nib

Mid Private Hospital Cover
Policy document

Contents

Introduction

Thank you for trusting nib to insure your good health. This Policy document explains what your Policy covers. It should be read in conjunction with all the documents that form part of your Contract of Insurance.

It is important you read the information carefully to 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. However you should always make enquiries with nib before undergoing any Health Service (see Claims on page 19).

Unless specified, this Policy document only describes nib Mid Private Hospital Cover as at the date of issue of this Policy document. Each nib Cover can be amended from time to time in accordance with its terms.

Contract of insurance

Your Contract of Insurance consists of:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document);
- the Hospital Category List;
- the Prosthesis Schedule; and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

Words in capitals

Some words in this document start with a capital letter, indicating a specific meaning which applies to nib Mid Private Hospital Cover only. Please refer to the Glossary of important terms on page 43.

This is an important document

Please keep this Policy document and the other documents that form your Contract of Insurance in a secure place for future reference.

How to contact nib

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

Call us on **0800 123 nib** (0800 123 642)
Email us at contactus@nib.co.nz

Write to us at:

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

Go to **nib.co.nz**

Our opening hours are Monday to Friday 8:00am to 5:30pm. We are closed on public holidays.

General terms of Mid Private Hospital Cover

Applying for an nib Cover

All applications for an nib health insurance Cover must be accompanied by proof of identity and any other relevant information we may require.

We may at our discretion refuse to accept an application until such time as the relevant information is provided or until the Premiums for the minimum period relevant to the applicant have been paid.

- Subject to the terms of this Policy document we may, at our discretion, refuse an application to join nib as an Insured Person, as described below.
  - We have the right to refuse an application to join a Cover that has been closed for sale.
  - We have the right to refuse an application to combine a Cover currently for sale with a Cover that has been closed for sale.
  - We have the right to refuse an application to move a Cover that has been closed for sale to a Cover currently for sale.
  - We have the right to refuse an application to move to another nib Cover.
- If we refuse an application, we will provide a reason for the refusal to the applicant.

Duty of disclosure

The Policyowner and all Insured Persons had a legal duty to disclose everything they knew (or ought to have known) which would have influenced the decision of a prudent insurer whether to accept the Policyowner's application, and if so, on what terms. For example, an Insured Person must have disclosed any medical Condition or any sign, symptom, treatment or surgery of any medical Condition they had at the time of applying, or have had in the past. The Insured Person must have told us about any changes to the information given to us before any Commencement Date, Effective Date or Join Date (as applicable) of this Policy. If the Insured Person failed to do so, or if any of the above information was not disclosed to us, we can cancel this Policy from the Commencement Date, Effective Date or Join Date (as applicable) and not pay any Claims after those dates. We may retain all the Premiums paid, and any Claims paid by us after those dates may be recovered from the Insured Person.

Financial statements

The Policyowner or any Insured Person can obtain a copy of nib nz limited's financial statements for the last reported financial year by writing to nib nz limited, PO Box 91 630, Victoria Street West, Auckland 1142.

Period of Cover

Cover for the Mid Private Hospital Cover shown on the Acceptance Certificate or Renewal Certificate starts on the Commencement Date, Effective Date or where the Insured Person is added to this Policy, the Join Date, subject to any applicable Waiting Period.

All information given by, or on behalf of, the Policyowner 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, Effective Date or Join Date (as applicable). If we cancel this Policy, any Premiums paid may be retained by us. If we have already made any Claims payments, we may recover these from the Policyowner.

14-day free-look period

A 14-day free-look period applies to all nib Covers.

The Policyowner can receive a full refund of Premiums if they decide to cancel the Policy within the first 14 days – providing no Claims have been made during that time, and that the cancellation is requested in writing. This period starts three days after we send you your Contract of Insurance. During this time, should you decide the Policy doesn't meet your needs, please send written confirmation to us and we will cancel the Policy and refund the full Premiums paid, providing no Claims have been made.

Health Cover reviews

It is the Policyowner and all Insured Persons' responsibility to understand what is and what is not covered by their health insurance Policy. We recommend you review your health insurance at least once each year. We are happy to discuss your health Cover – you are welcome to call us on **0800 123 nib** (0800 123 642).

nib Recognised Providers

Claims are only eligible for Health Services carried out by an nib Recognised Provider.

We will pay for Benefits under Mid Private Hospital Cover if the Insured Person attends an nib Recognised Provider, who must:

- meet all the minimum criteria outlined by us relating to their education, qualifications and active membership of any governing body specified by us; and
- be in Private Practice.

In the rare instance that we do not recognise a provider, for example in the case of overcharging or suspected fraud, we will advise the Insured Person that there is no cover for treatment carried out by that provider. If the treatment itself is eligible for cover, we will be able to Pre-approve treatment with another Recognised Provider.

Hospital Category List

Benefits / Health Services under the Mid Private Hospital Cover are categorised by body part according to the Hospital Category List. These categories are reviewed annually and the Policyowner and all Insured Persons must refer to the most up-to-date list to understand what they are covered for.

Prosthesis Schedule

For certain Surgeries requiring Prosthesis, we will pay up to the maximum amount as defined in the Prosthesis Schedule. This schedule is reviewed annually and the Policyowner and all Insured Persons must refer to the most up-to-date list, to understand what they are covered for and the limits that apply.

Key information found on nib's website

Our website provides key information such as our Hospital Category List, Prosthesis Schedule and Claim forms. All the relevant information can be found by visiting **nib.co.nz**

Who is covered

This Policy provides Cover for an Insured Person who:

- is a citizen or permanent resident of New Zealand living in New Zealand; or
- is an Australian citizen or permanent resident who has lived, or intends to live, in New Zealand for two years or more; or
- is permanently employed in New Zealand and holds a current New Zealand work permit which has been issued for at least two years; or
- is 17 years or younger whose parent(s) holds a current New Zealand work permit which has been issued for at least two years; or
- is entitled to publicly funded health and disability services provided by the New Zealand Government.

We may request to see originals or certified copies of each relevant Insured Person's documents (including visas or work permits in the Insured Person's passports, birth certificates or driver's licences).

We reserve the right to cancel the relevant Insured Person's Cover if the relevant person no longer meets one of the criteria above.

Dependent Children

A Dependent Child will become subject to adult premium rates on the next Policy Anniversary Date after they reach age 21. We will automatically continue to cover that person on this Policy as an Insured Person and deduct the additional Premium based on their age, gender, smoking status and Excess for the Cover, from the same payment source and at the same frequency as this Policy, unless you advise us otherwise. If the smoking status is not known, smoker Premiums will apply.

