAANZ); · Dietitians Board; · Nutritionist Society of New Zealand; · Lymphoedema NZ; · New Zealand Audiological Society (MNZAS); · Occupational Therapy Board of NZ (OTBNZ); · New Zealand Speech-Language Therapists Association (NZSTA). Treatment outlined above is also covered if performed by a Registered Medical Practitioner. Fertility treatment or sterilisation procedures are covered. Dietitian or Nutritionist consultations are covered if referred by a Registered Medical Practitioner. Chelation therapy, allergy testing or consultations and treatment related to allergies are covered if performed by a Registered Medical Practitioner. Medications, remedies, aids, food supplements or other items relating to treatment by the providers listed above are not included.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
HOSPITAL TREATMENT			
A CONTRIBUTION TOWARDS THE COST OF PRIVATE HOSPITAL TREATMENT. INCLUDES REIMBURSEMENT OF EXCESSES ON ELIGIBLE HOSPITAL COVER POLICIES ($500 MAXIMUM APPLIES)	50% reimbursement of actual costs incurred up to $700 per Calendar Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of: Surgery provided by a Registered Medical Specialist · Surgeon's fees, Anaesthetist's fees, Hospital charges · This benefit covers endoscopy procedures (where a theatre/facility fee applies) i.e. gastroscopy and colonoscopy procedures. Cover commences from the date of hospitalisation or treatment and continues through to post operative consultations (up to 6 months after hospitalisation). Consultations prior to admission to hospital may be claimed under the Medical Benefit. Documentation for all parts of the procedure must be submitted with the application even if they are not being claimed at that time. Travel, newspapers, television, telephone and any extras are excluded. Oral surgery is not included under this benefit. If you have an Approved Hospital Cover policy, please refer to the note at the end of this Coverage Table. An Excess reimbursement may apply.
MAJOR DIAGNOSTIC IMAGING			
A CONTRIBUTION TOWARDS THE COST OF CT/CAT, MRI AND ANGIOGRAMS.	50% reimbursement of actual costs incurred up to $600 per Calendar Year for each Insured Adult or for all Insured Children collectively	6 months	Covers the cost, up to the maximum cover for this benefit, of: · CT/CAT scans · MRI scans · Angiograms If you have an Approved Hospital Cover policy, please refer to the note at the end of this Coverage Table.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
MEDICAL APPLIANCE			
SPECIFIED ITEMS PRESCRIBED BY A GP, SPECIALIST OR HOSPITAL	50% reimbursement of actual costs incurred up to $400 per Calendar Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of medical appliances prescribed by a Registered Medical Practitioner, Registered Medical Specialist or provided by an approved hospital facility, including: · Prosthesis (not related to surgery), · Hearing aids, · Toric and Irlen lenses, · Aids for the control of diabetes or lung-related disease, · Epipens, · Mirena, · CPAP Machine/Mask, · Specially made footwear (excluding inserts for shoes provided by a podiatrist), · Compression Stockings/Sleeves, · Baby monitor or any equipment essential for the disabled Any subsidy payable or assistance available from any other source must be claimed first and disclosed on the claim form with supporting documentation. A medical referral or supporting letter from a Registered Medical Practitioner must be provided with your claim. Hire costs are not included.
ORTHODONTIC TREATMENT			
A CONTRIBUTION TOWARDS THE COST OF ORTHODONTIC TREATMENT FOR INSURED CHILDREN	30% reimbursement of actual costs incurred up to $750 for each Insured Child, up to a policy maximum of $1500 for the duration of the Member's Membership	12 months	Covers the cost, up to the maximum cover for this benefit, of orthodontic treatment to straighten dental arches or crooked teeth, to improve breathing, eating or speaking difficulties. This benefit covers Insured Children only. A treatment plan and estimate of the expected total cost is required from the orthodontist with the first application for the Orthodontic Benefit. Preliminary consultation and extraction costs will be considered only when a brace or appliance for the straightening of the dental arch(es) has been fitted. Permanent fixtures or devices for other purposes eg dentures, thumb crib are excluded. Where a consultation or treatment occurred prior to the end of the Waiting Period for eligibility (12 months) for this benefit, all subsequent orthodontic expenses in relation to that child are ineligible. Full orthodontic guidelines may be viewed on the HealthCarePlus website.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
SICK LEAVE WITHOUT PAY GRANT			
DUE TO SICKNESS OF THE MEMBER	$50 per week plus $5 for each Insured Child up to a maximum of $60 per week for 26 weeks for the Member.	12 months	The period may be extended by up to 26 weeks provided a full sickness benefit is being received from Work and Income and the HealthCarePlus benefit does not prejudice the right to additional assistance from Work and Income benefits. The minimum recognised period, which can be claimed, is 5 consecutive working days' approved sick leave without pay. A medical certificate must be supplied stating the nature of the illness and specifying the period of absence from work. A letter from the Member's pay office, or employer stating the start date of approved sick leave without pay and proposed finish date must be supplied. Once the Member resigns or retires, this benefit is no longer claimable. A Member absent from duty on approved sick leave without pay is not required to pay subscriptions in respect of any complete fortnight of absence for which a salary payment is not received. Persons in receipt of this benefit may continue to apply for other mandatory benefits for up to 12 months from the start of the period of approved sick leave without pay. This benefit is not applicable to employees who have sick leave with pay available. Members who return to work on reduced hours cannot claim this benefit. A Member receiving payments under the Accident Compensation Act 2001 (ACC) is not entitled to this benefit, except for the first week of a non-work related accident if salary is not received. Members on maternity or parental leave, teacher trainees, relieving teachers and Members who are free to take up other employment cannot apply for this benefit.
BIRTH GRANT			
	$200 for each live child born to a Member or their partner/ $200 for each child adopted by a Member or their partner.	12 months	An adoptive parent may claim this benefit. Claims must be supported by an original or certified copy of the child's birth certificate or a statement of adoption issued by the adoption agency or solicitor.

