HEALTH PLAN DOCUMENT

Day to Day

Here's all you need to know

UniMed

Welcome to Day to Day

Thank you for choosing Day to Day.

We want you to understand your *policy* and be confident in your health insurance cover, so please read this document carefully. You must provide true, correct, and complete information about yourself and any additional *Members* when setting up this policy and when making any changes.

This Health Plan was previously issued under the Accuro brand. Accuro is becoming UniMed. You will still see reference to Accuro as we transition.

Please note that the terms and conditions for this Health Plan are included within this document. The general UniMed terms and conditions do not apply to this Health Plan.

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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.

Day to Day at a glance

Health Plan document

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Policy Certificate

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

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

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

Extra care and support

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

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

Terms used in this document

We've explained some common health insurance terms. Words printed in italics are key terms as defined in the glossary on pages 14 to 15. Key terms only appear in italics the first time they are used.

'We' and 'us' means UniMed.

'You' means the Primary Member (the policy holder) and may include all other individuals attached to your policy as additional Members.

The Day to Day cover and benefits

The following benefits apply to your Day to Day Health Plan, which provides a maximum limit of $600 per person in a *policy year*. Please take the time to read over the benefits and if you have any queries please get in contact with us. For further information on other Member offers, please visit Accuro's website accuro.co.nz/memberbenefits

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

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

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

This benefit covers the costs of a consultation with a *registered medical specialist* when referred by a registered medical practitioner.

Mental Health consultations — $100 first visit, $40 follow up visit

This benefit covers the costs of consultations with a psychiatrist, psychologist, psychotherapist or counsellor. They must be registered either under the psychiatry scope with the Medical Council of New Zealand, as a psychologist with the New Zealand Psychologists Board, as a psychotherapist with the Psychotherapists Board of Aotearoa New Zealand, or as a counsellor with the New Zealand Association of Counsellors or other relevant association.

Prescription drugs — $100 in a year

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

Imaging and private hospital fees — $600 in a year

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

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

Registered health practitioner treatments — $150 in a year

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

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

Health surveillance test — $100 in a year

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

Flu vaccination — $45 in a year

This benefit covers the cost of a flu vaccination.

Optical and dentistry **$150 in a year**

This benefit covers the cost of:

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

What's not covered (exclusions)

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

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

Health conditions we don't cover

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

- Any condition connected with the use of non-prescription drugs
- AIDS or HIV infection or any condition arising from the presence of AIDS, HIV infection or sexually transmitted diseases
- Pregnancy, childbirth, miscarriage, or any associated conditions or complications for the mother, or foetus or child
- Treatment, investigation, and diagnosis of infertility and assisted reproduction
- Sterilisation or contraception of any kind, or intrauterine devices (except a Mirena when used for medical reasons)
- Termination of pregnancy

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

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

- *Cosmetic procedures* or other enhancement or appearance medicine as defined by us
- Procedures or treatment relating to obesity or weight loss, performed for any reason
- Breast reduction or treatment of gynaecomastia, regardless of whether *medically necessary*
- Gender affirmation surgery/treatment or *gender dysphoria*
- Any investigation or treatment for sleep disturbances, snoring, or sleep apnoea
- Circumcision, except where medically necessary
- Any expense recoverable from a third party or insurance or any statutory scheme or any government-funded scheme or agent (for example, *ACC*)
- Any medical costs declined by ACC if injury is caused by an *accident* outside New Zealand
- Any medical costs incurred outside New Zealand
- Medical mishap or misadventure
- Charges for a treatment or procedure that is provided by a registered medical practitioner practising outside his or her scope of practice
- Any costs not specifically provided for under a benefit section outlined in the policy

Other expenses and costs we don't cover

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

- Any costs not specifically related to the consultation or treatment such as administration costs or statement fees
- Disability or illness arising from misuse of alcohol, drugs, participation in a criminal act, or intentional self-injury
- Attempted suicide or suicide within 13 months from the start date of the policy

How to make a claim after treatment

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

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

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

Collect a claim form

You'll need to complete a claim form. On Accuro's website you can find the claim form or submit a claim through the Member portal, or we can post or email a copy to you. The Primary Member must sign this form and so must the patient if they are over 16 years of age.

Collect invoices or receipts

Include all invoices or receipts with your claim.

Submit your claim

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

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

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

Things to remember

We can only accept and provide cover for costs:

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

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

General conditions of your policy

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

How policy benefit limits affect your claim

Unless specifically stated in this Health Plan 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 Members covered by the policy. The maximum amount for each benefit that you can claim is set out in the 'The Day to Day cover and benefits' section of this Health Plan document.

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

Please note that we do not cover excess that is applicable for another insurance plan, whether it be another UniMed Health Plan or one from another insurer.

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

We don't cover claims covered by ACC

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

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

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

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

If ACC agrees to partially pay

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

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

If ACC declines cover

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

If ACC refuses cover or cover stops

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

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

There is a 30-day *No-claiming period* that applies to all Members on the Health Plan. You're not covered for any events that happen during this No-claiming period.

