nib

Health Plus
Policy document

Contents

Introduction

This policy describes our Health Plus Plan. It is your contract with us.

It is divided into four sections:

1 Help Section

2 Benefits Section – Base Cover and Options

3 General Conditions Section

4 Definitions Section

The application form and the **acceptance certificate** are also part of **your** contract with **us**. The **acceptance certificate** shows the options **you** have chosen, the **insured persons** covered, and any special conditions **we** may have applied to the policy (e.g. an exclusion for a **pre-existing condition**).

Please keep this policy and your acceptance certificate in a secure place.

Free look for 14 days

If for any reason **you** are not satisfied with **your** policy and have made no claims, **you** can cancel it within 14 days of the **commencement date**. **We** will refund **your** premium.

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

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** 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 the 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**.

Defined terms

In this policy, some words have particular meanings. Those words are in bold and the meanings are set out in the Definitions Section at the end.

Help Section

It is important that **you** read and understand this section of **your** policy document as it contains important information about **pre-approvals**, claims and payment.

1 How to seek pre-approval

1.1 Contact us

If any **insured person** has to go into an **approved private hospital**, **we** recommend **you** obtain **our pre-approval**. 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.

The policy number must be quoted for all claims.

1.2 If we accept your claim we will 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**. If the request has been made by a **recognised provider we** will also notify them. **We** will give **you** a letter that gives the **recognised providers** authority to invoice **us** direct for **our** portion of the **costs**, which saves **you** time and money.

1.3 Give copies to your recognised providers

Give a copy of the **pre-approval** letter to the **insured person's recognised 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** who 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

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

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

- Calling **us** on 0800 123 642 or
- E-mailing **us** at claims@nib.co.nz or
- Writing to **us** at
  nib nz limited
  PO Box 91 630
  Victoria Street West
  Auckland 1142.

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 the policy ending.

5.2 Claims conditions

5.2.1 Provide full information

You must give **us** 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. **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, **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.

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

Where the policy includes a 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

When claiming for a Waiver of Premium, 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 the 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 Lump Sum Option

When claiming under the Lump Sum 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.
- 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 Refund by direct credit

We will process **your** claim within five working days unless further information is required.

We will send **you** a refund according to the terms under **your** policy. Payment can be made by direct credit to **your** bank account.

6 How to change your details or your plan

6.1 Contact us

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

6.1.1 Adding a **partner** or **dependent child**

You can add **your partner**, or a **dependent child**, to this policy at any time. **You** must complete **our** application form and send it to **us**. **We** charge an additional premium for each additional **adult** and for the first **dependent child**.

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**.

6.1.2 Removing an **insured person**

You can only remove an **insured person** from the next **policy anniversary date**.

You must tell **us** in writing at least 30 days prior to that date. At that date the **insured person** being removed will have the option, within 30 days, of arranging a separate policy with **us** on similar terms without having to provide any further evidence of health.

6.1.3 Adding or removing options

You can add options at any time. **You** must complete **our** application form and send it to **us**. (**You** can obtain an application form by ringing **us**).

You can only remove an option at the next **policy anniversary date**. **You** must give **us** at least 30 days prior written notice.

6.1.4 Changing **your excess**

You can change the **excess** on the next **policy anniversary date**. If **you** wish to reduce the level of the **excess we** may request **you** to obtain a medical declaration.

6.1.5 Policy must include an **adult**

The policy must cover at least one **insured person** aged 16 years or older at all times. In the case of a **dependent child** under age 16 without parents, an **adult** must be included on the policy.

6.1.6 Changes in contact details

Please notify **us** of all changes in contact details of **insured persons**. Where possible, please provide an email address.

6.1.7 Making changes

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.

Alternatively, to make a change either:

- Call **us** on 0800 123 642 or
- Send **us** a fax on 0800 345 134 or
- E-mail **us** at contactus@nib.co.nz or
- 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 plan 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

If **we** accept the changes **we** will send **you** a new **acceptance certificate** that will show the changes. The changes will be effective from the date shown on the **acceptance certificate** for each change.

Benefits Section

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

It's in five parts: Base Cover and four options. **You** must take the Base Cover. If **you** chose an option it is shown on **your acceptance certificate**.

Please ensure **you** have read the Help Section on page 4 for details in relation to the **nib First Choice network** which applies to the **benefits** under this policy.

Base Cover

1 Introduction

1.1 What we cover

Base Cover provides cover for each **insured person** for the **cost** of diagnosis and treatment during this policy of a **health condition** on the terms set out below.

