nib

Bank Healthcare Policy

Contents

Introduction

Thank you for trusting nib to insure your health. This document explains what your policy covers and should be read with your acceptance certificate.

It is important **you** read **your** policy carefully. This will ensure **you** know what **you** are covered for, what **you** need to tell **us**, how to make a claim and any other terms and conditions of **your** policy.

We understand insurance can be complex and policy documents are not always easy to understand. If there is something **you** don't understand, or if any information is incorrect, or if **you** have any questions, just call **us** on **0800 123 642** – **we** will do everything **we** can to help **you**.

14-day free-look period

We understand the cover **you** have chosen needs to fit with **your** overall financial and health needs. To allow **you** time to review **your** policy and ensure it meets **your** needs **we** provide a 14-day free-look period. This period starts three days after **we** send **you your** policy information. During this time, should **you** decide **your** policy doesn't meet **your** needs, please send **your** written confirmation to **us** and **we** will cancel the policy and refund any premiums **you** have paid providing no claims have been made.

Financial Statements

You can obtain a copy of **our** financial statements for the last reported financial year by writing to **us** at nib nz limited, PO Box 91 630, Victoria Street West, Auckland 1142.

Privacy

We comply with the Privacy Act 1993, including the Health Information Privacy Code 1994, and **we** will preserve the privacy of **your** and all **insured persons'** personal information. To see the full privacy policy, please go to **nib.co.nz/about-us/privacy-policy**.

Duty of Disclosure

Where **we** required an **insured person** to provide health information, **you** and the **insured persons** had a legal duty to disclose everything **you** or they knew (or ought to have known) which would have influenced the decision of a prudent insurer whether to accept **your** application, and if so, on what terms (for example, an **insured person** must have disclosed any **health condition** they had at the time of applying, or have had in the past). **You** and the **insured persons** must have told **us** about any changes to the information given to **us** before the **commencement date** or **join date** of this policy. If **you** or any **insured person** failed to do so, or if any of the material information was not disclosed to **us**, **we** can cancel this policy from the **commencement date** and not pay any claims. **We** may retain all the premiums paid, and any claims paid by **us** may be recovered from **you**.

Headings

In this policy, **we** have headings which are for **your** guidance only – these don't form part of the policy.

Words in bold

We have some words in bold, which may indicate the words have a special meaning. To find out the meaning, please refer to Definitions section on page 73.

Help Section

1 How to seek pre-approval for a claim

1.1 Contact us

If any **insured person** has to go into an **approved private hospital**, **we** recommend **you** obtain **our pre-approval**. That way **you** know exactly what **we** will pay for and **you** can take advantage of **our** rapid refund service.

Contact **us**:

- The my nib portal provides 24 hour access to your policy and claims details. This information can be found by visiting **nib.co.nz/portal**
- Call **us** on **0800 123 642**.
- Email **us** at **claims@nib.co.nz**
- Write to **us** at:

  nib nz limited
  PO Box 91 630
  Victoria Street West
  Auckland 1142.

1.2 A pre-approval request can be made by you or a recognised provider on your behalf.

- If they have access to the nib First Choice Portal (**nibfirstchoice.co.nz/portal**), **you** can ask **your recognised provider** to request a **pre-approval** and submit the subsequent claim on **your** behalf.
- **You** can also submit **pre-approvals** and claims by visiting **our** customer portal (my nib) at
  - **nib.co.nz/portal**
  - Call **us** on **0800 123 642**.
  - Email **us** at **claims@nib.co.nz**

1.3 If we accept your pre-approval for a claim we will tell you and send you a pre-approval letter

It will take **us** up to five working days to reply, unless further information is required.

If **we** accept **your** claim **we** will tell **you**. **We** will give **you** a letter that gives the **health service providers** authority to invoice **us** direct for the **costs covered**, which saves **you** time and money.

If the request has been made by a **recognised provider we** will also notify them.

1.4 Give copies to your health service providers

Give a copy of the **pre-approval** letter to the **insured person's health service providers**.

2. Choosing your provider

The **nib First Choice network** is a group of **recognised providers** that provide health services within **our** First Choice price range.

- If **you** choose a **recognised provider** from the **nib First Choice network** for that health service, **your** claims will be covered for 100% of eligible costs, less any **excess**.
- **You** can still choose to receive treatment from a **recognised provider** that is not part of the **First Choice network**, however **you** may not be covered for 100% of eligible costs.
- **We** may separate **First Choice network** claim costs into two components:
  - **Your approved private hospital charges** (if applicable)
  - The **surgical cost grouping**, which consists of the **registered specialist**, anaesthetist and any **prosthesis** costs.

- If either the **approved private hospital** or **registered specialist** is not a **First Choice provider** for the health service provided, then the maximum **we** will pay for claims associated with each component is the **Efficient Market Price (EMP)** determined individually for that component.
- Using a **First Choice provider** gives certainty that **you** will be covered for 100% of approved associated health service costs included in the policy up to the Benefit maximum.
- Not all health services are included in the **First Choice network**. To find out whether a health service is included or which **recognised providers** are part of the **First Choice network** visit **nibfirstchoice.co.nz/directory**
- **We** will pay 100% of costs, up to the Benefit maximum and less any **excess**, for health services provided by **recognised providers** that are part of the **First Choice network**.
- If a **recognised provider** is not part of the **First Choice network**, and the network applies to that health service, then the maximum we will pay for that portion of the treatment is the **EMP**.
- Any costs above the **EMP** must be paid by the **policyowner** or the insured person. **We** recommend that the **policyowner** and all **insured persons** ensure they understand all the potential costs before undertaking any health services with a **recognised provider** that is not part of the **First Choice network**.

3. Efficient Market Price (EMP)

The **Efficient Market Price** is the maximum amount **we** will pay for a health service provided by a **recognised provider** that is not part of the **First Choice network**, when the network applies to that health service.

We determine the **EMP** based on:

- health providers' charges for a particular health service;
- **our** own claims statistics; and
- **our** experience of the national and regional New Zealand health market.

The **EMP** is subject to change at **our** discretion.

- For **pre-approved** health services, the **EMP** payable will be determined as at your **pre-approval** date.
- For health services that have not been **pre-approved**, the **EMP** payable will be determined as at the treatment date.

4. Changes in network status

A **recognised provider's** inclusion in the **First Choice network** for a particular health service may change from time to time and further health services may be added to the network.

- If **you** hold a valid **pre-approval** for a **First Choice provider** we will honour the original terms of the **pre-approval**, regardless of whether that **recognised provider** is still a **First Choice provider** on the treatment date.
- If **you** hold a valid **pre-approval** for a **recognised provider** that is not a **First Choice provider**, but they are a **First Choice provider** on **your** treatment date **we** will recognise the change when assessing **your** claim, and the limit of the **Efficient Market Price** will no longer apply.

5 How to make a claim

5.1 Contact us

Please pay any smaller claims such as doctor's accounts, pharmaceutical charges and dental bills directly with the **health service provider**. Please always obtain a receipt.

When the receipts exceed a reasonable amount (say $100) request a claim form:

- Call **us** on **0800 123 642**.
- Email **us** at **claims@nib.co.nz**
- Write to **us** at:

  nib nz limited
  PO Box 91 630
  Victoria Street West
  Auckland 1142.

If **your recognised provider** has access to the nib First Choice Portal they can submit a claim on **your** behalf.

Note:

- Receipts must be submitted within 12 months of incurring the cost, so **we** suggest **you** submit a claim at least once a year.
- Any claim must be made within 30 days of this policy ending.
- The claim must relate to an **insured person**. Reimbursement cannot be made for any other person, regardless of whether an **insured person** has paid the account or bill.

5.2 Claims conditions

5.2.1 Provide full information

You must give **us** a full description of:

- the treatment undertaken;
- the reason for the treatment;
- the date of the treatment; and
- all medication required.

on the claim form. **You** must state if the treatment was accident-related. **You** must provide **us** with any other information or assistance **we** reasonably require.

5.2.2 Medical report or assistance

If **you** or an **insured person** need assistance to complete the claim form, or **we** request a medical report with the claim form, these will be at **your** expense. **We** may request additional information in order to assess **your** claim and this will be at **our** expense.

5.2.3 Prescriptions

When submitting claims for prescriptions under the **GP** option (if selected), **you** must submit pharmacist receipts stating the name of the patient, prescription number, the name of the medication prescribed and the cost of each item. The reason for the medication must be stated on the claim form.

Any claim for reimbursement of prescription costs must relate to the **insured person**, regardless of whether the **insured person** paid the account or bill.

We will only reimburse the cost of the prescription. **We** will not reimburse administration costs (faxing costs incurred between the prescribing **GP, registered specialist** or pharmacy).

5.2.4 Home Nursing Care

When submitting claims for home nursing care, all accounts and receipts presented to **us** for payment must show the qualifications of the home nurse, dates of visits and fees charged. A **GP** or **registered specialist** letter stating the reason why home nursing care is required and the length of time for which it is required must be submitted with the claim.

5.2.5 Public Hospital Cash Grant

For the Public Hospital Cash Grant **you** must obtain a certificate from the hospital stating the reason and the date of the admission, and the date of the discharge to support **your** claim.

5.2.6 Waiver of Premium Benefit

When claiming for a Waiver of Premium Benefit, please provide the original death certificate or a certified copy or similar documentation acceptable to **us**.

5.2.7 Referral by a GP or registered specialist

Where this policy requires that a service or treatment must only be performed after referral by a **GP** or **registered specialist**, the name of the referring practitioner must be shown on the account or receipt presented to **us** for payment.

5.2.8 Glasses and contact lenses

When submitting a claim for glasses or contact lenses under the Dental and Optical Option, **we** require written confirmation from the **insured person's** optometrist that they are required as a result of a vision change.

5.2.9 Trauma Option

When claiming under the Trauma Option, the **insured person** covered must first:

- seek a diagnosis as soon as possible after that **insured person** first becomes aware that they might be suffering from a Medical Condition; and
- receive a definite diagnosis of the Medical Condition. The diagnosis must be by a **registered specialist** based on conventional medical testing acceptable to **us**; and
- obtain and follow regular medical advice and treatment from a **GP** or **registered specialist** as soon as possible after that **insured person** first becomes aware that they might be suffering from a Medical Condition; and
- co-operate with any requests **we** make to confirm diagnosis of that **insured person's** Medical Condition. For example, undergoing a medical examination by a **registered specialist** of **our** choice at **our** expense.