Health Care Service or Benefit	Benefit Maximums	Waiting Periods	Other Terms and Conditions
BEREAVEMENT GRANT			
	$1,000 on the death of an Insured Adult or child (including still birth).	3 months	Where the Member dies, the benefit is payable to the surviving partner or to the person who is the accredited next of kin. In the event that the deceased has no accredited next of kin a discretionary application may be made by the person responsible for the funeral expenses and arrangements (a supporting letter is required from the solicitor). It should be noted that the benefit is not payable to an estate. All applications must be supported by the original or a certified copy of the death certificate or an original newspaper notice.
Approved Hospital Cover Policy			
Members may be eligible for a full or partial reimbursement of hospital treatment, diagnostic tests or specialist consultations included in this policy if they have a HealthCarePlus linked and Approved Hospital Cover policy.			
Excess Reimbursement – Hospital Treatment			
If Members claim under an Approved Hospital Cover policy for hospital treatment (as outlined in the Hospital Treatment section) and an Excess applies, then they may submit a claim for the Excess reimbursement available under this policy. Excess reimbursement related to oral surgery is not available under this policy. The Excess reimbursement is calculated based upon the value of the claims submitted to the Hospital Cover provider. For Hospital Cover claims submitted which are greater than $1,000, the Excess reimbursable is the actual Excess paid up to a maximum of $500. For example; a Member has a hip operation in a private hospital. It costs $25,000 and they claim this from their Hospital Cover provider and pay their Excess of $500. They then claim their Excess from their HealthCarePlus policy and are reimbursed $500. For Hospital Cover claims of less than $1,000 the reimbursement will be 50% of the actual claim submitted, provided that this amount is not greater than the Excess paid (in which case the Excess reimbursement will be the actual Excess paid). For example a Member requires a minor operation performed by a dermatologist, which costs $800. Their Hospital Cover provider deducts their Excess of $500 from the amount charged, paying the Member $300. The Member claims their $500 Excess from their HealthCarePlus policy and are reimbursed $400 (i.e. 50% of $800[3]).			

3 Health Funds Association of New Zealand – Fact File, Health Insurance in New Zealand, 2013.

How to claim

We recommend that you read this section before you submit your claim.

If you have any further questions you can contact us on **0800 600 666** Monday – Friday, 8 am – 5 pm.

Online claiming – it's easy

You can submit a claim by emailing the claim to claims@unimed.co.nz. Simply download and complete the claim form. Attach to an email along with your scanned or photographed receipts and submit your claim – it's that easy.

All sections of the claim form must be completed to avoid delays in processing your claim.

Please make sure that all scanned or photographed receipts are legible and are itemised, showing the date of treatment, treatment provider, patient treated, description of health services received and fees charged.

