Real Value Plan Hospital Cover

UniMed

Standard benefits

General surgery in an accredited private hospital - excess applies

This *benefit* covers the costs of reasonable charges up to a maximum of $150,000 per *claim* for the surgical treatment of a non-acute medical condition. A *claim* is the aggregation of all costs associated with the initial procedure and all subsequent eligible treatment or expenses. 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
- Surgeon's fees
- Anaesthetist's fees
- Costs of essential prostheses listed in the *Accuro* schedule
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist *benefit* below provided they occur within six months of 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, culdoscopy and arthroscopy.

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

This benefit includes:

Spinal Surgery

This *benefit* covers the costs of spinal surgeries. You can *claim* this *benefit* as needed but it only provides cover up to $200,000 for each person over their lifetime. A list of all spinal surgeries which fall under this *benefit* can be found under the Resource page on the *Accuro* website.

Major diagnostic procedures

This *benefit* covers the costs of reasonable charges of diagnostic procedures for angiograms, MRI scans, CT scans, CAT scans, MP scans, PET scans, and myelograms (if general anaesthetic is required), whether or not you're admitted to a private 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 Health Plan.

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 Health Plan.

Prophylactic surgery - excess applies

This *benefit* covers up to $60,000 for each person for 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 $60,000 for each person over their lifetime.

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

Specialist – consultations, tests and related costs **No cover**

You have selected to not have Specialist cover. If you would like to add this to your *policy*, please contact us. Please note that underwriting will apply.

Mental health

This *benefit* covers the costs of reasonable charges up to $1,000 per person per policy year for 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.

Private hospital medical admission - excess applies

This *benefit* covers the costs of reasonable charges associated with admission to a private hospital for reasons other than surgery up to a maximum of $100,000 per person per *policy* year. Non-surgical cancer treatment is covered to a maximum of $60,000 per person per *policy* year.

Admissions do not cover convalescence, recovery, obstetrics or psychiatric and/or psychological treatment or counselling, geriatric, senile and recurrent or on-going health conditions.

Please note that any palliative care treatment is not covered as per the Real Value Plan Hospital Cover's terms and conditions.

Post-operative therapy

This *benefit* covers up to $1,000 per event towards costs associated with post-operative therapy that is provided within 12 months following a related surgery, cycle of chemotherapy or radiation treatment that we've approved under this *policy*. This includes:

- Occupational therapy
- Physiotherapy
- Speech and language therapy
- Osteopathy
- Chiropractic treatment
- Dietitian/Nutritionist consultations
- Lymphedema physiotherapy

You must be treated by a New Zealand-registered health or medical practitioner with a current practising certificate who is registered with their professional association. The treatment must occur and be completed within 12 months after the event date of your surgery or treatment. This doesn't include costs for personal items such as food/food substitutes, materials or garments.

Minor surgery - excess applies

This *benefit* covers up to a maximum of $200 per event (consultations and materials are not covered) when performed by a New Zealand registered medical practitioner in private practice. The invoice must clearly indicate the procedure.

Public hospital benefit

This *benefit* provides $100 per night up to a maximum of $500 per person per *policy* year for any public hospital stay of a *Member* for three or more consecutive nights. The *benefit* does not apply to a private fee-paying patient in a public hospital or private wing of a public hospital.

Overseas treatment - excess applies

This *benefit* covers reimbursement up to $20,000 per person per *policy* year of reasonable charges for a surgical procedure/treatment performed at an overseas hospital and travel to and from, where the procedure isn't available in New Zealand.

To qualify for this *benefit* , the *Member* must:

- be in New Zealand when they are diagnosis and they must not have started an appropriate medical process in New Zealand
- request a surgical procedure or treatment that is medically necessary and is not experimental or being trialled
- get the surgical procedure or treatment pre-approved by us
- make sure the procedure meets all Health Plan criteria including being subject to all excess, reasonable charges, maximums and exclusions described elsewhere in this Health Plan or under the Real Value Plan Hospital Cover's terms and conditions.

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. Please also provide the invoices and receipts for travel.