You must:

- Advise **us** as soon as possible but no later than 30 days after that **insured person** is diagnosed with a Medical Condition.

- Give **us** an original or certified copy of that **insured person's** birth certificate.

5.3 Rapid refund

We will process **your** claim within five working days of receipt of the claim form, unless further information is required.

We will send **you** a refund either by cheque or by direct credit to **your** bank account.

6 How to change your details or your health policy

6.1 Contact us

You may add or remove **insured persons** from **your** policy, add or remove options, or change the **excess**.

Each **policyowner** is authorised to enquire about, and make changes to, the cover he or she owns. If any cover is owned by more than one **policyowner,** the cover is owned jointly by those **policyowners** and they must consent to all changes.

6.1.1 Adding a partner or dependent child

You can add **your partner** or **dependent child** to this policy. **You** must complete **our** application form and send it to **us**. **We** charge an additional premium for additional people added. **We** will add the **insured person** to this policy on the nearest billing date, immediately after **you** request this change. If **we** make the change on any other date **we** will let **you** know.

If **you** add a **dependent child** within four months of birth, **we** will cover that child for **pre-existing conditions**, other than a known **congenital health condition** or a **pre-existing condition** excluded under the standard policy exclusions.

A person is added to this policy from the **join date** shown on the **acceptance certificate** or **renewal certificate.**

6.1.2 Removing an insured person or a policyowner

We will only remove an **insured person** from this policy, from the next **policy anniversary date**:

- At the request of that **insured person**. He or she has the option, within 30 days of removal, to arrange a separate policy on terms determined by **us** without providing any evidence of his or her current state of health.
- At the request of the **policyowner**. **We** require at least 30 days' prior notice from the **policyowner**. If the policy has more than one **policyowner**, the notice must be from all **policyowners**.

We will only remove a **policyowner** from this policy at the request of all **policyowners**.

If **we** make the change on any other date **we** will let **you** know.

6.1.3 Adding or removing options

You can add options to **your** cover for an additional premium. **You** must complete **our** application form and send it to **us**. (**You** can obtain an application form by ringing **us**.) The application must be received and assessed by **us** before cover can start.

If an option is added to this policy, that option will be added to this policy on the nearest billing date immediately after **you** request this change. If **we** make the change on any other date **we** will let **you** know.

An option is added to this policy from the effective date shown on the **acceptance certificate** or **renewal certificate** for that option.

You can only remove this option at the next **policy anniversary date**. At **our** discretion, **we** may waive this limitation. **You** must give **us** at least 30 days' prior notice in writing or by email.

6.1.4 Changing your excess

You can change the **excess** on any **policy anniversary date**. If **you** have made no claims **we** may, at **our** discretion, allow **you** to change the **excess** earlier. **You** must give **us** at least 30 days' prior notice in writing or by email.

If **you** wish to reduce the level of the **excess, we** may require an assessment of all the affected **insured persons'** current state of health before **we** agree.

6.1.5 Policyowner must be an adult

A **dependent child** under age 16 must be accompanied by at least one adult aged 21 or over, as an **insured person**, or have his or her parent or legal guardian as the **policyowner**.

6.1.6 Changes in contact details

You must notify **us** of all changes in contact details of **insured persons**. Where possible, please provide an email address. **You** can advise **us** in writing or by email.

6.1.7 Making changes

To make a change:

- Call **us** on **0800 123 642**.
- Email **us** at **contactus@nib.co.nz**
- Write to **us** at:

  nib nz limited
  PO Box 91 630
  Victoria Street West
  Auckland 1142.

6.2 We will process the change

We may require **you** to complete a change of policy form. **We** will let **you** know if this is the case and **we** will send **you** the change of plan form within five working days. **We** will process the change of plan form within five working days of receiving it from **you**, unless further information is required.

6.3 New acceptance certificate

Once **we** have accepted the changes, **we** will send **you** a new **acceptance certificate** or **renewal certificate** that will show the changes.

Benefits Section

This section of this policy lists and defines the benefits we insure.

It is in five parts: the Base Cover and four options (Specialist Option, Trauma Option, GP Option and Dental and Optical Option). All insured persons must take the Base Cover. If you have chosen an option, it is shown on your acceptance certificate or renewal certificate.

Base Cover

1 Introduction

1.1 What we cover

The Base Cover provides the benefits set out below during the policy period for each **insured person** to investigate and treat the **insured person's health condition**. Where a benefit is subject to a benefit maximum, the benefit maximum will apply to the **policy year** in which the **diagnostic investigation** or treatment was provided.

1.2 What we pay

We pay the **costs covered** up to the benefit maximum, less any **excess**.

Unless stated otherwise, the **excess** applies to each **insured person** for each separate treatment covered under the following benefits:

- Hospital – Surgical Benefit

- Hospital – Medical Benefit
- Cancer Treatment Benefit (**excess** will be applied per **cycle**)
- Major Diagnostics Benefit
- Specialist Minor Surgery Benefit
- Specialist Minor Surgery Benefit – Skin lesions
- **ACC Top-up** Benefit
- Overseas Treatment Benefit
- Complications of Pregnancy / Childbirth Benefit
- Loyalty Benefit – Obstetrics
- Loyalty Benefit – Sterilisation.

However, where a **health condition** results in **hospitalisation**, all benefit payments relating to that **health condition** for up to six months prior to **hospitalisation** and for up to six months after discharge, will be subject to one **excess**. For the Cancer Treatment Benefit, the **excess** will be applied per **cycle** of chemotherapy or radiotherapy treatment unless stated otherwise in this policy.

2 Hospital – Surgical Benefit

2.1 What we cover

Surgery

We cover the cost of surgery requiring an anaesthetic in an **approved private hospital**. Surgery includes (for example, without limitation): general and cancer surgery, cardiac surgery, orthopaedic surgery, laparoscopic surgery, oral surgery, angiography, angioplasty and lithotripsy.

We also cover the cost of intensive nursing care, X-rays, disposables and consumables, dressings, and drugs listed under Sections A to G of the **PHARMAC** Pharmaceutical Schedule, where they meet **PHARMAC's** funding criteria, etc.

Diagnostic investigations

We cover the cost of **diagnostic investigations** requiring an anaesthetic in an **approved private hospital**. Diagnostics covered include (for example, without limitation): endoscopy, laporoscopy and bronchoscopy. Cover for other specific diagnostic investigations may be available under the Major Diagnostics Benefit (see Benefit 7).

2.2 Benefit maximum

We pay up to $300,000 per **insured person** per **policy year,** less any **excess**.

This benefit maximum also includes associated **costs covered** under the following benefits:

- Hospital Related Specialist Consultations Benefit – refer to Benefit 6
- Major Diagnostics Benefit – refer to Benefit 7
- Hospital Related Diagnostic Radiology and Imaging Benefit – refer to Benefit 8
- Hospital Related Cardiac Investigations Benefit – refer to Benefit 9
- Ambulance Transfer Benefit – refer to Benefit 10
- Travel and Accommodation Benefit – refer to Benefit 11
- Parent Accommodation Benefit – refer to Benefit 12
- Post-treatment Physiotherapy Benefit – refer to Benefit 13
- Post-treatment Home Nursing Care Benefit – refer to Benefit 14
- **ACC Top-up** Benefit – refer to Benefit 19

Individual limits for these benefits may also apply.

2.3 Other terms

Chemotherapy / radiotherapy

- **We** cover chemotherapy and radiotherapy (when this is provided privately in New Zealand) following surgery under the Cancer Treatment Benefit. The **excess** will not apply to the chemotherapy or radiotherapy treatment where this treatment is administered within six months of that surgery.

Prostheses

- **We** cover certain **prostheses** costs (such as hip and knee implants) up to specified maximums set by **us**. A **prosthesis schedule** specifies the **prostheses** which have a specified maximum applicable. The **prostheses schedule** is reviewed annually and is available from **our** website or from **us** on request. The cost of **prostheses** is included in the Benefit maximum.

Oral surgery

- **We** only cover oral surgery by a registered oral and maxillo-facial surgeon.
- **We** only cover removal of unerupted and impacted teeth if a registered oral surgeon or registered dentist performs the procedure.
- A 12-month **stand-down period** from the **join date** of each **insured person** applies to the extraction of wisdom teeth.
- **We** do not cover any other dental treatments, including periodontal, orthodontic and endodontal procedures and implants.

3 Hospital – Medical Benefit

3.1 What we cover

We cover the cost of medical treatment (not involving surgery) in an **approved private hospital**. Medical treatments covered include (for example, without limitation): heart disease, treatment of respiratory disease (asthma, pneumonia, etc) and treatment for endocrine disease (diabetes, etc).

We also cover the cost of intensive nursing care, X-rays, disposables and consumables, dressings and drugs listed under Sections A to G of the **PHARMAC** Pharmaceutical Schedule where they meet **PHARMAC's** funding criteria, etc.

3.2 Benefit maximum

We pay up to $200,000 per **insured person** per **policy year,** less any **excess**.

The most **we** will pay for all claims under this Hospital – Medical Benefit and the Cancer Treatment Benefit (below) and any other associated benefit payments is $200,000 per **insured person** per **policy year**, less any **excess**.

This benefit maximum also includes associated **costs covered** under the following benefits:

- Cancer Treatment Benefit – refer to Benefit 4
- Associated Oncology and Diagnostic Radiology and Imaging Benefit – refer to Benefit 5
- Hospital Related Specialist Consultations Benefit – refer to Benefit 6
- Major Diagnostics Benefit – refer to Benefit 7
- Hospital Related Diagnostic Radiology and Imaging Benefit – refer to Benefit 8
- Hospital Related Cardiac Investigations Benefit – refer to Benefit 9
- Ambulance Transfer Benefit – refer to Benefit 10
- Travel and Accommodation Benefit – refer to Benefit 11
- Parent Accommodation Benefit – refer to Benefit 12
- Post-treatment Physiotherapy Benefit – refer to Benefit 13
- Post-treatment Home Nursing Care Benefit – refer to Benefit 14
- **ACC Top-up** Benefit – refer to Benefit 19

Individual limits for these benefits may also apply.

