HealthAon HospitalPlus

Policy document

nib

it's worth it

Contents

Product Brochure Section 4

1.1 Introduction 4
1.2 Policy Structure 4
1.3 General Conditions of Cover 5

HospitalPlus Base Plan 7

1.4 Hospitalisation – Surgical 7
1.5 Hospitalisation – Non-Surgical 7
1.6 Specialist Minor Surgery 7
1.7 Accidents 7

Extension 1 8

1.8 Specialist Care 8
1.9 Diagnostic Radiology and Imaging 8
1.10 MRI and CT Scans 8
1.11 Sterilisation 8

Extension 2 9

1.12 General Practitioners 9
1.13 Prescriptions 9
1.14 Laboratory Tests 9
1.15 Independent Nurse Practitioners 9
1.16 Acupuncture 9
1.17 Physiotherapists 9
1.18 Chiropractors 10
1.19 Osteopaths 10
1.20 Podiatrists 10
1.21 Speech, Occupational and Eye Therapists 10
1.22 Dietician 10
1.23 Cardiac Diagnostic Procedures 10
1.24 Audiology Tests 10
1.25 Hearing Aid Grant 10
1.26 Overseas Treatment Benefit 11
1.27 Ambulance 11
1.28 Accidents 11

Extension 3 12

1.29 Dental Benefits 12
1.30 Optical Benefits 12
1.31 Glasses or Lenses 12

Terms and Conditions Section 13

2.1 Interpretation 13
2.2 Wellness Benefits 14
2.3 Health Payback....15
2.4 Specialist Cover Option....15
2.5 Loyalty Benefits 15
2.6 Other Benefits 15
2.7 Conditions of Cover....17
2.8 Exclusions....18
2.9 Invalidation of Policy.... 20
2.10 Claims Procedure 20
2.11 Choosing Your Recognised Provider 20
2.12 Efficient Market Price (EMP)....21
2.13 Change in Network Status 21
2.14 Pre-approval 22
2.15 14 Day Free Look.... 22

Product Brochure Section

01 SECTION

1.1 Introduction

HealthAon HospitalPlus is designed to allow you to choose the health insurance plan that suits your needs. HospitalPlus is structured in a building block format where each 'block' covers a different area of healthcare and you have the flexibility to add or delete building blocks as your healthcare needs change.

1.2 Policy Structure

HospitalPlus Base Plan

- Covers your medical costs up to $100,000 per procedure for Private Hospital Surgery and $60,000 per annum for Medical Hospitalisation (non-surgical treatment).

This Policy can be extended to include:

Extension 1

- Cover for the cost of visits to Specialists or Vocational GPs following referral by General Practitioner (GP). Extension 1 also provides cover for treatment costs such as X-rays, MRI and CT Scans and Ultrasounds.

Extension 2

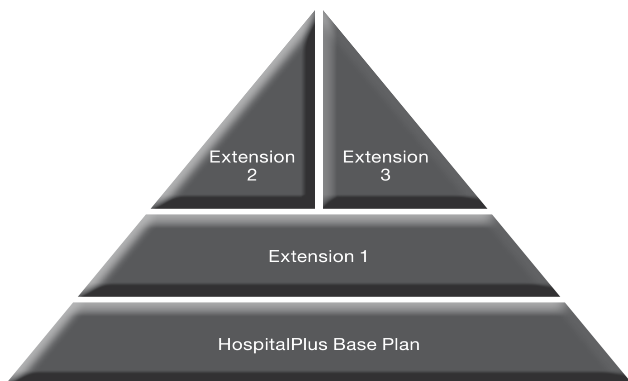
- Cover for the day-to-day medical costs such as GP visits, Prescriptions, Osteopaths and Physiotherapy.

Extension 3

- Partial cover for treatment such as Vision and Dental care.

The following pages provide a more detailed description of HealthAon HospitalPlus and its optional extensions.

Policy Structure



NOTE: To take out Extension 2 and/or 3, HospitalPlus Base Plan and Extension 1 cover must first be taken out.