Sterilisation - excess applies

After three years of continuous cover this *benefit* will cover reimbursement up to a maximum of $3,000 per person per policy year towards the cost of reasonable charges for a sterilisation procedure carried out on a *Member*, where the procedure is necessary in the interest of the physical health of that *Member*.

This procedure must be recommended by a registered medical specialist.

Oral surgery - excess applies

This *benefit* covers the costs of reasonable charges up to $150,000 per person per *policy* year for oral or maxillofacial surgery listed below:

- Surgical removal of impacted or unerupted teeth carried out after a *Member* has been covered by the Health Plan for at least 12 months.
- Surgical removal of cysts, soft tissue swellings and other medical (not dental) problems of the mouth that require major surgical intervention.
- Surgical drainage of abscesses.
- Pre-operative and post-operative diagnostics, consultations, or tests as described in the specialist *benefit* provided they occur within six months of the approved surgery.

This *benefit* does not cover orthodontic, periodontal, orthognathic or endodontic treatment, as well as crowns, dental plates, root canals, other extractions, tooth exposures or implants.

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 additional *Member* 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.

Travel expenses

This *benefit* covers travel expenses as described below if required and is included in the aggregation for the maximum *benefit* limit. These costs must directly relate to a private hospitalisation under this Health Plan. Pre-operative and post-operative consultations/treatments do not qualify. Payment will be made by reimbursement on evidence of expenses.

- **Ambulance transfer**
  Where an air or road ambulance transfer to or from a private or public hospital within New Zealand has been authorised by a registered medical specialist, we will reimburse the cost provided the original admission to hospital as a private fee-paying patient was pre-approved by *UniMed*.
- **Transport costs**
  If the condition cannot be treated locally and the *Member* is required to travel by air, road or rail, we will pay either return public transport costs (economy airfares, bus fares or train fares) or return road travel to the place of hospitalisation within New Zealand. The refund for road travel is calculated on the mileage travelled at $0.30 per km. In addition, a taxi fare from the airport/station to the private hospital and return for the *Member* if required, is also covered.
- **Support person travel and accommodation costs**
  In the above circumstances where the condition cannot be treated locally, similar travel costs will be available for a support person, if this is recommended by a registered specialist, plus accommodation costs not exceeding $100 per night for up to five nights or the period the *Member* is in hospital, whichever is shorter.

Special benefits and grants - 100% refund

- ### Sick leave without pay benefit
  $100 per week to a maximum of $600 per *policy* year
  Before you are eligible to *claim* under this *benefit*, you (the *Member*) would need to be sick for five consecutive working days and have exhausted your sick leave entitlement at your current employment. A medical certificate and written confirmation that there is no valid sick leave with pay left from your employer are required to support every *claim*.
- ### Bereavement grant
  $2,500 payment
  We will pay a bereavement grant on the death of any *Member* covered under the *policy* into the bank account of the deceased *Member*'s estate. A copy of the full death certificate and proof of the executor, administrator or solicitor acting for the estate must be provided.
- ### Birth grant
  $400 payment
  We will pay a birth grant after the *Member* has contributed continuously for 12 months prior to the birth. One grant is claimable on the birth, adoption or stillbirth of a child to a *Member* on the *policy*. *Member*s aged 24 years or younger do not qualify for this *benefit*. A copy of the full birth certificate to clearly identify *parent*(s) must be provided. Adoption of a *Member*'s child from a previous relationship does not qualify.
- ### Home support benefit
  Up to $100 per week to a maximum of $600 per *policy* year
  The *Member* may *claim* $20 per day up to $100 per week. A medical certificate and confirmation of payment to the domestic assistance supplier is required. The *benefit* is payable where daily domestic assistance is essential after illness or accident.

Loyalty Benefits

Loyalty benefits allow you to use your insurance not just for treatment but to maintain good health after you've held your Real Value Plan Hospital Cover for more than 3 years.

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

For further information and other Member offers, please visit *Accuro's* website accuro.co.nz/memberbenefits

GP health check

$150 per person every three *policy* years.