If you have the Day to Day free cover for 12 months and then carry on with your Day to Day policy after the free cover has finished, the 30-day No-claiming period will not apply.

You must pay your policy's premium

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

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

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

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

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

We may increase your premium at any time

We may apply a general premium increase and other changes to premiums at any time. The premiums and discounts for your Day to Day Health Plans are not guaranteed. We reserve the right to review and adjust premiums and discounts at our discretion to make sure our policies and Health Plan 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 cover and make sure it's right for you.

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

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

Adding additional Members to the policy

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

Cover for an additional Member begins from the start date listed on the policy certificate that has the additional Member listed as covered.

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

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

If you have three or more Children on your policy, you only pay premiums for the first two Children as long as the Health Plan selected is the same for each Child. All Children will remain on Child rates up to 25 years old.

How do I remove additional Members from my policy?

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

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

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

How can a policy end?

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

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

Suspending your policy

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

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

- Travelling overseas for a period longer than 2 months (maximum length of suspension is 24 months)
- Taking maternity leave (maximum length of suspension is 12 months)
- Being registered as unemployed for a period longer than 2 months (maximum length of suspension is 12 months)
- Being made redundant or suffering financial hardship (maximum length of suspension is 12 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 additional Member on your policy who is suspended at the time an event occurs.

The Primary Member or additional Member 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 additional Members have on the policy.

Cancelling your policy

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

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

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

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

When you cancel the policy or cover for an additional Member, 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 Health Plan document

This Health Plan document may change from time to time according to prevailing conditions and policies, and at the discretion of UniMed. This is to make sure that the cover provided reflects current trends and is commercially sustainable. We'll do our best to give reasonable notice (at least 21 days) before any changes. You may cancel the policy at any time (see 'How can a policy end?' on page 9).

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

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

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

Privacy statement — we're committed to respecting your privacy

Personal and health information is collected and held by UniMed in accordance with the Privacy Act 2020 and Health Information Privacy Code 2020.

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

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

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:

UniMed
PO Box 10075
Wellington 6140

Or you can download a copy of UniMed's annual report from the UniMed webiste unimed.co.nz.

Membership of the Society

This Health Plan is insured and underwritten by Union Medical Benefits Society (UniMed). 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 Health Plan document, we may refer to you as the Primary Member and all other individuals attached to your policy as additional Members. 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 Primary Member and all additional Members. You must disclose all previous medical history in the health declaration on the application form. The Primary Member must sign the form, as well as any additional Members 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 Health Plan document and current at the time of claim
- the rules of the Society.

All Members are bound by and subject to the rules of the UniMed Society and this Health Plan 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 at unimed.co.nz/important-documents/

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 Health Plan 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 make a claim, or make changes to your policy.

Phone: 0800 222 876

Email: info@accuro.co.nz
Web: www.accuro.co.nz

Post: UniMed
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 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 customer service, care, and support to our Members, so if you have a concern, please let us know. We will work with you to resolve your concerns as quickly as we can.

We are always working on ways to improve your customer experience. You can email your feedback to feedback@accuro.co.nz.

Complaints

If you are unhappy with a claim decision, or you wish to make a complaint, please contact us. Please also provide us with any information or documentation that supports your complaint.

We encourage complaints to be made in writing by using the feedback form on Accuro's website, or you can email us at feedback@accuro.co.nz.

When we receive your complaint or request to review a claim decision, we will 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.

UniMed will acknowledge receipt of your complaint as soon as possible, usually within two business days of receipt.

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

Please see accuro.co.nz/contact for a full copy of our complaints process, or you can request a copy from us.

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
- 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** was a brand owned, operated and underwritten by Union Medical Benefits Society (UniMed). Accuro is becoming UniMed.

benefit means the reimbursement available for Members for specific types of expenses as specified in this Health Plan document, including grants.

Child/Children means a Member's child (including any stepchild, adopted child or whāngai) who has been accepted as an additional Member on the policy before the age of 25 years.

claim means the request by a Member to have their costs refunded as described in this Health Plan document, providing the Member is eligible.

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

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

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

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

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

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

Member means a person who has been accepted as a Member of UniMed, who is named on the policy certificate and for whom premiums for are currently being paid to UniMed. This could the Primary Member or their partner, parent, child or whāngai. It doesn't include generic use of the word 'member' or 'members' when referring to members of families, associations, or our Member portal on Accuro's website.

No-claiming period means the period of 30 days after the start date or, in the case of an additional Member added to a policy, 30 days after the date on which that additional Member is added. You cannot claim on events that happen during the No-claiming period.

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

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

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

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

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

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

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

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

Reasonable 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
- holds a vocational scope of practice.

This does not include those holding Medical Council of New Zealand registration for:

- accident and medical practice
- emergency medicine
- family planning and reproductive health
- general practice
- medical administration
- public health medicine
- sexual health medicine
- urgent care.

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

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

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

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

UniMed means Union Medical Benefits Society Ltd 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 an additional Member on the policy. A whāngai is considered a Child under this policy.

UniMed