1.3 General Conditions of Cover

The benefits available under the HospitalPlus health-care range are described in general terms in this Product Brochure section of your Policy document. Once we have accepted your application we'll forward our official Acceptance Certificate and Policy Terms and Conditions, setting out full details of your cover, and conditions of acceptance and the names of those covered by your plan. You have a 14 day 'free look' period after receiving your Acceptance Certificate.

Note: From June 2017 the HealthAon HospitalPlus Product Brochure and Terms and Conditions documents have been amalgamated into this one Policy document.

The Policy Terms and Condition section contains details of the conditions of cover, exclusions and how claims should be made. Some of the main Policy Terms and Conditions are outlined below.

- Benefits relate to treatment in a licensed private medical or surgical hospital or private facility approved by us.
- Plan cover is on an annual basis.
- We'll only accept claims for recognised treatment performed by 'Registered Health Service Providers'.
- We'll only pay on original receipts unless written approval has otherwise been given.
- All family members on the same plan must choose the same plan combinations and payment options.
- There must be at least one person 16 years or over on the plan.
- There is no limit to the number of dependent children (under 19 years of age) who can be covered under a family or single parent family plan.

Principal Exclusions

- Pregnancy (unless otherwise specified), psychiatry, impotency, breast reduction, laser eye surgery and dental treatment (unless otherwise specified). War injury or disability, geriatric, disability support services, congenital ailments, infertility, contraception, appliances, health surveillance testing, elective or cosmetic treatment. AIDS, HIV and illnesses occurring as a result of AIDS or the HIV virus. Any illness arising from drug or alcohol abuse, self infliction or suicide attempt. Ailments that originate from illnesses or accidents existing before the date the plan commences, unless disclosed and specifically accepted by us.
- Treatment received outside New Zealand, unless otherwise specified.
- Any treatment or ailment arising within the relevant stand down period.
  - Extension 2 stand down period: three months.
  - Extension 3 stand down period: six months.

  Unless transferring from a similar competitor's product.

Quick, No Fuss Claims Services.

Besides knowing that you're well covered, it's also important to know that your claims will be dealt with quickly and efficiently. We want to make claiming as easy as possible for you, so below are answers to some of the most frequently asked questions:

- We suggest that you take advantage of our pre-approval service for surgical treatment. You can then arrange to have your unreceipted accounts sent to us for settlement, which means you do not have to wait for the reimbursement.
- You can make a claim at any time as long as it's within 12 months of incurring the costs. If your plan is not current, then claims must be made within 30 days of the non-renewal.
- When you wish to lodge a claim simply complete a Claim Form and send it with originals of all receipts to: nib nz limited, PO BOX 91630, Victoria Street West, Auckland 1142. Alternatively, you can email us at **claims@nib.co.nz** or call us on **0800 123 nib** (0800 123 642).
- Our aim is to refund your claim promptly within five working days unless further information is required.
- You have the flexibility to go to any licensed private surgical hospital or private facility approved by us. (However, please see refer to clause 2.11, Choosing Your Provider on page 20).

When you have paid the accounts from your surgeon, anaesthetist etc. you will need to fill out claims forms and send them to us with your receipts.

If you have any queries, simply phone one of our Claims Advisors on **0800 123 642** Monday Friday, 8.00am to 5.30pm.

HospitalPlus Base Plan

1.4 Hospitalisation – Surgical

Covers treatment costs in a private hospital approved by us for ailments requiring surgery. For example, Oral Surgery*, General Surgery, Cardiac Surgery, Laparoscopic Surgery, Angiography, Angioplasty.

Benefit up to $100,000 per operations with no yearly limits.

For hospital benefits, we cover costs including intensive nursing care, Xrays, prostheses, disposables, ambulance, dressings, drugs etc.

Specialist visits are not covered under this health plan with the exception of Specialist Minor Surgery.

**Note: Oral Surgery must be performed by a registered Oral or Maxillofacial Surgeon for ailments of the mouth. Removal of unerupted and impacted teeth may be treated by a registered Oral surgeon or registered Dentist but excludes all other dental treatments including periodontal, orthodontal and endodontal procedures and implants.*

1.5 Hospitalisation – Non-Surgical

Covers treatment costs in a private hospital approved by us for ailments not requiring surgery. For example, Asthma, Diabetes, Pneumonia, Epilepsy.