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

Children aged 25 years or younger do not qualify for this *benefit*.

Melanoma

No cover

This is part of the Specialist cover, which you have selected not to have. If you would like to add Specialist cover to your *policy*, please contact us. Please note that underwriting will apply.

Bowel screening

A bowel screening kit per person, every three continuous *policy* years.

After 3 years of continuous cover, this *benefit* covers the cost of a Bowel screening kit. Please contact us if you wish to redeem this *benefit* and we'll arrange for a kit to be sent to you.

Children aged 25 years or younger do not qualify for this *benefit*.

General information

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

Acceptance into the Real Value Plan Hospital Cover entitles a *Member* to full cover as described in this Health Plan document, less the specified excess and in accordance with any special conditions stated in the *policy certificate* issued at the time of acceptance. Membership commences from the date on which the first subscription is received by *UniMed*.

- All *claims* are subject to an excess of 20% of costs to a maximum of the Health Plan excess per *Member* per *policy* year.
- All *claims* and prior approvals are based on reasonable charges for the services provided.

On receipt of the confirmation of membership from *UniMed*, you have a free-look period of 14 days in which the Health Plan may be cancelled. Any *premiums* paid will be refunded if the Health Plan is cancelled within the free-look period, provided that, during this period, no *claim* has been made in respect of any person covered by this application.

All *benefits* described in this Health Plan document are subject to the provisions described in the Real Value Plan Hospital Cover's terms and conditions of as amended from time to time and should be read in conjunction with your *policy certificate*. The general *UniMed* terms and conditions do not apply to this Health Plan.

UniMed

This Health Plan is insured and underwritten by Union Medical Benefits Society (*UniMed*). *UniMed* is the trading name for the Union Medical Health Benefits Society Limited.

Accident, treatment injuries or employment-related conditions

Accidental injury can happen at any time. In New Zealand, the Accident Compensation Corporation (ACC) covers accidents, treatment injuries and employment-related injuries, amongst other situations. Prior to any treatment costs being incurred, ACC must have first been approached and a copy of their letter of acceptance, in full or part, or declination provided to *UniMed*. In instances where ACC has declined a *claim* or only accepted part payment for injury, *UniMed* will, at its sole discretion, either assist with full or part payment if the treatment is covered under the Health Plan or require the *Member* to apply for a review and, if necessary, an appeal of the decision.

Six months' free cover for Children

A *Child* who is under 6 months of age is eligible to receive cover free of *premiums* for the first 6 months after birth. We will charge the relevant *premium* once the *Child* has reached 6 months of age. Exclusions listed under Real Value Plan Hospital Cover's terms and conditions will still apply.

Pre-existing health conditions

Only pre-existing health conditions that have been declared on the application form and accepted by *UniMed* will be covered.

General exclusions

Some situations are not covered (unless specifically provided for in the Health Plan document), for example (without limitation), general practitioners' fees; drugs and medication; cosmetic procedures and/or other enhancement/appearance medicine; medical mishap; palliative care; contraception of any kind; dental care; orthodontic, endodontic, orthognathic and periodontal treatment; psychiatric and/or psychological treatment or counselling; disability or illness arising from the misuse of alcohol or drugs; preventative healthcare treatments and services; AIDS or HIV infection; any expense recoverable from a third party under any contract of indemnity or insurance; any acute care; breast reduction; chelation therapy; long-term care; surgery or laser treatment for the correction of visual errors and astigmatism; personal health related appliances; any medical cost incurred outside New Zealand; and any cost not specifically provided for under a *benefit* section contained in the plan selected. Exclusions are subject to change. For a full list of exclusions, please see the Real Value Plan Hospital Cover's terms and conditions.

Procedure for prior approval

Prior approval is required for any event over $1,000 or where the procedure and/or medical treatment involves any hospitalisation, day-stay or in-patient care regardless of the cost. Failure to do so may prejudice the ability to *claim* for the treatment costs at a later date.

A minimum of two working days' notice is required to give *UniMed* time to do any necessary checks and send out confirmation before the procedure and/or medical treatment takes place. However, to ensure that the procedure and/or medical treatment is covered under the *Member's* Health Plan, it is recommended you contact us as soon as possible to check eligibility.

