nib

# Hospital Cover Plus
# Policy document

# Contents

# Introduction

Thank you for trusting nib to insure your health. This document explains what your policy covers, and contains all policy terms and conditions. This should also be read in conjunction with your acceptance certificate.

It is important that **you** read **your** policy document carefully.

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

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

## 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 person**'s personal information. **Our** privacy policy explains how **we** may collect, use and disclose personal information. To see the full privacy policy, please go to nib.co.nz/about-us/privacy-policy.

## Duty of disclosure

At the time of application, **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, the **insured persons** must have disclosed any medical condition or sign or symptom of a medical condition they had at the time of applying, or have had in the past.

**You** and the **insured persons** must have told **us** about any changes to the information given to **us** before the **commencement date** or **join date** of this policy or at any time changes are made to the policy in the future. If **you** or any **insured person** fail to do so, or if any of the information was not disclosed to **us**, **we** can cancel this policy from the **commencement date** and not pay any claims. **We** may retain all the premiums paid, and any claims paid by **us** may be recovered from **you**.

## Contract of insurance

The contract of insurance consists of:

- Policy wording (this document), and
- The **prosthesis schedule**, and
- The **acceptance certificate** or **renewal certificate**.

## Headings

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

## Words in bold

**We** have some words in bold, which indicate words that have a special meaning. To find out the meaning, please refer to the Definitions section.

# Help section

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

## 1. How to contact us

- The my nib portal provides 24 hour access to **your** policy and claims details. This information can be found by visiting nib.co.nz/portal

Alternatively to enquire about or make a change to **your** policy, either:

- Call **us** on 0800 123 642, or
- Email **us** at contactus@nib.co.nz, or
- Write to **us** at:
  nib nz limited,
  PO Box 91 630,
  Victoria Street West,
  Auckland 1142, or
- Visit **our** website at nib.co.nz

**Our** website provides key information such as the **prosthesis schedule** and claim forms.

## 2. How to seek pre-approval for a claim

2.1 Contact **us**

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

2.2 Provide complete information

Please ensure that the **insured person** provides **us** with a full description on the claim form of:

- The treatment to be undertaken
- The clinical reason for the treatment
- The name of the **registered specialist** who will conduct the treatment
- The expected date of treatment
- Whether the treatment was accident related
- The **GP** referral letter and **registered specialist consultation** letter.

2.3 **We** confirm acceptance of **your** pre-approval

Pre-approvals will be processed within five working days, unless further information is required or insufficient information was initially supplied. **We** will let **you** know the outcome of **your** claim in writing, if the request has been made by a **recognised provider we** will also notify them. If approved, **we** will give **you** a letter that gives the **recognised provider** authority to invoice **us** directly for the costs covered, which saves **you** time and money. This 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.

2.4 Give the pre-approval letter to **your recognised providers**

**You** must give a copy of the pre-approval letter to your **recognised providers** so that they know what **we** have agreed to cover.

## 3. Choosing your provider

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

- If **you** choose a **recognised provider** from the **nib First Choice network** for that health service, **your** claims will be covered for 100% of eligible costs, less any **excess**.
- **You** can still choose to receive treatment from a **recognised provider** that is not part of the **First Choice network**, however **you** may not be covered for 100% of eligible costs.
- **We** may separate **First Choice network** claim costs into two components:
  - **Your approved private hospital** charges (if applicable)
  - The **surgical cost grouping**, which consists of the **registered specialist**, anaesthetist and any **prosthesis** costs.
- If either the **approved private hospital** or **registered specialist** is not a **First Choice provider** for the health service provided, then the maximum **we** will pay for claims associated with each component is the **Efficient Market Price (EMP)** determined individually for that component.
- Using a **First Choice provider** gives certainty that **you** will be covered for 100% of approved associated health service costs included in the policy up to the benefit maximum.
- Not all health services are included in the **First Choice network**. To find out whether a health service is included or which **recognised providers** are part of the **First Choice network** visit nibfirstchoice.co.nz/directory.
- **We** will pay 100% of costs, up to the benefit maximum and less any **excess**, for health services provided by **recognised providers** that are part of the **First Choice network**.
- If a **recognised provider** is not part of the **First Choice network**, and the network applies to that health service, then the maximum **we** will pay for that portion of the treatment is the **EMP**.
- Any costs above the **EMP** must be paid by the **policyowner** or the **insured person**. **We** recommend that the **policyowner** and all **insured persons** ensure they understand all the potential costs before undertaking any health services with a **recognised provider** that is not part of the **First Choice network**.

## 4. 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.

## 5. 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.

## 6. How to make a claim

6.1 Contact **us**

- Visit **our** website at nib.co.nz for a claim and pre-approval form.
- Call **us** on **0800 123 642**
- Email **us** at claims@nib.co.nz
- If **your recognised provider** has access to the nib First Choice Portal they can submit a claim on **your** behalf.

For smaller claims, such as doctor's accounts and pharmaceutical charges, please pay the **recognised provider** directly. Remember to always get a receipt.

6.2 Claims conditions

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

6.2.1 Provide full information

**You** must give us a full description on the claim form of:

- The pre-approval number for the treatment (if obtained)
- The treatment undertaken
- The reason for the treatment (if not included on the pre-approval information)
- The date of the treatment
- Whether the treatment was accident-related (if not included on the pre-approval information)
- Any other information or assistance **we** reasonably require
- If not pre-approved, please submit supporting medical information.

**You** must submit original invoices or receipts.

6.2.2 **ACC** treatment **injury**

In the event of an **injury** occurring that arises out of an **insured person**'s treatment that is covered under this policy, the **insured person** must submit a **treatment injury** claim to **ACC**. This claim may be submitted by **your registered specialist** or your **GP**. Application forms for a **treatment injury** claim are available on the **ACC** website.

6.2.3 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.

6.2.4 Referral by a **GP** or **registered specialist**

Where this policy specifies that treatment must only be performed after referral by a **GP** or **registered specialist**, please provide a copy of the referral letter.

6.3 Rapid refund

**We** will process **your** claim within five working days of receipt of the claim form, unless further information is required. Typically **we** refund the **recognised provider** directly. For claims that cover **you** for costs incurred, **our** policy is to refund **you** by direct credit so please ensure **your** banking details on the claim form are accurate.

## 7. How to change your policy

7.1 Each **policyowner** is authorised to enquire about, and make changes to, the cover he or she owns. If any cover is owned by more than one **policyowner**, the cover is owned jointly by those **policyowners** and they must consent to all changes unless expressly specified. **You** must give **us** at least 30 days prior notice in writing or by email before any changes can be made. **We** will make the requested change to this policy on the same (or nearest equivalent) date in the month that corresponds to your **policy anniversary date**, immediately after **you** request this change. For example, if the **policy anniversary date** is 30 September and **you** request a change on 15 June, the **effective date** of the change will be 30 June. If **we** make the change on any other date **we** will let **you** know.

To enquire about or make a change to **your** policy, either:

- Call **us** on 0800 123 642, or
- Email **us** at contactus@nib.co.nz, or
- Write to **us** at:
  nib nz limited,
  PO Box 91 630,
  Victoria Street West,
  Auckland 1142.