1.2 What we pay

We will refund **you** the **cost** incurred less any **excess**, up to the **benefit** maximum. The **excess** is applied per **insured person** for each claim separately for the following **benefits**:

- Hospital – Surgical Benefit
- Hospital – Medical Benefit
- MRI / CT Scan Benefit
- Specialist Minor Surgery Benefit
- **ACC Top-up** Benefit
- Overseas Treatment Benefit
- Complications of Pregnancy / Childbirth Benefit.

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**.

2 Hospital – Surgical Benefit

Covers the **cost** of surgery and **diagnostic investigations** requiring an anaesthetic in an **approved private hospital**. For example (without limitation): general and cancer surgery, cardiac surgery, orthopaedic surgery, laparoscopic surgery, oral surgery, angiography, angioplasty, lithotripsy and diagnostic procedures undertaken under anaesthetic such as endoscopy and gastroscopy.

This includes the **cost** of intensive nursing care, x-rays, disposables and consumables, dressings, drugs listed on the Pharmaceutical Management Agency (PHARMAC) New Zealand Pharmaceutical Schedule, etc.

Benefit Maximum:

Up to $120,000 per operation.

Note:

- There is no limit to the number of operations.
- Covers chemotherapy and radiotherapy following surgery.

Prostheses

- Certain **prostheses costs** are covered up to specified maximums set by **us**. A copy of the specified maximums is available from **our** website nib.co.nz.
- Any additional **costs** of surgically implanted **prostheses** made from titanium or any other exotic material are not covered.

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.
- **We** do not cover any other dental treatments including periodontal, orthodontic and endodontal procedures and implants.

3 Hospital – Medical Benefit

Covers the **cost** of medical treatment (not involving surgery) in an **approved private hospital**. For example (without limitation): heart disease, chemotherapy, treatment for respiratory disease (asthma, pneumonia, etc), and treatment for endocrine disease (diabetes, etc).

This includes the **cost** of intensive nursing care, x-rays, disposables and consumables, dressings, drugs listed on the PHARMAC Schedule, etc.

Benefit Maximum:

Up to $60,000 per **policy year** with a maximum of up to $35,000 per **hospitalisation**.

Note:

- Rehabilitation, convalescence, respite, disability support, geriatric care and **long term care costs** are not covered under this **benefit**.
- Covers chemotherapy and radiotherapy.

4 Hospital Related Specialist Consultations Benefit

Covers 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 **hospitalisation** after a **referral** from a **GP** or a **registered specialist**.

Benefit Maximum:

No limit per visit.

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

Note:

Registered specialist or **vocational GP** visits that do not relate to **hospitalisation** are not covered unless **you** have chosen the Specialist Option.

5 Hospital Related Diagnostic Radiology and Imaging Benefit

Covers 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 **hospitalisation** after a **referral** from a **GP** or a **registered specialist**.

Benefit Maximum:

No limit per visit.

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

Note:

- Diagnostic radiology and diagnostic imaging tests that do not relate to **hospitalisation** are not covered. If **you** have chosen the Specialist Option, an **insured person** will have cover for some specific diagnostic radiology and diagnostic imaging even when the **insured person** has not been, or will not be **hospitalised**.
- Radiotherapy is covered under the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).

6 Hospital Related Cardiac Investigations Benefit

Covers 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 **hospitalisation** after a **referral** from a **GP** or a **registered specialist**.

Benefit Maximum:

No limit per visit.

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

Note:

Cardiac investigations that do not relate to **hospitalisation** are not covered unless **you** have chosen the Specialist Option.

7 MRI / CT Scan Benefit

Covers the **cost** of MRI and CT scans if a **registered specialist** recommends the scan, even when the **insured person** has not been, or will not be, **hospitalised**.

Benefit Maximum:

MRI Scan	$2,500
CT Scan	$2,000

Note:

The **benefit** maximums apply to each **insured person** per **policy year**.

If the MRI or CT scan results in surgical or medical treatment in an **approved private hospital** within six months after the scan, the **cost** of these scans will be covered under the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies) and the **benefit** maximum above will not apply.

8 Specialist Minor Surgery Benefit

Covers the **cost** of treatment for minor surgery performed by a **registered specialist** or **vocational GP**, on **referral** from a **GP**.

Benefit Maximum:

All **costs** paid under this **benefit** come within the **benefit** maximum for the Hospital – Surgical Benefit.

Note:

Pre-approval is recommended as some minor surgery is deemed cosmetic surgery and is not covered.