We will pay your account(s) directly to the provider. All *claims* and prior approvals are based on reasonable charges for the services provided.

Prescription drugs

Prescription drugs must be listed under section A to I of the *Pharmac Schedule*, however any drugs listed under section H of the *Pharmac Schedule* will only be covered if used during a procedure in a private facility. The *Member* must also be eligible to meet Pharmac's funding criteria.

Waiver of premium

If the *Primary Member* or *partner* (who is covered under this Health Plan) dies, we will continue to provide cover for the member-paid *premium* for the remaining *Members* covered under this Health Plan for 12 months. Other terms:

- Once notified, the waiver of *premium* will start from the date of death
- 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 benefit* ends, the *premium* payments for all remaining *Members* will be the responsibility of the *policy*'s *Primary Member*

Appropriate certificates and documentation must be provided.

Real Value Plan Hospital Cover terms and conditions

These are the terms and conditions governing the benefits available to Members as described in the Health Plan document and the rules of the Union Medical Benefits Society Limited (the Society). This Health Plan is insured and underwritten by Union Medical Benefits Society (*UniMed*). *UniMed* is the trading name for the Union Medical Health Benefits Society Limited. The terms and conditions should be read in conjunction with the Health Plan document. *UniMed* reserves the right at all times to vary these terms and conditions, however it deems appropriate. In all matters that require interpretation, *UniMed*'s decision shall be final. We will endeavour to provide reasonable notice (minimum 21 days) prior to such change. All benefits relate to private care only (including consultation, procedure and/or medical treatment or hospitalisation), unless public procedure and/or medical treatment is specified in the benefit wording.

1. Membership

1.1 Membership is available to anyone (individual or group) who is accepted by *UniMed* for membership or permitted to become a *Member* under the *rules of the society*.

1.2 A *Member* may apply to include a *partner* and/or *children/whāngai*.

1.3 *Children/whāngai* aged 25 years and over have *premiums* based on age and will automatically remain on the *policy* unless removal is requested.

1.4 *Children/whāngai* aged 25 years and over who have been included on the *policy* may apply to have their own *policy*. If they do so within 30 days of leaving the *policy*, they will not be required to be *underwritten*.

1.5 *Partners* who have been included on the *policy* of a deceased *Primary Member* may retain membership while they continue paying the appropriate *premiums*. The *partner* is then considered the *Primary Member*.

1.6 Where there is a rearrangement of a family, a separated *partner* may apply to become a *Member* in his or her own right and continue on a separate *policy*.

1.7 A *Member* may contact *us* requesting suspension of cover for the following reasons:

- Travelling overseas for a period longer than two months (maximum length of suspension – 24 months).
- Taking maternity leave (maximum length of suspension – 12 months).
- Being registered as unemployed for a period longer than two months (maximum length of suspension – 12 months).
- Being made redundant and/or suffering financial hardship (maximum length of suspension – 12 months).

Please contact us if you wish to apply to suspend your *policy* for any of the above reasons, and *we* will advise if any further documentation or evidence is required to do so.

To be eligible for suspension of cover, the following conditions must be met:

- The *Member* covered must have been covered by the *policy* for at least 12 months up to the date the suspension is to take effect.
- The *Member* must be continuously covered under the *policy* for a period of 12 months between the end of the last suspension and the *start* date of the next suspension.

We will not pay any *benefits* under the *policy* to any *Member* who is suspended in respect of any *event* occurring while cover is suspended.

2. Applications for membership

2.1 All applications for membership and subsequent alterations to a *policy* must be made in writing by completing all sections of our application form.

2.2 Full details of the *Primary Member* and all proposed *additional Members* are required.

2.3 All previous medical history must be disclosed in the health declaration on the application form.

2.4 A new *Child* is not automatically enrolled, and the *Member* must apply in writing on an application form to have a new *Child* included on the *policy*. A period of free cover is provided for a *Child* added to the *policy* at time of birth – the exact period of free cover varies between *Health Plans*.