Benefit up to $60,000 per year.

1.6 Specialist Minor Surgery

Covers treatment for minor surgery performed by a registered medical Specialist or Vocational GP in rooms approved by us. Prior approval is recommended.

The Benefits of HospitalPlus apply to each person on your plan.

1.7 Accidents

This benefit provides cover for the difference between ACC reimbursement and the actual applicable surgical and medical costs. Where the ACC approves the claim but declines to pay the costs of surgical treatment of accidental injury in a private hospital, and a copy of this decision is supplied to us PRIOR to treatment being performed, these costs may be claimed in line with the Policy Terms and Conditions.

We may require that you apply for a review of the ACC's decision. You agree to fully pursue such application, and agree to pay and amount equivalent to any monies obtained as a result of such a review to us. Benefit levels are listed under each appropriate section.

Prior approval is strongly recommended for all above procedures.

Medical Hospitalisation excludes Psychiatric or Geriatric Care.

Extension 1

To cover expensive medical costs relating to surgery, medical hospitalisation, Specialists, and scans.

Taken in conjunction with HospitalPlus.

The benefits apply to each person on your plan.

1.8 Specialist Care

After referral from a General Practitioner, you may need to see a Specialist or Vocational GP. This extension covers both visits which lead to hospitalisation and Specialist or Vocational GP costs where the ailment does not require hospitalisation.

1.9 Diagnostic Radiology and Imaging

Covers treatment costs such as X-rays, Ultrasound and Mammography even if you are not hospitalised.

1.10 MRI and CT Scans

After referral by a GP or Specialist, you are covered for MRI and CT Scans even if you are not hospitalised.

1.11 Sterilisation

Sterilisation procedures for males and females are included to a maximum of $1,000.

Extension 2

3-month stand down unless transferring from similar cover.

1.12 General Practitioners

Covers General Practitioner (GP) visits including home visits.

- Refund up to $50 per surgery visit, in and out of hours.
- Refund up to $70 per home visit.
- Refund maximum of 12 visits per year.
- Also covers cost for Minor Surgery by a GP where a general anaesthetic is not required.
- Refund up to $150 per procedure.

1.13 Prescriptions

Covers items on Pharmaceutical Management Agency's (PHARMAC's) Pharmaceutical Schedule, prescribed by a Registered Medical practitioner.

- Refund up to $15 per item.
- Refund maximum $300 per year.

1.14 Laboratory Tests

- Occult Blood or glucose Tests requested by a Registered Medical Practitioner,
- Refund maximum $70 per year.

1.15 Independent Nurse Practitioners

Covers costs for visit to Independent Nurse practitioners.

- Refund up to $20 per visit.
- Refund maximum six visits per year.

1.16 Acupuncture

Covers costs of Acupuncture treatment by a GP, or by Registered Physiotherapist on referral from a GP.

- Refund up to $30 per visit.
- Refund maximum $200 per year.

1.17 Physiotherapists

Covers Physiotherapy treatment costs, on referral by a GP.

- Refund up to $30 per visit.
- Refund maximum $300 per year.

1.18 Chiropractors

Covers Chiropractors treatment costs on referral from a GP.

- Refund up to $30 per visit.
- Refund maximum $200 per year.
- Additional refund up to $70 per year for X-rays.

1.19 Osteopaths

Covers Osteopathy treatment costs on referral from a GP.

- Refund up to $30 per visit.
- Refund maximum $200 per year.

1.20 Podiatrists

Covers Podiatry treatment costs on referral from a GP.

- Refund up to $30 per visit.
- Refund maximum $150 per year.

1.21 Speech, Occupational and Eye Therapists

Covers speech, occupational and eye therapy costs on referral from a GP.

- Refund up to $30 per visit.
- Refund maximum $250 per year (combined total of any or all of the above therapies)

1.22 Dietician

- Consultation by NZ Registered Dietician on referral from a Medical Practitioner
  - $40 per visit.
  - $200 per year.

