Priority Health Business™ Policy

Module 1: Other Surgical Cover

This document explains the cover provided under Priority Health Business™, Module 1: Other Surgical Cover.

IMPORTANT – This document must be read in conjunction with:

- the policy document for Priority Health Business™, Base Cover: Major Surgical Module;
- the **diagnostic list** and the **surgical list**;
- the **prosthseses schedule**; and
- the **acceptance certificate** or **renewal certificate**.

Module 1: Other Surgical Cover can be added to the Priority Health Business™, Base Cover: Major Surgical Module for an additional premium. If **you** have chosen any additional modules, these are shown on **your acceptance certificate** or **renewal certificate**.

Benefits under Module 1: Other Surgical Cover apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**, unless stated otherwise in this policy.

Any **excess** chosen on the Base Cover does not apply to this module.

Please ensure **you** have read the Help section in the Priority Health Business™, Base Cover: Major Surgical Module policy document on page 7 for details in relation to the **nib First Choice network** which applies to the Benefits under this policy.

Module 1: Other Surgical Cover

This module is procedure based, meaning it covers **diagnostic procedures** and **surgical procedures** under Module 1: Other Surgical Cover. These procedures are reviewed annually.

Benefit Maximum

We pay up to a benefit maximum of $100,000 per **insured person** per **policy year**. This benefit maximum is inclusive of all benefits under this module. Individual limits may apply under each of the benefits.

1. Surgical Benefit

1.1 **We** cover the cost to an eligible **insured person** of a **surgical procedure** under Module 1: Other Surgical Cover, carried out by a **registered specialist** in an **approved private hospital**.

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

- Intensive nursing care;
- Diagnostic imaging;
- Disposables and consumables;
- Dressings;
- **Drugs** required while hospitalised that are directly related to the **surgical procedure**; and
- **Prostheses** covered as per the **prostheses schedule** up to the maximum shown in that schedule.

2. Pre and Post-Procedure Registered Specialist Consultation Benefit

2.1 **We** cover the cost of:

- up to two **consultations** with the **insured person's registered specialist** or **vocational GP** before a covered **diagnostic procedure** and / or **surgical procedure** is undertaken, up to four months prior to admission to an **approved private hospital**, and
- up to two **consultations** with the **insured person's registered specialist** or **vocational GP** after a covered **diagnostic procedure** and / or **surgical procedure** is undertaken, up to four months after the date of discharge from the **approved private hospital**.

These **consultations** are covered if they relate directly to the admission to an **approved private hospital** for the purposes of undergoing a **surgical procedure** under Module 1: Other Surgical Cover.

3. Procedure-Related Diagnostic Radiology, Imaging & Cardiac Investigation Benefit

3.1 **We** cover the cost of diagnostic radiology and imaging and cardiac investigations procedures in the **diagnostic list** for Module 1: Other Surgical Cover, up to four months prior to the date of admission to an **approved private hospital**, in connection with a **surgical procedure** under Module 1: Other Surgical Cover.

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

3.3 **We** will pay up to a maximum of $4,000 per **insured person** per **policy year**.

4. Post-Procedure Physiotherapy Benefit

4.1 **We** reimburse the cost of necessary post-procedure physiotherapy as recommended by the treating **registered specialist** in connection with a pre-approved **surgical procedure** under Module 1: Other Surgical Cover.

4.2 **We** pay for up to five **consultations**, for up to a maximum of two months following each **surgical procedure**.

4.3 **We** pay up to a maximum of $300 per **insured person** per **policy year**.

5. Procedure-Related Travel Allowance Benefit

5.1 Where a **registered specialist** has recommended a **surgical procedure** under Module 1: Other Surgical Cover, 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 approved by **us**, of a return economy class 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 and 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 $150 per night for the accommodation costs incurred by the support person.
- Ambulance transfer – where medically necessary and approved by **us**, to and from an **approved private hospital** or public hospital.

  No other transfers are covered apart from carriage between medical facilities as approved by **us**.

5.2 **We** pay up to a maximum of $500 per **insured person** per **surgical procedure**.

6. ACC Top-Up Benefit

6.1 If the **insured person** is hospitalised in an **approved private hospital** for a **surgical procedure** under Module 1: Other Surgical Cover, and he or she is covered by **ACC** for that procedure, **we** will cover the shortfall between the **insured person's ACC** payment and the cost of the **surgical procedure**, and any other associated benefits under this module.