A receipt for $100 or more must be accompanied by an itemised account. UniMed will not accept EFTPOS, cash register receipts, credit card receipts or Income Support Services Reports. You are required to retain your original receipts until claim settlement in the event they are required to assess your claim.

The Member is required to submit the claim on behalf of all Members on the policy. Claims are paid by direct credit into the Member's nominated bank account.

Payments received by Members are not subject to income tax and are inclusive of GST.

Please note the minimum amount that will be processed for any claim is $10.

Posting your claim

Download a claim form from the website, fill it in, attach your original receipts to the claim form and then post it to UniMed. If you do not have website access, please call **0800 600 666** and we will post a claim form out to you.

The same conditions for online claims (as specified opposite) apply to claims submitted by post.

How long do I have to claim?

It is recommended that all claims are lodged promptly after a Member uses or receives the relevant eligible healthcare services.

Other considerations applying to particular claims

Sick leave without pay

Members receiving the Sick Leave Without Pay Grant are eligible for all benefits until contributions resume, up to a maximum of 12 months from the start of approved sick leave without pay.

Parental leave

Members on maternity or parental leave who do not pay contributions in advance may apply for the Birth Grant (and Bereavement Grant if the child dies) but eligibility for all other benefits ceases until contributions recommence and the requisite Waiting Periods have been observed.

Claims from outside New Zealand

Costs incurred outside New Zealand are ineligible except for any Member on approved overseas exchange or study leave who continues to have NZ$ salary paid to them and continues to make contributions for their HealthCarePlus policy. Costs within the country of exchange only are eligible. Claims must be supported by a letter from the Member's pay office confirming the country of exchange and the start and finish date of approved overseas exchange or study leave.

Events claimable from any other source

Reimbursement must be claimed from other sources first. Copies of receipts/accounts must support claims. All claims must be accompanied by evidence of the amount received from the other society/provider.

Note: When submitting a copy of the list of events claimed from another society/provider with a HealthCarePlus claim form, this will reduce form filling, as it is not necessary to complete these same details on your HealthCarePlus claim form.

Claims subject to the Accident Compensation Corporation (ACC), Work and Income, Ministry of Health, Ministry of Social Development, Ministry of Justice, other government refunds or assistance must be settled before applying to HealthCarePlus. In these cases a maximum of 50% of the balance less other medical insurance refunds will be paid.

No Member may receive an aggregated refund of more than 100% of original costs.

Other conditions for the orthodontic benefit

Please refer to the orthodontic guidelines available on the HealthCarePlus website.

Exclusions – what you are not covered for

These are expenses or items that are not covered and will not be reimbursed by your HealthCarePlus policy.

The following items are excluded from coverage:

- Excesses charged from other insurers (apart from reimbursement of Excesses on HealthCarePlus Approved Hospital Cover policies linked to a HealthCarePlus Primary Care or Primary Care Extra policy).

Expenses arising from and/or associated with the following treatments or activities are excluded:

- Oral surgery
- Dental or periodontal treatment
- Pregnancy and birth
- Accommodation and travel related expenses
- Food supplements
- Non-health related consultations e.g. examinations for employment, insurance purposes or drivers' licences
- Preventative treatment/vaccinations
- Cosmetic surgery/treatment
- Over the counter medication
- Consumables, accessories, replacement parts or repairs
- Treatment and expenses incurred outside of New Zealand (refer to paragraph entitled "Claims from outside New Zealand")
- Any treatment or benefit that is not specifically included in the Coverage Table
- Hire fees

Please call **0800 600 666** Monday – Friday 8 am – 5 pm for further information on restrictions.

Who can join?

An applicant for cover must be a financial member of, or be employed by one of the following participating unions:

- TEU: Tertiary Institutes Allied Staff Association Incorporated
- NZEI: New Zealand Educational Institute Incorporated Te Riu Roa Incorporated
- PPTA: New Zealand Post Primary Teachers' Association Incorporated
- TIASA: Tertiary Institutes Allied Staff Association Incorporated
- PSA: NZ Public Service Association Te Pukenga Here Tikanga Mahi Incorporated
- ISEA: The Independent Schools Education Association

A former employee of a participating union who is a financial member of a participating union is eligible to take out a HealthCarePlus policy.

An applicant who is linked through 'Family/ Whanau' Membership* is eligible to take out a HealthCarePlus policy.