7.1.1 Adding a **partner** or **dependent child** to your policy

**You** can add an **insured person**'s **partner** or add a **dependent child** to this policy. To do this, **you** must complete **our** application form and send it to **us**. **You** can obtain an application form by ringing **us** or by contacting **your** financial adviser. **We** charge an additional premium for each additional person added.

7.1.2 Rules for adding a **dependent child** to **your** policy

The first child born after the **commencement date** is covered under this policy for four months from the date of birth of the child on the standard terms and conditions of this policy. If **you** wish to include this child on **your** policy after the end of the four month period, **you** must apply for cover by completing an application before the four month period ends.

**We** will charge a premium from the date the **dependent child** becomes an **insured person** at the current premium rate for a one parent family or two parent family policy. Each child born after the **commencement date** will be covered under this policy on the standard terms and conditions of this policy as soon as **we** receive advice from you of the child's name and date of birth.

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 medical condition** or a medical condition excluded under the standard policy exclusions. A person is added to this policy from the **join date** shown on the **acceptance certificate** or **renewal certificate**.

7.1.3 Removing an **insured person** or a **policyowner**

**We** will remove an **insured person** or **policyowner** from this policy at the written request of that person. **We** do not need the consent of any other **insured person** or **policyowner** (whether a joint owner or not). He or she has the option, within 30 days of removal, to arrange a separate policy on terms determined by **us** without providing any evidence of his or her current state of health. **We** require at least 30 days prior notice to effect this change.

7.1.4 Adding or removing options

**You** can add options to **your** cover for an additional premium. **You** must complete **our** application form and send it to **us**. **You** can obtain an application form by ringing **us** or by contacting **your** financial adviser. The application form must be received and assessed by **us** before cover can start. Any additional options added to this policy from the **effective date** will show on the **acceptance certificate** or **renewal certificate**.

7.1.5 Changing your **excess**

**You** can change the **excess** on any **policy anniversary date**. If **you** have not made any claims **we** may, at **our** discretion, allow **you** to change the **excess** earlier. **You** must give **us** at least 30 days prior notice in writing or by email before this change can be made. If **you** wish to reduce the level of the **excess**, before **we** agree, **we** may require a medical assessment of all **insured persons** on the policy to determine their current health status.

7.1.6 **Policyowner** must be an adult

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

7.1.7 Changes in contact details

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

7.2 **We** will process the change

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

7.3 New **acceptance certificate**

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

# Your policy

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

All **insured persons** must take the Base Cover. Optional add ons are the Active Option, the Select Option and the Serious Care Option. If **you** have chosen any of these optional add ons, it will be shown on **your acceptance certificate** or **renewal certificate**.

IMPORTANT – This section must be read in conjunction with:

- This policy document, and
- The **prosthesis schedule**, and
- The **acceptance certificate** or **renewal 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.

## 1. What we cover

1.1 **We** cover during the policy period those benefits set out below that are necessary for each **insured person** to investigate and treat that **insured person**'s medical condition. Where a benefit is subject to a benefit maximum, the benefit maximum will apply to the **policy year** in which the investigation or treatment was provided.

1.2 **We** cover certain **prostheses** costs (replacement implants only) used in a surgical procedure, up to fixed benefit maximums set by **us**. A **prosthesis schedule** specifies the **prostheses** which have a specified benefit maximum applicable. This schedule is reviewed annually and is available from **our** website or from **us** on request. The cost of **prostheses** is included in the benefit maximum for a surgical procedure. **We** will only contribute to scheduled **prostheses** (components in situ) and not to components that are trialled, that are contaminated back-ups or made available but not implanted.

1.3 The benefits listed apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**.

1.4 Please refer to **your acceptance certificate** or **renewal certificate** for any specific medical exclusions and/or concessions specific to **your** cover and to the Exclusion section which outlines all general policy exclusions applicable to **your** policy.

## 2. What we pay

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

Unless stated otherwise, the **excess** applies to each **insured person** for each separate treatment covered.

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

# Your benefits

## 1. Surgical Hospitalisation Benefit

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

During a covered procedure, **we** also cover the cost of:

- In-hospital **registered specialist** and anaesthetist
- Intensive nursing care
- Diagnostic imaging
- Disposables and consumables
- Dressings
- **Drugs** required while **hospitalised** that are directly related to the surgical procedure
- **Prostheses** covered as per the **prosthesis schedule** up to the maximum shown on the schedule.

### Benefit maximum

**We** pay up to $150,000 per **insured person** per **policy year**, less any **excess**.

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

- Pre and Post-Procedure or Pre and Post-Treatment Registered Specialist Consultation Benefit
- Pre and Post-Procedure or Pre and Post-Treatment Related Diagnostic Radiology Benefit
- Pre and Post-Procedure or Pre and Post-Treatment Related Cardiac Investigation Benefit
- Post-Procedure or Post-Treatment Physiotherapy Benefit
- Post-Procedure or Post-Treatment Home Nursing Benefit
- Procedure-Related Travel and Accommodation Benefit
- Ambulance Transfer Benefit
- Radiotherapy Travel and Accommodation Benefit
- ACC Top-Up Benefit
- Parent Accommodation Benefit

Please note: Individual limits for these benefits may also apply.

### Other terms

- **Chemotherapy/radiotherapy**

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

- **Oral surgery**

**We** will cover **you** for the costs of the following types of oral surgery carried out on an **insured person** if the surgery is done by a registered oral and maxillo-facial surgeon and the **insured person** has been referred by a **registered specialist**, dental surgeon or dentist:

- Surgical removal of impacted or unerupted teeth carried out after this policy has been in force for at least six months
- Surgical removal of cysts, soft tissue swellings and enlargements
- Surgical drainage of abscesses
- Surgical removal of benign or malignant tumours of the oral cavity (mouth) and salivary glands
- Surgical removal of odontogenic (hard tissue) cysts and tumours, including osteoma.

**We** will not cover **you** for periodontal surgery or prosthodontal surgery or for implant **prostheses** or check-ups, fillings, caps, repair of broken teeth or orthodontics.

## 2. Cancer Treatment Benefit

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

There is no cover for treatment where initial care has been performed in a public hospital or in any other circumstance that has not been approved by **us**.

### Benefit maximum

**We** pay up to a benefit maximum of $120,000 per **insured person** per **policy year**, less any **excess**.

Where this policy has an **excess**, it will be applied to each **cycle of treatment**. This benefit maximum is inclusive of the following benefits:

- Pre and Post-Procedure or Pre and Post-Treatment Registered Specialist Consultation Benefit
- Registered Specialist Consultations During Cancer Treatment Benefit
- Procedure or Treatment Related Diagnostic Radiology Benefit
- Post-Procedure or Post-Treatment Physiotherapy Benefit
- Post-Treatment Home Nursing Benefit
- Radiotherapy Travel and Accommodation Benefit
- Parent Accommodation Benefit

Please note: Individual limits may apply under each of the benefits.