9 Post-operative Physiotherapy Benefit

Covers the **cost** of post-operative physiotherapy after being discharged from an **approved private hospital**.

Benefit Maximum:

Up to $300 per **hospitalisation**.

No limit per visit.

Note:

The physiotherapy must directly relate to the **hospitalisation**.

10 Home Nursing Care Benefit

Covers the **cost** of home nursing care by a **registered nurse**, after being discharged from an **approved private hospital**, on **referral** by a **GP** or **registered specialist**.

Benefit Maximum:

Up to $125 per day

Up to $5,000 per **policy year**.

Note:

The home nursing care must directly relate to the **hospitalisation**.

11 ACC Top-up Benefit

Covers the difference between what **ACC** pays for a physical **injury** and the actual **cost** of the surgical and / or medical treatment in an **approved private hospital**. A copy of **ACC's** decision must be supplied to **us** prior to treatment being undertaken. The difference between the actual **cost** of the treatment and **ACC's** payment, less any **excess you** may have chosen, will be covered.

Benefit Maximum:

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

Note:

- 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.
- The surgical and medical **costs** must directly relate to the **hospitalisation**.

12 Travel and Accommodation Benefit

Covers 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** only 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**.

Benefit Maximum:

Travel

The **cost** of a return economy air travel fare within New Zealand for the **insured person** requiring treatment and a support person. The taxi fares from the airport to the **approved private hospital** (on admission) and from the **approved private hospital** (on discharge) to the airport.

Accommodation

Up to $100 per night for the accommodation **cost** incurred by the support person, up to a maximum of $1,800 per **hospitalisation**.

Note:

- All **costs** paid under this **benefit** come within the **benefit** maximum for the Hospital – Surgical Benefit or Hospital – Medical Benefit (whichever applies).
- The travel and accommodation **cost** must directly relate to the **hospitalisation**.
- Air travel **cost** to and from New Zealand is not covered unless under the Overseas Treatment Benefit.
- This **benefit** does not apply to the **cost** of air travel to or from the Chatham Islands.

13 Ambulance Transfer Benefit

Covers 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.

Note:

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

14 Overseas Treatment Benefit

Covers the **cost** of surgical or medical treatment that cannot be performed at all in New Zealand, and reasonable travel **costs**, 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.

Benefit Maximum:

Up to $20,000 per overseas visit for treatment.

Note:

- 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.
- 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.

15 Parent Accommodation Benefit

Covers the **cost** per night of the accommodation expenses actually incurred by a parent accompanying a child aged under five years listed in the **acceptance certificate**, where that child is being treated in an **approved private hospital**.

Benefit Maximum:

Up to $200 per night

Up to $2,000 per **hospitalisation**.

16 Waiver of Premium Benefit

Covers the **cost** of the premiums due on the policy for the Base Cover only for all surviving **insured persons** if an **adult** dies before the age of 65 from any cause.

No **excess** will be deducted.

Benefit Maximum:

Two years premium, or until the surviving **adult** is aged 65, whichever occurs first.

Note:

- The **benefit** applies from the next premium payment date and the **benefit** payment period starts from this 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, unless **you** request otherwise in writing and agree to pay any additional annual premiums at the end of the waiver period.

17 Complications of Pregnancy / Childbirth Benefit

Covers the **cost** of treatment associated with an abnormal pregnancy and / or childbirth, but excludes caesarean sections.

Benefit Maximum:

Up to $1,000 per **policy year**.

18 Podiatric Surgery Benefit

Covers the **cost** of surgery performed by a **podiatric surgeon** under local anaesthetic, including up to one pre and one post surgery consultation and related x-rays.

Benefit Maximum

Up to $6,000 per **policy year**.

Note:

- This **benefit** maximum includes the **cost** of surgically implanted **prosthesis**.
- **We** do not pay this **benefit** in relation to the removal of corns and callouses.

19 Loyalty Benefit – Suspension of Cover

After 12 months continuous cover, the policy and premium for an **insured person** can be suspended as follows:

Overseas travel / residence

Cover and premiums for the **insured person** can be suspended for between three and 24 months if the **insured person** lives or travels outside New Zealand for longer than three consecutive months.

To suspend cover **you** must tell **us** in writing before the **insured person** travels overseas, and provide any evidence of travel **we** require.

Unemployment

The policy can be suspended for between three and six months if **you** are registered as unemployed.

To suspend cover **you** must tell **us** in writing within 30 days of **you** registering as unemployed.