Once the applicant is admitted as a Member to HealthCarePlus, the Member must advise any change to union status.

Membership

The Member must include a partner and/or children and pay the appropriate premium in order to apply for benefits for them.

A parent or other adult who is not recognised as the Member's partner, cannot be included in the policy as a partner for the purpose of obtaining benefits as a family.

Dependent children included in a policy are eligible for benefits up to the end of the year in which they become 21 to 31 December in any year.

Note: students, although living with a parent, may be eligible for the Community Services Card and this should be used where appropriate before claiming HealthCarePlus policy benefits.

Over 21 year olds may continue to enjoy HealthCarePlus policy benefits by moving to a non-union premium rate.

To discuss these options, call **0800 600 666**
Monday – Friday 8 am to 5 pm.

Special Membership categories

Applicants who do not meet the above requirements can be admitted with approval as follows:

Trainee Teachers

Trainee teachers need to provide an annual declaration that they still qualify for and are a current member of a participating union. If not, their membership will terminate at the end of the period when they no longer meet the eligibility requirements of their qualifying union. Trainee teachers qualify for union member rates.

*Family/Whanau

Family or Whanau is defined as a family member residing in the household of a HealthCarePlus Member, or an ex- partner of a Member, or a child of a Member who is over 21 years of age.
The HealthCarePlus Member must be a financial member of, or be employed by a recognised organisation. Such a person, who is linked as Family/ Whanau, can be a HealthCarePlus Member by paying for the policy under their own name at a non-union rate.

Payment of Premiums

Members will be notified in writing of changes made to the level of premiums (or contributions).

If you are in the education sector payment can be made by fortnightly salary deductions.

Note **Salary deduction is not available to PSA members, or anyone not in the education sector, ie; Family/Whanau, or Trainee Teachers.**

Fortnightly, monthly and annual direct debit / credit card options are available to all Members.

Fortnightly direct debits are deducted every second Wednesday in conjunction with payroll dates. Monthly and annual direct debits are deducted on the first business day of the month.

Premiums received may not be refunded.

Managing your Membership

Continuing your Membership when circumstances change

Life can be unpredictable so it's good to know that HealthCarePlus has options that enable you and your family to maintain your Membership when your circumstances change.

These life events can include:

- Starting a family
- A change in career
- Travelling overseas for an extended period
- Relationship break-ups and new relationships
- Children reaching 21
- Retirement

HealthCarePlus Members and their families can continue their coverage, when their circumstances change, and they are no longer Members of a qualifying union. They will simply move to the non-union Member premium rate.

In order to continue to enjoy lower premiums some Members may elect to remain in their union, through associate union Membership.

Honorary/Associate or Retired Member

Members can continue paying contributions to HealthCarePlus provided they either:

- become an Honorary or Associate Member of a participating union or,
- choose to continue as a non-union Member and pay the non-union Member premium rate.

Relieving Teacher/Support Staff

Irregular salary payments make it impossible for some Members to maintain their eligibility for HealthCarePlus benefits. Long-term relievers are also disadvantaged when salary ceases at vacation time. To ensure continuous eligibility for benefits premiums can be paid in advance or by regular monthly direct debits.

Leave Without Pay

Where leave without pay has been approved for a specific period up to 12 months, a Member may pay HealthCarePlus premiums for the full period in advance before leave commences or may choose to pay monthly by bank direct debit if leave is more than 6 months.

Members who do not pay in advance to cover periods of approved leave without pay must re-serve the requisite Waiting Periods when payments for your HealthCarePlus policy resume (except for those Members who have suspended Membership whilst overseas).

Overseas Suspension of Membership

HealthCarePlus Membership can be suspended for a maximum period of 12 months if a Member is travelling overseas for 3 months or more. Written/Email confirmation is required.

Waiting Periods for benefits must be again observed after any break in the payment of premiums (except for those Members who resume within 12 months of the start of approved sick leave without pay/have suspended Membership whilst overseas).

Changing your policy

Members may choose to increase their range of Benefits by moving from one policy to another, provided that:

- All family Members are covered in the same policy and
- The appropriate premium is paid

Members who elect to change their policy will serve the Waiting Period applicable for all benefits that are not included in their current policy. These additional Waiting Periods apply over and above the standard Waiting Periods for their current policy and from the date of the first premium payment on the new policy rate.