### Other terms

- Where surgery follows within six months of the last **cycle of treatment**, only one **excess** will apply to that surgery under the Surgical Hospitalisation Benefit and the chemotherapy and radiotherapy treatment during that six months. Any other excess paid for chemotherapy or radiotherapy treatment during that six month period will be refunded.
- To qualify for reimbursement, a **cycle of treatment** for chemotherapy must meet the following criteria:
  - **PHARMAC** has approved the **chemotherapy agent** under sections A to G of the **PHARMAC** Pricing Schedule (or as subsequently amended), and

- The **chemotherapy agent**:

  Meets the **PHARMAC** funding criteria, and

  Is prescribed by a **registered specialist** and administered in New Zealand
- To qualify for reimbursement for a **cycle of treatment** for radiotherapy, the treatment must be administered in New Zealand by an appropriately qualified medical professional registered in New Zealand.

## 3. Non-Surgical Hospitalisation Benefit

**We** cover the cost of treatment (not involving surgery) for any **insured person** in an **approved private hospital** for two or more consecutive nights, up to a maximum of 14 nights per **insured person**, per **policy year**.

During treatment, **we** also cover the cost of:

- In-hospital **registered specialist**
- Intensive nursing care
- Diagnostic imaging
- Disposables, consumables and dressings
- **Drugs** required while **hospitalised**.

**Benefit maximum**

**We** pay up to $30,000 per **insured person** per **policy year**, less any **excess**.

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

- Pre and Post-Procedure or Pre and Post-Treatment Registered Specialist Consultation Benefit
- Pre and Post-Procedure or Pre and Post-Treatment Diagnostic Radiology Benefit
- Ambulance Transfer Benefit
- Post-Procedure or Post-Treatment Physiotherapy Benefit
- Post-Procedure or Post-Treatment Home Nursing Benefit
- Parent Accommodation Benefit.

Please note: Individual limits for these benefits may also apply.

## 4. Pre and Post-Procedure or Pre and Post-Treatment Registered Specialist Consultation Benefit

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

A documented referral from a **GP** or New Zealand **registered specialist** is required by **us**.

**Benefit maximum**

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Cancer Treatment Benefit or Non-Surgical Hospitalisation Benefit (whichever applies).

**Other terms**

- **We** do not cover **registered specialist** or **vocational GP** visits that do not relate to **hospitalisation**.
- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

## 5. Registered Specialist Consultations During Cancer Treatment Benefit

**We** cover the cost of **registered specialist consultations** resulting from a referral by a **GP** or **registered specialist**, where the **registered specialist consultation** directly relates to, or results in, the **insured person** having private chemotherapy, radiotherapy or brachytherapy treatment for cancer.

The cost must be incurred from the start of the **cycle of treatment** until the end of the **cycle of treatment**.

**Benefit maximum**

All costs paid under this benefit are included within the Cancer Treatment Benefit maximum.

## 6. Pre and Post-Procedure or Pre and Post-Treatment Related Diagnostic Radiology Benefit

**We** cover the cost of diagnostic radiology up to six months before the date of treatment or admission to an **approved private hospital** and up to six months after the date of completion of an approved course of treatment or discharge from that **approved private hospital**.

A documented referral from a **GP** or New Zealand **registered specialist** is required by **us**.

**Benefit maximum**

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Cancer Treatment Benefit or Non-Surgical Hospitalisation Benefit (whichever applies).

**Other terms**

- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

## 7. Pre and Post-Procedure or Pre and Post-Treatment Related Cardiac Investigations Benefit

**We** cover the cost of cardiac investigations, up to six months before the date of treatment or admission to an **approved private hospital**, and up to six months after the date of completion of an approved course of treatment or discharge from that **approved private hospital**.

A documented referral from a **GP** or New Zealand **registered specialist** is required by **us**.

**Benefit maximum**

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

**Other terms**

- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

## 8. Post-Procedure or Post-Treatment Physiotherapy Benefit

**We** cover the cost of necessary post-procedure or post-treatment physiotherapy as recommended by the treating **registered specialist**, up to six months after being discharged from an **approved private hospital** or after a **cycle of treatment**.

**Benefit maximum**

**We** pay up to a total maximum of $500 per **insured person** per **policy year**.

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

**Other terms**

- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

## 9. Post-Procedure or Post-Treatment Home Nursing Care Benefit

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

Applications must be received by **us** in writing up to 21 days after being discharged from an **approved private hospital** or after the completion date of a **cycle of treatment** for cancer along with the **registered specialist**'s written recommendation for the benefit. This benefit remains valid for up to six months after being discharged from an **approved private hospita**l or after the completion date of a **cycle of treatment**.

**Benefit maximum**

**We** pay up to a total maximum of $3,000 per **insured person** per **policy year**.

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Non-Surgical Hospitalisation Benefit or Cancer Treatment Benefit (whichever applies).

**Other terms**

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

## 10. Procedure-Related Travel and Accommodation Benefit

Where a **registered specialist** has recommended a surgical procedure, and that surgery cannot be performed in an **approved private hospital** within 100 kilometres from the **insured person**'s usual residence, this benefit covers the following where applicable:

- Air travel – **we** cover the costs of a return economy class airfare within New Zealand for an **insured person** requiring the treatment, and for a support person to travel to and from an **approved private hospital**
- Taxi fares – for hospital admission from the airport of arrival direct to the **approved private hospital**, and on hospital discharge, from the **approved private hospital** direct to the airport of departure
- Road or rail travel – a mileage allowance is available as calculated by **us**
- Accommodation – if recommended by the **insured person**'s **registered specialist**, **we** pay up to $100 per night for the accommodation costs incurred by the support person while the **insured person** is **hospitalised**, up to a maximum of $500 per **hospitalisation**.

**Benefit maximum**

**We** pay up to a maximum of $1,000 per **insured person** per **hospitalisation**.

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit.

**Other terms**

- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit.

## 11. Ambulance Transfer Benefit

**We** cover the cost of road ambulance where medically necessary and approved by **us**, 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. No other transfers are covered apart from carriage between medical facilities as approved by **us**.

**Benefit maximum**

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit, Non-Surgical Hospitalisation Benefit or Cancer Treatment Benefit (whichever applies).

**Other terms**

- The cost of ambulance society subscriptions are not covered.
- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit, Cancer Treatment Benefit, or Non-Surgical Hospitalisation Benefit (whichever applies).

## 12. Radiotherapy Travel and Accommodation Benefit

Where a **registered specialist** has recommended radiotherapy for cancer, and treatment is not available in an **approved private hospital** within 100 kilometres from the **insured person**'s usual residence, this benefit covers the following where applicable:

- Air travel – **we** cover the costs, of a return economy class airfare within New Zealand for an **insured person** requiring the treatment, and for a support person to travel to and from an **approved private hospital**
- Taxi fares – for hospital admission from the airport of arrival direct to the **approved private hospital**, and on hospital discharge, from the **approved private hospital** direct to the airport of departure. Two fares only per **cycle of treatment**
- Road or rail travel – a mileage allowance is available as calculated by **us**
- Accommodation – **we** cover the cost of accommodation incurred by the **insured person** and a support person up to $100 per night up to the benefit maximum for the **insured person** and a support person only during the **insured person**'s cycle of radiotherapy for cancer.

**Benefit maximum**

**We** pay up to a maximum of $4,500 per **insured person** per **policy year**.

All costs paid under this benefit are included in the Cancer Treatment Benefit.