6.2 The shortfall payment must not exceed the benefit maximum under this module for the applicable benefit.

6.3 At pre-approval of **your** claim **you** must supply to **us** a copy of the **ACC** acceptance documentation, including the amount of **ACC's** payment.

6.4 If **ACC** declines the **insured person's** claim, **you** must supply to **us**, when seeking pre-approval of the claim, a copy of **ACC's** letter of declinature. **We** may require the **insured person** to apply for a review of **ACC's** grounds of declinature. **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**.

7. Minor Surgical Benefit

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

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

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.

8. Parental Accommodation Benefit

8.1 **We** cover the cost per night of the accommodation cost incurred by a parent or legal guardian accompanying an insured child under 15 years listed in the **acceptance certificate** or **renewal certificate**, where that child is being treated for a **surgical procedure** under Module 1: Other Surgical Cover in an **approved private hospital**.

The benefit only applies to one adult – a parent or legal guardian as approved by **us**.

8.2 **We** pay up to $100 per night while the insured child is hospitalised, to a maximum of $500 per **insured person** per **surgical procedure**.

9. Varicose Vein – Endovenous Laser Therapy or Surgery

9.1 **We** cover the cost of treatment for varicose vein **surgical procedure** providing the following criteria are met:

- **We** only cover the cost of treatment for a varicose vein if a **registered specialist** or **vocational GP** performs the **surgical procedure**; and
- no claim can be made for the first 12 months from the **effective date** of this module for each **insured person**.

9.2 **We** cover the cost of two varicose vein **surgical procedures** per **insured person** while covered under this module.

10. Impacted or Unerupted Wisdom (Third Molars) Teeth

10.1 **We** cover the cost of removal of impacted or unerupted wisdom teeth providing the following criteria are met:

- **We** only cover removal of unerupted and impacted teeth if a registered oral surgeon or registered dentist performs the **surgical procedures**; and
- No claim can be made for the first 12 months from the **effective date** of this module for each **insured person**.

10.2 **We** cover the cost of removal for four impacted or unerupted wisdom teeth per **insured person** while covered under this module.

For more information

Call **0800 287 642**
Visit **nib.co.nz**
Email **grouphealth@nib.co.nz**

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Priority Health Business™ Policy

Module 2: Cancer and Non-Surgical Hospitalisation Cover

This document explains the cover provided under Priority Health Business™, Module 2: Cancer and Non-Surgical Hospitalisation Cover.

IMPORTANT – This document must be read in conjunction with:

- the policy document for Priority Health Business™, Base Cover: Major Surgical Module;
- the **diagnostic list**; and
- the **acceptance certificate** or **renewal certificate**.

Module 2: Cancer and Non-Surgical **Hospitalisation** Cover can be added to the Priority Health Business™, Base Cover: Major Surgical Module for an additional premium. If **you** have chosen any additional modules, these are shown on **your acceptance certificate** or **renewal certificate**.

Benefits under Module 2: Cancer and Non-Surgical **Hospitalisation** Cover apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**, unless stated otherwise in this policy.

Any **excess** chosen on the Base Cover does not apply to this module.

Please ensure **you** have read the Help section in the Priority Health Business™, Base Cover: Major Surgical Module policy document on page 7 for details in relation to the **nib First Choice network** which applies to the Benefits under this policy.

Module 2: Cancer and Non-Surgical Hospitalisation Cover

This module covers **diagnostic procedures** under Module 2: Cancer and Non-Surgical **Hospitalisation** Cover. These **diagnostic procedures** are reviewed annually.

1. Cancer Treatment Benefit

1.1 **We** cover the cost to an eligible **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**.

We pay up to a benefit maximum of $65,000 per **insured person** per **policy year**. This benefit maximum is inclusive of the following benefits under this module. Individual limits may apply under each of the benefits.

- Pre and Post-Procedure or Pre and Post-Treatment **Registered Specialist Consultation** Benefit.
- **Registered Specialist Consultations** During Treatment Benefit.
- Procedure or Treatment-Related Diagnostic Radiology, Imaging & Cardiac Investigation Benefit.
- Post-Treatment Follow-Up Investigation Benefit for Treatment of Cancer.
- Chemotherapy and Radiotherapy Travel and Accommodation Benefit.
- Community Care Benefit.

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

2.1 **We** cover the cost of:

- up to two **consultations** with the **insured person's registered specialist** before chemotherapy, radiotherapy or brachytherapy, or non-surgical **hospitalisation**, up to four months before the date of treatment or admission to hospital; and
- up to two **consultations** with the **insured person's registered specialist** after chemotherapy, radiotherapy or brachytherapy, or non-surgical **hospitalisation**, up to four months after the date of completion of an approved course of treatment or discharge from hospital.