3.3 Other terms

- This benefit does not cover: rehabilitation, convalescence, respite, **disability support services,** geriatric care or **long-term care** costs.
- Cover for chemotherapy and radiotherapy is provided in the Cancer Treatment Benefit (refer to Benefit 4) and Associated Oncology and Diagnostic Radiology and Imaging Benefit (refer to Benefit 5).
- Radiotherapy is covered when it is privately available in New Zealand.

4 Cancer Treatment Benefit

4.1 What we cover

We cover the cost of the **chemotherapy agent(s)** and radiotherapy (where this is available privately in New Zealand) used in a **cycle** of treatment for cancer administered outside the public health system, including the cost of a **registered specialist** or **health service provider** to administer these treatments.

4.2 Benefit maximum

All costs paid under this benefit are included within the benefit maximum for the Hospital – Medical Benefit.

The most **we** will pay for all claims under this Hospital – Medical Benefit and the Cancer Treatment Benefit and any other associated benefit payments is $200,000 per **insured person** per **policy year,** less any **excess**.

Where this policy has an **excess**, it will be applied to each **cycle** of chemotherapy or radiotherapy treatment.

4.3 Other terms

- Where surgery follows within six months of the last **cycle** of chemotherapy or radiotherapy treatment, only one **excess** will apply to that surgery under the Hospital – Surgical Benefit and the chemotherapy and radiotherapy treatment during that six months. Any other **excess** paid for chemotherapy or radiotherapy treatment during that six month period will be refunded.
- To qualify for reimbursement a **cycle** of chemotherapy treatment must meet the following definition:
  - A specified number of sequentially administered doses of **chemotherapy agent(s)** where:
    - the **chemotherapy agent** is administered at prescribed intervals within a planned time frame; and
    - **PHARMAC** has approved the **chemotherapy agent** under sections A to G of the **PHARMAC** Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and
    - the **chemotherapy agent:**
      - meets the **PHARMAC** funding criteria; and
      - is prescribed by a **registered specialist** and administered in New Zealand.
- To qualify for reimbursement for a **cycle** of radiotherapy treatment, the radiotherapy must be administered in New Zealand by an appropriately qualified medical professional registered in New Zealand.
- This benefit does not cover: rehabilitation, convalescence, respite, **disability support services**, geriatric care or **long-term care** costs or hospice care.

5 Associated Oncology and Diagnostic Radiology and Imaging Benefit

5.1 What we cover

We cover the cost of:

- **registered specialist** consultations;
- diagnostic radiology; and
- diagnostic imaging such as X-rays, ultrasound, mammography, scintigraphy, MRI and CT scans,

resulting from a referral by a **GP** or **registered specialist** where the **registered specialist** consultation, diagnostic radiology or diagnostic imaging directly relates to, or results in, the **insured person** having private chemotherapy or radiotherapy treatment for cancer which has been paid for under this policy.

The cost must have been incurred during the six months prior to the start of a **cycle** of treatment, during the **cycle** of treatment and during the period six months after that **cycle** of treatment ends.

A benefit must have been paid under the Cancer Treatment Benefit.

5.2 Benefit maximum

No limits per visit.

All costs paid under this benefit are included within the benefit maximums for the Cancer Treatment Benefit (refer to Benefit 4) and the benefit maximum for Hospital – Medical Benefit (refer to Benefit 3).

5.3 Other terms

- **We** do not cover diagnostic radiology and diagnostic imaging tests (such as X-rays, ultrasound, mammography) that do not relate to **hospitalisation** or a **cycle** of treatment.
- **We** do not cover **registered specialist** consultations, diagnostic radiology and diagnostic imaging that do not relate to, or result in, a **cycle** of treatment.

6 Hospital Related Specialist Consultations Benefit

6.1 What we cover

We cover the cost of **registered specialist** or **vocational GP** consultations up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital** where those visits directly relate to that **hospitalisation**, after a referral from a **GP** or a **registered specialist**.

6.2 Benefit maximum

No limit per visit.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

6.3 Other terms

- **We** do not cover **registered specialist** or **vocational GP** visits that do not relate to **hospitalisation** unless **you** have chosen the Specialist Option.
- Cover is only provided where a claim has been paid under the Hospital – Surgical or Hospital – Medical Benefit (whichever applies).

7 Major Diagnostics Benefit

7.1 What we cover

We cover the cost of the following **diagnostic investigations** after referral by a **GP** or **registered specialist**:

- arthroscopy
- capsule endoscopy
- colonoscopy
- colposcopy
- CT scan
- CT angiogram
- cystoscopy

- gastroscopy
- MRI scan
- myelogram
- PET scan (including PET/CT scan)

7.2 Benefit maximum

There is no limit to the number of **diagnostic investigations** for each **insured person** every **policy year**.

Surveillance testing is not covered.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

7.3 Other terms

If the **diagnostic investigation** results in **hospitalisation** within six months, it will be covered under:

- the Associated Oncology and Diagnostic Radiology and Imaging Benefit (refer to benefit 5);
- Hospital Related Diagnostic Radiology and Imaging Benefit (refer to benefit 8); or
- Hospital Related Cardiac Investigations Benefit (refer to benefit 9);

whichever is applicable.

8 Hospital Related Diagnostic Radiology and Imaging Benefit

8.1 What we cover

We cover the cost of diagnostic radiology and diagnostic imaging such as X-rays, ultrasound, mammography, scintigraphy, MRI and CT scans up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital,** where those diagnostic procedures directly relate to that **hospitalisation,** after a referral from a **GP** or a **registered specialist**.

8.2 Benefit maximum

No limit per visit.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

8.3 Other terms

- **We** do not cover diagnostic radiology and diagnostic imaging tests (such as X-rays, ultrasound, mammography), that do not relate to **hospitalisation**.
- Cover for chemotherapy and radiotherapy is provided in the Cancer Treatment Benefit (refer to benefit 4) and Associated Oncology and Diagnostic Radiology and Imaging Benefit (refer to benefit 5).
- Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

9 Hospital Related Cardiac Investigations Benefit

9.1 What we cover

We cover the cost of cardiac investigations such as treadmills, holter monitoring, ambulatory blood pressure monitoring, cardiovascular ultrasound, echocardiography, myocardial perfusion scans and cardioversion up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital,** when those investigations directly relate to that **hospitalisation,** after a referral from a **GP** or a **registered specialist**.

9.2 Benefit maximum

No limit per visit.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

9.3 Other terms

- Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

10 Ambulance Transfer Benefit

10.1 What we cover

We cover the cost of a road ambulance to and from an **approved private hospital**, within New Zealand for the **insured person** for **hospitalisation**, if a **GP** or **registered specialist** has recommended the transfer by ambulance.

10.2 Other terms

- All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).
- The cost of ambulance society subscriptions is not covered.

11 Travel and Accommodation Benefit

11.1 What we cover

This Benefit applies where a **GP** or **registered specialist** has recommended treatment and where that treatment cannot be performed in the **insured person's** local **approved private hospital**.

11.1.1 Rail or road travel

We cover the cost of rail or road travel within New Zealand where the nearest **approved private hospital** is more than 100km one way from the **insured person's** usual residence. **We** will reimburse the cost of mileage for road travel, at the amount determined by **us** from time to time, to and from the nearest **approved private hospital,** or the cost of return transport by rail or bus to and from the nearest **approved private hospital**.

11.1.2 Air travel

We cover the cost of a return economy airfare within New Zealand for the **insured person** requiring treatment and for a support person to travel to and from an **approved private hospital**. This Benefit applies where a **GP** or **registered specialist** has recommended treatment and where that treatment cannot be performed in the **insured person's** local **approved private hospital**.

11.1.3 Accommodation

We cover the cost of accommodation incurred by a support person during an **insured person's hospitalisation** or **cycle** of chemotherapy or radiotherapy treatment.

11.2 Benefit maximum

11.2.1 Rail or road travel

We pay up to $1,800 per **hospitalisation** or per **cycle** of chemotherapy or radiotherapy treatment for the cost of mileage, at the amount determined by **us** from time to time, or for the cost of a return rail or bus trip.

11.2.2 Air travel

We pay the cost of a return economy airfare within New Zealand for the **insured person** requiring treatment and one support person. **We** also pay the taxi fares from the airport of arrival to the **approved private hospital** (on admission) and from the **approved private hospital** (on discharge) to the airport of departure. This applies per **hospitalisation** or per **cycle** of chemotherapy or radiotherapy treatment.

11.2.3 Accommodation

We pay up to $150 per night for the accommodation costs incurred by the support person.

We pay up to $1,800 per **hospitalisation** or per **cycle** of chemotherapy or radiotherapy treatment.

11.3 Other terms

- All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit, Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).
- The travel and accommodation cost must directly relate to the **hospitalisation** or **cycle** of chemotherapy or radiotherapy treatment.
- The air travel cost to and from New Zealand is not covered, unless covered under the Overseas Treatment Benefit.
- This benefit does not cover any travel and accommodation costs for chemotherapy or radiotherapy in a public hospital.

12 Parent Accommodation Benefit

12.1 What we cover

We cover the cost per night of the accommodation incurred by a parent or legal guardian accompanying an insured child aged under five years listed in the **acceptance certificate** or **renewal certificate**, where that child is being treated in an **approved private hospital,** and a benefit under sections 2, 3 or 4 has been paid.

12.2 Benefit maximum

We pay up to $150 per night.

We pay up to $1,800 per **hospitalisation** or per **cycle** of chemotherapy or radiotherapy treatment.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit, Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

12.3 Other terms

Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

13 Post-treatment Physiotherapy Benefit

13.1 What we cover

We cover the cost of post-treatment physiotherapy up to six months after being discharged from an **approved private hospital** on referral by the treating **registered specialist** or up to six months after a **cycle** of chemotherapy or radiotherapy treatment.

13.2 Benefit maximum

No limit per visit.

We pay up to $500 per **hospitalisation** or per **cycle** of chemotherapy or radiotherapy treatment.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit, Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

13.3 Other terms

- The physiotherapy must directly relate to the **hospitalisation** or **cycle** of chemotherapy or radiotherapy treatment. If **you** have chosen the GP Option, an **insured person** will have cover up to the benefit maximum in the Physiotherapy Benefit
- Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

14 Post-treatment Home Nursing Care Benefit

14.1 What we cover

We cover the cost of post-treatment home nursing care by a **registered nurse**, up to six months after being discharged from an **approved private hospital**, on referral by a **GP** or **registered specialist** or up to six months after a **cycle** of chemotherapy or radiotherapy treatment.