1.23 Cardiac Diagnostic Procedures

Holter Monitoring	$200 per year
Treadmill Exercise	$200 per year
Ambulatory BP Monitoring	$200 per year
Stress Echocardiography	$200 per year

Annual Combined Maximum of $400

1.24 Audiology Tests

On referral from a specialist covers costs of:

Audiology Treatment	$200 per year
Audiometric Tests	$200 per year

1.25 Hearing Aid Grant

After 3 years membership	$200 per year

1.26 Overseas Treatment Benefit

For treatment which cannot be performed in New Zealand, this benefit provides top-up cover for the costs of your travel and of the treatment performed overseas, where the Ministry of Health has declined funding under the 'Medical Treatment Overseas Scheme'.

Benefit of up to $12,500 per operation.

1.27 Ambulance

Emergency transportation for Public Hospital in-Patient admission.

- $180 per year.

1.28 Accidents

Covers shortfall of ACC payments.

- Refund up to $20 per visit to a GP.
- Refund up to $10 per visit to a Physiotherapist, Chiropractor, Osteopath.

Extension 3

6-month stand down period unless transferring from similar cover.

1.29 Dental Benefits

- 80% reimbursement up to $400 per year.

Dental treatment by a Registered Dental Practitioner or Oral Surgeon including examination, cleaning and scaling, fillings, associated X-rays and removal of teeth. Also covers Orthodontic treatment after two years' continuous cover.

Note: Excludes treatment for children covered under the School Dental Service, or General Dental Benefit scheme.

1.30 Optical Benefits

Covers Optometrist and Opticians examination fees. Also covers costs for glasses and contact lenses when required by vision change.

- Optometrist $50 per visit, $250 per year.
- Orthoptist $50 per visit, $250 per year.

1.31 Glasses or Lenses

- 80% reimbursement up to $300 per year.

Prescription glasses or lenses, excluding replacement for loss or breakage.

Terms and Conditions Section

02 SECTION

These Policy Terms and Conditions are to be read in association with the Product Brochure Section of this document (see Section 1) and your Acceptance Certificate. You will be covered from the Policy Commencement Date of your Policy as specified on your Acceptance Certificate.

2.1 Interpretation

In these Terms and Conditions:

'ACC' means Accident Compensation Corporation or any other work place insurer.

'Acceptance Certificate' means the most recent acceptance or renewal certificate issued to you by us.

'Ailment' means any disease or physical disorder or complaint or condition.

'Annual Renewal Date' means an anniversary of the Policy Commencement Date.

'Child' means a dependant of you who is under the age of 19 years.

'Disability Support Services' means 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.

'Efficient Market Price/EMP' means 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.

'First Choice Network' or **'nib First Choice Network'** means 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).

'First Choice Provider' or **'nib First Choice Provider'** means a Recognised Provider that is part of the nib First Choice Network for a particular health service (as may change from time to time).

'Insured Person' means a person specified as an Insured Person in your Acceptance Certificate.

'Health Plan' means this HealthAon HospitalPlus health plan.

'Health Plan Commencement Date' means, in respect of the Health Plan and an Insured Person, the date from which the Health Plan which you have selected applies to the Insured Person, as specified in your Acceptance Certificate.

'Policy' means your contract with us, the basis of which shall be

a) these Policy Terms and Conditions

b) your Acceptance Certificate

c) the Product Brochure and

d) if your Policy belongs to a Group Healthcare Programme, any Application Guide for your Group Healthcare Programme.

'Product Brochure' means the product information brochure applying from time to time detailing the specific benefits and conditions of the Health Plan which you have selected.

'Policy Commencement Date' means the commencement date of the Policy, as specified in your Acceptance Certificate.

'Recognised Provider' means a Registered Health Service Provider or private hospital approved by us.

'Registered Health Service Provider' means any person who holds a current practicing 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, the Physiotherapy Board in New Zealand or any person who is registered with the Podiatrist Board in New Zealand or with the Osteopath Board in New Zealand.

The singular shall include the plural and vice versa unless the context requires otherwise.

'Surgical Cost Grouping' means the overall cost for Registered Specialist, anaesthetist and any Prosthesis (if applicable) for a health service.

'Vocational GP" means a GP with a relevant, post-graduate qualification in the health service they are providing, as recognised by us.

'We', **'our'** and **'us'** refer to nib nz limited.

'**You'** and '**your'** refer to the policyholder.