These **consultations** are covered if they result in the **insured person** having private chemotherapy, radiotherapy, brachytherapy or non-surgical **hospitalisation** approved by us.

Included in the Cancer Treatment Benefit or Non-Surgical **Hospitalisation** Benefit maximum, whichever applies.

3. Registered Specialist Consultations During Treatment Benefit

3.1 **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**.

Included in the Cancer Treatment Benefit maximum.

4. Procedure or Treatment-Related Diagnostic Radiology, Imaging & Cardiac Investigation Benefit

4.1 **We** cover the cost of diagnostic radiology and imaging and cardiac investigations procedures in the **diagnostic list** for Module 2: Cancer and Non-Surgical **Hospitalisation** Cover, up to four months prior to the date of admission to an **approved private hospital**, in connection with the **insured person** having private chemotherapy, radiotherapy or brachytherapy for cancer or non-surgical **hospitalisation**.

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

4.3 **We** will pay up to a maximum of $4,000 per insured person per **policy year**. Included in the Cancer Treatment Benefit or Non-Surgical **Hospitalisation** Benefit maximum, whichever applies.

5. Post-Treatment Follow-Up Investigation Benefit for Treatment of Cancer

5.1 Following a course of chemotherapy, radiotherapy and / or brachytherapy approved by **us**, **we** cover one post-cancer investigation per **insured person** per **policy year** for up to five consecutive **policy years**.

5.2 A post-cancer investigation includes one consultation with a **registered specialist** and one relevant **diagnostic procedure** relating to the cancer for which the initial treatment had been undertaken.

5.3 **We** pay up to a maximum of $2,000 per **insured person** per **policy year**. Included in the Cancer Treatment Benefit maximum.

6. Chemotherapy and Radiotherapy Travel and Accommodation Benefit

6.1 Where a **registered specialist** has recommended chemotherapy or 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 approved by **us**, of a return economy class within New Zealand for an **insured person** requiring the treatment, and for a support person to travel to and from an **approved private hospital**. This benefit applies per **cycle of treatment** for cancer.
- 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 and rail travel – a mileage allowance is available as calculated by **us**.
- Ambulance transfer – where medically necessary to and from an **approved private hospital** or public hospital, within New Zealand and approved by **us**. There is no cover for ambulance transfer to an **insured person's** usual residence or for medical **consultations** or treatments outside of hospital care.

6.2 Accommodation – **we** cover the cost of accommodation up to the benefit maximum for the **insured person** and / or a support person only during the **insured person's** cycle of chemotherapy or radiotherapy for cancer.

6.3 **We** pay up to $150 per night for accommodation costs incurred by the **insured person** and / or support person to the benefit maximum which includes travel costs per course of chemotherapy or radiotherapy.

6.4 Additional terms – this benefit does not cover any travel and accommodation costs related to chemotherapy or radiotherapy performed in any publicly funded facility.

6.5 **We** pay up to a maximum of $4,500 per **insured person** per **policy year**. Included in the Cancer Treatment Benefit maximum.

7. Community Care Benefit

The Community Care Benefit is for an **insured person** who requires assistance in their usual home environment as the symptoms they are suffering are severe and they need support with daily functions.

7.1 This benefit is for care after an **insured person** has had chemotherapy or radiotherapy covered under this module.

7.2 The claim must relate to complications from chemotherapy or radiotherapy only and the care has been recommended by the **insured person's registered specialist**.

7.3 Applications must be received by **us** in writing up to five days after the completion date of a **cycle of treatment** for cancer along with the **registered specialist's** written recommendation for the benefit.

7.4 This benefit remains valid for up to four months after the completion date of the **cycle of treatment**.

7.5 All service providers must be a New Zealand resident or citizen and have recognised training for the task they are performing or belong to a recognised and registered New Zealand agency. No benefit will be paid to family members, friends, associates or those who do not meet the criteria as determined by **us**.

7.6 When submitting a claim for this benefit, all original accounts and receipts presented to **us** for payment must show the name of the **health service provider**, contact details, GST number and itemised invoicing including dates of visits and fees charged. **We** may request identification and registration details of the **health service provider**.

7.7 **We** pay only for the services as listed in the benefit cover. One Community Care Benefit only is payable for a **cycle of treatment** that has been approved by **us**.