Unless otherwise approved by us, a person under 18 years of age is not eligible to be a Policyowner. A Dependent Child under age 18 must be accompanied on the Policy by at least one adult aged 18 or older as the Policyowner, or have his or her parent or legal guardian as the Policyowner.

Who can view and change the Policy

The Policyowner is the primary account holder and has full and total authority to make changes to the Policy and make Claims enquiries about anyone on the Policy. If the Policy has more than one Policyowner then all the Policyowners must consent to any changes.

The Policyowner must give us at least 30 days' prior notice in writing or by email before any changes can be made.

The Policyowner may add or remove an Insured Person from the Policy, and may add or remove any nib Cover, at a Policy Anniversary Date.

If we agree to any other change, we will make the requested change to this Policy on the same (or nearest equivalent) date in the month that corresponds to the date in the month of the 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.

Adding a Partner, Dependent Child, parent or grandchild

The Policyowner can add their Partner, Dependent Child, parent or grandchild to this Policy. The person being added to a Policy will be required to serve a Waiting Period from the Effective Date or Join Date (as applicable). The Policyowner and any new Insured Person added must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details.

We will charge an additional Premium for each Insured Person added.

A new Insured Person added to this Policy from the Effective Date or Join Date is shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

Removing an Insured Person

We will remove an Insured Person from this Policy:

- at the written request of that Insured Person. He or she has the option, within 30 days of removal, to arrange a separate Policy on terms determined by us without providing any evidence of his or her current state of health; or
- at the written request of the Policyowner (see above).

Changes in contact details

The Policyowner must notify us of all changes in contact details of the Insured Persons covered under the Policy. Where possible, they must provide an email address. The Policyowner can advise us in writing or by email.

Changing the Insured Person's smoking status

If any Insured Person (aged 21 years or over) changes their smoking status, they must complete an nib smoking status questionnaire and send the completed questionnaire to us. If the smoking status is not known, smoker Premiums will apply. We will require at least 30 days' prior notice before this change will be applied on the Policy.

Adding or removing an EveryDay Cover

The Policyowner can add an EveryDay Cover to the Policy for an additional Premium, by following the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application must be completed fully and accepted by us before the EveryDay Cover can start.

The Premium will be adjusted from the next available billing date to reflect this change. The added EveryDay Cover will start from the Effective Date shown on the Acceptance Certificate or the Renewal Certificate (whichever is the later).

The Policyowner can only remove an EveryDay Cover at the next Policy Anniversary Date. The Policyowner must give us at least 30 days' prior notice in writing or by email before an EveryDay Cover can be removed.

We will process the change

We will process the change within five working days of receiving the relevant request, unless otherwise stated or further information is required.

Once we have accepted the changes, we will send the Policyowner a new Acceptance Certificate or Renewal Certificate that will show the changes.

Commencement of Cover

Any Insured Person will be able to Claim for the Benefits and / or Health Services and / or hospital Categories provided by the Cover once Waiting Periods have been served and provided that all Premiums have been paid up-to-date.

Waiting Period

Waiting Period means a period of time after the Commencement Date, Effective Date or the Join Date where an Insured Person is added to this Policy, for which no Claim will be paid for anything that happens during this period.

Waiting Periods vary according to the Benefit and / or Health Service and / or hospital Categories being provided.

The following Waiting Periods apply to each Insured Person for all the Mid Private Hospital Cover Policies:	
ACC top-up Claims	1 day
Removal of unerupted or impacted teeth	12 months

Waiting Periods when changing hospital Cover

For any change in Cover, the Policyowner must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application process must be completed fully and accepted by us before the new Cover can start.

We recognise the Waiting Periods already served on a Cover comparable to nib Mid Private Hospital Cover only. Please check with us to find out which Covers are comparable to the Mid Private Hospital Cover.

For Insured Persons changing their nib hospital Covers with nib, the following Waiting Period rules apply:

New Benefits and / or Health Service and / or hospital Categories	**No change in Benefits and / or Health Service and / or hospital Categories**
The Waiting Period will apply from the Effective Date, this will include any Waiting Period served on the previous comparable hospital Covers.	The Waiting Period applies from the Commencement Date or Join Date (as applicable) prior to the change.

Transfer to a new Policy

If for any reason an Insured Person needs to transfer to a new Policy with the same level of Cover, the Waiting Period applies from the Commencement Date, Effective Date or Join Date (as applicable) of the original Policy.

Excess

- If an Excess has been chosen, it is applied once to each Insured Person every Policy Year, as noted on the Acceptance Certificate or Renewal Certificate (whichever is the later).
- The Excess is only payable to an nib Recognised Provider.
- The Excess is not payable by nib, and cannot be made up by withdrawing from any other Benefits on your Policy.

Changing your Excess

The Policyowner may increase or decrease the Excess for any Insured Person on the Policy.

If the Excess is lower than the previous Cover, the Policyowner and all the affected Insured Persons must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application must be completed fully and accepted by us before the new Excess can start. Once the underwriting assessment is completed, the new Excess will commence from the next Policy Anniversary Date, which will be noted under the Effective Date on the Acceptance Certificate or the Renewal Certificate (whichever is the later).

In any case, the old Excess will apply to Claims before the Effective Date, and the new Excess will apply to Claims after the Effective Date. The date of the Claim will be assessed based on the date of the relevant Health Service.

The Premium will be adjusted in accordance with any Excess change.

Resuming your Policy or Cover from suspension

If the Policy or Cover for an Insured Person has been suspended it must be resumed within 90 days of the suspension end date, otherwise the Policy or Cover will be cancelled.

- If the same Cover is resumed before the suspension period ends, we will reinstate the Cover without enquiring into the affected Insured Person's health.

- If Waiting Periods have not been fully served, the remainder of the Waiting Periods must be served once the Policy or Cover is resumed.
- If the Policy or Cover is not reinstated at the end of the suspension period, we will write to the Policyowner at their last known address and give them 90 days within which to pay any arrears of Premium. If they do not pay the arrears within the 90 days the Policy or Cover for the affected Insured Persons will end.
- If the Policy or Cover for an Insured Person is cancelled, the affected Insured Persons will need to re-serve Waiting Periods if they re-join later. The Policyowner and all affected Insured Persons will need to complete an nib application process to resume the Policy. Please call us on **0800 123 nib** (0800 123 642) for more details.

Maintaining continuous Cover

It is important to maintain continuous Cover with nib to ensure you are able to continue to Claim Benefits and to avoid having to re-assess all the affected Insured Persons' health and to re-serve Waiting Periods if they decide to re-join later (see Contract of Insurance on page 4).