For details on the Waiting Periods refer to the Table of Coverage for the respective policy. All policy wordings may be viewed and downloaded from the website www.healthcareplus.org.nz or www.unimed.co.nz

Cancelling your Membership

If you are joining HealthCarePlus for the first time and are not satisfied with the policy during the first 30 days after the date you have received this policy document and your Membership Certificate, you can cancel the policy and we will provide a full refund of all premiums paid. You can only do this if no claim has been made under the policy during this period by you or in respect to any other Members insured by your policy. If you wish to cancel the policy within the 30 day period please contact us.

You can cancel your policy at any other time thereafter but if you do so you will not be entitled to a refund of any premium already paid to us and you will remain liable for premium due up to the date the cancellation takes effect. Cover will be provided until the date the policy is paid to.

Cancellation of a HealthCarePlus Primary Care Membership must be advised in writing/email to UniMed.

For cancellation of an Approved Hospital Cover policy not underwritten by UniMed; please call **0800 268 3763** (Monday – Friday 8.30 am – 5 pm)

Complaints Procedure

At UniMed we strive to provide excellent customer service and empathetic support to our Members. However occasionally things can go wrong or a Member is unhappy with a decision we have made.

Our Complaints Process provides the opportunity to provide feedback, seek review of a decision or request an alternative action.

As a Member of the Insurance & Financial Services Ombudman Scheme, Members who remain unhappy at the end of the Complaints Process can request a Letter of Deadlock in order to access the IFSO's services.

If you have made a complaint, we recommend that you contact us on 0800 600 666 Monday to Friday 8 am to 5 pm.

The Complaints Process varies depending on the type of complaint that you have. We will acknowledge your complaint by the end of the next business day and will respond fully once all information has been gathered and a full review has taken place. Please be aware that in some cases this process can take some time, especially if we have to seek information from third parties such as doctors or business partners.

Please also review our complaint procedures detailed on www.unimed.co.nz. It sets out the complaints procedure to follow if it relates to:

- Claims Decision
- Administration Decision, or
- Premium Payment

Privacy Statement

UniMed is committed to respecting the privacy of our Members and their personal information.

We understand the need to safeguard your personal information and the importance of our obligations under the Privacy Act 1993.

Collection & Usage of personal information

UniMed directly collects personal information when:

- you apply to become a UniMed member.
- you become a member as part of a workplace scheme.
- you use the UniMed member self-service portal.

Information held may include (but is not limited to):

- name, address, contact details, date of birth and email address.
- payment details and history.
- Current or past private health insurance coverage including level of cover and claims made.
- Health information including pre-existing information.
- Employment details where the policy is connected to a workplace scheme.

UniMed holds this information to:

- consider eligibility for cover under a policy.
- consider the specific terms applying to a policy (including any pre-existing conditions).
- Administer the policy and membership with UniMed.
- Determine whether any benefit is eligible for cover under a policy.
- process, investigate, and review any claims made and/or paid.
- Credit control.
- Prevent, detect, and investigate any instances of fraud.

UniMed may disclose your information to:

- The policyholder (or husband / wife / partner if also covered) or to individuals to whom the policyholder has granted authority to act on their behalf.
- Relevant health service providers of approved facilities.
- Any third party authorised by the policy holder or adult dependent.
- An advisor associated with the policy (including the disclosure of health information).
- A group administrator (if part of a work scheme) for the purpose of premium administration or verification of eligibility to be part of a work scheme (excludes the disclosure of health information).
- A previous underwriter of your health policy (that UniMed has taken over).
- Allow third party providers of other products and services to contact you where those third parties have a business relationship or other association with UniMed.
- Any other party in accordance with the law.

Where an adviser, broker or other sales agent is associated with you policy, either directly or via a current or previous group insurance scheme or as a previous underwriter of your health policy (that UniMed has taken over), you consent to the disclosure of the information to that adviser, broker, or sales agent to enable the adviser, broker, or sales agent to carry out transactions with you and UniMed, perform customer advocacy with UniMed, and generally to deal with UniMed in relation to your policy.

Is your information correct?

Any person about whom we hold information has rights under the Privacy Act to request any part of their private or health information held by UniMed. Prompt notification by phone or by email of any changes to contact details will help us ensure that all information UniMed holds is complete and up to date, and that we send correspondence to the correct address. Wherever possible, please provide a personal email address.