2.5 If you have three or more *Children* on your *policy*, you only pay *premiums* for the first two *Children* as long as the *Health Plans* selected are the same for each *Child*. All *children* will remain on child rates up to 25 years old. On the anniversary following reaching 25 years, the *premium* payable will be adjusted from a child rate to that of a 25-year-old adult and they will remain on your *policy* unless you request their removal.

2.6 *We* reserve the right to exclude any declared or non-declared *pre-existing condition* from the *policy*. This applies to you and any *additional Members* at the time of application and/or during the life of the *policy*.

All symptoms and conditions, including *congenital conditions*, will be excluded from cover under the *policy* and must be disclosed at the time of application of the original *policy*. Any such exclusion(s) that you disclose will be clearly stated on the *policy certificate* and should be read in conjunction with the Health Plan document. *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.

3. Policy purpose

Your *policy* is designed to assist you with meeting the financial costs associated with your health and wellbeing.

Please refer to the Health Plan documents of the Health Plan listed on your *policy certificate* to see what your *policy* covers.

4. Commencement of membership and cover start date

4.1 Membership *starts* from the date on the *policy* issued by *us*.

4.2 On receipt of the confirmation of membership, the *Member* has a free-look period of 14 days in which the Health Plan may be declined. Any *premiums* paid will be refunded if the Health Plan is declined within the free-look period, provided that, during this period, no *claim* has been made in respect of any *Member* covered by the application.

5. Extra care and support

5.1 Some *Members* 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.

6. Premiums

6.1 *Premiums* must be maintained to ensure continuity of membership and eligibility for *benefits*.

6.2 *Claim* payments will be withheld when *premiums* are in arrears until the arrears are cleared.

6.3 Membership will be terminated when 90 days of *premiums*, or more, remain unpaid.

6.4 *We* reserves the right to deduct any outstanding *premium* when making payment for an eligible *claim*.

7. Prior approval and claims process

A *Member* must seek prior approval for any *claim* that is likely to exceed $1,000. To ensure that the *procedure and/or medical treatment* is covered under the Health Plan, it is recommended you contact us as soon as possible to check eligibility.

You also need to provide estimated charges for the *procedure and/or medical treatment*. A minimum of two working days' notice is required to give *us* time to do any necessary checks and send out confirmation before the *procedure and/or medical treatment* takes place.

Subject to the terms of the *policy*, *we* will pay all *reasonable charges* for *medically necessary* treatment up to the relevant maximum cover. If the costs of the *procedure and/or medical treatment* exceed the maximum cover or the *reasonable charges*, the difference will be the *Member's* responsibility.

7.1 *Claims* will only be accepted for costs relating to *events* that occur after the cover *start* date. For *primary plans, claims* will be accepted after the *no-claiming period* has passed.

7.2 *Claims* will not be paid when *premiums* are in arrears or when membership has ceased for any reason, irrespective of the date of an *event*.

7.3 Visits to a *registered medical specialist* must be referred by a general practitioner or dentist. A copy of the referral letter must be attached to the *claim* form.

7.4 The *Member* will, upon request from *us*, supply *medical evidence* before *we* agrees to pay any *benefits*. This right of request applies from the prior approval process to the completion of treatment. On *our* request, the *Member* will also supply *medical evidence* after the *procedure and/or medical treatment* has been concluded. *Procedure and/or medical treatment* includes application for diagnostic or screening procedures. Any costs involved in obtaining the above information will be at the *Member's* expense.

7.5 Payment is limited to the lesser of the *benefit* levels or the *reasonable charges* for any approved *procedure and/or medical treatment* at the time as solely determined by *us*, taking into account circumstances *we* consider relevant. This means *we* may negotiate with your nominated health service provider(s) or recommend alternative health service providers if the estimated cost received from your chosen provider(s) is above the *reasonable charges*.