- If the Policy falls into arrears of Premium, all the Insured Persons on the Policy will be unable to Claim.
- After 90 days of non-payment the Policy will be cancelled.
- After more than 90 days without Cover all Insured Persons listed on the Policy will have to re-serve Waiting Periods if they decide to re-join later.
- It will be at nib's discretion to determine whether the Insured Persons listed on the Policy will be covered for any Mid Private Hospital Cover Claims requested during a period of non-payment.

Cancelling the Policy or Cover

Unless otherwise permitted by us, any cancellation of a Policy and / or Cover for an Insured Person must be authorised in writing by the Policyowner.
The Policyowner must give us at least 30 days' notice of the cancellation.

Termination of a Policy or Cover

We may terminate a Mid Private Hospital Cover Policy and / or Cover for an Insured Person:

- if the Premiums are in arrears by more than 90 days after the due date for payment; or
- if the Policy is not resumed following a suspension; or
- if an Insured Person holds a work permit at the Join Date, when that work permit ends or is no longer valid; or
- if an Insured Person is no longer entitled to publicly funded health and disability services provided by the New Zealand Government; or
- if the last Insured Person covered by this Policy dies; or
- if any Insured Person breaches the terms of the Policy; or
- if any information provided by, or on behalf of the Policyowner or any Insured Person when arranging this Policy or when making any changes to it, is false, incorrect or incomplete; or
- an Insured Person covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, whether for themselves or for any other Insured Person, to which they are not entitled under this Policy document; or
- an Insured Person has engaged in offensive or intimidating behaviour towards employees of nib.

If we terminate this Policy and / or Cover for an Insured Person, any Premiums paid may be retained by us. If we have already made any Claims payments for a health service that took place after our right to terminate arose, we may recover these from the Policyowner.

Your Premiums

Premiums must be up-to-date to keep the Policy active so that the Insured Persons listed on the Policy can continue to Claim Benefits.

- Where the Premium rate change takes effect during the period of advance payment, the change will not come into effect until the next Premium falls due.

- Premiums can be paid in advance for up to a maximum of 12 months.

Available payment methods and frequency

Payment periods are set out below and must be paid in advance, unless otherwise permitted by us:

- where Premiums are paid by direct debit from a bank, building society, credit union cheque or savings account – weekly, fortnightly, monthly, quarterly, half yearly and yearly.
- where Premiums are paid by credit card payment from a MasterCard or Visa – monthly, quarterly, half yearly and yearly.

nib direct debit service agreement

We will give the Policyowner at least 30 days' notice in writing if there are changes to the details of the direct debit.

- Any information about the nominated account will remain confidential, except where required to complete direct debits with the financial institution.
- When the due date is not a working day, we will debit the account on the first working day after the due date.

It is the Policyowner's responsibility to:

- ensure the nominated account can accept direct debits;
- ensure there are enough funds available in the account to make a payment on the due date;
- tell us if the account details change, or if the account is transferred or closed;
- arrange a different payment method if we cancel the direct debit arrangements;
- ensure all account holders of the nominated account sign the direct debit authority form; and
- tell us about new credit card details with the new expiry date.

The Policyowners can change the direct debit arrangements in line with the terms and conditions of our direct debit authority, at least 10 calendar days before the next due date .

The Policyowner must give instructions to stop or alter the direct debit details in writing.

We reserve the right to cancel direct debit arrangements if the nominated financial institution dishonours direct debits, and to arrange a different payment method with the Policyowner.

The details of the direct debit arrangement are contained in the direct debit authority form which the Policyowner submits to us. We will rely on those details to process payments until told otherwise.

Not all accounts held with a financial institution are available to be drawn on under the bulk electronic clearing system. The Policyowner should check with their financial institution if they are unsure whether their account can facilitate direct debits.

The Policyowner may cancel or stop a drawing with their financial institution.

If the Policyowner has a direct debit inquiry, or believes a debit has been made incorrectly, please contact us immediately on **0800 123 nib** (0800 123 642) or write to:

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

Important information about your Premiums and Benefits

The Premiums are calculated according to the rates applying from time to time for the Policy selected.

The Premiums automatically increase when an Insured Person reaches a specified age. Any changes to the Premium rates and age related steps apply across all Insured Persons with this Policy.

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

The Premiums and the Benefits for this Policy are not guaranteed. We may alter the Premium rates (including age related steps) and / or Benefits and / or the terms of cover (including 'What is not covered' and 'Glossary of important terms') 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.

We want to ensure your valuable cover continues if a deduction advice is returned to us as 'gone / no address'.

In these circumstances, we will continue to make deductions in accordance with our Premium rates until we are advised otherwise and the Policyowner authorises us to stop the deductions.

Claims

It is important that you read and understand this section of your Policy document as it contains important information about Pre-approvals, Claims and payment.

Benefits will only be paid for Claims which meet nib criteria.

- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to the Policy or law.
- Insured Persons will not be paid any Benefits if the Premiums are not paid up-to-date (see Your Premiums on page 16).
- Claims are only eligible for Health Services carried out by Recognised Providers.

How to make a Claim or Pre-approval

- 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 your Pre-approvals and Claims by visiting our customer portal (my nib) at **nib.co.nz/portal**
- Call us on **0800 123 nib** (0800 123 642).
- The Policy number must be quoted for all Claims.
- Any Claims must have all the relevant information submitted with the Claim form (see Supporting documentation for Pre-approval and Claims on page 23).

Always contact nib before going to hospital

Before going to hospital, please contact us to check that the procedure will be covered under the Mid Private Hospital Cover.

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 Recognised Private Hospital charges (if applicable)
  - The Surgical Cost Grouping, which consists of your Registered Specialist, anaesthetist and any Prosthesis costs.
- If either the Recognised 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 you certainty that you will be covered for 100% of the approved associated Health Service costs included on your Policy up to the Benefit Limit.
- 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 Limit 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.

Pre-approval

The Insured Person must seek Pre-approval prior to undertaking any Surgery, cancer treatment, related Consultation or Diagnostic Investigation, to understand what is covered under the Policy.

We reserve the right to decline any Claim relating to surgery that has not been Pre-approved.

Pre-approval will take up to five working days from the date the request is received by us, unless further information is required or insufficient information was initially supplied.

A Pre-approval request can be made by a Recognised Provider on your behalf. If we give an Insured Person a Pre-approval for a Claim, we will notify the Policyowner or the Insured Person and send the Policyowner or the Insured Person a Pre-approval notification.

If the request has been made by a Recognised Provider we will also notify them. If we do not accept the Pre-approval, we will also let the Policyowner or the Insured Person know by correspondence.

The confirmation of the Pre-approval is valid for three months from the date of issue recorded on the correspondence, unless the Cover is cancelled with effect from a date prior to the treatment date.

