HEALTH PLAN DOCUMENT

# SmartStay

Here’s all you need to know

UniMed

# Welcome to SmartStay

Thank you for choosing SmartStay. SmartStay is the only New Zealand health insurance plan for people and their families who are in New Zealand on a work or visitor visa, providing cover in New Zealand's public and private healthcare systems.

*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 *Member* 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.**

## Contents



## Tell us about changes

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

# SmartStay at a glance

Health Plan document

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Policy Certificate

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

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

Your SmartStay 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.



## Who SmartStay is for

This SmartStay policy is for people who have come to New Zealand and are not residents or citizens, who aren't entitled to funding under New Zealand's public healthcare system. We've designed this policy to provide cover under New Zealand's public and private health systems, while complementing the services that are provided by Accident Compensation Corporation (ACC).

**The New Zealand healthcare system has three main components:**

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

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

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

## Extra care and support

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

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

# Cover may change to suit your needs

People who come to New Zealand may become eligible for publicly funded healthcare at a later stage. This may happen, for example, if you obtain a work visa that allows you to stay in New Zealand for two years or more. In order to deliver the best possible outcomes to our members, we will contact you after the end of your second policy year to see whether another policy may better suit your needs.

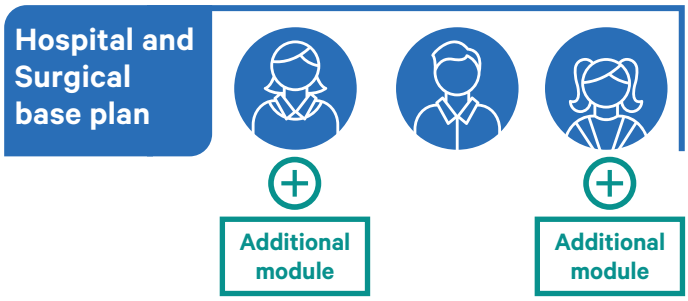
In rare situations, after a reasonable period of time, we may consider automatically transferring you to a SmartCare policy. If that occurs, we will provide you with no less than 21 days' notice of that change, including any change in premiums.

When we contact you, we will use the contact details you have most recently provided to us, so it's important to make sure you update us if they change.

# Start with the base plan and add additional modules

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

Check your policy certificate to see the additional modules and additional Members on your policy.






# Main benefits of SmartStay

| Hospital and Surgical base plan benefits: | cover for each person |
|---|---|
| General surgery | $150,000 per claim |
| Major diagnostic procedures such as CT and MRI scans | refer to benefit for limits |
| Oral surgery | $150,000 per claim |
| Private and public hospital medical admission (including chemotherapy and radiation treatment of $25,000) | $65,000 in a policy year |
| Treatment outside New Zealand | $25,000 in a policy year |

## Additional modules/Health Plan

**Specialist module**

Cover for specialist consultations and diagnostic tests.

**GP module**

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

**Day to Day Health Plan**

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

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

# Things to be aware of

- This policy covers you for treatment in New Zealand's public hospital system and the private hospital system. However, the procedure or medical treatment does need to fall under the base plan and any additional modules you select.
- If you do not give us your full medical history, then whenever you claim for a new medical condition in the first 5 years, we may need a Medical report. The general practitioner (GP) who holds your medical history needs to complete Accuro's Medical report form. If you do not have a GP in New Zealand, or your GP doesn't have your full medical history, then we recommend you get a copy of your full medical history from your previous GP. Your full medical history is from your date of birth up until today.
- If you do become eligible for cover under New Zealand's public health system at any time, let us know right away so that we can make sure that you have the right Health Plan for 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 33 to 35. 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.

For explanations of medical terms, please ask your GP or other healthcare provider, or consult the Health Navigator website at www.healthnavigator.org.nz

# The SmartStay cover and benefits

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

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

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

Your policy certificate will list any excess applicable under your Health Plan. An excess applies to the base plan or additional modules once for each person for each year they have the policy.

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



# Hospital and Surgical base plan

The following benefits apply to the Hospital and Surgical base plan. Please take the time to read over these and ensure you understand them. Contact us if you have any queries about any of our benefits.

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

## Standard benefits:

### General surgery

**$150,000 for each claim**
An excess applies to this benefit

If you're wanting to *claim* under this benefit, we strongly recommend you seek Prior approval before your treatment.

This benefit covers the costs of *Reasonable charges* associated with surgical treatment. The benefit covers the *procedure(s)* and all subsequent treatment or expenses listed below.