2.2 Wellness Benefits

2.2.1 Where a Health Plan includes Wellness Benefits the following will apply

a) Wellness Benefits don't apply in respect of any Child.

b) Wellness Benefits must be taken at the time they are awarded and can't be accumulated over subsequent years.

c) To qualify for a Wellness Benefit, the Insured Person must have been included as an adult under the Policy continuously for the prescribed period. Each period will begin and end on an anniversary of the Policy Commencement Date. Eligibility periods must be consecutive.

d) Acceptance of Wellness Benefits will invalidate any outstanding claims for treatment occurring during the relevant period of cover.

2.3 Health Payback

2.3.1 Where a Health Plan includes a Health Payback Benefit the following will apply

a) You must select your Health Payback Benefit period when you apply for the Health Plan and this benefit period will apply while your Policy includes this Health Plan.

b) The benefit applies to the premiums you have paid and claims we have paid under that particular Health Plan only and which relate to your nominated benefit period. The benefit applies per Policy not per person.

c) Acceptance of a Health Payback Benefit will invalidate any outstanding claims for treatment occurring during the relevant benefit period.

d) You must have had continuous cover under the Health Plan during the benefit period.

e) Benefit periods are consecutive and begin and end on an anniversary of the Policy Commencement Date.

2.4 Specialist Cover Option

Where a Health Plan includes a Specialist Cover option the Policy covers specialist costs, including minor surgery, performed by a registered medical specialist or vocational GP after referral by a registered General Practitioner.

2.5 Loyalty Benefits

2.5.1 Where a Health Plan includes Loyalty Benefits, they are provided in respect of each Insured Person. Loyalty Benefits are available after the Insured Person has been continuously covered under the Health Plan for the number of years specified in the Product Brochure.

2.5.2 Loyalty Benefits are subject to the specific terms and conditions contained in the Product Brochure.

2.6 Other Benefits

2.6.1 Where a Health Plan includes a Prescriptions Benefit

a) the Policy only covers medication, prescribed by a registered medical practitioner, which is on the Pharmaceutical Management Agency's (PHARMAC's) Pharmaceutical Pricing Schedule

b) pharmacist receipts stating the name of the patient, prescription number, the name of the medication prescribed and the cost of each item must be submitted, and the reason for the medication must be stated on the Claim Form and

c) the Policy doesn't cover the cost of contraceptives, or medication for excluded ailments.

2.6.2 Where a Health Plan includes a Public Hospital Cash Grant, you must obtain a certificate from the hospital stating details and date of the surgical operation performed, date of admission, and date of discharge to support your claim. The benefit entitlement commences on the night preceding surgical treatment under general anaesthetic and includes accident related conditions.

2.6.3 Where a Health Plan includes a Waiver of Premium or Funeral Benefit in respect of an Insured Person, those benefits cease when the Insured Person attains 65 years of age, unless you request otherwise in writing and agree to pay any additional annual premiums we determine. A claim under those benefits must be supported by the Death Certificate of the deceased Insured Person.

2.6.4 Where a Health Plan includes a Registered Home Nursing Care Benefit, all accounts and receipts presented to us for payment must show the qualifications of the home nurse, dates of visits and fees charged and must be supported by a registered medical practitioner's certificate stating the reason why home nursing care is required and the length of time for which it is required.

2.6.5 Where a Health Plan includes a Dental Care Benefit the Policy doesn't cover the additional cost of gold, titanium or other exotic materials.

2.6.6 Where a Health Plan includes an Overseas Transplant Benefit to be covered under the Policy, the transplant must be of a type which cannot be performed in New Zealand. You must provide evidence of the MOH's acceptance to partially fund the transplant operation, and of the amount which is payable by the MOH. The Policy covers the difference between the amount payable by the MOH and the medical costs of the transplant operation, up to the Health Plan maximum for this benefit.

2.6.7 Where a Health Plan includes an Overseas Treatment Benefit, to be covered under the Policy, the treatment must be of a type which cannot be performed in New Zealand and must be declined for funding by the MOH under the Medical Treatment Overseas scheme. You must provide evidence of the MOH's decision. The treatment must be recommended by a registered medical practitioner and must be recognised by us as a conventional form of treatment. The Policy covers the reasonable travel costs of the person requiring the treatment plus the costs of the treatment performed overseas to the Health Plan maximum for this benefit.