Please refer to our website **nib.co.nz** for our Prosthesis Schedule which details the maximum costs that we will pay for certain individual Prosthesis, and the Hospital Category List, which outlines the hospital Categories covered under the Mid Private Hospital Cover.

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 healthcare 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.

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.

Supporting documentation for Pre-approval and Claims

Supporting documentation for Pre-approval or Claims must:

- be made in a format approved by us;
- include a copy of the GP referral letter;
- include a copy of the Registered Specialist Consultation letter (if appropriate);
- Claims must be supported by original Recognised Provider invoices and / or original Recognised Provider itemised receipts, and / or itemised receipts on the Recognised Provider's letterhead or showing the Recognised Provider's official stamp and GST number; and
- Pre-approval Claims must be supported by an estimate of the cost on the Recognised Provider's letterhead or showing the Recognised Provider's official stamp.

If we require further information in order to assess the Pre-approval request or Claim, all necessary requests must be complied with.

We recommend all Claims be submitted within 12 months of the Surgery date, as no inflation adjustments apply.

The Claim must relate to an Insured Person. Reimbursement must be to a Recognised Porvider, Policyowner or Insured Person, regardless of whether any other person has paid the account or bill.

In cases where the Insured Person is deceased, Claim payment can only be made to the Recognised Provider, remaining Policyowner or the deceased Insured Person's estate.

The Policyowner and each Insured Person 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 will withhold payment of the Claim until all outstanding Premium(s) have been paid.

Medical report or assistance

If you need assistance to complete the Claim form, or we request a medical report with the Claim form, these will be at the Policyowner's expense. If we request additional information in order to assess the Claim, this will be at our expense.

Rapid refund and method

We will process the Claim within five working days of receiving the Claim form, unless further information is required. Typically we refund the Recognised Provider directly. In cases where we are refunding the Policyowner by direct credit, please ensure your banking details are accurate on the Claim form. We will only refund to a nominated New Zealand bank account in New Zealand dollars.

Medications provided in hospitals

The Policy will meet the cost of the PHARMAC funded medications listed under Section A to G of the PHARMAC Pharmaceutical Schedule.

No Benefits are payable for:

- drugs or pharmacy items issued for the sole purpose of use at home; or
- drugs listed under Section H of the PHARMAC Pharmaceutical Schedule; or
- pharmacy items charged in a Public Hospital.

ACC review

We are happy to assist, where appropriate, with an ACC decline review. This must be in relation to a Claim that is eligible for Benefit under the Mid Private Hospital Cover. In order to assist the Insured Person, they must provide us with a copy of the ACC decline letter and the case summary and co-operate fully with our review process.

What is covered

This section lists and defines the Benefits we insure, and should be read in conjunction with all other parts of your nib Contract of Insurance. All claims are subject to our general terms (see General terms of Mid Private Hospital Cover on page 6 and What is not covered on page 36).

Please ensure you have read the Claims section on page 19 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

Overall Benefit Limits

We will pay up to a total maximum of $300,000 for each Insured Person every Policy Year, less any Excess for all the Benefits covered under this Cover except any cancer related Benefits.

We will pay up to a total maximum of $200,000 for each Insured Person every Policy Year, less any Excess for all the cancer related Benefits covered under this Cover.

Individual limits may apply to each of the Benefits.

If an Excess has been chosen, it is applied once to each Insured Person every Policy Year under the Mid Private Hospital Cover (see Excess on page 14).

1 Hospital Surgical Benefit

This Benefit covers the following for eligible Claims:

- surgeon's operating fees;
- anaesthetist's fees;
- intensivist's fees;
- hospital accommodation (e.g. Admitted Patient's bed, a private room, excludes suites);
- operating theatre fees;
- surgically implanted Prosthesis (see Prosthesis Schedule on page 9);
- laparoscopic disposables;
- in-hospital x-ray examination and ECG;
- intensive post-operative care and special in-hospital nursing;

- in-hospital post-operative Physiotherapy;
- ancillary hospital charges (e.g. dressings, sutures, needles, bandages); and
- in-hospital Pharmaceutical Prescriptions (see Medications provided in hospitals on page 24).

Additional terms

Benefits are not payable for any Categories not listed on the Hospital Category List under the Mid Private Hospital Cover.

Dental Surgery in hospital

Dental Surgery in a Recognised Private Hospital must be performed by a registered oral and maxillo-facial surgeon. We will only cover the cost of removal of unerupted or impacted teeth if a registered oral surgeon or registered dentist performs the Pre-approved Surgery.

A 12-month Waiting Period from the Join Date for each Insured Person applies to the extraction of unerupted or impacted teeth if a registered oral surgeon or registered dentist performs this Surgery.

- **Benefit Limit for dental Surgery in hospital**

  We will only cover the cost of extraction of four impacted or unerupted teeth for each Insured Person while covered under the Mid Private Hospital Cover.

- **Additional terms for dental Surgery in hospital**

  Benefits are not payable for any other dental treatments, including periodontal, orthodontic and endodontal procedures and implants, and orthognathic Surgery.

2 Cancer treatment in hospital Benefit

This Benefit covers the following for eligible Claims for cancer treatment:

- chemotherapy;
- radiotherapy;
- brachytherapy;
- hospital accommodation (i.e. the Admitted Patient's bed and a private room if available);
- in-hospital x-ray examination and ECG;

- intensive post-operative care and special in-hospital nursing;
- in-hospital post-operative Physiotherapy;
- ancillary hospital charges (e.g. dressings, sutures, needles, bandages); and
- in-hospital Pharmaceutical Prescriptions (see Medications provided in hospitals on page 24).

Additional terms

- Costs relating to a cancer Surgery are covered under the hospital Surgical Benefit (see Hospital Surgical Benefit on page 25).

Medications for cancer treatment

This Benefit covers the full cost of PHARMAC funded drugs listed under Section A to G of the PHARMAC pharmaceutical schedule, if directly related to the cancer treatment (see Medications provided in hospitals on page 24).

Additional terms for medications for cancer treatment

No Benefits are payable for:

- contraceptive drugs; or
- drugs or pharmacy items issued for the sole purpose of use at home; or
- drugs not listed under Section A to G of the PHARMAC Pharmaceutical Schedule; or
- pharmacy items charged in a Public Hospital.

3 Registered Specialist Consultations Benefit

This Benefit covers Registered Specialist or Vocational GP Consultations for eligible Claims, whether the Consultation results in Surgery or cancer treatment or not.

Benefit Limit

- For Surgery related Registered Specialist or Vocational GP Consultations: we will pay for up to six Registered Specialist or Vocational GP Consultations for each Insured Person every Policy Year.