14.2 Benefit maximum

We pay up to $150 per day.

We pay up to $6,000 per **insured person** per **policy year**.

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit, Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

14.3 Other terms

- The home nursing care must directly relate to the **hospitalisation** or **cycle** of chemotherapy or radiotherapy treatment.
- Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit or Cancer Treatment Benefit (whichever applies).

15 Overseas Treatment Benefit

15.1 What we cover

We cover the cost of surgical or medical treatment that cannot be performed at all in New Zealand, where an application has been submitted to the Ministry of Health for funding under the 'Medical Treatment Overseas Scheme", and the Ministry of Health has declined funding.

15.2 Benefit maximum

We pay up to $20,000 per overseas visit for treatment, less any **excess**.

15.3 Other terms

- The treatment must be of a type which cannot be performed in New Zealand and must be declined for funding by the Ministry of Health under the 'Medical Treatment Overseas Scheme'. **You** must provide evidence of the Ministry of Health's decision not to fund the treatment.

- The treatment must be recommended by a **registered specialist** and must be recognised by **us** as a conventional form of treatment.
- **We** cover the reasonable travel cost of the **insured person** requiring treatment plus the cost of the treatment performed overseas, up to the benefit maximum, less any **excess**.

16 Specialist Minor Surgery Benefit

16.1 What we cover

We cover the cost of treatment for minor surgery, performed by a **registered specialist**, on referral from a **GP**.

16.2 Benefit maximum

We pay up to $6,000 per **insured person** per **policy year,** less any **excess**.

16.3 Other terms

- **We** recommend **pre-approval** as some minor surgery is deemed cosmetic surgery and is not covered.
- This benefit does not include the pre and post minor surgery **registered specialist** consultations, or any other diagnostic costs associated with treatment.

17 Specialist Minor Surgery Benefit – Skin Lesions

17.1 What we cover

We cover the cost of treatment for minor surgery on skin lesions performed by a **registered specialist**, on referral from a **GP**.

17.2 Benefit maximum

All costs paid under this benefit are included within the benefit maximum for the Specialist Minor Surgery Benefit.

17.3 Other terms

- **We** recommend **pre-approval** as some minor surgery is deemed cosmetic surgery and is not covered.
- This benefit does not include the pre and post minor surgery **registered specialist** consultations for skin lesions, or any other diagnostic costs associated with treatment.

18 Complications of Pregnancy / Childbirth Benefit

18.1 What we cover

We cover the cost of treatment associated with an abnormal pregnancy and / or childbirth, but excluding caesarean sections and ectopic pregnancies.

18.2 Benefit maximum

We pay up to $2,000 per **insured person** per **policy year**, less any **excess**.

19 ACC Top-up Benefit

19.1 What we cover

We cover any shortfall between what **ACC** pays for a physical **injury** and the actual **costs covered** of the surgical and / or medical treatment in an **approved private hospital**, less any **excess**. This is limited to the appropriate benefit maximum, less any **excess**. A copy of **ACC's** decision must be supplied to **us** prior to treatment being undertaken.

19.2 Benefit maximum

All costs paid under this benefit are included within the benefit maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

19.3 Other terms

- An **insured person** must obtain **ACC's** acceptance of their claim prior to the treatment being performed, and provide **us** with evidence of **ACC's** acceptance of their claim and the amount payable by **ACC** in respect of that treatment.
- **We** may require an **insured person** to apply for a review of **ACC's** decision. **You** must reimburse **us** for any cost subsequently covered by **ACC** as a result of the review. **We** may request **your** permission to seek legal advice at **our** cost to address the review of **ACC's** decision.
- The surgical and medical costs must directly relate to the **hospitalisation.**
- Cover is only provided where a claim has been paid under the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

20 Waiver of Premium Benefit

20.1 What we cover

We cover the premiums due on this policy for all surviving **insured persons** if a **policyowner** dies before the age of 65 from any cause.

20.2 Benefit maximum

We pay the premiums:

- for two years; or
- until any surviving **insured person** is aged 65, whichever occurs first.

20.3 Other terms

- No **excess** will be deducted.
- The benefit starts from the next premium payment date.
- This benefit ends at the earlier of when the **insured person** attains the age of 65, or at the end of the two years. When the benefit ends, the premiums will be paid by **you**.

21 Loyalty Benefit – Obstetrics

21.1 What we cover

After 12 months' continuous cover under this policy, an **insured person** is covered for the cost of the expenses relating to obstetrics.

21.2 Benefit maximum

We pay up to $1,000 per **insured person** per **policy year**, less any **excess**.

22 Loyalty Benefit – Sterilisation

22.1 What we cover

After five years' continuous cover under this policy, an **insured person** is covered for the cost of male or female sterilisation as a means of contraception.

22.2 Benefit maximum

We pay up to $1,000 per procedure, less any **excess**.

23 Loyalty Benefit – Suspension of Cover

23.1 What we cover

After 12 months' continuous cover under this policy, the cover (including the premium payments) can be suspended as follows:

23.1.1 Overseas travel / residence

If the **insured person** lives or travels outside New Zealand for longer than three consecutive months the cover for the **insured person** can be suspended for between three and 24 months. To suspend cover **you** must tell **us** in writing before the **insured person** travels overseas, and provide any evidence of travel **we** require.

23.1.2 Unemployment

If **you** are registered as unemployed, cover can be suspended for between three and six months. To suspend cover **you** must tell **us** in writing within 30 days of **you** registering as unemployed and provide evidence of registration.

23.2 Other terms

- **You** cannot suspend cover for more than 24 months in any 10-year period.
- While cover is suspended no premium is payable and no cover is provided for the **insured person** affected.
- Premium payments and cover recommences when this policy is reinstated.
- **We** will reinstate cover without inquiring into the **insured person's** health so long as **you** reinstate cover before the suspension of cover period ends.
- If **you** do not reinstate the cover at the end of the suspension of cover period, **we** will write to **you** to **your** last known address and give **you** 90 days within which to pay any arrears of premium. If **you** do not pay the arrears by the end of 90 days where this policy is suspended, this policy will end and where an **insured person's** cover is suspended, the cover on that **insured person** will end.
- If **you** have suspended **your** cover for overseas travel / residence and at the end of the suspension of cover period **you** do not wish to reinstate the cover on the **insured person** affected, this policy will end and **we** will issue a new policy to the remaining **insured persons**.

24 Loyalty Benefit – Wellness

24.1 What we cover

After an **insured person** aged 21 or over has been continuously covered under the Base Cover for 36 months, **we** cover the cost of a medical examination of that **insured person** by a **GP** including, for example, the cost of laboratory tests, **ECG**, blood pressure checks, breast examinations, cervical smears and prostate examinations.

24.2 Benefit maximum

We pay up to $100 per **insured person** aged 21 or over, after each 36 months of continuous cover.

24.3 Other terms

- **We** will advise **you** when an **insured person** is eligible to take up this benefit.
- This benefit is not available to **dependent children.**
- Once a **dependent child** reaches age 21, this benefit is available to him or her and the period of 36 months of continuous cover begins on the **policy anniversary date,** on or immediately after that **insured person** reaches age 21, if that **insured person** remains on this **policy**, or from the **commencement date** of that **insured person's** own policy.
- This benefit must be taken in the **policy year** after entitlement and cannot be accumulated over subsequent years.
- If cover is suspended, the suspended period is included in calculating the 36 months of continuous cover.
- Where an **insured person** is added to this policy, each period runs from that **insured person's join date.**
- The **excess** does not apply to this benefit.

Specialist Option

1 Introduction

1.1 What we cover

The Specialist Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Specialist Option.

This option covers the cost of **registered specialist** consultations and specific **diagnostic investigations** during this policy for a **health condition** on the terms set out below.

Benefits under the Specialist Option apply to each **insured person** shown on **your acceptance** or **renewal certificate**, unless stated otherwise in this policy.

It is highly recommended that **you** obtain **pre-approval** before an **insured person** visits a **registered specialist** or undergoes one of the specific **diagnostic investigations**.

1.2 What we pay

We will refund **you** the **costs covered** up to the benefit maximums. The Base Cover **excess** does not apply to the Specialist Option.

2 Specialist Benefit

2.1 What we cover

We cover the cost of **registered specialist** or **vocational GP** consultations, after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised**.

If consultations result in admission to an **approved private hospital** or **cycle** of chemotherapy or radiotherapy treatment within six months of the consultation, the cost of these will be covered under the Base Cover and are included within the applicable benefit maximum.

3 Diagnostic Radiology and Imaging Benefit

3.1 What we cover

We cover the cost of diagnostic radiology and diagnostic imaging tests, under the benefit maximums below, after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised** for treatment.

3.2 Benefit maximum

We pay up to the following:

- MRI scan $2,500
- CT scan $2,000
- X-rays $1,200
- Arteriogram $1,200
- Ultrasound $500
- Scintigraphy $400
- Mammography $300

Benefit maximums are per **policy year**.

3.3 Other terms

- The referral must be in response to a preliminary diagnosis. **Surveillance testing** is not covered.
- If any of these tests result in admission to an **approved private hospital** or **cycle** of chemotherapy or radiotherapy treatment within six months, the cost of these will be covered under the Base Cover and are included within the applicable benefit maximum.

4 Cardiac Investigations Benefit

4.1 What we cover

We cover the cost of cardiac investigations after referral from a **GP** or a **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised**. Investigations such as treadmills, holter monitoring, ambulatory blood pressure monitoring, cardiovascular ultrasound, echocardiography, myocardial perfusion scans and cardioversion are included.

4.2 Benefit maximum

We pay up to $60,000 per **policy year**.

4.3 Other terms

- The referral must be in response to a preliminary diagnosis. **Surveillance testing** is not covered.
- If these investigations result in admission to an **approved private hospital** within six months, the cost of these will be covered under the Base Cover and are included within the applicable benefit maximum.

5 New application

If **you** wish to add the Specialist Option to **your** policy after the **commencement date**, **you** must complete a new application form.

The terms of **our** acceptance will depend on the information **you** provide **us**. The option will be added to this policy on the nearest billing date immediately after **you** request this change.
If **we** make the change on any other date **we** will let **you** know. An additional premium is payable for this option.