- *Private hospital* or *public hospital* costs
- Physiotherapy while in hospital
- Surgeons' fees
- Anaesthetists' fees
- Costs of essential *prostheses* listed in the Accuro schedule
- Pre-operative and post-operative diagnostics, consultations, or tests, if they occur within 1 year before or after the approved surgery

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

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

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

This 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.

**Breast reconstruction**

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

**Breast symmetry**

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

## Prophylactic surgery

**$60,000 for each person**
An excess applies to this benefit

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

## Major diagnostic procedures

An excess applies to this benefit

This benefit covers the costs of Reasonable charges for the following diagnostic procedures.

- Angiograms — up to a maximum of $3,500 for each person in a policy year
- Computerised axial tomography (CAT or CT) scans — up to a maximum of $2,500 for each person in a policy year
- Positron emission tomography (PET) scans – up to a maximum of $2,500 for each person in a policy year
- Magnetic resonance imaging (MRI) scans — up to a maximum of $3,000 for each person in a policy year
- Myocardial perfusion (MP) scans — up to a maximum of $2,000 for each person in a policy year

Cover applies whether or not you're admitted to a hospital.

## Oral surgery

**$150,000 for each claim**
An excess applies to this benefit

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

- Surgical removal of impacted or unerupted teeth, provided the Member has been covered by the policy for 12 months
- Surgical removal of cysts or soft tissue swellings
- Surgical drainage of oral abscesses
- Pre-operative and post-operative diagnostics, consultations or tests if they occur within 6 months before or after the approved surgery

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

You must be treated by a New Zealand-registered oral or maxillofacial specialist, in an accredited private or public 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.

## Private and public hospital medical admission

**$65,000 for each person in a policy year**
An excess applies to this benefit

Non-surgical cancer treatment is limited to a maximum of $25,000 for each person in a policy year. This is included within the $65,000 benefit limit.

This benefit covers the costs of Reasonable charges for admission to a hospital for reasons other than surgery, such as cancer treatment. The non-surgical hospital treatment must be recommended by an appropriate registered medical practitioner as being necessary to improve the health of the Member.

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

- Private or public hospital accommodation fees
- Other hospital costs, including intravenous fluids, dressings, and prescription drugs throughout hospital admission
- Chemotherapy drugs administered orally at home that are prescribed by a registered medical specialist and to be used during an approved cycle of chemotherapy treatment under this policy
- Registered medical specialist fees, including fees directly related to the hospital admission and that have occurred within 6 months of the date of admission
- Diagnostic procedures, including diagnostic procedures directly relating to the hospital admission that occurred within 6 months of the date of admission

This benefit doesn't cover admission for convalescence, recovery, respite care, geriatric or senile care, obstetrics, mental health, psychiatric or psychological treatment or counselling, or recurrent health conditions.

## Treatment outside of New Zealand

**$25,000 for each person in a policy year**
An excess applies to this benefit

This benefit covers reimbursement of Reasonable charges for a surgical procedure or medical treatment performed at an overseas hospital, where the procedure or treatment isn't available in New Zealand.

To qualify for this benefit, the Member must:

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

A New Zealand-registered medical specialist must provide us with written confirmation that the surgical procedure or medical treatment is necessary and no similar treatment is available in New Zealand.

We don't cover travel and accommodation costs.

## Minor surgery

**$500 for each claim**
An excess applies to this benefit

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

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

# Other benefits

Other benefits that we offer are summarised below.

## Mental Health

**$1,000 for each person in a policy year**
No excess applies to this benefit

This benefit covers the costs of Reasonable charges 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.

## Post-operative therapy

**$1,000 per event**
No excess applies to this benefit

This benefit covers the costs of Reasonable charges associated with post-operative therapy 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.

## Home nursing

**$2,400 for each person in a policy year**
No excess applies to this benefit

$150 a day.

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

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

## Parent accommodation

**$1,500 for each person in a policy year**
No excess applies to this benefit

$125 a night for accommodation.

This benefit covers reimbursement of accommodation expenses paid by a parent accompanying a child aged under 18 years, who is listed on the policy certificate. The child must be undergoing medical treatment with overnight admission in a New Zealand public or private hospital that we've approved under this policy.

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

## Transport and accommodation

**$1,500 for each person in a policy year**
No excess applies to this benefit

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

We'll reimburse the cost below for the Member.

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the hospital

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

This includes:

### Support person benefits

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

We'll reimburse the costs below for the support person.