- For cancer treatment related Registered Specialist Consultations: there is no limit on the number of Registered Specialist Consultations after diagnosis of cancer.

Additional terms

Benefits are not payable for any Categories not listed on the Hospital Category List under the Mid Private Hospital Cover.

4 Diagnostic Investigations Benefit

This Benefit covers Diagnostic Investigations for eligible Claims when the Diagnostic Investigation has been requested by a GP or Registered Specialist, whether or not the Diagnostic Investigation results in Surgery or cancer treatment or not.

Benefit Limit

- For Surgery related Diagnostic Investigations: we will pay a maximum of $10,000 for each Insured Person every Policy Year.
- For cancer treatment related Diagnostic Investigations: there is no limit on the number of Diagnostic Investigations we will pay for after diagnosis of cancer.

Additional terms

Benefits are not payable for any Categories not listed on the Hospital Category List under the Mid Private Hospital Cover.

5 Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy after Pre-approved Surgery or cancer treatment.

This Benefit covers Physiotherapy up to six months following each Pre-approved Surgery or cancer treatment.

Benefit Limit

We will pay a maximum of $750 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any Categories not listed on the Hospital Category List covered under Mid Private Hospital Cover.

- Benefits are not payable for any Physiotherapy that does not relate to a Pre-approved Surgery or cancer treatment under the relevant Benefit Limits.
- Benefits are not payable for any Physiotherapy that occurs outside the six months following Pre-approved Surgery or cancer treatment.

6 Home nursing Benefit

This Benefit covers the cost of home nursing care after Pre-approved Surgery or cancer treatment, when the Insured Person requires assistance with any of the Activities of Daily Living.

The care must be recommended by the Insured Person's GP or Registered Specialist and provided by a Registered Nurse in Private Practice.

The Claim must relate to complications from the Pre-approved Surgery or cancer treatment and the care must be recommended by the Insured Person's GP or Registered Specialist.

This Benefit can be claimed up to six months following each Pre-approved Surgery or cancer treatment, as long as assistance is still required for Activities of Daily Living.

Benefit Limit

We will pay $150 per day, up to a maximum of $6,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for services such as Mothercraft, Tresillian or Karitane nursing.
- Benefits are not payable for any cost in relation to providing domestic duties / house keeping.
- Benefits are not payable for any home nursing care that does not relate to a Pre-approved Surgery or cancer treatment under the relevant Benefit Limits.

7 Ambulance transfer Benefit

This Benefit covers the cost of road ambulance transfer from a Public Hospital or Recognised Private Hospital to the closest Recognised Private Hospital. The road ambulance transfer must be recommended by a Registered Specialist who has cared for the Insured Person for at least 24 hours as an Admitted Patient.

Additional terms

- Benefits are not payable for any Categories not listed on the Hospital Category List under the Mid Private Hospital Cover.
- Benefits are not payable for any other ambulance transfers apart from carriage between medical providers as approved by us.
- Benefits are not payable on any ambulance society subscriptions.
- Benefits are not payable for any ambulance transfers that do not relate to a Pre-approved Surgery or cancer treatment under the relevant Benefit Limits.

8 Travel and accommodation Benefit

This Benefit covers the travel and accommodation costs incurred when Pre-approved Surgery or cancer treatment recommended by a GP or Registered Specialist is not available through a Recognised Provider within 100 kilometres from the Insured Person's usual residence.

Where a GP or Registered Specialist has recommended a support person for the Pre-approved Surgery or cancer treatment, the support person must travel together with the Insured Person to and from the Recognised Provider.

Travel

This Benefit covers the following where applicable:

- air: a return economy class flight within New Zealand for the Insured Person and the accompanying support person (where recommended); or
- car: mileage for road travel at the amount determined by us; or

- rail or bus: a return rail or bus trip within New Zealand for the Insured Person and the accompanying support person (where recommended); or
- taxi: taxi fares on Admission and discharge from the Recognised Provider to / from the airport or railway station for the Insured Person and the accompanying support person (where recommended).

Accommodation

If recommended by the Insured Person's GP or Registered Specialist, we will cover the cost of accommodation incurred by the support person whilst the Insured Person is an Admitted Patient.

Benefit Limit

- For Surgery or brachytherapy treatment: the maximum we will pay for travel is $2,000 for each Insured Person for each Policy Year. The maximum we will pay for the accommodation costs for the accompanying support person is $3,000 for each Insured Person for each Policy Year.
- For Chemotherapy and radiotherapy treatment: we will pay a maximum of $5,000 for each Insured Person for each Policy Year.

Additional terms

- Benefits are not payable for any costs incurred when travelling outside New Zealand.
- Benefits are not payable for any costs that do not relate to a Pre-approved Surgery and / or cancer treatment.
- Benefits are not payable for any costs relating to vehicle hire.
- Benefits are not payable for any costs relating to travel insurance.

9 GP skin lesion Surgery Benefit

This Benefit covers the cost of skin lesion Surgery performed by a GP including one pre and one post-Consultation and any related biopsy.

Benefit Limit

We will pay a maximum of $750 for each Insured Person every Policy Year.

10 Registered Specialist skin lesion Surgery Benefit

This Benefit covers the cost of skin lesion Surgery performed by a Registered Specialist.

Benefit Limit

We will pay a maximum of $2,500 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any pre or post-Registered Specialist Consultations. Pre or post-Registered Specialist Consultations relating to skin lesion Surgery are covered under the Registered Specialist Consultations Benefit (see Registered Specialist Consultations Benefit on page 27).
- Benefits are not payable for any relating biopsies. Costs relating to biopsies are covered under the Diagnostic Investigations Benefit (see Diagnostic Investigations Benefit on page 28).

11 Varicose veins Benefit

This Benefit covers the cost of varicose vein treatment performed by a Recognised Provider or Vocational GP, on recommendation from a GP or a Registered Specialist.

Benefit Limit

- We will pay for a maximum of four varicose vein Surgical procedures each Lifetime Limit of each Insured Person.
- The varicose vein Surgical procedure is not limited to leg varicose vein procedures.

Additional terms

- Benefits are not payable if a GP or Registered Specialist does not recommend the Surgical procedure.
- Benefits are not payable for any cosmetic Surgeries, including spider veins.

- Pre-approval must be obtained for this Benefit, and imaging studies will be required to complete the Pre-approval process.

12 ACC top-up Benefit

This Benefit covers the difference in cost between what ACC has paid for a physical Injury and the actual costs incurred for related Surgical procedures through a Recognised Provider.

A one day Waiting Period from the Commencement Date, Effective Date or Join Date (as applicable) for each Insured Person applies to this Benefit.