Trauma Option

1 Introduction

1.1 What we cover

The Trauma Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Trauma Option. Where it does, the **insured person** covered and the **sum insured** will be shown in **your acceptance certificate** or **renewal certificate**.

We cover the **insured person** for any one of the Medical Conditions defined below if:

- the **insured person** survives for at least 14 days following the date of the diagnosis of the Medical Condition; and
- the **insured person** first suffers the Medical Condition at least 90 days after the **commencement date** or the **join date** where an **insured person** is added to this policy or if the **sum insured** has been increased at any time, at least 90 days after the increase, and before this cover ends.

This does not apply to Paralysis. The **insured person** covered must first suffer Paralysis on or after the **commencement date** or the **join date** where an **insured person** is added to this policy and before this cover ends.

If any of the Medical Conditions result in a surgical procedure, then that surgical procedure must be the usual treatment for what has happened to that **insured person**.

1.2 What we pay

The Trauma Option pays the **sum insured** shown in the **acceptance certificate** or **renewal certificate** as a lump sum.

Only one **sum insured** is paid for each **insured person** covered by the Trauma Option.

We pay the **sum insured** that applied at the date that the **insured person** first suffered the Medical Condition.

1.3 Other terms

- The Base Cover **excess** does not apply to the Trauma Option.
- Some exclusions apply. Please refer to sections 7 and 8 of the General Conditions.
- The **sum insured** will be reduced proportionally if the **insured person** covered is older than the age stated in the application form.

2 Medical Conditions

2.1 Heart and circulation

Aortic surgery

The undergoing of necessary medical surgery to:

- repair or correct an aortic aneurysm; or
- an obstruction of the aorta; or
- a coarctation of the aorta; or
- a traumatic rupture of the aorta.

For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta, but not its branches.

Coronary artery bypass grafting surgery

The undergoing of medically necessary Coronary artery bypass grafting surgery to correct or treat coronary artery disease. This does not include angioplasty.

Primary pulmonary hypertension

Primary pulmonary hypertension with substantial right ventricular enlargement resulting in permanent irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association Classification of Cardiac Impairment, and resulting in the **insured person** being unable to perform his / her **usual occupation**.

Major heart attack (Myocardial infarction)

Means the **insured person** has had a Myocardial infarction (other than as a direct result of cardiac or coronary intervention) with the following criteria being satisfied:

- a diagnostic rise and fall in either **Troponin** I in excess of 2.0ug/L, **Troponin** T in excess of 0.6ug/L or cardiac enzyme **CK-MB**; and
- development on an **ECG** of either new pathological Q waves or new changes indicative of ischaemia.

If the above criteria are not met then **we** will pay a claim based on satisfactory evidence that the **insured person** has suffered a Myocardial infarction which has resulted in a permanent reduction in the Left Ventricular Ejection Fraction to less than 50%.

Heart valve surgery

The undergoing of surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. Repair via valvotomy, catheter surgery, minimally invasive, 'keyhole' or similar techniques are specifically excluded.

2.2 Cancer

Cancer – life threatening

The presence of one or more malignant tumours including leukaemia, lymphomas and Hodgkins disease. The malignant tumour is to be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

The following are not included:

- Tumours showing the malignant changes of carcinomas in situ* (including cervical dysplasia **CIN-1**, **CIN-2** and **CIN-3**) or which are histologically described as pre-malignant.
- All skin cancers, including hyperkeratoses, basal cell carcinomas and squamous cell carcinomas, unless there is evidence of metastases.**

- Non life-threatening cancers, such as:
  - Prostatic cancers which are histologically described as **TNM Classification** T1 or are of another equivalent or lesser classification.
  - Papillary Micro-Carcinoma of the thyroid or bladder.
- Chronic Lymphocytic Leukaemia less than **Rai** Stage 1.

*Carcinoma in situ of the breast is covered if it results directly in the removal of the entire breast. The procedure used must be performed specifically to arrest the spread of malignancy and be considered to be the usual and necessary treatment.

** Malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the **Breslow Method** are covered.

2.3 Blood disorder

Aplastic anaemia

Total bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood product transfusion.
- Marrow stimulating agents.
- Immunosuppressive agents.
- Bone marrow transplantation.

2.4 Functional Loss / Neurological

Advanced Dementia (including Alzheimer's disease)

Alzheimer's disease or other Dementia resulting in permanent irreversible failure of brain function and significant cognitive impairment for which no other recognisable cause can be identified. Significant cognitive impairment means a deterioration or loss of intellectual capacity that results in a requirement for a permanent caregiver.

Major head trauma resulting in functional loss

Accidental cerebral **injury** resulting in permanent neurological deficit causing either:

- at least 25% impairment of **whole person function**, that is permanent; or
- the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Motor neurone disease resulting in functional loss

Motor neurone disease with significant persistent neurological deficit resulting in either:

- at least 25% impairment of **whole person function**, that is permanent; or
- the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Multiple Sclerosis resulting in functional loss

Multiple Sclerosis with significant persistent neurological deficit resulting in either:

- at least 25% impairment of **whole person function**, that is permanent; or
- the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Paralysis

The permanent and total loss of function of two or more limbs as a result of **injury** to, or disease of, the spinal cord or brain as defined below. Limb is defined as the complete arm or the complete leg:

- Hemiplegia: the permanent and total loss of function of one side of the body as a result of **injury** to, or disease of, the spinal cord or brain.

- Diplegia: the permanent and total loss of function of both sides of the body as a result of **injury** to, or disease of, the spinal cord or brain.
- Paraplegia: the permanent and total loss of function of both legs as a result of **injury** to, or disease of, the spinal cord or brain.
- Quadriplegia: the permanent and total loss of function of both arms and both legs as a result of **injury**, to or disease of, the spinal cord or brain.
- Tetraplegia: the permanent and total loss of function of both arms and both legs and loss of head movement as a result of **injury** to, or disease of, the spinal cord or brain.

Parkinson's disease resulting in functional loss

Parkinson's disease where the condition cannot be controlled with medication and shows signs of progressive incapacity with either:

- at least 25% impairment of **whole person function**, that is permanent; or
- the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Stroke resulting in functional loss

The suffering of a stroke as a result of a cerebrovascular event producing neurological deficit and causing either:

- at least 25% impairment of **whole person function**, that is permanent; or
- the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

This requires clear evidence on a Computerised Tomography Scan (CT) or Magnetic Resonance Imaging Scan (MRI) or similar appropriate scan that a stroke has occurred and evidence of:

- infarction of brain tissue; or
- intracranial or subarachnoid haemorrhage.

This does not include neurological deficit due to transient ischaemic attacks, reversible neurological deficit, migraine, cerebral **injury** resulting from trauma or hypoxia and vascular disease affecting the eye, optic nerve or vestibular functions.

2.5 Loss of use

Loss of limbs and / or sight

The total and irrecoverable:

- loss of two or more limbs; or
- loss of sight of both eyes; or
- loss of one limb and the sight of one eye.

The loss of sight of an eye means the complete and irrecoverable loss of sight (whether aided or unaided). The loss of a limb means complete loss of the use of an entire hand or entire foot.

Total and permanent blindness

The complete and irrecoverable loss of the sight of both eyes to the extent that:

a) visual acuity is less then 6 / 60 vision, in both eyes after correction; or

b) field vision is constricted to 10 degrees or less; or

c) combined visual defects result in the same degree of visual impairment as that occurring in a) or b).

2.6 Organs

Chronic renal failure

End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is instituted or renal transplantation performed.

Major organ transplant

The medically necessary human-to-human transplant from a donor to the **insured person** of one or more of the following complete organs: kidney, liver, heart, lung, pancreas, small bowel or the transplantation of bone marrow.

2.7 Other conditions

Severe burns

Tissue **injury** caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by 'The Rule of Nines' or the Lund & Browder Body Surface Chart (or similar means of measurement as determined by **us**).

Occupationally acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where HIV was acquired as a result of an accident during the course of carrying out normal occupational duties with sero-conversion to HIV infection occurring within six months of the incident. Any incident giving rise to a potential claim must be reported to **us** within 30 days of the incident and be supported by a negative HIV antibody test taken by the **insured person**, taken within seven days after the incident. This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.

Infection in any other manner, including infection as a result of sexual activity or intravenous drug use is excluded. **We** must have open access to all blood samples and be able to obtain independent testing of such blood samples.

3 When the Trauma Option ends

The Trauma Option ends in relation to an **insured person** at the earliest of the following:

- at the **policy anniversary date** immediately after that **insured person's** 70th birthday; or
- when the **sum insured** is paid; or
- when that **insured person** dies.

4 New application or alteration to the sum insured

If **you** wish to add the Trauma Option to **your** policy or alter the **sum insured** (to a level set by **us**) after the **commencement date**, **you** must complete a new application form.

Pre-existing conditions would be excluded from cover under this option. The terms of **our** acceptance depend on the information **you** provide **us**. If **we** agree to the addition or alteration, then **we** will issue a new **acceptance certificate** or **renewal certificate** showing the new **sum insured**. The option will be added to this policy on the nearest billing date immediately after **you** request this change. If **we** make the change on any other date **we** will let **you** know. An additional premium is payable for this option.

GP Option

1 Introduction

1.1 What we cover

The GP Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the GP Option. This option covers the cost of the following treatments during this policy for a **health condition** on the terms set out below.

Benefits under the GP Option apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate** unless stated otherwise in this policy.

1.2 Stand-down period

The GP Option has a three-month **stand-down period** before benefits can be claimed, unless **we** have agreed otherwise. The **health condition** and resulting treatment must first occur after the **stand-down period**.

1.3 What we pay

We will refund **you** the **costs covered** up to the benefit maximums. The Base Cover **excess** does not apply to the GP Option.

2 General Practitioners Benefit

2.1 What we cover

We cover the cost of **GP** visits, including home visits, **ECG**, cervical smears and minor surgery under local anaesthetic.

2.2 Benefit maximums

We pay up to $55 per **GP** clinic visit, including after hours.

We pay up to $80 per home visit.

We pay up to $25 per visit for **ACC Top-up**. **You** cannot use the $55 / $80 per clinic / home visit benefit to add to this.

We pay up to 12 **GP** visits per **policy year**. Minor surgical procedures are not counted in the 12 visits.