2.6.8 Where a Health Plan includes a Travel and Accommodation Benefit, the Policy covers the cost of return economy air travel for the Insured Person receiving treatment and one support person to the place of private hospitalisation within New Zealand, provided that the treatment could not be performed within your province and that it is recommended by a registered medical practitioner. The Policy covers the cost of accommodation for the support person while the Insured Person is hospitalised, up to the Health Plan maximum for this benefit.

2.6.9 Where the benefits under a Health Plan cover the cost of prostheses, the Policy doesn't cover the additional cost of surgically implanted prostheses made from titanium or any other exotic material. Prostheses are refunded according to the UCR maximums.

2.6.10 Where the benefits under a Health Plan include the cost of ambulance call-outs, the Policy doesn't cover the cost of ambulance society subscriptions.

2.6.11 Where a Health Plan includes an Accidents Benefit, for the cost of treatment of injury to be covered you must obtain ACC's acceptance of your claim prior to the treatment being performed, and provide us with evidence of ACC's acceptance of your claim. Where you claim the shortfall costs of treatment of an injury.

2.7 Conditions of Cover

2.7.1 The benefits provided to you under the Policy are the benefits specified in the Product Brochure section (see Section 1).

2.7.2 The benefit maximums shown in the Product Brochure section include GST charged by the supplier of the goods or provider of the services.

2.7.3 Where a benefit is subject to a maximum per year, the maximum applies to the year which commences on your Health Plan Commencement Date or any Annual Renewal Date, and ends on the day immediately prior to the next Annual Renewal Date.

2.7.4 We'll refund up to the actual costs incurred for treatment, subject to the terms of the nib First Choice Network, for the procedure at the time of service or at the time of pre-approval whichever is favourable to you subject to the stated maximums.

2.7.5 You can include your current partner or any Child as an Insured Person at any time. If an Insured Person ceases to be your partner or a Child (as appropriate) then that person will remain an Insured Person until the next Annual Renewal Date at which time he or she will have 30 days to effect a separate Policy with us without providing any further evidence of health (unless that Policy includes a Health Plan that wasn't included under your Policy).

2.7.6 An additional premium will be payable where you include your partner as an Insured Person. An additional premium will be payable for each of the two eldest Children included as Insured Persons (except where the contrary is expressly specified). Subsequent Children can be included as Insured Persons free of charge.

2.7.7 There must be at least one Insured Person aged 16 years or older at all times.

2.7.8 You must select the same Health Plan for all Insured Persons. The Health Plan which you have selected is specified in your Acceptance Certificate.

2.7.9 You may only remove a Health Plan from your Policy, or remove an Insured Person as such or change to another of the reimbursement options specified in the Product Brochure (eg. excesses or percentage reimbursement levels), with effect from the next Annual Renewal Date and you must notify us of any such alterations by giving us not less than 30 days' notice in writing prior to the relevant Annual Renewal Date.

2.7.10 You must promptly notify us of all changes in the personal details of every Insured Person, including changes of name, address and telephone number.

2.7.11

a) An annual premium is payable by you to us. The annual premium is calculated according to the schedule of premium rates applying from time to time for the Health Plan which you have selected, and may in terms of that schedule automatically increase when an Insured Person attains a specified age. A copy of the schedule of premium rates is available from us on request.

b) The annual premium becomes due in full on the Policy Commencement Date and on each Annual Renewal Date. You may however pay the annual premium by monthly, quarterly or half-yearly instalments, but if you cancel the Policy during the year, you will be liable to immediately pay the balance of the annual premium still outstanding.

c) For some Health Plans, a once only establishment fee is payable with your first premium payment. This will be specified in the Product Brochure.

2.7.12

a) We may alter the schedule of premium rates (including the ages at which the premium automatically increases) or the benefits provided under any Health Plan at any time by giving you 30 days' prior written notice of the changes to your last known address.

b) We may alter these Terms and Conditions at any time by giving you 30 days' prior written notice of the changes to your last known address.

c) We reserve the right to charge different premiums in respect of the particular categories of Insured Persons, on the basis of gender, habits, pursuits, activities, or any other lawful factor we consider to be justified.