Additional terms

- Benefits are not payable for any physical Injury that occurred prior to the Commencement Date, Effective Date or the Join Date (as applicable).
- Evidence that ACC has accepted the related Claim must be provided to us with the amount payable by ACC in respect of that related Claim.
- Benefits are not payable when ACC declines the related claim.
- Benefits are not payable for any cosmetic aspect of the ACC approved treatments.

13 ACC treatment Injury Benefit

If an Injury occurs during an Insured Person's Health Service which relates to an eligible Claim, this Benefit covers the costs of reparative treatment providing an ACC treatment Injury Claim has been submitted.

If ACC declines the Claim for physical Injury where an Injury has occurred, an ACC review will be requested (see ACC review on page 24).

Additional terms

- Benefits are not payable for any Categories not listed on the Hospital Category List under the Mid Private Hospital Cover.
- Benefits are not payable for any cosmetic aspect of the ACC approved treatments.

14 Funeral support grant

This grant is provided if an Insured Person dies between the age of 16 and 64 (inclusive).

Benefit Limit

We will pay $3,000 to the Policyowner or the deceased Insured Person's estate in respect of the Insured Person.

Additional terms

- No Excess will be deducted for this grant.
- When Claiming for this grant, please provide a certified copy of the original death certificate.

15 Premium waiver Benefit

This Benefit covers the costs of Premiums due on this Policy for remaining Insured Persons if the Policyowner dies before the age of 65 from any cause.

We will pay the Mid Private Hospital Cover Premiums:

- for two years; or
- until any of the remaining Insured Persons turn 65 years old,

whichever occurs first.

Additional terms

- No Excess will be deducted for this Benefit.
- When Claiming for this Benefit, please provide a certified copy of the original death certificate.
- The Benefit starts from the next Premium payment date following the death of the Policyowner.
- When the Benefit period ends, the Premiums will be payable for all the remaining Insured Persons.

16 Suspension of Cover Benefit

After 12 months of continuous cover from the Commencement Date, Join Date or Effective Date (as applicable), the Policyowner can apply to suspend the Policy and / or Cover for an Insured Person, for reasons of unemployment or overseas travel.

Unemployment

If the Policyowner is registered as unemployed, this Cover can be suspended for up to a maximum of six months.

Overseas travel / residence

If the Insured Person lives or travels outside New Zealand for longer than 90 consecutive days the Cover for the relevant Insured Persons can be suspended for a minimum of 90 days and a maximum of 24 months.

Additional terms

- All relevant documentation in support of the application to suspend the Policy and / or Cover for an Insured Person must be supplied to us as required.
- All Premiums has been paid up-to-date before it can be suspended.
- While the Policy and / or Cover for an Insured Person is suspended, no Premiums are payable and no Benefits and / or Claims are payable.
- The Policy and / or Cover for an Insured Person cannot be suspended for more than 24 months in any 10 year period.
- For unemployment suspensions, the suspension ends on the date nominated by the Policyowner or at the end of the six-month maximum suspension period, whichever occurs first.
- If the Policy is suspended for unemployment, the Policy will automatically be resumed after six months.

17 Follow-up investigation for cancer Benefit

Following a cancer surgery or treatment approved by us, we cover one Consultation with a Registered Specialist and one relevant Diagnostic Investigation relating to the cancer for which the initial treatment had been undertaken every Policy Year.

Benefit Limit

- We will pay a maximum of $3,000 for each Insured Person every Policy Year.
- We will pay up to five consecutive Policy Years.

What is not covered

Benefits are not payable for any Health Services that are related to and / or any consequences of the following:

- Providers who do not meet our criteria.
- Any Excess.
- Health Services not mentioned in this Policy document.
- Health Services provided during a Waiting Period.
- Health Services provided after the Benefit Limit or Lifetime Limit has been reached.
- Policy applications or Claims where false or inaccurate information is supplied.
- Incomplete Claims.
- Any services provided by a family member (for example: Health Services, accommodation and travel costs).
- Expenses reimbursed by any third party (for example: any other person, company or insurer).
- Services provided outside of New Zealand.
- Goods purchased outside of New Zealand (for example: goods ordered on the internet which are from another country).
- Acute Medical Conditions.
- Organ / tissue transplants or donation (for example: stem cell transplant).
- Specialised transfusions (for example: transfusion of blood, blood products and derivatives and renal dialysis).
- HIV and AIDS.
- Cosmetic, reconstruction, reductions, weight loss / Obesity (for example: gastric banding, sleeve and bypass, gynaecomastia, breast reduction and blepharoplasty), unless approved by us.
- Sleep problems and disorders (for example: snoring, insomnia and sleep apnoea).
- Allergies or allergic disorders (for example: allergy testing and desensitisation).

- Vision enhancement (for example: myopia, hypermetropia, presbyopia, stigmatism, radial keratotomy and photo-refractive keratectomy).
- Any Congenital, hereditary or genetic Condition (for example: birth disorder, chromosomal disorder, familial predisposition, familial risk, gene therapy and genetic testing).
- Family planning (for example: infertility, pregnancy, termination of pregnancy, sterilisation, contraception, caesarean section, hormone replacement therapy and erectile dysfunction).
- A psychiatric, behavioural, psychological or developmental Condition (for example: depression, ADD, ADHD and eating disorders).
- Substance misuse (for example: misuse of alcohol and misuse of drugs).
- Self-inflicted injuries or injuries arising from attempted suicide.
- Charges under the Crimes Act (for example: any medical Condition which is related in any way to the Insured Person being involved in an incident which results in the Insured Person being charged under the Crimes Act).
- Any form of risk management (for example: Screening or preventative).
- Prophylactic (unless approved by us in advance).
- Wars or riots.
- Continuous care (for example: geriatric care, palliative and disability, support services costs, senile Condition and dementia).
- Any Pre-existing Conditions.
- Any medical Condition or medical treatment requiring an Admission to a Recognised Private Hospital for care that does not involve Surgical or medical treatment.

Benefits are not payable for any costs that are related to the following:

- New medical treatments, procedures and technologies that have not been approved by us.

- Alternative or complementary medicines or therapies (for example: massage therapy, homeopathy and natural therapy).
- Any Health Services that are provided by health professionals not recognised by the Medical Council of New Zealand (unless expressly specified in this Policy document).
- Costs associated with additional Surgery or treatment performed that has not been approved by us.
- Mechanical tools, aids, appliances as determined by us (for example: insulin pumps, C-PAP equipment, cochlear implants, pacemakers, crutches and artificial limbs).
- Any incidental costs (for example: car parking, newspapers, take out meals and TV rental).
- Administration costs (for example: fax charges, after hours costs, overtime, cancellation charges and prioritisation fees).
- Medications that are not on the PHARMAC Pharmaceutical Schedule under section A to G.
- Dental Conditions (unless expressly specified in this Policy document).
- Ambulance society subscriptions.
- GP and out-of-hospital prescription charges (except where the contrary is expressly specified in the Policy).
- 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.
- When Consultations do not occur face-to-face.
- For claims that do not meet our general terms (see General terms of Mid Private Hospital Cover on page 6).