We pay up to $200 per minor surgical procedure. **You** cannot use the $55 / $80 per clinic / home visit benefit to add to this.

3 Prescription Benefit

3.1 What we cover

We cover the cost of medicines and drugs listed under Sections A to G of the Ministry of Health **PHARMAC** Pharmaceutical Schedule prescribed by a **GP** or **registered specialist** that meet the eligibility criteria for funding.

3.2 Benefit maximums

We pay up to $15 per item.

We pay up to $300 per **policy year**.

3.3 Other terms

This excludes after hours fees.

4 Physiotherapy Benefit

4.1 What we cover

We cover the cost of physiotherapy treatment after referral by a **GP** or **registered specialist**.

4.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit benefit to add to this.

We pay up to $400 per **policy year**.

5 Independent Nurse and Nurse Practitioner Benefit

5.1 What we cover

We cover the cost of visits to / by an **independent nurse** or **nurse practitioner**.

5.2 Benefit maximums

We pay up to $30 per visit.

We pay up to six visits per **policy year**.

6 Public Hospital Cash Grant

6.1 What we cover

We make a cash payment when an **insured person** is admitted to a public hospital in New Zealand and is in the public hospital for three or more consecutive nights.

6.2 Benefit maximums

We pay $100 per night.

We pay up to $500 per **policy year**.

6.3 Other terms

We do not pay this benefit if a fee-paying **insured person** is admitted to the private wing of a public hospital.

7 Loyalty Benefit – Active Wellness

7.1 What we cover

After 24 months' continuous cover under the GP Option, and at the end of every 24 months thereafter, providing claims for events that occurred within the preceding 24-month period under the GP Option are less than $150, each **insured person** aged 21 or over will receive a reimbursement of the cost of either:

- membership to a recognised gym or sports club; or
- sports / fitness equipment purchased from a recognised sporting retailer.

If **you** submit a claim for events which occurred within the preceding 24 month period after this benefit has been paid, **we** will deduct the amount paid to **you** for this Active Wellness Benefit from the claim.

7.2 Benefit maximum

We pay up to $150 per **insured person**, aged 21 or over, after each 24 months of continuous cover under the GP Option.

7.3 Other terms

- Claims made under the Base Cover or the other options are not counted when **we** assess **your** eligibility for this benefit.
- **We** will advise **you** when an **insured person** aged 21 or over is eligible to take up this benefit.
- The benefit must be taken in the **policy year** after entitlement and cannot be accumulated over subsequent years.
- This benefit does not apply to **dependent children.**
- Once a **dependent child** reaches age 21, this benefit is available to him or her and the period of 24 months of continuous cover begins on the **policy anniversary date**, on or immediately after that **insured person** reaches age 21 if that **insured person** remains on this **policy**, or from the **commencement date** of that **insured person's** own policy.
- If cover is suspended, the suspended period is included when calculating the 24 months' continuous cover.
- Where an **insured person** is added to this policy, each period runs from that **insured person's join date**.

8 New application

If **you** wish to add the GP Option to **your** policy after the **commencement date**, **you** must complete a new application form. The terms of **our** acceptance depend on the information **you** provide **us**.

The option will be added to this policy on the nearest billing date immediately after **you** request this change. If **we** make the change on any other date **we** will let **you** know. An additional premium is payable for this option.

Dental and Optical Option

1 Introduction

1.1 What we cover

The Dental and Optical Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Dental and Optical Option.

This option covers the cost of the following treatments during this policy for a **health condition** on the terms set out below.

The Dental and Optical Option and the benefit maximums apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**, unless stated otherwise in this policy.

1.2 Stand-down period

This option has a six-month **stand-down period** before benefits can be claimed, unless **we** have agreed otherwise. The **health condition** and resulting treatment must first occur after the **stand-down period**.

1.3 What we pay

We will refund **you** either 100% or 80% of the cost incurred up to the benefit maximums. The percentage **you** choose is shown on **your acceptance certificate** or **renewal certificate**. The Base Cover **excess** does not apply to the Dental and Optical Option.

2 Dental Care Benefit

2.1 What we cover

We cover the cost of dental treatment by a registered dental practitioner or oral surgeon, including examination, cleaning and scaling, fillings, associated X-rays and removal of teeth.

2.2 Benefit maximum

We pay up to $500 per **policy year**.

2.3 Other terms

- This benefit excludes treatment for **dependent children** covered under the school dental service or general dental benefit scheme.
- The benefit excludes the additional cost of gold or other exotic materials.

3 Eye Care Benefit

3.1 What we cover

We cover the cost of optometrist, orthoptist and optician examination fees and the cost of glasses and contact lenses when these are required as a result of a vision change.

3.2 Benefit maximums

We pay up to $55 per consultation / examination.

We pay up to $275 per **policy year** for consultations / examinations.

We pay up to $330 per **policy year** for each **insured person** for glasses and contact lenses.

3.3 Other terms

- **We** do not cover the cost of changing glasses and contact lenses for fashion reasons.
- **We** only cover the cost of treatment by an orthoptist on referral by an optometrist, **GP** or **registered specialist**.

4 Ear Care Benefit

4.1 What we cover

We cover the cost of audiometric tests and audiology treatment after referral from a **registered specialist**.

4.2 Benefit maximums

We pay up to $250 per **policy year** for audiology.

We pay up to $250 per **policy year** for audiometric tests.

5 Acupuncture Care Benefit

5.1 What we cover

We cover the cost of acupuncture treatment by a **GP** or by a registered physiotherapist, after referral from a **GP** or **registered specialist**.

5.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit benefit to add to this.

We pay up to $250 per **policy year**.

6 Spinal Care Benefit

6.1 What we cover

We cover the cost of chiropractic treatment after referral from a **GP** or **registered specialist**.

6.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit benefit to add to this.

We pay up to $250 per **policy year** for visits.

We pay up to $80 per **policy year** for X-rays.

7 Joint Care Benefit

7.1 What we cover

We cover the cost of osteopathy treatment after referral from a **GP** or **registered specialist**.

7.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit benefit to add to this.

We pay up to $250 per **policy year** for visits.

We pay up to $80 per **policy year** for X-rays.

8 Foot Care Benefit

8.1 What we cover

We cover the cost of podiatry treatment after referral from a **GP** or **registered specialist**.

8.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $250 per **policy year**.

9 Therapeutic Care Benefit – Speech, Occupational and Eye

9.1 What we cover

We cover the cost of speech, occupational and eye therapy after referral from a **GP** or **registered specialist**.

9.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $300 per **policy year** for the combined total of all of these therapies.

10 Loyalty Benefit – Orthodontic Treatment

10.1 What we cover

After an **insured person** has been continuously covered under the Dental and Optical Option for 24 months, the Dental Care Benefit will be extended to include orthodontic treatment up to the same benefit maximums.

10.2 Benefit maximum

All costs paid under this benefit are included within the benefit maximum for the Dental Care Benefit of up to $500 per **policy year**.

11 New application

If **you** wish to add the Dental and Optical Option to **your** policy after the **commencement date**, **you** must complete a new application form. The terms of **our** acceptance depend on the information **you** provide **us**.

The option will be added to this policy on the nearest billing date immediately after **you** request this change. If **we** make the change on any other date **we** will let **you** know. An additional premium is payable for this option.

General Conditions Section

1 Period of cover

Cover for the Base Cover and any options shown on the **acceptance certificate** or **renewal certificate** start on the **commencement date** or the **join date** where an **insured person** is added to this policy.

Cover ends when any of the following happen:

- **you** ask **us** to cancel it. **You** must give **us** not less than 30 days' notice in writing or by email; or
- **you** fail to pay the premium or any premium installment within 90 days after the due date for payment; or
- **you** or any **insured person** breach the terms of the contract; or
- when the last **insured person** covered by this policy dies.

All information given by, or on behalf of, **you** or any **insured person** when arranging this policy or making any changes to it must be true, correct and complete. If it is not, **we** may at **our** discretion, cancel this policy from the **commencement date**.
If **we** cancel this policy, any premiums **you** have paid may be retained by **us**. If **we** have already made any payments, **we** can recover these from **you**.

2 Dependent children

Cover for a **dependent child** ends on the **policy anniversary date** after they reach age 21.

We will automatically continue cover for that person on this policy as an **insured person** and deduct the additional premium for the cover from the same payment source and at the same frequency as this policy, unless **you** advise **us** otherwise.

That person can arrange a separate policy with **us** on similar terms without having to provide any further evidence of health other than their smoking status. That person's smoking status may need to be provided to enable the appropriate adult premium to be calculated. If the smoking status is not known, the adult premium will be calculated using smoker rates.

3 Important information about premiums

You must pay **us** the premium at one of the frequencies provided by **us**.

The premium is calculated according to the rates applying at the time for the policy **you** selected. Any changes to the premium rates and age related steps apply across all **insured persons** with this policy.

No changes will be made to **your** individual policy alone, based upon the individual claims experience of **your** policy.

The premiums for this policy are not guaranteed. **We** may alter the schedule of premium rates (including the ages at which premiums increase) and / or the Benefits during the life of the policy, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

- if the law that applies to the policy changes (including changes in taxation); or
- if **our** costs increase as a result of medical inflation, as determined by **us**; or
- in order to increase the level of cover under a Benefit or to add a new Benefit; or
- to allow for an unexpected and significant increase in the type and / or level of claims under the policy, which are not sustainable long term and which threaten its commercial viability; or
- to align this policy with a newer version of the same type of policy **we** subsequently offer with similar (but not necessarily the same) premiums and / or Benefits; or
- to take into account unexpected and severe public health threats e.g. a pandemic.

We will give the **policyowne**r 30 days' prior written notice of any alteration. The **policyowner** retains the right to cancel this policy at any time.

We want to ensure **your** valuable cover continues if a deduction advice is returned to **us** 'gone / no address'. **We** will continue to make deductions in accordance with **our** premium rates until **we** are advised otherwise. **You** authorise **us** to do this.

4 Altering the terms and conditions of your policy

We may alter the terms of this policy at any time by giving **you** 30 days' prior written notice, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

- if the law that applies to the policy changes (including changes in taxation); or
- if **our** costs increase as a result of medical inflation, as determined by **us**; or
- in order to increase the level of cover under a Benefit or to add a new Benefit; or
- to allow for an unexpected and significant increase in the type and / or level of claims under the policy, which are not sustainable long term and which threaten its commercial viability; or
- to align this policy with a newer version of the same type of policy **we** subsequently offer with similar (but not necessarily the same) premiums and / or Benefits; or
- to take into account unexpected and severe public health threats e.g. a pandemic.