Note:

- **You** cannot suspend cover for more than 24 months in any ten 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 the 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** 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 the policy ends.
- 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, the policy will end and **we** will issue a new policy to the remaining **insured persons**.

20 Loyalty Benefit – Wellness

After an **adult** has been continuously covered under the Base Cover for 36 months they receive a reimbursement up to the **benefit** maximum towards the **cost** of a medical examination by a **GP** including, for example, the **cost** of laboratory tests, ECG, blood pressure checks, breast examinations, cervical smears and prostate examinations.

Benefit Maximum:

Up to $100 per **adult** after every 36 months of continuous cover.

No **excess** will be deducted.

Note:

- **We** will advise **you** when an **adult** is eligible to take up this **benefit**.
- This **benefit** is not available to **dependent children**.
- 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.
- Each period runs from **policy anniversary date** to **policy anniversary date**.

Specialist Option

1 Introduction

1.1 What we cover

The Specialist Option can be added to the Base Cover. **Your acceptance certificate** shows whether **you** have chosen the Specialist Option.

This option covers the **cost** of **registered specialist** or **vocational GP** 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 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 a **vocational GP** or undergoes one of the specific **diagnostic investigations**.

1.2 What we pay

We will refund **you** the **costs** incurred up to the **benefit** maximums.

Note:

The Base Cover **excess** does not apply to the Specialist Option.

2 Specialist Benefit

Covers 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**.

Note:

If consultations result in admission to an **approved private hospital** within six months of the consultation, the **cost** of these will be covered under the Base Cover and come within the applicable **benefit** maximum.

3 Diagnostic Radiology and Imaging Benefit

Covers 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.

Benefit Maximum: (Up to the following)

- X-rays $1,000
- Arteriogram $1,000
- Ultrasound $400
- Scintigraphy $300
- Mammography $200

Benefit maximums are per **policy year**.

Note:

- 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** within six months, the **cost** of these will be covered under the Base Cover and come within the applicable **benefit** maximum.
- Radiotherapy is covered in the Base Cover.

4 Cardiac Investigations Benefit

Covers 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.

Benefit Maximum:

Up to $60,000 per **policy year**.

Note:

- 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 come 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**. An additional premium is payable for this option.

Lump Sum Option

1 Introduction

1.1 What we cover

The Lump Sum Option can be added to the Base Cover. **You** can choose a **sum insured** of either $10,000 or $20,000. **Your acceptance certificate** shows whether **you** have chosen the Lump Sum Option, the **insured persons** who are covered by it, and the **sum insured** for each of the **insured persons** covered.

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

- the **insured person** covered survives for at least 14 days following the date of the diagnosis of the Medical Condition. The 14-day period is calculated by only counting the time during which that **insured person** is not totally dependent on artificial life support systems, and
- the **insured person** covered suffers the Medical Condition at least 90 days after the **commencement date**, or if the **sum insured** has been increased at any time, at least 90 days after the increase, and before this cover ends. If that **insured person** suffers a Medical Condition within either 90-day period and that **insured person** later suffers from the same Medical Condition again **we** will not pay anything in relation to that later Medical Condition.

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

If any of the Medical Conditions results 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 Lump Sum Option pays the **sum insured** shown in the **acceptance certificate** as a lump sum.

We will pay the **sum insured** to **you** upon the **insured person** covered first suffering the Medical Condition. Only one **sum insured** is paid for each **insured person** covered by the Lump Sum Option.

If the **sum insured** in relation to the **insured person** covered has changed at any time and that **insured person** suffers a Medical Condition, then the relevant **sum insured** is the one that applied at the date that **insured person** suffered the Medical Condition.

Note:

- The Base Cover **excess** does not apply to the Lump Sum Option.
- Some exclusions apply. Please refer to section 8 and 9 of the General Conditions Section.
- 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

Coronary artery disease requiring open chest bypass surgery: the undergoing of medically necessary coronary artery bypass surgery by way of thoracotomy to correct or treat coronary artery disease. This does not include angioplasty, other intra-arterial, 'keyhole' or laser procedures.

Heart attack (myocardial infarction): the death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis shall be supported by the following criteria being consistent with a heart attack:

- clinical features,
- confirmatory new electrocardiogram (ECG) changes, and
- diagnostic elevation of cardiac enzyme CKMB.

Elevation of troponin for the purpose of a benefit payment under this definition is not considered to be diagnostic of a heart attack.

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 for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered medically necessary.