Before going to hospital, call us on **0800 123 nib** (0800 123 642). We can check what will be covered and help you understand the best ways to avoid potential Out-of-Pocket Expenses.

nib's obligations

We will:

- Treat Insured Persons as valued nib customers.
- Answer questions promptly and accurately at the first point of contact (whenever possible).
- Provide detailed health Policy information and help the Policyowner and the Insured Persons understand what they are covered for.
- Deal with feedback and complaints in a timely and responsible manner.
- Provide timely and accurate Pre-approval (whenever possible).
- Keep the Policyowner and the Insured Persons informed regarding the process of their Claim (whenever possible).
- Make every possible effort to resolve complaints to the Policyowner's and the relevant Insured Person's satisfaction (whenever possible).
- Provide at least 30 days' written notification of Cover changes and at least 30 days' notification of a Premium increase.
- Meet the terms outlined in our direct debit authority.
- Provide a 14-day free-look period on all health Cover sales (providing no Claims are made during that time).
- Treat personal information with respect and in total accordance with the Privacy Act 1993, including the Health Information Privacy Code 1994.

Policyowner and Insured Person's obligations

By taking out a Policy with us, the Policyowner and all Insured Persons agree to:

- Comply with this Policy in full.
- Be accurate and truthful in their health insurance application and Claims.
- Undertake to understand Waiting Periods and what they are covered for, and if unsure – ask us.
- Call us as soon as they learn they need to go to hospital.
- Keep their health insurance Premiums up-to-date to ensure they remain covered.
- Meet the terms outlined in our direct debit authority.
- Provide all information reasonably required by us in relation to all the Policy.
- Provide a relevant referral letter where the specific service or treatment must only be performed after referral by a GP or Registered Specialist. The name of the referral practitioner must be shown on the account or receipt presented to us for payment.
- Refer to the Hospital Category List in order to understand their relevant level of Cover.
- Notify us as soon as reasonably possible for any change that may affect their Policy, and if unsure – ask us.
- Comply with the duty of disclosure (see Duty of disclosure on page 7).

nib's privacy policy

We are committed to protecting the privacy and security of the personal information we collect. We have implemented measures to comply with our obligations under the Privacy Act 1993, including the Health Information Privacy Code 1994. Our privacy policy explains how we may collect, use and disclose personal information. To read our current privacy policy, please go to **nib.co.nz/about-us/privacy-policy**

Feedback and complaints

Any questions? More information?

We know that customer feedback can help improve the quality of our service.

How to contact us:

Call nib on **0800 123 nib** (0800 123 642),
Monday to Friday 8:00am – 5.30pm

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

We have a process for dealing with complaints to ensure they are heard.

You are welcome to contact us on the details above to talk to the person who handled your enquiry of Claim, or to talk to a senior team member or team leader.

Alternatively, you can write to the nib Complaints Committee:

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

Email complaints@nib.co.nz

We will make every possible effort to resolve complaints to your satisfaction. In the event that you are not satisfied with the outcome, we will issue a letter of "deadlock" which gives you the option to take your complaint to the Insurance & Financial Services Ombudsman (IFSO):

The Insurance & Financial Services Ombudsman
PO Box 10-845, Wellington 6143
Phone 0800 888 202
Email info@ifso.nz

Glossary of important terms

"ACC" means the Accident Compensation Corporation or any "Accredited Employer" as defined in the Accident Compensation Act 2001 or its successor under any subsequent legislation.

"Acceptance Certificate" means the most recent document entitled 'Acceptance Certificate' forwarded to the Policyowner by nib as part of the Contract of Insurance.

"Activities of Daily Living" means any of the following:

- bathing and showering; or
- dressing and undressing (including grooming and fitting artificial limbs); or
- eating and drinking; or
- using a toilet to maintain personal hygiene; or
- moving to or from place to place by walking, wheelchair or walking aid.

"Acute Medical Condition" means a sign, symptom or Condition that requires immediate, or within 48 hours, hospital admission for treatment or monitoring.

"Admission" means to have followed an administration process to become an Admitted Patient for treatment of a sign, symptom or Condition as a private patient in a registered Recognised Private Hospital. A treatment in the emergency room of a Recognised Private Hospital is not an Admission.

"Admitted Patient" means an Insured Person who is formally admitted to a Recognised Private Hospital for the purposes of treatment.

"Benefit" means an amount of money payable from nib to or on behalf of an Insured Person, in respect of approved expenses incurred by that Insured Person for treatment, in accordance with the Policy document and the Contract of Insurance.

"Benefit Limit" or **"Benefit Limits"** means the maximum amount we will pay for each Benefit for each Insured Person every Policy Year.

"Category" or **"Categories"** means the area of the body or the specific Surgical procedure covered by Policy as detailed on the published Hospital Category List.

"Chemotherapy" means a medication and its administration for the treatment of cancer that is approved by nib and is listed on the PHARMAC Pharmaceutical Schedule under sections A to G and meets the PHARMAC funding criteria. This excludes all medication listed under Section H of the PHARMAC Pharmaceutical Schedule.

"Claim" or **"Claiming"** means a request from an Insured Person for the payment of Benefits or a confirmation of future payment of Benefits, which complies with this Policy document.

"Commencement Date" means the start date of your Policy that is shown as 'Original policy commencement date' on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Condition" means any illness, injury, ailment, disease, sickness, disorder or disability.

"Congenital" means a health anomaly or defect which is present at birth whether it is recognised or not and whether it is inherited or due to external or environmental factors such as drugs or alcohol.

"Consultation" or **"Consultations"** means a necessary face-to-face meeting with a Recognised Health Professional 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. This does not include virtual consultation.

"Contract of Insurance" means the following:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document);
- the Hospital Category List;
- the Prosthesis Schedule; and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

"Cover" means the defined group of Benefits which are payable to an Insured Person under their chosen level of health insurance subject to relevant rules.

"Dependent Child" or **"Dependent Children"** means an Insured Person's child or children under the age of 21 years.

"Diagnostic Investigation" means an investigative procedure undertaken to determine the presence or cause of a sign, symptom or Condition. This does not include any skin biopsies or treatment of any kind including but not limited to pain relief.

"Effective Date" means the date any changes made to the Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Efficient Market Price" or **"EMP"** means the maximum amount (as may change from time to time) we will pay for a Health Service provided by a Recognised Provider that is not part of the nib First Choice Network.