- **Air transport**
  Return economy airfares and return taxi fare from the airport to the hospital
- **Accommodation expenses** incurred up to $125 per night

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

## Ambulance transfer

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

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

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

## ACC top-up

An excess applies to this benefit

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

These other terms apply.

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

# Additional modules

You can choose to add any of our additional modules for yourself or any additional Member on your policy. These modules include:

- Specialist module
- GP module.

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

We recommend that you read over the benefits carefully and make sure you understand them. Please contact us if you have any queries about the following modules, or would like to add an additional module to your policy.

## You can also add our Day to Day Health Plan

Our Day to Day Health Plan provides a mixture of the benefits from our additional modules up to a maximum of $600 for each person in a policy year.

This Health Plan is designed to help you cover the everyday costs of staying healthy, such as going to the doctor, dentist or optician. It covers the costs of prescription drugs and the annual flu vaccine. You can also enjoy natural therapy treatments to help improve your health and wellbeing.

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



# Specialist module

The Specialist module is our most popular additional module. It provides access to diagnostic tests and specialist consultations. This is an additional module, so please check your policy certificate to see if you're covered and if there is an excess.

## Specialist consultations and diagnostic tests

**$4,000 for each person in a policy year**
An excess applies to this benefit

### Specialist consultations

This benefit covers the costs of Reasonable charges for consultations with a registered medical specialist when referred by a registered medical practitioner, even when you don't require hospitalisation. This includes:

- Cardiac surgeons
- Cardiologists
- Ear, nose and throat specialists
- Gastroenterologists
- General surgeons
- Gynaecologists
- Neurosurgeons
- Oncologists
- Ophthalmologists
- Orthopaedic surgeons
- Paediatricians
- Urologists

Cover is not applicable to obstetricians unless specifically provided for.

### Diagnostic tests and treatment

This benefit covers the costs of Reasonable charges of diagnostic procedures that directly relate to a medical condition when referred by a registered medical specialist. This includes:

- Allergy test
- Ambulatory blood pressure monitoring
- Audiology
- Audiometric test
- Bone density scan
- Cardiovascular ultrasound
- Cardioversion
- Colposcopy
- Dobutamine transoesophageal echocardiography
- Electroencephalography (EEG)
- Electromyography (EMG)
- Endoscopy
- Exercise electrocardiogram (ECG)
- Holter monitoring
- Laboratory test
- Mammography
- Nerve conduction test
- Nuclear scanning
- Stress echocardiogram
- Ultrasound
- Urodynamic assessment
- X-ray

Please note that some diagnostic tests are covered under the Hospital & Surgical base plan. These are specifically listed under the Major diagnostic procedures benefit.

### Mental health consultations

**$1,000 for each person in a policy year**

This benefit covers the costs of Reasonable charges 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.

# GP module

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

This module has an initial *No-claiming period* of 30 days, which means that you can't make a claim for any benefit on the module, such as GP visits, in the first 30 days.

## General practitioner (GP) and nurse visits

This benefit covers the costs of GP visits (including home and after-hours visits) and registered nurse visits.

Up to $80 for each visit, to a maximum of $500 for each person in a policy year.

## Laboratory tests

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

$100 for each person in a policy year.

## Prescription drugs

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

Up to $20 for each item, to a maximum of $300 for each person in a policy year.

# What's not covered (exclusions)

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

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

## Health conditions we don't cover

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

### Psychiatric, psychological and neurodevelopmental disorders

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

- attention-deficit or hyperactivity disorder
- autism spectrum disorder
- dyslexia
- geriatric care including geriatric hospitalisation
- intellectual disability (intellectual developmental disorder)
- motor disorders (including but not limited to Tourette's disorder)
- pre-senile dementia
- senile illness or dementia
- specific learning disorders

### Certain types of care

We don't cover these types of care.

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

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

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

### Treatment for preventative reasons

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

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

### Dental or eye treatment or surgery

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

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

### Organ failure or donation

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

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

### Other treatment or surgery

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

- *Cosmetic procedures* or other enhancement or appearance medicine as defined by us
- Procedures or treatment relating to obesity or weight loss, performed for any reason
- Breast reduction or treatment of gynaecomastia, regardless of whether medically necessary
- Gender 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.