**Other terms**

- This benefit applies per **cycle of treatmen**t for cancer.
- This benefit does not cover any travel and accommodation costs related to radiotherapy performed in any publicly funded facility.
- Cover is only provided where a claim has been paid under the Cancer Treatment Benefit.

## 13. ACC Top-Up Benefit

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

**Benefit maximum**

All costs paid under this benefit are included within the benefit maximum for the Surgical Hospitalisation Benefit or Non-Surgical Hospitalisation Benefit (whichever applies), less any **excess**.

**Other terms**

- An **insured person** must obtain **ACC**'s acceptance of their claim prior to the treatment being performed, and provide **us** with evidence of **ACC**'s acceptance of their claim and the amount payable by **ACC** in respect of that treatment.
- If **ACC** declines the **insured person**'s claim, **you** must supply to **us**, when seeking pre-approval for **your** claim, a copy of the **ACC**'s letter of declinature. **We** may require an **insured person** to apply for a review of **ACC**'s grounds of declinature and **we** may also seek legal advice, at **our** cost, about **ACC**'s grounds of declinature. If the review is successful, **you** must reimburse to **us** any payments subsequently made to the **insured person** by **ACC**.
- The surgical and medical costs must directly relate to the **hospitalisation**.
- Cover is only provided where a claim has been paid under the Surgical Hospitalisation Benefit or Non-Surgical Hospitalisation Benefit (whichever applies).

## 14. General Diagnostic and Radiology Benefit

Includes diagnostic and radiology procedures such as X-rays, ultrasound, MRI, CT, colonoscopy, ECG, CT angiogram.

**We** cover the cost of diagnostic and radiology procedures, 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**

**We** pay up to a total maximum of $5,000 per **insured person** per **policy year**, less any **excess**.

A documented referral from a **GP** or New Zealand **registered specialist** is required by **us**.

Please note: **We** cover the cost of arthroscopy, hysteroscopy, laparoscopy and coronary angiogram in an **approved private hospital**. Included in the Surgical Hospitalisation Benefit maximum.

If the diagnostic radiology procedures results in hospitalisation in an **approved private hospital** or chemotherapy or radiotherapy treatment for cancer, within six months after the diagnostic procedure, the cost of these diagnostic procedures will be covered under the Surgical Hospitalisation Benefit maximum, Cancer Treatment Benefit maximum or Non-Surgical Hospitalisation Benefit maximum, whichever applies

## 15. MRI and CT Scan Benefit

**We** cover 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** for treatment.

**Benefit maximum**

MRI Scan: **We** pay up to $2,500 per **insured person** per **policy year**, less any **excess**.

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

A documented referral from a **registered specialist** is required by **us**.

Note: If the MRI or CT scan results in hospitalisation in an **approved private hospital** or chemotherapy or radiotherapy treatment for cancer within six months, the cost of these scans will be covered under the Surgical Hospitalisation Benefit maximum, Cancer Treatment Benefit maximum or Non-Surgical Hospitalisation Benefit maximum, whichever applies.

## 16. Specialist Minor Surgery Benefit

**We** cover the cost of minor surgery performed by a **registered specialist** or **vocational GP** after referral by a **GP** or a **registered specialist**.

**Benefit maximum**

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

**Other terms**

- This benefit does not include any pre and/or post minor surgery, **GP** or **registered specialist consultations** or any other diagnostic costs associated with the treatment.
- There is no cover for cryotherapy, intravitreal injections, pharmaceuticals, pulse light or any similar treatments under this benefit.

## 17. Specialist Minor Surgery Benefit – Skin Lesions

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

**Benefit maximum**

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

**Other terms**

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

## 18. Podiatric Surgery Benefit

**We** cover 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**

**We** pay up to $6,000 for each **insured person** per **policy year**, less any **excess**. This benefit maximum includes the cost of surgically implanted **prosthesis (**see **prosthesis schedule).**

**Other terms**

- There is no cover for removal of corns and callouses.

## 19. Overseas Treatment Benefit

**We** cover the cost of an overseas surgical or medical treatment that cannot be performed at all in New Zealand, and reasonable travel cost, 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.

A documented referral from a **GP** or New Zealand **registered specialist** is required by **us**.

**Benefit maximum**

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

**Other terms**

- The treatment must be of a type which cannot be performed in New Zealand. **You** must provide evidence of the Ministry of Health's decision regarding funding to **us**.
- The treatment must be recommended by a **registered specialist** and must be recognised by **us** as a conventional form of treatment.

## 20. Public Hospital Cash Grant

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

**Benefit maximum**

**We** pay $100 per night, up to $500 per **insured person** per **policy year**.

**Other terms**

- **You** must submit a copy of your discharge summary specifying the date and reason for admission and date of discharge.
- **We** do not pay this benefit if a fee-paying **insured person** is admitted to the private wing of a public hospital.
- The **excess** does not apply.
- **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.

## 21. Waiver of Premium Benefit

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

**Benefit maximum**

**We** pay the premiums:

- For two years, or
- Until any surviving **partner** aged 65, whichever occurs first.

**Other terms**

- There is no **excess** applicable to this benefit.
- The benefit starts from the next premium payment date.
- The benefit ends at the earlier of when the **insured person** attains the age of 65, or at the end of the two years. When the benefit ends, the premiums will be paid by **you**.

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

## 22. Complications of Pregnancy/Childbirth Benefit

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

**Benefit maximum**

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

## 23. Parent Accommodation Benefit

**We** cover the accommodation costs incurred by a parent or legal guardian accompanying an insured child under the age of 15 years listed in the **acceptance certificate** or **renewal certificate** where that child is **hospitalised** in an **approved private hospital**.

**Benefit maximum**

**We** pay up to $100 per night.

**We** pay up to a maximum of $500 per **hospitalisation**.

## 24. Loyalty Benefit – Suspension of Cover

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

**Overseas travel/residence**

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

**Unemployment**

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

**Other terms**

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

## 25. Loyalty Benefit – Wellness

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

**Benefit maximum**

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

**Other terms**

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

# Active Option

## What we cover

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

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

## Stand-down period

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

## What we pay

**We** will refund **you** 100% of the costs covered up to the benefit maximums. The Base Cover **excess** does not apply to the Active Option.

## 1. Registered Specialist Consultation Benefit

After a referral by a **GP**, **we** cover the cost of the **insured person** receiving a **registered specialist** or **vocational GP consultation** even if not **hospitalised**.

**Benefit maximum**

No limit per visit. No limits per **insured person**, per **policy year.**

## 2. General Practitioners Benefit

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

**Benefit maximum**

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

**We** pay up to $80 per home visit.

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

**We** pay up to 12 **GP** visits per **insured person**, per **policy year**. Minor surgical procedures are not included in the 12 visits.

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

**Other terms**

This excludes after hours fees.

## 3. Prescription Benefit

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

**Benefit maximum**

**We** pay up to $15 per item.

**We** pay up to $300 per **insured person**, per **policy year**.

**Other terms**

This excludes after hours fees.