2.7.13 All benefits provided under the Policy are conditional upon the continued payment by you of all premiums as they become due. If any premium or instalment thereof remains unpaid for 90 days after the date on which it became due, the Policy shall automatically terminate and no further benefits will be payable. You will be liable to immediately pay the balance of the annual premium still outstanding.

2.7.14 Provided you comply with these Policy Terms and Conditions, we can't cancel your Policy.

2.7.15 We may require you to support a claim with a certificate from a registered medical practitioner or, if we decide it's appropriate, some other Registered Health Service Provider, to confirm that an ailment didn't exist prior to the relevant Policy Commencement Date.

2.7.16 Hospital related benefits are only available for treatment in a licensed private medical or surgical hospital or private facility which has been approved by us. This clause does not apply to Public Hospital Cash Grant (if applicable).

2.7.17 The Policy only covers treatment by an Orthoptist following a referral by an Optometrist or registered medical practitioner; and treatment by an Oral Surgeon following referral by a registered medical practitioner or Dentist.

2.7.18 Where it is a condition of the Policy that a service or treatment must only be performed after referral by a Registered Health Service Provider, the name of the referring practitioner must be shown on the account presented to us for payment.

2.7.19 Where an excess applies under a Health Plan, unless otherwise stated in the Product Brochure the excess applies per Insured Person per claim.

2.7.20 You may cancel the Policy at any time by giving us not less than 30 days' notice in writing but you will remain liable

2.8 Exclusions

2.8.1 No benefit will be payable in respect of an Insured Person under the Policy for

a) Congenital ailments (except where the contrary is expressly specified)

b) Infertility, pregnancy, impotency, breast reduction, sterilisation and contraceptive procedures (except where the contrary is expressly specified)

c) Ailments wholly or partially attributable to the misuse of alcohol and/ or prescription drugs

d) Ailments wholly or partially attributable to the use of non-prescription drugs

e) Psychiatric ailments (except where the contrary is expressly specified)

f) Dental ailments (except where the contrary is expressly specified)

g) Geriatric care, including geriatric hospitalisation

h) Disability Support Services

i) Acquired immune deficiencies (AIDS) or associated ailments including HIV and related ailments

j) Appliances (except surgically implanted prostheses)

k) Cosmetic treatment, elective treatment (such as treatment of or for an ailment not materially detrimental to health), preventative treatment, health surveillance testing (investigative procedure where there is no medical condition) and treatment for self-inflicted injuries or ailment

l) Any ailment arising or treatment performed during any stand-down period for the relevant Health Plan as specified in the Product Brochure section (see Section 1). Stand-down periods do not apply, however, to a newborn Child registered as an Insured Person within 3 months of birth

m) Injury or disability as a consequence of war, warlike hostilities, civil war or civil commotion

n) Expenses recovered or recoverable from a third party or under any other contract of indemnity or insurance

o) Any services or treatment other than services or treatment relating to a medical ailment treated by a Registered Health Service Provider, and recognised by the Medical Council of New Zealand or the New Zealand Ministry of Health

p) Any ailment not registered with the Ministry of Health as a disease entity

q) Any ailment occurring or existing before the relevant Policy Commencement Date or any ailment consistent with any symptom or circumstance occurring or existing before that date. This condition doesn't apply, however, in respect of ailments declared on your Application Form and not excluded by us on your Acceptance Certificate

r) The cost of treatment of injury except as provided under the specified Accidents Benefit, in which case we provide top up cover only. This means that where an ACC top up maximum is specified for a particular benefit, the amount we will pay will be the actual cost of the relevant aspect of treatment* subject to the nib First Choice Network LESS the amount payable by ACC, up to the ACC top up maximum.

Where no ACC top-up maximum is specified, the amount we will pay will be the lesser of the actual cost of the relevant aspect of treatment subject to the nib First Choice Network or the Health Plan benefit maximum, LESS the amount payable by ACC.

Should the ACC decide not to pay for treatment in a private hospital, then any such treatment is not covered by the Accidents Benefit and the Policy (except where the contrary is expressly specified).