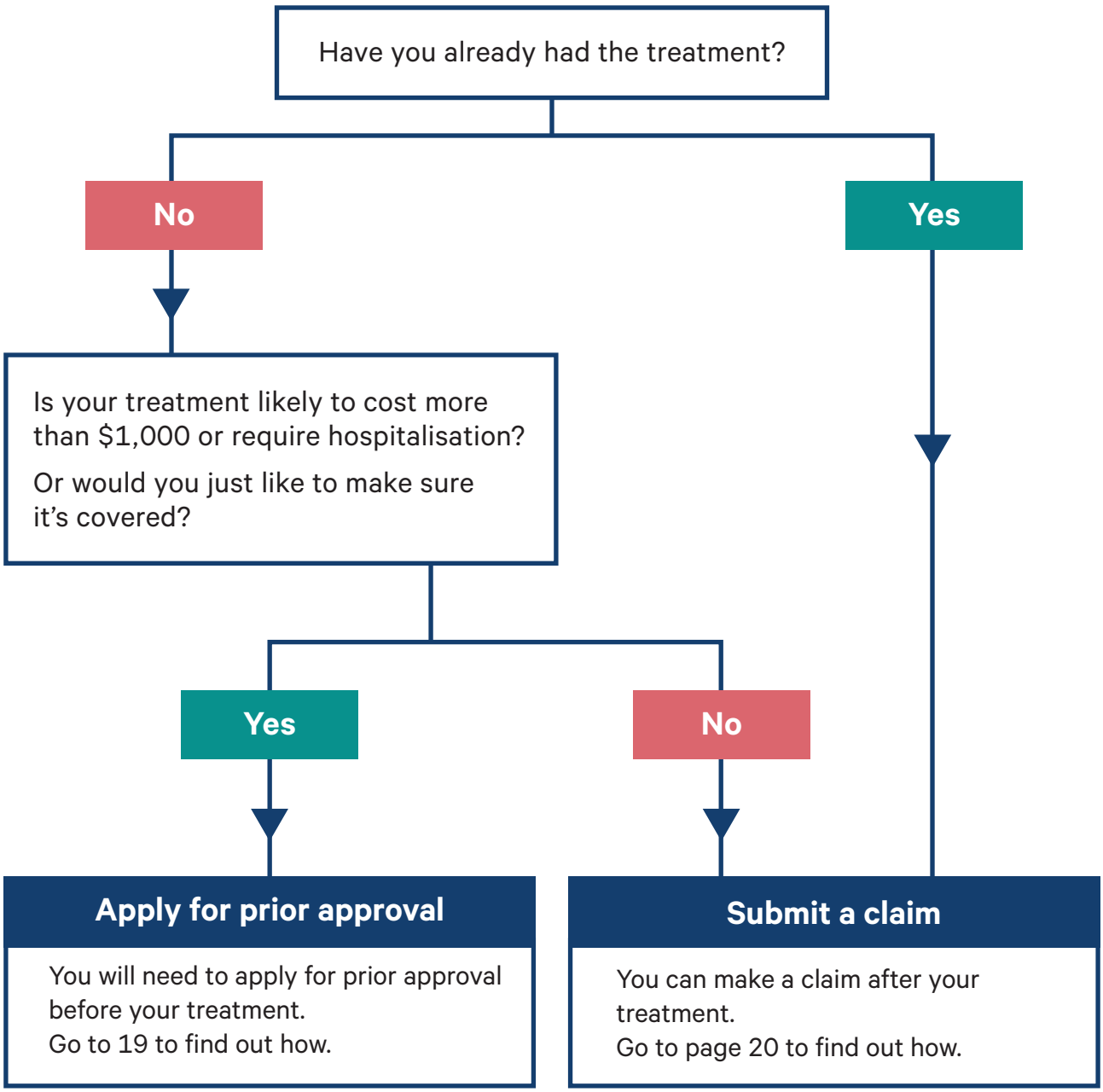
- Disability or illness arising from misuse of alcohol, drugs, participation in a criminal act, or intentional self-injury
- Attempted suicide or suicide within 13 months from the start date of the plan

# How to submit a claim

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

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

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



# How to apply for prior approval

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

Prior approval is required:

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

If in doubt, get prior approval. If you don't get prior approval, we may not be able to approve your claim.

## Collect a prior approval form

You'll need to complete a prior approval form. On Accuro's website you can find the prior approval form or submit a prior approval request 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.

## Get an estimate of the cost

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

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

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

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

## Provide medical evidence

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

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

You will also need to ask the GP who holds the patient's medical history to complete Accuro's Medical report if:

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

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

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

## Submit your prior approval

You can submit your prior approval by post or email, or through the online Member portal on Accuro's website. In some cases, we may need to contact you or the healthcare providers to request additional details to make sure we assess your prior approval correctly. We'll contact you if this is the case.