## 4. Physiotherapy Benefit

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

**Benefit maximum**

**We** pay up to $40 per visit.

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

**We** pay up to $400 per **insured person**, per **policy year**.

## 5. Registered Nurse Benefit

**We** cover the cost of visits to/by a **registered nurse**.

**Benefit maximum**

**We** pay up to $30 per visit.

**We** pay up to six visits per **insured person**, per **policy year**.

## 6. Loyalty Benefit – Pre-existing Conditions

After three years continuous cover, some **pre-existing conditions** previously excluded may qualify for normal 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** or **renewal certificate** confirming this.
- Cover will start from the date shown on the **acceptance certificate** or **renewal certificate**.

## 7. Loyalty Benefit – Active Wellness

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

- Membership to a recognised gym or sports club, or
- Sports/fitness equipment purchased from a recognised sporting retailer.

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

### Benefit maximum

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

### Other terms

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

### New application

If **you** wish to add the Active Option to your policy after the **commencement date**, you must complete a new application form (**you** can obtain an application form by ringing **us**). The terms of our acceptance depend on the information **you** provide **us**. An additional premium is payable for this option.

# Select Option

## What we cover

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

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

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

## Stand-down period

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

## What we pay

**We** will refund **you** 80% of the cost incurred up to the benefit maximums. The Base Cover excess does not apply to the Select Option.

### 1. Dental Care Benefit

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

**Benefit maximum**

**We** pay up to $500 per **insured person**, per **policy year.**

**Other terms**

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

### 2. Eye Care Benefit

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

**Benefit maximum**

**We** pay up to $55 per **consultation**/examination.

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

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

**Other terms**

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

### 3. Ear Care Benefit

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

**Benefit maximum**

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

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

### 4. Acupuncture Care Benefit

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

**Benefit maximum**

**We** pay up to $40 per visit.

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

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

### 5. Spinal Care Benefit

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

**Benefit maximum**

**We** pay up to $40 per visit.

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

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

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

### 6. Joint Care Benefit

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

**Benefit maximum**

**We** pay up to $40 per visit.

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

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

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

### 7. Foot Care Benefit

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

**Benefit maximum**

**We** pay up to $40 per visit.

**We** pay up to $250 per **insured person**, per **policy year**.

## 8. Therapeutic Care Benefit – Speech, Occupational and Eye

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

**Benefit maximum**

**We** pay up to $40 per visit.

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

## 9. Loyalty Benefit – Orthodontic Treatment

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

**Benefit maximum**

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

**New application**

If **you** wish to add the Select Option to your policy after the **commencement date**, **you** must complete a new application form (**you** can obtain an application form by ringing **us**). The terms of **our** acceptance depend on the information **you** provide **us**. An additional premium is payable for this option.

# Serious Care Option

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

## Amount of cover

**You** can choose either a $10,000 or $20,000 **sum insured**.

**We** will pay the **sum insured** to **you** if:

- An **insured person** suffers one of the following Serious Care conditions; and
- The **insured person** suffers for the first time, the Serious Care condition:
  - If the condition is marked with an asterisk '*' in section 1 below on or after the **effective date** of the Serious Care Option, or the **effective date** of the Serious Care Option being reinstated, or **you** increasing the **sum insured** and before this cover ends, or
  - If the condition is not marked with an asterisk '*' in section 1 below at least 90 days after the **effective date** of the Serious Care Option, or the **effective date** of the Serious Care Option being reinstated, or **you** increasing the **sum insured**, and before this cover ends.

If the **insured person** suffers a Serious Care condition within either 90 day period and the **insured person** later suffers from the same Serious Care condition again **we** will not pay anything in relation to that later condition.

## 1. Serious Care conditions covered:

The following Serious Care conditions are defined in 5 below.

**Heart and circulation**

- Coronary artery disease requiring open chest bypass surgery.
- Heart attack (myocardial infarction).

**Cancer**

- Cancer – life threatening.

**Organs**

- Chronic renal failure.
- Major organ transplant.

**Functional Loss/Neurological**

- Paralyisis:
  - Hemiplegia*
  - Diplegia*
  - Paraplegia*
  - Quadriplegia*
  - Tetraplegia*.
- Stroke resulting in Functional Loss

If the Serious Care condition is a surgical procedure, then that surgical procedure must be the usual treatment for what has happened to the **insured person**.

1.1 **We** will pay only one **sum insured** in relation to an **insured person**

Before **we** pay anything the **insured person** must first:

- Obtain an unequivocal diagnosis of the Serious Care condition. The diagnosis must be both by an appropriately qualified **registered specialist** and on the basis of (but not limited to) clinical findings, standardised testing and reports acceptable to **us**; and
- Obtain the diagnosis as soon as possible after the **insured person** first becomes aware that he or she might be suffering from a Serious Care condition; and
- Obtain, as soon as possible after the **insured person** first becomes aware that he or she might be suffering from a Serious Care condition, and continue to obtain, advice and medical treatment from an appropriately qualified **registered specialist**; and
- Have followed and continue to follow the advice and medical treatment.

1.2 If the **sum insured** in relation to the **insured person** has changed at any time and the **insured person** suffers a Serious Care condition then the relevant **sum insured** is the one that applied at the date the **insured person** suffered the Serious Care condition.

## 2. What is not covered

2.1 **We** will not pay anything under this cover if what happens to the **insured person** is directly or indirectly caused by:

- Intentional self inflicted injury whether sane or insane; or
- War or act of war; or
- Alcohol abuse or drug abuse; or
- Engaging in conduct which constitutes or gives rise to any criminal offence for which the **insured person** is convicted; or
- The misuse of prescribed **drugs** or the deliberate taking or use of non prescribed **drugs** other than for proper medical purposes.

2.2 **We** will not pay anything under this cover if the **insured person** suffers a Serious Care condition which is solely directly and proximately caused by an **injury**, or the increase where the **sum insured** has been increased, if:

- The **injury** happened within the 90 day period following either the **effective date** of the Serious Care Option, or the **effective date** of the Serious Care Option being reinstated, or you increasing the **sum insured**, and
- The **injury** is self inflicted (whether intentional or not); and
- The Serious Care condition is diagnosed more than 12 months after the date of the **injury**; and
- The Serious Care condition is not marked with an asterisk '*' in section 1.

2.3 **We** will not pay anything under this cover, or the increase where the **sum insured** has been increased, if:

- The first symptom appeared; or
- The Serious Care condition first occurred; or
- The Serious Care condition was first diagnosed; or
- Surgery was undertaken relating to the Serious Care condition;

within the 90 day period following either the **effective date** of the Serious Care Option, or the **effective date** of the Serious Care Option being reinstated, or **you** increasing the **sum insured**.

This exclusion does not apply to Serious Care conditions marked with an asterisk '*' in section 1.

2.4 **We** will not pay anything under this cover if the **insured person** dies within the 14 day period following the date of diagnosis of the Serious Care condition. However the 14 day period is calculated by only including the time during which the **insured person** is not totally dependant on artificial life support systems.

2.5 **We** will not pay anything under this cover if the Serious Care condition suffered by the **insured person** arises from, or is traceable to, or is medically related to a **pre-existing condition**.