No alterations will be made to **your** individual policy alone, based upon the individual claims experience of **your** policy.

If **you**, and all **insured persons**, comply with this policy, **we** cannot cancel it unless stated otherwise in the policy.

If **we** have changed the terms of **your** policy for an **insured person** (e.g. added an exclusion) this will be shown in the **acceptance certificate** or **renewal certificate**. **You** must instigate any review of the additional terms. Any cost in relation to the review would be at **your** cost.

4.1 Correspondence and notices

Notices to **us** regarding this policy must be sent or emailed to **our** address in Section 4.2 below. All notices **we** send to **you** must be sent to **your** last known address (unless previous correspondence has been returned 'gone / no address' in which case no further correspondence will be sent until **we** receive notification of **your** new address), or sent by email to **your** last known email address.

4.2 Our address

Our address is:

nib nz limited
PO Box 91 630
Victoria Street West
Auckland 1142.

The physical address of **our** head office at the time of printing this document is:

nib nz limited
48 Shortland Street
Auckland 1010.

Our email address is: **contactus@nib.co.nz**

4.3 Authority

Changes to this policy

A **policyowner** is authorised to enquire about, and make changes to, the cover he or she owns. However, if there is more than one **policyowner**, this policy is owned jointly and any changes to this policy require the approval of all **policyowners** unless stated otherwise in this policy.

If a **policyowner** requests that another **insured person** or **policyowner** on this policy be removed, the approval of all **policyowners** is required.

However, if an **insured person** requests to be removed from this policy, **we** may remove that **insured person** without the approval of the **policyowner(s)**. The removed **insured person** may arrange a separate policy determined by **us** without providing any further evidence of health.

5 Reinstating this policy

If this policy ends, and **we** agree to reinstate it:

- cover starts on the date **we** reinstate it; and
- **we** will give **you** a new **acceptance certificate** or **renewal certificate**.

6 Making a claim

All information given by, or on behalf of, **you** or any **insured person** when making a claim must be true, correct and complete. If it is not, **we** may, at **our** discretion, decline the claim and / or cancel this policy from the **commencement date**. If **we** cancel this policy, any premiums **you** have paid may be retained by **us**. If **we** have already made any payments, **we** can recover these from **you**.

You and the **insured persons** authorise disclosure to **us** of **your** personal information held by others that is relevant to a claim.

Details of **your** claim or a claim on any **insured person** can be provided to anyone who **you** nominate in writing, verbal communication or claim form.

You must comply with this policy in full before any claim is paid.

If any premium is outstanding on this policy at the date **we** accept a claim, **we** can:

- Deduct the outstanding premium(s) from the claim payment.
- Withhold payment of the claim until the outstanding premium(s) have been paid.

7 Exclusions – what we will not pay for

We will not pay a Benefit for, or the cost, of:

7.1 The following health conditions:

a) A **health condition** in connection with the misuse of alcohol and / or prescription drugs.

b) A **health condition** in connection with the use of non-prescription drugs.

c) A psychiatric **health condition** or any mental disorder and subsequent treatment.

d) A dental **health condition** (except where the contrary is expressly specified in this policy).

e) Senile illness or dementia (except where the contrary is expressly specified in the policy).

f) Acquired immune deficiency syndrome (AIDS) or associated **health conditions** including human immunodeficiency virus (HIV) and related **health conditions** (except where the contrary is expressly specified in this policy).

g) Infection by any sexually transmitted disease and any resulting complication.

h) A known **congenital health condition** (ie a **health condition** which is recognised at birth, or diagnosed within four months of birth, whether it is inherited or due to external factors such as drugs or alcohol).

i) Any **health condition** as a consequence of war, invasion, act of foreign enemy, hostilities or warlike operations (whether war is declared or not), civil war, civil commotion, mutiny, rebellion, revolution, insurrection, act of terrorism, act of bio terrorism, peace keeping duties, or military or usurped power.

j) Any **health condition** not registered with the Ministry of Health as a disease entity.

k) Any **pre-existing condition** and any **health condition** excluded under the Benefits Section or General Conditions Section. This exclusion does not apply, however, in respect of a **health condition** declared on **your** application form and accepted by **us**, and not excluded on the **acceptance certificate** or **renewal certificate**, or where it is noted on the **acceptance certificate** or **renewal certificate** that **pre-existing conditions** are covered.

l) Any **acute health condition**.

m) A **health condition** arising from a criminal offence by an **insured person** that resulted in a conviction under the Crimes Act.

n) Infertility, normal pregnancy and childbirth, caesarean sections, termination of pregnancy, erectile dysfunction, sterilisation, contraception or contraceptive procedures (except where the contrary is expressly specified in this policy).

o) Any **health condition** requiring an admission to a private hospital for care that does not involve surgical or medical treatment.

7.2 The following tests, diagnostic procedures, treatments or health services:

a) Geriatric care, including geriatric **hospitalisation** or **long-term care**.

b) Breast reduction.

c) The treatment of obesity, such as but not limited to, gastric banding, gastric bypass, medication, **GP** or **registered specialist** consultations and weight reduction treatments or any complications thereof.

d) Rehabilitation (except where the contrary is expressly stated within this policy), **long-term care**, convalescence, respite, geriatric care and **disability support services** costs.

e) Cosmetic treatment or elective treatment which does not improve an **insured person's** health.

f) All forms of preventative treatment, for example (without limitation) drug treatment or any vaccines, mole mapping and **surveillance testing** except where provided for under a Wellness Benefit.

g) Any investigation and / or treatment for sleep disturbances, snoring or obstructive sleep apnoea.

h) Treatment for self-inflicted injuries or attempted suicide.

i) Any services or treatment not normally conducted by a **GP** or **registered specialist**, and / or not recognised by the Medical Council of New Zealand or Ministry of Health (except where the contrary is expressly stated within this policy).

j) Specialised tertiary treatments such as any transplants (including but not limited to heart, lung, kidney, liver and bone marrow transplants) as provided by government funded agencies.

k) Costs related to an organ donation.

l) Specialised transfusions of blood, blood products, renal dialysis or CAPD as provided by government funded agencies.

m) Any treatment for the correction of myopia (short sightedness) or hypermetropia (long sightedness), or presbyopia (blurred vision) or any related complications except where provided for under the Dental and Optical Option.

n) Radial keratotomy or photo-refractive keratectomy (such as laser or Lasik treatment) or any related complications.

o) Any costs incurred as a result of cancellation of treatment under one of the eligible Benefits, except where that cancellation is on medical advice.

p) Costs incurred outside New Zealand (except where expressly specified otherwise in this policy).

q) Costs of periodontal, orthodontic and endodontal procedures and implants, except where provided for under the Dental and Optical Option.

r) Costs of after hours and other administration costs (e.g. faxing charges incurred between the prescribing doctor, specialist or pharmacy) associated with prescriptions.

s) Costs of changing glasses and contact lenses for fashion reasons where there has been no change in vision.

t) Costs associated with additional procedures performed along with a procedure approved by **us**.

u) Prophylactic (preventative) healthcare services.

7.3 The following mechanical tools, aids or appliances:

a) Mechanical tools as determined by **us**. For example (without limitation): glucometers, oxygen machines and respiratory machines.

b) Aids as determined by **us**. For example (without limitation): hearing aids, cochlear implants, pacemakers, personal alarms and orthotic shoes.

c) Appliances to assist with mobility as determined by **us**. For example (without limitation): crutches, wheelchairs and artificial limbs.

These do not include any surgically implanted **prostheses** listed on **our prosthesis** schedule.

7.4 The following:

a) Treating a physical **injury** except as provided under the **ACC Top-up** Benefit.

b) Medicines or drugs that are not funded by **PHARMAC** as detailed in Sections A to G of **PHARMAC** Pharmaceutical Schedule in accordance with the funding criteria as stated in the **PHARMAC** Pharmaceutical Schedule, or medicines or drugs that are listed under Section H of the **PHARMAC** Pharmaceutical Schedule.

c) A **health condition** that arose during a **stand-down period** unless stated otherwise in the **acceptance certificate** or **renewal certificate**. **Stand-down periods** do not apply to newborn **dependent children** added to this policy within four months of birth.

d) Ambulance society subscriptions.

e) Treatment for **dependent children** covered under the school dental service or general dental benefit scheme.

f) Drug trials or experimental drug treatment of any kind.

g) Anything which is not medically necessary or does not directly relate to the **health condition** including (for example, without limitation) hiring a TV, takeout meals or taxi fares unless otherwise stated in this policy.

h) Anything that can be recovered or recoverable from a third party or under any other contract of indemnity or insurance.

7.5 New medical treatments, procedures, diagnostics or technologies that:

a) are experimental or unorthodox; and

b) are not widely accepted professionally as effective, appropriate or essential, based on recognised standards of healthcare specifically for the condition being treated, either in New Zealand or elsewhere; and

c) have not been approved by us.

8 Additional exclusions for the Trauma Option

8.1 We will not pay anything under the Trauma Option, or where the sum insured has been increased, we will not pay the amount of the increase, if within the 90-day period following either the commencement date, or an increase in the sum insured, or where an insured person is added to this policy from their join date:

a) The first symptom appeared.

b) The Medical Condition first occurred.

c) The Medical Condition was first diagnosed.

d) Surgery was undertaken relating to the Medical Condition.

This exclusion does not apply to Paralysis.

8.2 We will not pay anything under the Trauma Option if:

a) The **insured person** covered dies within the 14-day period immediately following the date of diagnosis of the Medical Condition.

b) The Medical Condition suffered by the **insured person** covered is in connection in anyway with any **pre-existing condition**.

c) A Medical Condition has not been suffered for the first time after the **commencement date, effective date** or **join date** where an **insuredwperson** is added to this policy.

d) What happens to the **insured person** is in connection with:

- Intentional self-inflicted **injury** whether sane or insane by the **insured person**.
- The **insured person** engaging in conduct which constitutes or gives rise to any criminal offence for which the **insured person** covered is convicted.
- The **insured person** not following the advice and treatment recommended by a **GP** or **registered specialist**.