Please call or email us if you're unsure about how to apply for prior approval, including whether or not you need to supply a Medical report.

# How to make a claim after treatment

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

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

## Collect a claim form

If you haven't got prior approval, 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 as well as any receipts if you've already paid for the procedure or medical treatment.

## Provide medical evidence

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

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

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

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

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

## Submit your claim

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

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

## How to claim for acute treatment

If for some reason you need to be seen urgently for acute treatment and are unable to get prior approval beforehand, you can submit a claim for this afterwards. Please be aware that while acute care is covered, the treatment or service that you have still needs to fall under one of the benefits under your Health Plan for us to provide cover. We recommend that you familiarise yourself with what is covered by your benefits, and let us know if you have any questions.

## What if you already have prior approval?

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

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

# Why do you need to provide medical evidence?

We need medical evidence to confirm that the service you are claiming for is covered under your policy. We need medical evidence to assess a claim or prior approval.

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

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

## When do we need a Medical report?

You need to provide a Medical report form with your claim or prior approval if:

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

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

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

# Things to remember

We can only accept and provide cover for costs:

- for a person who is covered under your policy
- for events that occur after your policy begins
- under a policy that has premiums paid up to date
- for benefits listed in the base plan or modules you have cover for
- charged at a reasonable and fair cost (within our Reasonable charges).

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

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

# What we will pay

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

## How an excess under your cover affects your claim

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

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

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

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

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

## How policy benefit limits affect your claim

Unless specifically stated in this 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 minimum or maximum amount for each benefit that you can claim for an event is set out in the 'The SmartStay cover and benefits' section of this Health Plan document.

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

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

**For example, if you had an x-ray that cost $110 and ACC agreed to cover $60 of it, we would only be able to assess reimbursement of the remaining $50 under your Specialist module.**

## We will cover Reasonable charges

'Reasonable charges' is the cost for a procedure or medical treatment that we judge to be reasonable and within a range of cost charged for the same procedure under similar circumstances. Our reasonable charges make sure that healthcare providers are fair with the amount charged, and within a reasonable range, for similar medical treatment or procedures.

For procedures that have a Reasonable charge applied to them, we look at the average cost as well as the range of charges for the same, or similar, procedure throughout New Zealand. The Reasonable charge that is set represents the cost that is within what we consider to be a reasonable range for that, or a similar, procedure.

We understand that some healthcare providers charge more than others, which is why we set an upper limit, while maintaining costs within a reasonable range.

**For example, if a procedure has an average cost of $27,500 throughout New Zealand. We may determine that the Reasonable charge of $33,000 applies for this procedure. This means that if you were to have a procedure of this type, we'd provide cover up to $33,000 as it's unlikely that the procedure would cost above that. However, if it did cost over $33,000, you'd need to pay any costs over this. If it costs less than that, we only pay the actual amount charged.**

If the cost for your procedure or medical treatment is above what we judge a Reasonable charge, we may ask for further information or you may want to consider an alternative treatment or healthcare provider.

If you choose to proceed, then you will need to pay the difference between the amount we approve and the actual cost for the procedure or medical treatment, regardless of the benefit's maximum limit. You will need to pay this extra amount directly to your healthcare provider. If you apply for prior approval, our approval letter will advise you of this and the maximum amount we can cover.

## Maximum cost we will pay

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

**For example, if you had surgery done by your GP under the Minor Surgery benefit and it came to $1,200, we would only be able to provide reimbursement of $500. The remaining $700 would be your responsibility. This is because the benefit limit for Minor Surgery is $500 for each claim, so we are unable to provide cover for costs above this amount.**

# General conditions of your policy

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

## We don't cover claims covered by ACC

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

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

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

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

### If ACC agrees to partially pay

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

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

## If ACC declines cover

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

## If ACC refuses cover or cover stops

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

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

The GP module has a 30-day No-claiming period that applies to all Members on the module. You're not covered for any events that happen during this No-claiming period.

# We waive the premium on death or terminal illness

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

- 36 months

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

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

# Conditions of cover for prescription drugs

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

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

Unless outlined differently in the policy, prescription drugs must be:

- listed on the *Pharmac Schedule,* note that section H is only applicable if the drug is used during a procedure in a public or private hospital/facility
- *Pharmac*-approved
- medically necessary
- prescribed by a registered medical practitioner.