If *we* are unable to negotiate a reduction in the cost for your *procedure and/or medical treatment* and you choose to continue with the *procedure and/or medical treatment* under your nominated health service provider(s), you will be responsible for any monetary difference between the *reasonable charges* and the cost for the *procedure and/or medical treatment*, regardless of the *benefit's* maximum cover, and must arrange for payment on this basis directly with your nominated health service provider(s).

7.6 *Benefits* are calculated on the net amount paid after deducting any refunds, subsidies or entitlements available from other sources, for example (without limitation), *ACC*, another health insurer, a government-funded agency, Work and Income or your employer.

7.7 No *Member* shall receive a *benefit* that, together with any other refunds, subsidies or entitlements, amounts to more than 100% of the actual costs incurred for any *event*.

7.8 Where relevant, the minimum or maximum amount that may be *claimed* for each *event* is set out in the Health Plan *document*.

7.9 A *Member* may request *us* to pay hospital and related accounts on his or her behalf if prior approval has been sought and obtained before entering hospital.

7.10 *Claims* for *benefits*, as listed in the Health Plan *document*, must be made on the Accuro *claim* form (relevant only for *primary plans*). The *claim* form must be fully completed and signed by the *Primary Member*. Attach all receipts to your *claim* form as proof of payment.

7.11 Prescription drugs must be listed under section A to I of the *Pharmac Schedule*, however any drugs listed under section H of the *Pharmac Schedule* will only be covered if used during a procedure in a private facility. *The Member* must also be eligible to meet Pharmac's funding criteria. If the prescription drug require special authority from *Pharmac* to be covered, we need confirmation from the *registered medical practitioner* that the *Member* does meet the special authority criteria before we can assess cover for the prescription drug cost.

8. Claims on other insurers

Where another insurer, including but not limited to *ACC*, may have responsibility in respect of a *claim* the following provisions apply:

- It is the *Member's* responsibility to advise *us* that another insurer is involved in a *claim* that has been submitted to *us*.
- Before *we* accepts a *claim* under the *policy*, the *Member* must firstly make a *claim* to the other insurer for any expense recoverable from a third Party or under any contract of indemnity or insurance. Any expenses recoverable in this way will be deducted from the reimbursement provided by *us* under the *policy*. For the purposes of the *policy, ACC* is defined as another insurer.

Claims involving ACC

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

- full payment option (*ACC* contracts a provider to provide the *procedure and/or medical treatment* and pays the total cost), or
- partial payment option (*ACC* contracts a provider to provide the treatment but only funds a portion of it).

The full payment option should be the claimant's first choice, as the claimant will not have to make any contribution towards *surgery* costs.

8.1 It is the claimant's responsibility to submit all *claims* to *ACC* in the first instance. Where *surgery* is indicated, the claimant must seek or obtain prior approval from *ACC* for *private hospital* costs.

8.2 If, due to the claimant's failure to comply with *ACC's* requirements, *ACC* refuses to cover the *claim* or ceases *claim* cover, the claimant will be deemed by *us* to not have made a reasonable effort to secure cover or maintain cover and will therefore be ineligible to *claim* under the *policy*.

8.3 If *ACC* declines *ACC* cover or declines to pay in full for *private hospital surgery*, treatment or any other relevant entitlement, for whatever reason, *we* reserves the right to insist that the claimant applies to *ACC* for a review of that decision before *we* accept any *claim*. The claimant must co-operate fully with *us* in pursuing the review or appeal. Where *ACC* reverses a decision for a previously declined *claim*, *we* reserves the right to seek reimbursement from *ACC* or the claimant for any related *claims* paid by *us*.

8.4 Where *ACC* agrees to contribute to the claimant's *private hospital* costs, *we* will cover the difference in cost between the *ACC* contribution and the usual *reasonable charges* or as specified in the Health Plan *document*. Copies of appropriate acceptance documentation from *ACC* must be provided to *us* prior to *our* acceptance of the *procedure and/or medical treatment*.

9. Cancellation of membership

9.1 Cancellation of a policy, Health Plan or additional *Member* must be requested by the ***Primary*** *Member* or designated financial advisor (if applicable).

9.2 *We* will acknowledge all requests for cancellation of membership on receipt of the request.