This does not include:

- tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant.
- all skin cancers, including hyperkeratoses, basal cell carcinomas and squamous cell carcinomas, unless there is evidence of metastases.
- malignant melanomas of less than 1.5mm maximum thickness as determined by histological examination using the Breslow method or less than Clark level 3 depth of invasion.
- non life-threatening cancers, such as:
  - prostatic cancers which are histologically described as TNM classification T1 (or similar classification as **we** may decide in **our** sole discretion from time to time).
  - papillary micro-carcinoma of the thyroid or bladder.
- chronic lymphocytic leukaemia less than Rai Stage 3.
- Kaposi's sarcoma and other tumours associated with Acquired Immune Deficiency Syndrome.

2.3 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 organ transplant from a donor to the **insured person** covered of one or more of the following organs: kidney, liver, heart, lung, pancreas, small bowel or the transplantation of bone marrow. This does not include the transplant of any other organ, parts of organs or any other tissue transplant.

2.4 Functional Loss / Neurological

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 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.
- **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.
- **Paraplegia:** the permanent and total loss of function of both legs as a result of **injury** to or disease of the spinal cord.
- **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.
- **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.
- **Stroke resulting in functional loss:** a cerebrovascular event producing neurological deficit and causing at least a 25% impairment of **whole person function** that is permanent. This requires clear evidence on a Computerised Tomography (CT) scan or Magnetic Resonance Imaging (MRI) scan or similar appropriate scan that a stroke has occurred and of:
  - infarction of brain tissue and
  - intracranial or subarachnoid haemorrhage, or
  - embolisation from an extracranial source.

This does not include cerebral symptoms 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.

3 When the Lump Sum Option ends

The Lump Sum Option ends in relation to an **insured person** covered at the earlier of:

a) the **policy anniversary date** immediately after that **insured person's** 70th birthday, or

b) when the **sum insured** is paid, or

c) when that **insured person** dies, or

d) when the policy is cancelled

e) when General Conditions Section 1 (Period of cover) applies.

4 New application or alteration to the sum insured

If **you** wish to add the Lump Sum 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. 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** showing the new **sum insured**. 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. **Your acceptance 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. It 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**.

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

1.2 What we pay

We will refund **you** the **costs** incurred up to the **benefit** maximums.

Note:

The Base Cover **excess** does not apply to the GP Option.

2 General Practitioners Benefit

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

Benefit Maximums:

Up to $45 per **GP** clinic visit including after hours.

Up to $70 per home visit.

Up to $20 per visit for **ACC top-up**. **You** cannot use the $45 / $70 per clinic / home visit **benefit** to add to this.

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

Up to $150 per minor surgical procedure. **You** cannot use the $45 / $70 per clinic / home visit **benefit** to add to this.

3 Prescription Benefit

Covers the **cost** of medicines and drugs listed on the PHARMAC Schedule prescribed by a **GP** or **registered specialist**.

Benefit Maximums:

Up to $15 per item.

Up to $300 per **policy year**.

Note:

Excludes 'after hours' fees.

4 Physiotherapy Benefit

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

Benefit Maximums:

Up to $30 per visit.

Up to $10 per visit for **ACC top-up**. **You** cannot use the $30 per visit **benefit** to add to this.

Up to $300 per **policy year**.

5 Independent Nurse and Nurse Practitioner Benefit

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

Benefit Maximums:

Up to $20 per visit.

Up to six visits per **policy year**.

6 Public Hospital Cash Grant

Provides a cash payment towards the **cost** of an **insured person** being admitted overnight to a public hospital in New Zealand.

Benefit Maximums:

Adults

$25 per night.
Up to $625 per **policy year**.

Dependent Children

$13 per night.
Up to $325 per **policy year**.

Note:

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 – Pre-Existing Conditions

After three years continuous cover under the GP Option, cover may be provided for **pre-existing conditions** that have previously been excluded from cover.

Note:

- **You** must apply to **us** in writing to have any **pre-existing condition** exclusions reviewed.
- **You** must pay for any medical information that **we** may require for the review.
- If **we** agree to cover the **pre-existing condition**, **we** will provide **you** with a new **acceptance certificate** confirming this.
- Cover will start from the date shown on the **acceptance certificate**.

8 Loyalty Benefit – Sterilisation

After five years continuous cover under the GP Option, sterilisation procedures for males and females will be covered.

Benefit Maximum:

Up to $1,000 per procedure.