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

# What you need to do

Your responsibilities are explained in the next section.

## You must disclose pre-existing conditions

Our Health Plans are set up to cover treatment of signs, symptoms and conditions that arise after your policy has started. This means that when you apply for your policy, you must disclose all pre-existing conditions for all additional Members, including congenital conditions.

A pre-existing condition is:

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

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

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

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

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

### Your duty of disclosure

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

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

We can take any of these actions immediately if:

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

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

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

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

# You must pay your policy's premium

You must continue to pay your premium to make sure you're a Member and are eligible for benefits. It's your responsibility to make sure that your policy is paid up to date for yourself and all 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 send you letters to tell you that your policy has fallen into arrears. We'll cancel your policy if you haven't paid your premium for 90 days or longer. Cancellation takes effect from the last date you have paid premiums up to.

## We may increase your premium at any time

We may apply a general premium increase and other changes to premiums at any time. The premiums and discounts for your SmartStay policy are not guaranteed. We reserve the right to review and adjust premiums and discounts at our discretion to make sure our policies and Health Plans are viable. We'll give you a minimum of 21 days' notice of such a change.

## We'll continue to make deductions if your contact details change

We want to make sure you are covered. If our letters are returned and marked 'no address', we'll continue to make deductions until you tell us otherwise. When you accept this policy, you're authorising us to make deductions.

# Making changes to your policy

This section explains what you can do with your policy — from start to finish.

## 14-day free-look period

We provide a 14-day free-look period that begins from the start date on your policy certificate, or 5 working days after you receive your policy documents (whichever is later). This free-look period allows you to review your cover and make sure it is 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 Children and additional Members to the policy

The Primary Member under this policy must be aged between 18 and 69 years at the time of application.

The Primary Member must hold one of the visas below.

- New Zealand work visa valid for 12+ months with at least 3 months remaining
- New Zealand visitor visa valid for 12+ months with at least 12 months remaining

You can add your spouse or partner and Children under the age of 25 years, onto your policy at any time. To add an additional Member to your SmartStay policy, you'll need to complete a full application form for each additional Member and answer the health questions, or provide their full medical history.

We'll assess each application and decide whether the additional Member can be added on the basis of the health information we receive. 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 and modules selected are the same for each Child. All Children will remain on Child rates up to 25 years old.

### Adding a Child

You can add a Child who is under 6 months of age to your policy by completing a Making Changes form with no personal exclusions placed due to their medical history. The exclusions listed on pages 15 to 17 will still apply, including congenital conditions. A Child who is under 6 months of age is eligible to receive cover free of premiums for the first 6 months after birth. We will charge the relevant premium once the child has reached 6 months of age.

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

## How long can Children stay on my policy?

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

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

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

## How do I remove 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 full application process.

# What if I become eligible under the public health system?

If you become eligible for cover under the public health system at any time, please let us know, as other Health Plans would better suit your needs. Commonly, you become eligible when your visa is or has been valid for 2 years or more.

# How can a policy end?

Cover for your SmartStay 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
- when you tell us that you now have cover under New Zealand's public health system. At this time, we would transfer you onto one of our other Health Plans, which will have more appropriate cover for you and your family.

# Death of the Primary Member

If the Primary Member of the policy dies, the partner who has been included on the policy may retain the policy and continue paying the appropriate premium. The partner is then considered the Primary Member. The 'We waive the premium on death or terminal illness' section on page 24 has more information about whether the waiver of premium applies.

# 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.

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

# Cancelling your policy

If you cancel your SmartStay 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 on our application form.

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 28).

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

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

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 UniMed's website 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 on the 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 apply for prior approval, 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 prior approval or claim
- save invoices to submit with a claim at a later date.

## Contact us if you have any concerns

We pride ourselves on providing great 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 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 Accuro's 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 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 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: 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.

**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/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 under their base plan or chosen modules refunded as described in this 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.

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

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

**hospitalisation** means admission to hospital for treatment.

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

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

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

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

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

**Member** means a person who has been accepted as a Member of UniMed, 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, 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.

**module** and **base plan** means a specified range of benefits.

**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.

**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).

**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.

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

**Pharmac** is the New Zealand Pharmaceutical Management Agency, a Crown entity that decides which medicines and pharmaceutical products are subsidised for use in the community and public hospitals.

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

**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 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.

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

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

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

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

**Reasonable 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.

**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 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