9.3 The date of cancellation depends on the frequency of the *premium* payments.

- If *premiums* are paid 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 *premiums* are paid 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

9.4 Membership will not be reinstated following the cancellation. This does not prevent a *Member* from applying to rejoin at a later date, but a new application must be made.

10. Other important information governing the policy

10.1 Any information the *Member* gives *us* or that is given to *us* on the *Member's* behalf when making a *claim* must be true, correct and complete. If any information given to *us* is untrue, incorrect or incomplete or if the *Member* has not told *us* about anything else that the *Member* or additional *Member* knows or a reasonable person in the circumstances would be expected to know it was relevant to *our* decision to accept a *claim*, in these instances, *we* may not pay a *claim* and *we* may void all or part of the *policy* or cancel it. If *we* have already paid the *claim*, it can recover from the *Member* the amounts paid.

10.2 All *Members* are bound by and subject to the *rules of the society*, the Health Plan document and these terms and conditions. The general *UniMed* terms and conditions do not apply to this Health Plan.

10.3 The *rules of the society* may change from time to time in accordance with the powers of amendment it contains.

10.4 A copy of the current *rules of the society* is available from *UniMed*.

10.5 These terms and conditions and the Health Plan document are subject to change in accordance with prevailing conditions and at the discretion of *UniMed*. *We* will endeavour to provide reasonable notice (minimum 21 days) prior to such change.

10.6 We reserves the right to review and adjust *premiums* and discounts at its discretion to ensure the viability of any Health Plan or grouping of *Members* on a Health Plan. *We* will endeavour to provide reasonable notice (minimum 21 days) prior to such change.

10.7 In all matters that require interpretation, *Unimed's* decision shall be final.

11. Complaints

If you are unhappy with a claim or prior approval 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 our website, or you can email us at feedback@accuro.co.nz.

When we receive your complaint or request to review a claim or prior approval 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 2 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 prior 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 our 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 prior 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: ifso.nz

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

12. Code of practice

UniMed is a member of the Financial Services Council (FSC) and such complies with the FSC Code of Conduct.

13. Legal

13.1 *UniMed* conducts all its business in accordance with the laws of New Zealand.

13.2 All currency quoted in all of *our* material is in New Zealand dollars. All *benefits* and *premiums* are GST inclusive.

13.3 The rights and obligations of the *Member* and *UniMed* are set out in the composite set comprising:

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

Exclusions

We aim to fully explain what is not covered in your *policy*. Unless specifically provided for in the Health Plan you select, *we* don'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/or neurodevelopmental disorders

We don't cover treatment or counselling for any psychiatric, psychological and/or neurodevelopmental disorders. This includes but isn't limited to:

- attention-deficit/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)

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 and/or complications for the mother or foetus/child, and all normal effects of pregnancy.
- 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 affirmation surgery/treatment or *gender dysphoria*
- Sleep disturbances, snoring, or sleep apnoea
- Robotically assisted surgery
- 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*

Glossary of key terms

Words printed in italics are key terms as defined in this 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*.

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 Health Plan document, including *grants*.

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

claim means the request by a *Member* to have their costs under their chosen Health Plan refunded as described in the Health Plan 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.

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 the Health Plan document or that may be made at our discretion.

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.

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*, who is named on the policy certificate and for whom premiums for are currently being paid to *UniMed*. This could be the *Primary Member* or their *partner, 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 90 days after the *start* date or, in the case of a *Member* added to a *policy*, 90 days after the date on which that *Member* is added during which *events* are not *claimable*.

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).

parent means a *Member's parent* who has been accepted as an additional *Member* on the *policy*.

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*, these terms and condition and the Health Plan document.

policy certificate means the most recent *policy certificate* issued to a *Member* that confirms initial acceptance or subsequent alteration to the *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.

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.

primary plans means (without limitation) the Basic Plan, Advanced Plan and Value Plus Plan.

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 and/or 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.

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 charges means charges for medical treatment that are determined by *us* in its 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 the 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.

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 an additional *Member* on the *policy*. A *whāngai* is considered a *Child* under this *policy*.