If you do not provide us with your information

If the information provided to UniMed is not accurate or complete, we may not be able to process the application or claim and it may result in UniMed not being able to provide cover until such information is provided. The consequences of providing incomplete, false, or misleading information are set out in the UniMed Conditions of Membership.

Is your information secure?

UniMed takes reasonable steps to ensure that all personal information is kept secure. We protect the privacy and security of the personal information we hold through the use of security access, firewalls, encryption, and computer security systems. UniMed has physical, electronic, and procedural safeguards to protect members' personal information which is held by us, and access to information stored electronically is restricted to staff whose positions require access to this. We may also use third party data storage providers and servers to store personal information.

Do you need more information?

Personal information is collected and held by Union Medical Benefits Society Ltd (UniMed), 165 Gloucester Street, Christchurch 8011. For further information regarding this privacy statement or to discuss the steps that have been taken to protect personal information and privacy, contact our Privacy Officer by calling 0800 600 666 or by emailing feedback@unimed.co.nz

Changes to this privacy statement

UniMed reserves the right to change this privacy statement from time to time. This privacy statement was last updated in December 2017.

Definitions

These are terms used in this Policy Wording that are defined to provide clarity.

Benefit Maximum or Entitlement The maximum, total (or aggregate) sum that will be reimbursed for the specified period relating to the health care services or benefit outlined in the Benefit Section. Note: in some cases Sub-limits will apply.

Business Day This means a day that is not a Saturday, Sunday or public holiday in Auckland, Wellington, or Christchurch, New Zealand.

Benefit Section This is a category of health care services or benefits that have a common Benefit Maximum. For example, Optical.

Calendar Year A 12-month period starting 1st of January and ending 31 December.

Family/Whanau Family or Whanau is defined as a family member residing in the household of a Member, or an ex-partner of a Member (including a deceased Member), or a child of a Member who is over 18 years of age.

HealthCarePlus The trading name for The Education Benevolent Society Incorporated.

Insured Adult A Member who is aged 18 (and over) and not registered as an Insured Child on the policy.

Insured Child A registered dependant child who is aged under 21 and 21 year olds up until the end of the year in which they turn 21 years of age, ie 31 December.

Member The person who is eligible to join HealthCarePlus and is responsible for the payment of all premiums associated with the Members on their HealthCarePlus policy.

Note: Although the Member is responsible for payment of premiums, a family member may elect to pay the premiums on behalf of the Member.

Membership All persons insured by HealthCarePlus under the same Primary Care policy.

Participating Union Members of: NZEI, PPTA, ISEA, TIASA, PSA and Tertiary Education Union

Registered Medical Practitioner A person who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or any subsequent Acts) and is a Member of the appropriate registration body.

Registered Medical Specialist A Registered Medical Practitioner who is a Member of an appropriately recognised specialist college and has authority granted under the Health Practitioners Competence Assurance Act 2003 (or any subsequent Acts) to perform that health service and has Medical Council of New Zealand vocational registration for that health service.

Sub-limit This is a limit that applies to a specific health care service or benefit within a Benefit Section. For example a prescription limit of $10 per item.

The Board The Board of Directors of The Education Benevolent Society Incorporated. (trading as HealthCarePlus).

Trainee Teacher Is a student that is; registered with and studying at a tertiary education institution, to become a teacher, and who is a current and eligible member of a participating union.

Waiting Period/Qualifying Period This is the minimum period that all Members on a policy must have been continuously insured (with premiums fully paid) before they are eligible to claim. Benefits may be claimed for events that occur after the Waiting Period has been completed in full.

"We" or "Us" Refers to The Education Benevolent Society Incorporated. trading as HealthCarePlus.

"You" or "Your" Refers to the Member or their insurance policy.

HealthCare
It's good to belong

HealthCarePlus services and claims:

0800 600 666
Ph: 03 365 4048
Fax: 03 365 4066

Queries: members@unimed.co.nz

Claims: claims@unimed.co.nz

Download forms at: healthcareplus.org.nz

or unimed.co.nz/important-documents

Monday - Friday 8 am - 5 pm

HealthCarePlus Representative line:

0800 268 3763

Monday - Friday 8 am - 5 pm

Remember, the sooner you join,
the sooner we can help you pay for
your day-to-day health costs.