## 3. How to make a claim under the Serious Care optional add-on Benefit

If **you** wish to claim under this cover **you** must:

- Advise **us** as soon as possible but no later than 30 days after the **insured person** is diagnosed with a Serious Care condition.
- Give **us** an original or certified copy of the **insured person**'s birth certificate and the complete policy document.
- Complete and return a claim form supplied by **us**.
- At **your** own expense supply medical certificates and any other information **we** may require to consider **your** claim.

Before **we** pay anything, **you** must first comply with the above conditions.

**We** are entitled to require confirmation from **our** medical advisers that what **you** have claimed for has happened. If **we** do require this then it will be at **our** expense.

- This may mean **we** will, and are entitled to, require the **insured person** to undergo an examination or other reasonable tests to confirm what has happened.
- For example, the examination can include the **insured person** undergoing medical examinations by a **registered specialist** of **our** choice.

What **we** can require **you** to do

- **You** must promptly give **us**, or obtain for **us**, any information, document or statement **we** reasonably require. This includes completing and signing claim forms.
- If **our** request relates to any **insured person**, **you** must do everything reasonably practicable to obtain authority for **us** to obtain the information, document or statement **we** may require.

## 4. Some important points about the Serious Care optional add-on

- Serious Care is available for an **insured person** aged 21 to 65, insured on this health plan and each can choose a different sum insured.
- No **excess** applies to this benefit.
- **Serious Care cover ends:**
  In relation to an **insured person** at the earlier of:
  - The **policy anniversary date** immediately after the **insured person**'s 70th birthday; or
  - When the **sum insured** is paid; or
  - When the **insured person** dies; or
  - When **we** receive **your** written request to cancel the cover in relation to the **insured person**; or
  - When the policy ends.
- **We** are also entitled to not pay any claim and avoid the policy, or cancel it if:
  - Any material statement (other than as to the age of an **insured person**) made in the application, personal statement, declaration or other documents on the faith of which the policy was granted by **us** was untrue, incorrect or incomplete; or
  - Any information material to the risk which should have been disclosed in the application, personal statement, declaration or any other document was not disclosed.
- If **we** do avoid the policy all monies **we** have paid in respect of the policy may be recovered by **us** and all **premiums we** have been paid may be retained by **us**.

## 5. Serious Care condition definitions

The below words have the following meanings unless inconsistent with the context:

**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.

**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.

**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.

**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, and
- Confirmatory new electrocardiogram (ECG) changes, and
- Diagnostic elevation of cardiac enzyme **CK-MB**.

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

**Major organ transplant:** the medically necessary human to human organ transplant from a donor to the insured person 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.

**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 scan or Magnetic Resonance Imaging 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.

# General conditions section

## 1. Cover in New Zealand

This policy only provides cover for costs incurred in New Zealand, unless expressly specified otherwise in the policy.

## 2. Period of cover

Cover for this policy as shown on the **acceptance certificate** or **renewal certificate** starts on the policy **commencement date** or the **effective date** (whichever is the later date).

Cover ends when any of the following happen:

- **You** ask **us** to cancel **your** policy. **You** must give **us** not less than 30 days notice in writing or by email, or
- **You** fail to pay the premium or any premium instalment within 90 days after the due date for payment, or
- Where an **insured person** holds a work permit at the **join date** and when that work permit ends or is no longer valid, or
- **You** or any **insured person** breaches a term of this policy, or
- When the last **insured person** covered by this policy dies.

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

## 3. Eligibility

To be eligible for cover **you** must meet one of the following conditions:

- Be a New Zealand citizen or permanent resident, or
- Be permanently employed in New Zealand and satisfy one of the following criteria:
  - Hold a valid New Zealand work permit for at least two years with a minimum of 11 months remaining on the work permit, or
  - Have been in New Zealand legally for a period of at least two years with a minimum of 11 months remaining, or
- Be an Australian citizen confirming your intention of living permanently in New Zealand for a minimum of two years.

## 4. Documentation of identity

**We** may request to see originals or certified copies of **your** visa or work permit, passport, birth certificate or driver's licence.

## 5. Dependent children

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

**We** will automatically continue cover for that person on this policy as an **insured person** and deduct the additional premium based on their age and gender from the same payment source and at the same frequency as this policy. Alternatively, within 30 days following the **policy anniversary date** after the **dependent child** has reached the age of 21, **you** may apply for **our** current on-sale product on or immediately after their birthday without having to provide any further evidence of health other than their smoking status. If the smoking status is not known, the adult premium will be calculated using smoker rates at the premiums applying at the time the policy is issued. Any special terms and conditions, exclusions or premium loadings applying to that person prior to cover ending will apply to their new policy.

## 6. Important information about premiums and benefits

6.1 Cover types

There is a choice of cover types:

- Single adult
- Couple
- One parent family
- Two parent family.

6.2 Premiums

6.2.1 The premiums are based on the age of the **insured person**(s) on the policy. For the couple rate, the premium is based on the age of the youngest adult on the policy. For a two parent family rate, the premium is based on the age of the youngest parent on the policy. The premium is also affected by the **excess** option **you** choose.

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

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

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

6.2.3 **You** must pay **us** the premium at one of the frequencies provided by **us**. These are payable in advance. The premium is calculated according to the rates applying from time to time for the policy **you** selected.

- The premiums automatically increase when an **insured person** attains a specified age.
- Any changes to the premium rates and age related steps apply across all **insured person(s)** with this policy.
- No changes will be made to **your** individual policy alone, based upon the individual claims experience of **your** policy.
- A copy of the rates is available from **us** on request.

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

6.3 Premium Payback

**You** can choose one of the following:

**Five Year Premium Payback Option**

After every five consecutive years, from policy anniversary date to policy anniversary date, **we** will pay back to **you** an amount equal to 30% of the premiums paid by **you** for the five years, less the amount of all claims paid by **us** relating to that same period.

**Ten Year Premium Payback Option**

After every 10 consecutive years, from policy anniversary date to policy anniversary date, **we** will pay back to **you** an amount equal to 50% of the premiums paid by **you** for the 10 years, less the amount of all claims paid by **us** relating to that same period.

For both options only premiums and claims under **your** Hospital Cover Plus Base Plan are counted, not those under the Active, Select or Serious Care parts of **your** health plan.

This benefit is per policy, not per **insured person**.

## 7. Altering the terms and conditions of your policy

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

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

No alterations will be made to **your** individual policy alone, based upon the individual claims experience of **your** policy. If **you**, and all **insured persons**, comply with this policy, **we** cannot cancel it. Any changes to the terms of **your** policy for any **insured person** (for example, added an exclusion) will be shown in the **acceptance certificate** or **renewal certificate**. **You** must instigate any review of the additional terms. Any cost in relation to the review is at **your** cost.

7.1 Correspondence and notices

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

## 8. Reinstating this policy

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

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

## 9. Full information at claim time

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

**You** and the **insured person**'s authorise disclosure to **us** of **your** personal information held by others that is relevant to a claim. Details of **your** claim or a claim for any **insured person** can be provided to anyone who **you** nominate in writing, by verbal communication with **us** or on the claim form. **You** must comply with this policy in full before any claim is paid. If any premium is outstanding on this policy at the date **we** accept a claim, **we** can:

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

## 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 of **our** profits or bonuses.

## 13. If you have a problem

**We** want **you** to remain satisfied with this policy. **We** have an internal complaints process that is intended to resolve any problems quickly and fairly. All complaints will initially be handled internally through **our** complaints process. If **your** complaint cannot be resolved through this process, **you** can refer it to the Insurance & Financial Services Ombudsman (IFSO) who may be able to help. The types of complaints the IFSO can consider are outlined on their website: www.ifso.nz.