**Where refunds under the Health Plan are subject to a maximum percentage of actual costs e.g. 80%, this amount is subject to that maximum percentage.*

s) Services, treatment or costs incurred outside New Zealand (except where the contrary is expressly specified).

2.9 Invalidation of Policy

2.9.1 The Policy shall be invalid, no benefits shall be payable and we'll retain all premiums which have been paid if

a) Any statement made in any Application Form or other document on the faith of which the Policy was issued, reinstated or renewed was substantially incorrect in any material particular; or

b) In any such Application Form or other document you did not disclose all matters material to the risk accepted by us under the Policy.

2.10 Claims Procedure

2.10.1 You should settle any surgical, hospital, medical or dental accounts directly with the Registered Health Service Provider concerned.

2.10.2 Claims must be submitted on our prescribed Claim Form which can be obtained by telephoning **0800 123 642**.

2.10.3 You must give a full description of the reason for treatment, the investigation/treatment undertaken, the date of treatment and all medication required on the Claim Form. You must state if the treatment was accident-related.

2.10.4 Claim Forms must be accompanied by original receipted itemised accounts showing the name of the Registered Health Service Provider and the patient concerned (photocopies or duplicates are not acceptable).

2.10.5 Please ensure that the account shows a tax invoice GST number so that the GST content of the account can be refunded.

2.10.6 Small claims should be accumulated until they exceed a reasonable amount (say $300) but all claims must be lodged within 12 months of the costs being incurred. In any event, claims must be submitted within 30 days of cancellation or termination of the Policy.

2.10.7 Claims should be sent to nib nz limited, PO BOX 91630, Victoria Street West, Auckland 1142.

2.11 Choosing Your Recognised Provider

The nib First Choice Network is a group of Recognised Providers that provide health services within our First Choice price range.

2.11.1 If you choose an nib First Choice Provider for that health service, your claims will be covered for 100% of eligible costs, less any excess..

2.11.2 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.

2.11.3 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.

2.11.4 If either the 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 Marker Price (EMP) determined individually for that component.

2.11.5 Using a First Choice Provider gives you certainty that you will be covered for 100% of approved associated health service costs included in your Policy up to the benefit maximum.

2.11.6 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**.

2.11.7 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.

2.11.8 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.

2.11.9 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.

2.12 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.

2.12.1 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.

2.12.2 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.

2.13 Changes in Network Status

2.13.1 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.

2.13.2 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.

2.13.3 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.

2.14 Pre-approval

2.14.1 Pre-approval of a claim is available where surgery or hospitalisation is required.

2.14.2 To obtain pre-approval, complete a pre-approval application which is available by telephoning **0800 123 642**.

2.14.3 We'll process your pre-approval within five working days of receiving it unless it is necessary to obtain further information.

2.14.4 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 provider to request a pre-approval and submit the subsequent claim on your behalf. If the request has been made by a Recognised Provider will also notify them of the decision.

2.14.5 If your claim is accepted, we'll send you a pre-approval advice. You can then send the hospital's, surgeon's or anaesthetist's account to us with your Claim Form and we'll send eligible payment to the Service Provider directly. The payment will either be sent direct to the provider of service or to you so that you can add any additional payment and forward them to the Service Provider.

2.14.6 The pre-approval letter is valid for three months from the date of issue recorded on the letter. If we do not accept your claim, we will also let you know in writing.

2.15 14 Day Free Look

2.15.1 If for any reason the Policy is not to your total satisfaction, you can cancel it within 14 days of receiving your Acceptance Certificate and these Terms and Conditions, and we will refund in full the premium which you have paid. To cancel the Policy simply return your Acceptance Certificate with a written request that the Policy be cancelled, to our address shown in **2.10.7** above.

nib

it's worth it

Need help?

Talk to your financial adviser
Call us on **0800 123 nib** (0800 123 642)
Mon to Fri: 8am – 5.30pm
Email us at **contactus@nib.co.nz**
Go to **nib.co.nz**
PO Box 91630, Victoria Street West, Auckland 1142

©2017 nib nz limited. All rights reserved. AONPD 06-17 nib8031_0617