"Excess" means the amount each Insured Person must pay towards the cost of Health Services that they receive each Policy Year that would otherwise be covered under the Policy. The Insured Person's Excess amount is shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"First Choice Network" or **"nib First Choice Network"** means the group of Recognised Providers that are pre-determined by us to charge a fair and reasonable amount for a particular Health Service (as may change from time to time).

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

"GP" or **"General Practitioner"** means a doctor registered under 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, and approved by nib.

"Health Services" means Consultations, assessments, Diagnostic Investigations or treatments of a sign, symptom or Condition provided by a Recognised Health Professional.

"Hospital Category List" means the list of Categories published by nib.

"Injection" means forcing a liquid / pharmaceutical into any part of the body for any reason.

"Injury" or **"Injuries"** means the ACC definition of an injury at the time of injury (not at the time of Claim if they differ).

"Insured Person" means a person named as an 'Insured Person' on the Acceptance Certificate or Renewal Certificate (whichever is the later), and may, as applicable, include the Policyowner.

"Join Date" means the date when Cover commences for an Insured Person is added to this Policy shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Lifetime Limit" means the maximum amount we will pay for each Benefit for each Insured Person over the lifetime of the Insured Person.

"nib" or **"we"** or **"us"** means nib nz limited.

"Obesity" means the World Health Organisation recognised definition of Obesity.

"Out-of-Pocket Expenses" means charges and fees not covered by nib that are billed by the hospital or Recognised Provider for which the Insured Person will be liable, and includes any charges, costs or fees that exceed the EMP if the Insured Person does not use a Recognised Provider in the nib First Choice Network. Excess amounts are separate, and in addition, to Out-of-Pocket Expenses.

"Partner" means an Insured Person's spouse or a person who cohabits with the Insured Person in a nature of a marital, de-facto or civil union relationship.

"PHARMAC" means 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).

"Pharmaceutical Prescription" means a legally written order by a Registered Specialist, GP, dentist or nurse practitioner for the preparation and administration of a medicine (pharmaceutical), dispensed by a registered pharmacy and listed under sections A to G of the Ministry of Health PHARMAC Pharmaceutical Schedule (or its successor under any subsequent legislation).

"Physiotherapist" means a Recognised Health Professional who is:

(a) in Private Practice and holds a current annual practicing certificate; and

(b) a member of The Physiotherapy Board of New Zealand (or its successor under any subsequent legislation).

"Physiotherapy" means treatment provided by a Physiotherapist.

"Policy" or **"Policies"** means this contractual agreement between the Policyowner and nib as governed by the Contract of Insurance.

"Policy Anniversary Date" means the date 12 months after the Commencement Date and every 12-month anniversary of that date.

"Policy Year" means the 12-month period that commences on the Commencement Date and ends at 6am on the Policy Anniversary Date, and each successive 12-month period from a Policy Anniversary Date to the next Policy Anniversary Date.

"Policyowner" means a person who administers the Policy and whose name is on the Acceptance Certificate or Renewal Certificate (whichever is the later) as 'Policyowner(s)'. This means all Policyowners if there is more than one.

"Pre-approval" or **"Pre-approve"** means nib's confirmation of the eligibility of an Insured Person's Claim made in advance.

"Pre-existing Condition" means any sign, symptom, treatment or Surgery of any Condition that occurs on or before the:

- Commencement Date; or
- Effective Date; or
- Join Date,

whichever is applicable, and:

- which the Policyowner or any Insured Person was aware of; or
- of which the Policyowner or any Insured Person has had the first indication that something was wrong; or
- for which the Policyowner or any Insured Person sought investigation or medical advice; or
- where the Condition, or the sign or symptom of a Condition, existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment.

"Premium" means the amount of money the Policyowner is required to pay to nib in respect of a specified period of Cover for the Policy.

"Private Practice" means a practice (whether sole, partnership or group) which receives its primary income from the fees charged to its patients without subsidy or funding from the public health sector, and recognised by nib.

"Prophylactic" means any Diagnostic Investigation or treatment prescribed to prevent the risk of a Condition developing in the future.

"Prostheses" or **"Prosthesis"** means an artificial implant used for functional reasons to replace a joint or body part that has been removed due to disease or injury and is approved by nib. This does not include corrective lenses, mechanical tools or appliances (battery operated units). The relevant Prosthesis Schedule is available on nib's website **nib.co.nz**

"Prosthesis Schedule" means the list of Prostheses as approved by nib.

"Public Hospital" means a hospital owned and administered by the public funded health sector of the New Zealand Government.

"Recognised Health Professional" means 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, for example Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand or the Chiropractic Board in New Zealand and recognised by nib.

"Recognised Private Hospital" means a private hospital, day surgery unit or private wing in a Public Hospital, within New Zealand that has been recognised by nib. It does not include any other type of medical facility.

"Recognised Provider" means a Recognised Health Professional, Recognised Private Hospital or other medical facility that is recognised by nib.

"Registered Nurse" means any person who holds a current practising certificate issued by the Nursing Council of New Zealand and recognised by nib.

"Registered Specialist" means a medical practitioner who has trained and specialised in a specific branch of medicine and who is a member of an appropriately recognised specialist college and has Medical Council of New Zealand vocational registration in that speciality, and approved by nib. For the purposes of this definition it will not include those holding vocational registration for accident and medical practice, emergency medicine, family planning, sexual health and reproductive health, general practice, medical administration, or public health medicine or sports medicine.

"Renewal Certificate" means the most recent document entitled 'Renewal Certificate' forwarded to Policyowner by nib in relation to this Policy.

"Screening" means a Diagnostic Investigation carried out in the absence of any sign or symptom of a Condition in order to confirm whether or not a Condition is present, for example: testing due to a family history of cancer.

"Surgery" or **"Surgical"** or **"Surgeries"** means an operation performed in a Recognised Provider under an anaesthetic (general, intravenous sedation, local or spinal) requiring a surgical incision to remove or repair damaged or diseased tissue. This does not include Injections of any type.

"Surgical Cost Grouping" means the overall cost for Registered Specialist, anaesthetist and any Prosthesis (if applicable) for a Health Service.

"Vocational GP" means a General Practitioner (GP) with a relevant, post-graduate qualification in the Health Service they are providing, as recognised by nib.

"Waiting Period" means, in relation to a Benefit, a period of time after the Commencement Date, Effective Date or where an Insured Person is added to this Policy, the Join Date, for which no Claim will be paid for that specific Benefit.

Mid Private Hospital Cover 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**
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PO Box 91 630, Victoria Street West, Auckland 1142

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