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

If this does not resolve **your** problem, **you** should write to:
nib nz limited,
PO Box 91 630,
Victoria Street West,
Auckland 1142.

# Exclusions – what we will not pay for

Important – these exclusions apply to this policy. The Definitions section will assist **you** with interpretation of these exclusions.

## 1. We will not pay any benefit in connection with the following medical conditions:

a) A medical condition in connection with the misuse of alcohol, prescription drugs or nonprescription drugs

b) A mental health condition which includes but is not limited to psychiatric, behavioural, psychological and developmental conditions or eating disorders

c) Senile illnesses and/or dementia

d) Dental health conditions and/or treatment(s) (except where the contrary is expressly specified in this policy)

e) Acquired immune deficiency syndrome (AIDS) or associated medical conditions including human immunodeficiency virus (HIV) and related medical conditions

f) Any sexually transmitted disease and any related medical conditions or resulting complications

g) Any:

- **Congenital medical condition**, or
- Developmental medical condition relating to a congenital deformity

h) Any medical 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

i) Any **pre-existing condition** as determined by **us**. This exclusion does not apply:

- To any medical condition declared on the application form and accepted by **us**, or
- Where it is noted on the **acceptance certificate** or **renewal certificate** that **pre-existing conditions** are covered, but subject to the other exclusions in this policy and any special terms on the **acceptance certificate** or **renewal certificate**

j) Any **acute medical condition**

k) Any medical condition arising from a criminal offence that results in a conviction under the Crimes Act 1961 (and any revisions thereafter)

l) Infertility, pregnancy and childbirth, caesarean sections, termination of pregnancy, erectile dysfunction, reversal of sterilisation, sterilisation, contraception or contraceptive procedures, hormone replacement therapy and slow replacement hormone therapy (except where the contrary is expressly specified in this policy)

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

n) Any medical condition not registered with the Ministry of Health as a disease entity.

## 2. We will not pay for the following tests, diagnostic procedures, treatments or health services:

a) Geriatric care including geriatric **hospitalisation**, rehabilitation (except where the contrary is expressly stated within this policy), **long-term care**, convalescence, respite, palliative and disability support services costs

b) Breast reduction, mastopexy or gynaecomastia, gender reassignment for any reason, whether or not the undertaking is functional, physical, medical, psychological, emotional or social

c) **Obesity** and any consequence of **obesity** for which assessment or treatment may be required or deemed necessary. This includes, but is not limited to bariatric surgery and complications thereof

d) Any treatment (including dentistry) that improves, alters or enhances your appearance whether or not undertaken for medical, physical, functional, psychological, social or emotional reasons, including complications arising from this treatment

e) All forms of prophylactic (preventative) treatment which means any treatment in the absence of signs or symptoms of an illness, disease or medical condition that seeks to reduce or prevent the risk of an illness, disease or medical condition developing in the future (except where the contrary is expressly stated within this policy)

f) Any surveillance testing or screening measures where any diagnostic investigation or procedure is undertaken where no signs or symptoms of a medical condition are present (except where the contrary is expressly stated within this policy)

g) Gene therapy or genetic testing

h) Any investigation, diagnoses, provision of medical advice, assessment and management and treatment of an **insured person** in relation to an inherited genetic, chromosomal disorders and any familial predispositions (unless specifically accepted by **our chief medical office**r)

i) Sleep disorder assessment or treatment. This includes, but is not limited to sleep disturbances, snoring or sleep apnoea and lung function tests

j) Treatment of self-inflicted injuries or treatment of injuries arising from attempted suicide

k) Any specialised tertiary treatments such as organ and/or tissue transplants or organ donation

l) Renal dialysis or specialised transfusions of blood, blood products and derivatives

m) Any costs incurred as a result of a cancellation of something covered under one of the Benefits except where the cancellation is on medical advice

n) Costs of periodontal, orthodontic and endodontal procedures, implants and orthognathic surgery

o) Costs incurred outside New Zealand (except where the policy expressly states this)

p) After hours and other administration costs associated with prescriptions. For example, faxing charges incurred between the prescribing doctor, specialist or pharmacy

q) Costs associated with additional treatments performed that have not been approved by **us** which are performed along with a treatment approved by **us**

r) Any treatment for the correction of myopia (short sightedness) or hypermetropia (long sightedness), or presbyopia (blurred vision) or any related complications

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

t) 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)

u) Costs of changing glasses, sunglasses and contact lenses for fashion reasons where there has not been any change in vision.

## 3. We will not pay for the following mechanical tools, aids, appliances:

a) Mechanical tools as determined by **us**. For example (without limitation): glucometers, blood glucose and ketone meters, insulin pumps, oxygen machines, C-PAP equipment, dialysis equipment, respiratory machines

b) Aids as determined by **us**. For example (without limitation): hearing aids, battery operated aids, cochlear implants, pacemakers, defibrillators, personal alarms

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

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

## 4. We do not pay for the following:

a) Any **injury** covered under **ACC** (unless the **ACC Top-Up** Benefit applies)

b) Medicines or pharmaceuticals that are not funded by **PHARMAC** under Sections A to G of **PHARMAC**'s Pharmaceutical schedule, including all medicines or drugs that are listed under Section H of **PHARMAC**'s Pharmaceutical schedule

c) Any kind of drug trials or experimental drug treatments in connection with a treatment

d) Anything that is not medically necessary for example (without limitation) hiring a TV, sound system, DVD, video, takeout meals, alcoholic beverages, taxi fares (unless agreed by **us**), other transport costs or any incidental costs

e) Anything that is recoverable from a non-insurer third party or under any other contract of insurance except to the extent that the other contract of insurance is exhausted.

f) Ambulance society subscriptions

g) **General Practitioner** bills and prescription charges (except where the contrary is expressly stated in this policy).

## 5. Any treatment or procedure that:

a) Is experimental or unorthodox in nature

b) Uses alternative or complementary medicines or therapies where these products or practices are not part of the standard of care and conventional medicine

c) Is not widely accepted professionally as effective, appropriate or essential based on recognised standards of healthcare in New Zealand specifically for the condition being treated.

# Definitions section

We realise that insurance language can sometimes be difficult to understand, so we have provided the following section to help explain special meanings in the context of this policy.

Please read the definitions in conjunction with your policy terms, conditions and exclusions.