9 Loyalty Benefit – Active Wellness

Each **adult** will receive a reimbursement of up to the **benefit** maximum towards the **cost** of either membership to a recognised gym or sports club, or sports / fitness equipment purchased from a recognised sporting retailer. Each **adult** will be eligible for this **benefit** after they have each had 24 months continuous cover under the GP Option, and at the end of every 24 months thereafter, providing claims which are submitted for events that occurred within the preceding 24 month period under the GP Option are less than $150. 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 Wellness Benefit from the claim.

Benefit Maximum:

Up to $150 per **adult** after every 24 months of continuous cover under the GP Option.

Note:

- 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 **you** are 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**.
- If cover is suspended, the suspended period is included when calculating the 24 months continuous cover.
- Each period runs from **policy anniversary date** to **policy anniversary date**.

10 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**. 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. **Your acceptance 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.

It 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**.

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

1.2 What we pay

We will refund **you** 80% of the **cost** incurred up to the **benefit** maximums.

Note:

The Base Cover **excess** does not apply to the Dental and Optical Option.

2 Dental Benefit

Covers 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.

Benefit Maximum:

Up to $400 per **policy year**.

Note:

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

3 Optical Benefit

Covers 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.

Benefit Maximums:

Up to $50 per consultation / examination.

Up to $250 per **policy year** for consultations / examinations.

Up to $300 per **policy year** for each **insured person** for glasses and contact lenses.

Note:

- **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 Audiology Benefit

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

Benefit Maximums:

Up to $200 per **policy year** for audiology.

Up to $200 per **policy year** for audiometric tests.

5 Acupuncture Benefit

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

Benefit Maximums:

Up to $30 per visit.

Up to $10 per visit for **ACC top-up**. **You** cannot use the $30 per visit **benefit** to add to this.

Up to $200 per **policy year**.

6 Chiropractic Benefit

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

Benefit Maximums:

Up to $30 per visit.

Up to $10 per visit for **ACC top-up**. **You** cannot use the $30 per visit **benefit** to add to this.

Up to $200 per **policy year**.

Up to $70 per **policy year** for x-rays.

7 Osteopathy Benefit

Covers the **cost** of osteopathy treatment on **referral** from a **GP** or **registered specialist**.

Benefit Maximums:

Up to $30 per visit.

Up to $10 per visit for **ACC top-up**. **You** cannot use the $30 per visit **benefit** to add to this.

Up to $200 per **policy year**.

8 Podiatry Benefit

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

Benefit Maximums:

Up to $30 per visit.

Up to $150 per **policy year**.

9 Speech Therapy, Occupational Therapy and Eye Therapy Benefit

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

Benefit Maximums:

Up to $30 per visit.

Up to $250 per **policy year** for the combined total of all of these therapies.

10 Loyalty Benefit – Orthodontic Treatment

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

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**. An additional premium is payable for this option.

General Conditions Section

The general conditions are as follows:

1 Period of cover

Cover for the Base Cover and any options shown on the **acceptance certificate** start on their **commencement date**.

Cover ends when any of the following happen:

a) **You** ask **us** to cancel it. **You** must give **us** not less than 30 days notice in writing. **You** must pay any annual premium still due.

b) **You** fail to pay the premium or any premium instalment within 90 days after the due date for payment.

c) **You** or any **insured person** breach the policy.

2 Dependent children

Cover for a **dependent child** ends on the next **policy anniversary date** on or after the day they turn 21 or no longer live at home (unless attending tertiary study) which ever occurs first. They can then either remain on **your** policy and pay the **adult** premium, or opt within 30 days of cover ending to arrange a separate policy with **us** on similar terms without having to provide any further evidence of health.

3 Premiums

You must pay **us** the annual premium in full on the **commencement date** and on each **policy anniversary date**. However **you** may pay the annual premium by monthly, quarterly, or half-yearly instalments. These are payable in advance.

We may refuse to pay a **benefit** if the premium is overdue.

The premium is calculated according to the rates applying from time to time for the plan **you** selected. They automatically increase when an **insured person** attains a specified age. A copy of the rates is available from **us** on request.

We can alter the schedule of premium rates (including the ages at which premiums increase) or the **benefits** provided under Health Plus and its options at any time by giving **you** 30 days prior written notice to **your** last known address.

If **you** cancel the policy during the **policy year**, **you** must pay the balance of the annual premium still outstanding.

4 Altering the terms of your policy

We may alter this policy at any time by giving **you** 30 days prior written notice to **your** last known address.

