Value Plus Plan

UniMed

Claims year from the 1 April to 31 March

Standard benefits	100% refund up to:
Physiotherapy treatment By a registered physiotherapist (materials not covered).	$300 per year
Chiropractic treatment By a registered chiropractor (materials not covered).	$300 per year
Podiatry treatment By a registered podiatrist (materials not covered). Orthotics are not covered.	$300 per year
Acupuncture treatment By a registered acupuncturist (materials not covered).	$300 per year
Osteopath treatment By a registered osteopath (materials not covered).	$300 per year
Traditional Chinese medicine Includes treatment and consultations provided by a registered Chinese Medicine practitioner (materials or supplements not covered).	$300 per year
Natural therapies treatment Provided by naturopaths, homoeopaths, herbalists and remedial body therapists. Covers the cost of consultations performed by New Zealand health practitioners or New Zealand registered medical practitioners with a current annual practising certificate who are registered members of their professional bodies (materials not covered).	$300 per year
Hearing aids Repair and/or purchase of hearing aids through a registered audiologist.	$750 per year
Orthodontic Corrective orthodontic appliances when an orthodontic plate or brace has been fitted by a registered orthodontic specialist to a *Member* under 25 years of age.	$600 per year Maximum of $1,800 per event
Oral surgery consultation Consultation by a registered oral surgeon only.	$300 per year
Denture Repair by or purchase of dental plates from a registered dental technician or registered dental surgeon.	$750 per year
Occupational therapy By an occupational therapist holding a current annual practising certificate.	$300 per year
Optical This *benefit* is only payable when glasses or contact lenses are purchased. Stand-alone examinations or consultations when there has been no purchase of glasses or contact lenses are not covered. A certified account that details charges for examination, net cost of lenses, frames and so on is required. We are unable to provide cover for cases, sundry charges, or contact lenses or glasses purchased outside New Zealand.	$500 per year
Health surveillance tests Mammogram, smear test, mole mapping and prostate check only.	$200 per year
Flu vaccination By a relevant registered person.	$40 per year
Mental health 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.	$600 per year

Special benefits and grants	100% refund up to:
Sick leave without pay *Member* or *partner* (who is covered by the Health Plan) may *claim*. Before you are eligible to *claim* under this *benefit*, you will need to be sick for at least 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 sick leave with pay left from your employer are required to support every *claim*.	$100 per week, to a maximum of $600 per year
Bereavement grant Grant payable on the death of any *Member* 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.	$3,000
Birth *Benefit* is payable 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*. *Members* aged 24 years or younger do not qualify for this *benefit*. A copy of the full birth certificate to clearly identify parents must be provided. Adoption of a *Member*'s *child* from a previous relationship does not qualify.	$400 per birth
Home support *Member* or *partner* (who is covered by the Health Plan) may *claim* $20 per day up to $100 per week. A medical certificate and written confirmation of payment to the domestic assistance supplier is required. Payable where daily domestic assistance is essential after illness or accident.	$20 per day, up to $100 per week, to a maximum of $1,000 per year
Hospital cover excess – refund Excess refundable only if a *Member* has Tower Hospital Cover plan, NZNO Real Value Plan (RVP) and Major Medical Plan (MMP).	$500 per *Member* per year

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 Value Plus Plan entitles a *Member* to full cover as described in this Health Plan document and in accordance with any special conditions stated in the *policy* certificate issued at the time of acceptance. Membership commences from the date listed on your *policy* certificate and for which the first *premium* is received for by *UniMed*.

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 Value Plus Plan's terms and conditions 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.

Cover start date

The Value Plus Plan has a 90-day no-claiming period. This 90-day period applies to Members added to this Health Plan, and *claims* cannot be made for any event for a *Member* within the 90-day time period after their start date on this Health Plan. The *Member*'s start date will be listed on the *policy* certificate.

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 the Value Plus Plan's terms and conditions will still apply.

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 Value Plus Plan's terms and conditions.

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.

Value Plus Plan
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*.