9 Jurisdiction

The laws of New Zealand apply to this policy. The New Zealand Courts have exclusive jurisdiction.

10 Currency and GST

All monetary amounts referred to in this policy are in New Zealand dollars and include GST.

11 No surrender value

This is not an investment policy. It does not acquire a surrender value or participate in any profits or bonuses.

12 If you have a problem

We want **you** to remain satisfied with this policy, and have a process for dealing with complaints to ensure they are heard. **You** are welcome to talk to the person who handled **your** enquiry or claim, or to a senior team member or team leader.

Alternatively **you** can write to the nib Complaints Committee:

PO Box 91 630, Victoria Street West, Auckland 1142

Email **contactus@nib.co.nz**

If **your** complaint cannot be resolved through this procedure, **you** can refer it to the Insurance & Financial Services Ombudsman (IFSO):

PO Box 10-845, Wellington 6143

Phone **0800 888 202**

Email **info@ifso.nz**

13 Headings

Headings used in this policy are for reference only. They do not form part of this policy and are not to be used as an aid to interpretation.

Definitions

We realise that insurance language can sometimes be difficult to understand, so we have provided the following section to explain the special meanings of words in the context of this policy. This helps simplify your policy document and makes it easier to read and understand. The words in bold in this policy (and any derivatives) have the following meanings:

Definition	Meaning
ACC Top-up	The difference between what **ACC** pays for services and what the **recognised provider** charges for those services.
ACC	The Accident Compensation Corporation as defined in the Injury Prevention, Rehabilitation and Compensation Act 2001 or its successor under any subsequent legislation.
acceptance certificate	The most recent document entitled 'Acceptance Certificate' forwarded to **you** by **us** in relation to this policy.

Definition	Meaning
activities of daily living	Activities of daily living are: ■ bathing and showering; ■ dressing and undressing (including grooming and fitting artificial limbs); ■ eating and drinking; ■ using a toilet to maintain personal hygiene; and ■ moving to or from place to place by walking, wheelchair or walking aid.
acute health condition	A condition requiring: a) an unplanned admission to a hospital on the day of presentation to the hospital; or b) an unplanned accident and emergency department service provided by a hospital within 48 hours of presentation for treatment; or c) an outpatient service associated with services provided under (a) or (b); or d) an outpatient service, not associated with services provided under (a) or (b), provided within 48 hours of the **insured person** being referred to those services by a **GP** or **registered specialist**; or e) a community service associated with (a), (b) or (c); or f) admission to an acute secondary or tertiary service.

Definition	Meaning
approved private hospital	A private hospital, day surgery unit, or private wing in a public hospital, within New Zealand that has been approved by **us**. However, it does not include a hospice, nursing home or outpatient clinic, even if it is connected in anyway with an approved private hospital.
Breslow Method	A method of measuring (staging) melanoma.
chemotherapy agent	A chemotherapy drug orally or intravenously administered for the treatment of cancer that is approved, listed on the **PHARMAC** Pharmaceutical Schedule under sections A to G and meets the **PHARMAC** funding criteria.
CIN-1, CIN-2, CIN-3	Cervical Intra Epithelial Neoplasia (CIN). A form of grading cells of the cervix which may indicate cancer.
CK-MB	An enzyme that is specific to heart muscle and increases following a heart attack.
commencement date	The policy start date shown on the **acceptance certificate** or **renewal certificate** for the Base Cover and for each option for each **insured person**.
congenital	A **health condition** which is recognised at birth, or diagnosed within four months of birth, whether it is inherited or due to external factors such as drugs or alcohol.
costs covered	The GST inclusive costs that are covered by a benefit under this policy.

Definition	Meaning
cycle	For chemotherapy treatment: A specified number of sequentially administered doses of **chemotherapy agent(s)** where: ■ the **chemotherapy agent** is administered at prescribed intervals within a planned time frame; and ■ **PHARMAC** has approved the **chemotherapy agent** under Sections A to G of the **PHARMAC** Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and ■ the **chemotherapy agent**: ■ meets the **PHARMAC** funding criteria; and ■ is prescribed by a **registered specialist** and administered in New Zealand. For radiotherapy treatment: A specified number of sequentially administered doses of radiation where: ■ the radiation is administered at prescribed intervals within a planned time frame; and ■ the radiation is prescribed by a **registered specialist** and administered in a licensed facility in New Zealand.

Definition	Meaning
dependent child	The **insured person's** child under the age of 21 years, who usually lives with the **insured person** or who is a tertiary student. **Dependent children** has the same meaning.
diagnostic investigation	An investigative medical procedure undertaken to determine the causes of a **health condition**.
disability support services	Support services provided where a condition or disability or illness has been, or is likely to be, present for six months or more, but does not include surgical or medical treatment.
effective date	The date when a change is made to the cover under this policy.
Efficient Market Price/ EMP	The maximum amount (as may change from time to time) **we** will pay for a health service provided by a **recognised provider** that is not part of the **nib First Choice network**.
electrocardiogram (ECG)	A tracing (recording) that provides a visual record of electrical activity in the heart.
excess	The amount shown on the **acceptance certificate** or **renewal certificate** which **we** do not pay. It is the amount **you** pay.
First Choice network/ nib First Choice network	The group of **recognised providers** that are pre-determined by us to charge a fair and reasonable amount for a particular health service (as may change from time to time).

Definition	Meaning
First Choice provider/ nib First Choice provider	A **recognised provider** that is part of the nib **First Choice network** for a particular health service (as may change from time to time).
GP	A doctor registered in terms of the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) to practice in general practice.
health condition	Any **health condition** that is not an **acute health condition** and is not covered under the Injury Prevention, Rehabilitation and Compensation Act 2001 or its successor under any subsequent legislation (except where the **ACC Top-up** Benefit applies).
health service provider	Any registered person who holds a current practising certificate issued by the Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand, the Chiropractic Board in New Zealand and any hospital, organisation or entity which is approved by **us**.
hospitalisation / hospitalised	Admission in New Zealand to an **approved private hospital** for the purposes of undergoing a surgical procedure or diagnostic procedure under anaesthetic or for the purposes of receiving medical treatment or chemotherapy or radiotherapy treatment for a **health condition**.

Definition	Meaning
independent nurse	Any person who holds a current practising certificate issued by the Nursing Council of New Zealand and who operates in private practice.
injury	External or internal bodily injury caused solely and directly by violent, external or visible means.
insured person	A person named as an 'insured person' in **your acceptance certificate** or **renewal certificate**.
join date	Date when cover for an **insured person** starts or the date an **insured person** is added to this policy.
long-term care	Those public and private hospital-based services provided on an ongoing regular basis where a **health condition** has been or is likely to be present for more than six months.
nurse practitioner	Any person who is approved by the Nursing Council of New Zealand as a nurse practitioner and who operates in private practice.
partner	The **insured person's** spouse or a person who cohabits with the **insured person** in the nature of a marriage.
PHARMAC	The Pharmaceutical Management Agency being a Crown entity established by the New Zealand Public Health and Disability Act 2000 or its successor under any subsequent legislation.

Definition	Meaning
policy anniversary date	The date 12 months after the **commencement date** and every 12-month anniversary of that date.
policy year	The 12-month period that starts on the **commencement date** and ends at midnight on the **policy anniversary date**. Each policy year after the first one is from **policy anniversary date** to **policy anniversary date**.
policyowner	The person shown under that heading on the **acceptance certificate** or **renewal certificate**.
pre-approval	Approval of a claim by **us** prior to an **insured person** undergoing treatment, surgery or a **diagnostic investigation**.
pre-existing condition	Any illness, sickness, disease, **injury** or medical condition or symptom or sign, on or before the cover **commencement date** or the **join date** where an **insured person** is added to this policy: a) which **you** or any **insured person** was aware of; or b) of which **you** or any **insured person** had the first indication that something was wrong; or c) for which **you** or the **insured person** sought investigation or medical advice; or d) where a symptom existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment.

Definition	Meaning
prosthesis / prostheses	A surgically implanted artificial replacement of a joint or body part used to restore functionality, but does not include spectacles or corrective lenses, appliances or an aid of any kind unless stated otherwise in this policy. **Prostheses** costs are covered up to specified maximums set by **us**. A copy of the specified maximums is available from **us** on request.
Rai	A system of measuring (staging) chronic lymphocytic leukaemia.
recognised provider	A h**ealth service provider, registered specialist, approved private hospital** or other medical facility that is recognised by **us**.
registered nurse	Any person who holds a current practising certificate issued by the Nursing Council of New Zealand.
registered specialist	Any health provider who is a Member or Fellow of an appropriately recognised specialist college and has Medical Council of New Zealand vocational registration in that speciality. For the purposes of this definition it will not include those holding vocational registration for accident and medical practice, breast medicine, emergency medicine, family planning and reproductive health, general practice, medical administration, occupational medicine, public health medicine and sports medicine or a podiatrist.

Definition	Meaning
renewal certificate	The most recent document entitled 'Renewal Certificate' forwarded to **you** by **us** in relation to this policy.
stand-down period	Period of time after the **commencement date** or the **join date** where an **insured person** is added to this policy, for which no claim will be paid for anything that happens during this period.
sum insured	The total amount of cover shown on the **acceptance certificate** or **renewal certificate** for an **insured person** covered by the Trauma Option.
surgical cost grouping	The overall cost for **registered specialist**, anaesthetist and any **prosthesis** (if applicable) for a health service.
surveillance testing	A **diagnostic investigation** or procedure undertaken (where the **insured person** has no signs or symptoms of a **health condition**) as a preventative measure to ensure that an **insured person** does not have an undiagnosed **health condition**. Follow-up investigations or diagnostic procedures undertaken to enable early detection of the re-occurrence of a known **health condition** is an exception.
TNM Classification	A method of measuring (staging) cancers.

Definition	Meaning
Troponin	Protein specific to the heart muscle cell.
usual occupation	The occupation in which the **insured person** was engaged and from which he or she was deriving income at the time of diagnosis of the Medical Condition.
vocational GP	A **GP** with a relevant, post-graduate qualification in the health service they are providing, as recognised by **us**.
we, **our** or **us**	nib nz limited.
whole person function	A criteria based on the current edition of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment' until similar means of measurement have been established by the New Zealand or Australian medical associations that are acceptable to **us**.
you and **your**	The **policyowner**.

Bank Healthcare Policy

Need help?

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