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

| Term | Definition |
|---|---|
| **ACC** | The Accident Compensation Corporation as defined in the Accident Compensation Act 2001 or any successor legislation. |
| **ACC Top-Up** | The difference between what **ACC** pays for a treatment and what the **recognised provider** charges for that treatment. |
| **acceptance certificate** | The most recent document entitled '**acceptance certificate**' forwarded to **you** by **us** as part of this policy. |
| **approved private hospital** | A private hospital, day surgery unit, medical unit, oncology facility or private wing in a New Zealand public hospital that has been approved by **us**. It does not include a specialist clinic, hospice, nursing home, residential care (long term or age related) or outpatient clinic, even if it is connected in any way with a private hospital, day surgery unit, medical unit, oncology facility or private wing in a New Zealand public hospital that has been approved by **us**. |
| **acute medical condition** | A condition requiring care in response to a sign, symptom, condition or disease that requires immediate or within 48 hour hospital admission for treatment or monitoring. |
| **breslow method** | A method of measuring (staging) melanoma. |
| **carcinoma in situ** | Carcinoma in situ is characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction. |
| **chemotherapy agent** | A chemotherapy drug orally or intravenously administered for the treatment of cancer that is approved and listed on the **PHARMAC** Pricing Schedule under sections A to G and meets the **PHARMAC** funding criteria. |
| **chief medical officer** | **Our chief medical officer**. |
| **CIN-1, CIN-2, CIN-3** | Cervical Intra Epithelial Neoplasia (CIN). A form of grading cells of the cervix which may indicate cancer. |
| **CK-MB** | An enzyme that is specific to heart muscle and increases following a heart attack. |
| **commencement date** | The 'Original **policy commencement date**' shown on the **acceptance certificate** or **renewal certificate**. |
| **congenital medical condition** | A health anomaly or defect which is recognised at birth, or diagnosed within four months of birth whether it is inherited or due to external or environmental factors such as drugs or alcohol. |
| **consultation** | A necessary meeting with a **registered specialist** for discussion or the seeking of advice, or conferring to evaluate the medical case and any treatment. A consultation does not include the treatment itself. |
| **cycle of treatment** | A prescribed sequential dose of chemotherapy or radiotherapy administered at specified intervals within a planned timeframe. |
| **dependent child** | The **insured person**'s child under the age of 21 years, who usually lives with the **insured person** or who is a tertiary student. '**Dependent children**' has the same meaning. |
| **drugs** | Subsidised prescription medicines as listed on the **PHARMAC** schedule A to G that meet the **PHARMAC** approved criteria. This does not include nutrition products or dietary supplements. |
| **effective date** | The date shown on the **acceptance certificate** or **renewal certificate** in relation to a particular cover. This is the date when that cover commences for **you** and any **insured persons**. |
| **Efficient Market Price/EMP** | The maximum amount (as may change from time to time) **we** will pay for a health service provided by a **recognised provider** that is not part of the **nib First Choice network**. |
| **excess** | The 'Base Cover **excess** amount' shown on the **acceptance certificate** or **renewal certificate** which **we** do not pay. It is an amount that **you** pay. |

| Term | Definition |
|---|---|
| **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). |
| **General Practitioner (GP)** | A doctor registered in terms of the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) and recognised by the Medical Council of New Zealand to practise as a **General Practitioner**. |
| **health service provider(s)** | Any registered person who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) and is a member of the appropriate registration body e.g. Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand or the Chiropractic Board in New Zealand. |
| **hospitalisation/ hospitalised** | Admission to a New Zealand **approved private hospital** for the purposes of:<br>▪ Undergoing a diagnostic procedure, or<br>▪ Undergoing a surgical procedure, or<br>▪ Receiving medical treatment or chemotherapy or radiotherapy treatment approved by **us**. |
| **injury** | External or internal **injury** caused solely or directly by violent, external or visible means. |
| **insured person(s)** | A person named as an '**insured person**' in your **acceptance certificate** or **renewal certificate**. |
| **join date** | Date when an **insured person** is added to this policy. |
| **long-term care** | Those public and private hospital-based services provided on an ongoing regular basis where a medical condition has been or is likely to be present for more than 14 nights. |
| **obesity** | A medical condition in which excess body fat has accumulated to a body mass index (BMI) of 30.00 or more on more than three recordings over a three year time frame. Metric: BMI = kilograms/metres2. In the absence of BMI measures being available the **chief medical officer** reserves the right of decision to accept or decline a claim. |
| **partner** | The **insured person**'s spouse or a person who cohabits with the **insured person** in the nature of marriage. |
| **PHARMAC** | The Pharmaceutical Management Agency being a Crown entity established by the New Zealand Public Health and Disability Act 2000 or its successor under any subsequent legislation. |
| **podiatric surgeon** | A **recognised provider** who is:<br>a) in private practice and holds a current annual practising certificate; and<br>b) a member of the Podiatrists Board of New Zealand (or its successor); and<br>c) 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. |
| **policyowner** | The person(s) who is/are named in the **acceptance certificate** or **renewal certificate** as '**Policyowner**(s)'. |
| **policy year** | The 12 month period that commences on the **commencement date** and ends at midnight on the **policy anniversary date**, and each successive 12 month period from **policy anniversary date** to **policy anniversary date**. |
| **pre-existing condition** | Any illness, sickness, disease, **injury** or medical condition or symptom or sign, on or before the cover **commencement date** or the **join date** (whichever is the later) or the **effective date** where an option is added:<br>a) which you or any **insured person** was aware of, or<br>b) of which **you** or any **insured person** had the first indication that something was wrong, or<br>c) for which **you** or the **insured person** sought investigation or medical advice, or<br>d) where the medical condition, or the sign or symptom of a medical condition, existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment. |
| **prosthesis/ prostheses** | A surgically implanted artificial replacement of a joint or body part used to restore functionality. |
| **prosthesis schedule** | A list of **prostheses** covered by **us** and the specified benefit maximum. |

| Term | Definition |
|---|---|
| **RAI** | A system of measuring (staging) chronic lymphocytic leukaemia. |
| **recognised provider** | A **health service provider**, **registered specialist, approved private hospital** or other medical facility that is recognised by **us**. |
| **renewal certificate** | The most recent document entitled '**renewal certificate**' forwarded to **you** by **us** in relation to this policy. |
| **registered nurse** | Any person who holds a current practising certificate issued by the Nursing Council of New Zealand |
| **registered specialist** | A medical practitioner who has trained and specialised in a specific branch of medicine. Any specialist who is a member 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, emergency medicine, family planning and reproductive health, general practice, medical administration, public health medicine or sports medicine. |
| **stand-down period** | A period of time after the **commencement date**, the **join date** where an **insured person** is added to this policy, or the **effective date** where an option is added, for which no claim will be paid for anything that happens during this period. |
| **surgical cost grouping** | The overall cost for **registered specialist**, anaesthetist and any **prosthesis** (if applicable) for a health service. |
| **TNM classification** | A method of measuring (staging) cancers. |
| **troponin** | Protein specific to the heart muscle cell. |
| **vocational GP** | A **General Practitioner (GP)** with a relevant, post-graduate qualification in the health service they are providing, as recognised by **us**. |
| **we, our and us** | nib nz limited. |
| **whole person function** | A criteria based on the current edition of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment' until similar means of measurement have been established by the New Zealand or Australian medical associations that are acceptable to **us**. |
| **you and your** | The **policyowner**. |

# Hospital Cover Plus
# Policy document

## Need help?

Call us on **0800 123 nib** (0800 123 642)
Mon to Fri: 8:00am - 5.30pm
Go to **nib.co.nz**
Email us at contactus@nib.co.nz
PO Box 91 630, Victoria Street West, Auckland 1142



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