This can be for a variety of reasons. For example (without limitation):

a) the law changes, or

b) the **costs we** cover increase, or

c) medical inflation, or

d) an increase in claims beyond normal, or

e) a change in rating factors or the emergence of new rating factors.

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.

5 Reinstating this policy

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

a) Cover starts on the date **we** reinstate it, and

b) **We** will give **you** a new **acceptance certificate**.

6 Information when 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** option, decline the claim and / or cancel the policy from the **commencement date**. If **we** cancel the 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. **You** must comply with this policy in full before any claim is paid.

7 About other benefits

Where the policy includes cover for prescribed medications:

a) Only medication prescribed by a **GP** or **registered specialist**, which is on the PHARMAC Schedule is covered.

b) Medications for **health conditions** that are listed among the policy exclusions are not covered.

Where a **benefit** is subject to a maximum per **policy year**, the maximum applies to the **policy year** in which the treatment or service was provided.

8 Exclusions – what we will not pay for

We will not pay a **benefit** for –

8.1 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

f) Acquired immune deficiencies (AIDS) or associated **health conditions** including HIV and related **health conditions**

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

h) A known congenital **health condition**. (i.e. a **health condition** which is recognised at birth, or diagnosed within three 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**. This exclusion does not apply, however, in respect of a **health condition** declared on **your** application form and accepted by **us**

l) Any **acute health condition**

m) A **health condition** arising from a criminal offence by an **insured person** that resulted in a conviction

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

8.2 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

d) Rehabilitation, convalescence, respite, **disability support services costs** (except where the contrary is expressly stated within this policy)

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

f) Preventative treatment 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 heart, lung, kidney, liver and bone marrow transplants as provided by government funded agencies

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

l) 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 Benefit

m) Radial keratotomy or photo-retractive keratectomy or any related complications

n) Any **costs** incurred as a result of cancellation of treatment under one of the eligible **benefits** except where that cancellation is on medical advice

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

8.3 The **cost** of:

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, personal alarms, and orthotic shoes

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

This does not include surgically implanted **prostheses**.

8.4 **Cost** and expenses recovered or recoverable from a third party or under any other contract of indemnity or insurance.

8.5 The **cost** of treating a physical **injury** or medical misadventure except as provided under the **ACC top-up** Benefit. Where no **ACC top-up** maximum is specified, the amount **we** pay is the lesser of the actual **costs** of the treatment or the health plan **benefit** maximum, less the amount payable by **ACC**. Where the **benefit** maximum is subject to a maximum percentage of actual **costs**, e.g. 80%, this amount is subject to that maximum percentage.

8.6 Medicines or drugs that are not listed on the PHARMAC Schedule.

8.7 Any **costs** for a **health condition** that arose during a **stand-down period**. **Stand-down periods** do not apply to newborn **dependent children** added to the policy within four months of birth.

9 Additional exclusions for the Lump Sum Option

9.1 **We** will not pay anything under the Lump Sum Option if what happens to the **insured person** covered is directly or indirectly caused by:

a) intentional self inflicted **injury** whether sane or insane

b) war or act of war

c) alcohol abuse or drug abuse

d) engaging in conduct which constitutes or gives rise to any criminal offence for which the **insured person** covered is convicted

e) the misuse of prescribed drugs or the deliberate taking or use of non prescribed drugs other than for proper medical purposes.

9.2 **We** will not pay anything under the Lump Sum Option, or where the **sum insured** has been increased, **we** will not pay the amount of the increase, if:

a) the **insured person** covered suffers a Medical Condition which is solely directly and proximately caused by an **injury**, and

b) the **injury** happened within the 90 day period following either the **commencement date** or an increase in the **sum insured**, and

c) the **injury** is self inflicted (whether intentional or not), and

d) the Medical Condition is diagnosed more than 12 months after the date of the **injury**, and

e) the Medical Condition is one of the following:

- Cancer – life threatening
- Coronary artery disease requiring open chest bypass surgery
- Chronic renal failure
- Heart attack (myocardial infarction)
- Major organ transplant
- Stroke resulting in functional loss.

9.3 **We** will not pay anything under the Lump Sum 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**:

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.

9.4 **We** will not pay anything under the Lump Sum Option if the **insured person** covered dies within the 14-day period following the date of diagnosis of the Medical Condition. However the 14-day period is calculated by only counting the time during which that **insured person** is not totally dependent on artificial life support systems.

9.5 **We** will not pay anything under the Lump Sum Option if the Medical Condition suffered by the **insured person** covered arises from, or is traceable to, or is medically related to a **pre-existing condition**. This exclusion does not apply to the extent the **acceptance certificate** expressly covers one or more **pre-existing conditions**.

10 Jurisdiction

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

11 Currency and GST

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

12 No surrender value

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

13 If you have a problem

We want **you** to remain satisfied with this policy. **We** have a complaints procedure that is intended to resolve any problems quickly and fairly.

If **you** have any questions or complaints about this policy, please phone **us** on 0800 123 642.

If this does not resolve **your** problem, **you** should write to:

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

14 Headings

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

Definitions Section

The following words in bold in the policy (and any derivatives) have the following meanings:

Definition	Meaning
ACC	The Accident Compensation Corporation as defined in the Injury Prevention, Rehabilitation and Compensation Act 2001 or its successor under any subsequent legislation.
ACC Top-up	The difference between what a **recognised provider** charges for services and what the **ACC** pays.
Acceptance certificate	The most recent acceptance certificate issued to **you** by **us**.
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 services 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), (c), or f) admission to an acute secondary or tertiary service.
Adult	**You** and any **insured person** aged 21 or over.
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 any way with an approved private hospital.
Benefits	The **costs** covered by this policy.
Commencement date	The date shown on the **acceptance certificate** for the Base Cover and for each option for each **insured person**. Where a person is added to this policy or an option is added, the commencement date will be the date shown on the **acceptance certificate** for the Base Cover and for each option for that person.
Cost	The GST inclusive costs charged by a **recognised provider** for the provision of services.
Dependent child	**Your** child under the age of 21 years, who usually lives with **you** or who is a tertiary student.
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.
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 **First Choice network**.
Excess	The amount shown on the **acceptance 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).
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 Medical Practitioners Act 1995 (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 any subsequent legislation (except where the **ACC top-up benefit** applies).
Health service provider	Any registered 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 and any hospital, organisation or entity which is approved by **us**.
Hospitalisation	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 for a **health condition**.

Definition	Meaning
Independent nurse	Any person who holds a current practicing certificate issued by the Nursing Council of New Zealand 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**.
Long term care	Those public and private hospital based services provided on an ongoing 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	**Your** spouse or a person who cohabits with **you** in the nature of marriage.
Podiatric surgeon	A **health service provider** who holds a current annual practising certificate; and is a member of the Podiatrists Board of New Zealand (or its successor); and is vocationally registered and recognised as a podiatric surgeon.
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.**
Pre-existing condition	Any illness, sickness, disease, **injury**, medical condition or symptom, on or before the **commencement date**: a) which **you** or any **insured person** was aware of, or b) which **you** or the **insured person** had signs or symptoms of, or c) which **you** or the **insured person** sought investigation or medical advice for, or d) where a symptom existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment.
Pre-approval	Approval of a claim by **us** prior to an **insured person** undergoing treatment, surgery or a **diagnostic investigation.**
Prosthesis / prostheses	A surgically implanted artificial replacement of a joint or body organ used to restore functionality.
Recognised provider	A **health service provider**, **registered specialist**, **approved private hospital** or other medical facility that is recognised by **us**.
Referral	A letter written by a **GP** or **registered specialist** to another **health service provider** requesting that an **insured person** be assessed and / or treated for a **health condition**.
Registered nurse	Any person who holds a current practicing 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 & Reproductive Health, General Practice, Medical Administration, Occupational Medicine, Public Health Medicine and Sports Medicine, or a podiatrist.
Stand-down period	Period of time after the **commencement date** for which no claim will be paid.
Sum insured	The amount of cover shown on the **acceptance certificate** in relation to the **insured person** covered by the Lump Sum Option.
Surgical cost grouping	The overall costs for **registered specialist**, anaesthetist and any **prosthesis** (if applicable) for a health service.
Surveillance testing	A **diagnostic investigation** or procedure undertaken as a preventative measure to ensure that an **insured person** does not have an undiagnosed **health condition**. It does not include follow-up investigations or diagnostic procedures undertaken to enable early detection of the re-occurrence of a known **health condition.**
Vocational GP	A **GP** with a relevant, post-graduate qualification in the health service they are providing, as recognised by **us**.
We	nib nz limited. **Our** and **us** have the same meaning.
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 an equivalent New Zealand or Australian guide that has been sanctioned by the New Zealand or Australian Medical Association has been produced, or where one is not produced, any replacement publication sanctioned by the American Medical Association.
you and your	The person or persons named in the application form as an Applicant.

Health Plus
Policy document

Need help?

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