7.8 **We** pay up to:

- Registered **GP** visits – a maximum of $500 per **insured person** per policy year.
- Registered **health service provider** visits (district nurse, hospice nurse, physiotherapist) – a maximum of $500 per **insured person** per **policy year**.
- Home nursing and/or home help, to assist with showering and toileting and/or assisting with meals and fluids – a maximum of $1,000 per **insured person** per **policy year**.

  We pay up to a maximum of $2,000 in total under this benefit per **insured person** per **policy year**. Included in the Cancer Treatment Benefit maximum.

8. Non-Surgical Hospitalisation Benefit

8.1 **We** cover the cost to an eligible **insured person** for a **diagnostic procedure** or treatment (not involving surgery) in an **approved private hospital** for two or more consecutive nights.

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

- In-hospital specialist **consultations**.
- Intensive nursing care.
- Diagnostic imaging.
- Disposables and consumables.
- Dressings.
- **Drugs** required while **hospitalised**.

8.3 **We** pay up to $20,000 per **insured person** per **policy year**. This benefit maximum is inclusive of the following benefits under this module. Individual limits may apply under each of the benefits:

- Pre and Post-Procedure or Pre and Post-Treatment **Registered Specialist Consultation** Benefit.
- Procedure or Treatment-Related Diagnostic Radiology, Imaging and Cardiac Investigations Benefit.

For more information
Call **0800 287 642**
Visit **nib.co.nz**
Email **grouphealth@nib.co.nz**

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Priority Health Business™ Policy

Module 3: Trauma Cover

This document explains the cover provided under Priority Health Business™, Module 3: Trauma Cover.

IMPORTANT – This document must be read in conjunction with:

- the policy document for Priority Health Business™, Base Cover: Major Surgical Module; and
- the **acceptance certificate** or **renewal certificate**.

Any **excess** chosen on the Base Cover does not apply to this module.

Pre-existing conditions are excluded from cover under Module 3: Trauma Cover.

Module 3: Trauma Cover can be added to the Priority Health Business™ Base Cover: Major Surgical Module for an additional premium. If **you** have chosen any additional modules, these are shown on **your acceptance certificate** or **renewal certificate**.

Where it does, the **insured person** covered and the sum **insured** will be shown on **your acceptance certificate** or **renewal certificate**.

What we cover

We cover the **insured person** for any one of the Trauma Conditions listed below if:

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

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

What we pay

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

Only one **sum insured** will be paid for each **insured person** covered by Module 3: Trauma Cover.

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

The **sum insured** will be reduced proportionally if the **insured person** covered is older than the age stated in the application form.

Trauma Conditions

Aortic surgery

Where surgery is medically necessary to repair or correct:

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

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

Coronary artery angioplasty – three vessels or more

The actual undergoing of coronary artery angioplasty that is considered medically necessary to correct or treat a narrowing or blockage of three or more coronary arteries during the same procedure.

Coronary artery bypass grafting surgery

The undergoing of medically necessary coronary artery bypass grafting surgery to correct or treat coronary artery disease.

Heart valve surgery

The undergoing of surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. Repair via angioplasty, intra-arterial procedures or other non-surgical techniques are specifically excluded.

Major heart attack (myocardial infarction)

A myocardial infarction (other than as a direct result of cardiac or coronary intervention) with the following criteria being satisfied:

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

  If the above criteria are not met then **we** will pay a claim based on satisfactory evidence that the **insured person** has suffered a myocardial infarction which has resulted in a permanent reduction in the left ventricular ejection fraction to less than 50%.

Benign tumour of the brain or spinal cord

A non-cancerous tumour in the brain or spinal cord giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The tumour must result in either:

- medically necessary surgery to remove the tumour; or
- neurological deficit causing:
  - at least 25% impairment of **whole person function** that is permanent; or
  - the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

This does not include cysts, granulomas, cholesteatomas, malformations in or of the arteries or veins of the brain, haematomas, and tumours in the pituitary gland.

Cancer – life threatening

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

The following are not included:

- Tumours showing the malignant changes of **carcinomas in situ*** (including cervical dysplasia **CIN-1**, **CIN-2** and **CIN-3**) or which are histologically described as pre-malignant.
- All skin cancers, including hyperkeratosis, basal cell carcinomas and squamous cell carcinomas, unless there is evidence of metastases.**
- Prostatic cancers which are histologically described as **TNM Classification** T1 or are of another equivalent or lesser classification.

- Chronic Lymphocytic Leukaemia less than **Rai** Stage 1.

  The procedure used must be performed specifically to arrest the spread of malignancy and be considered to be the usual and necessary treatment.

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

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

Pneumonectomy

The surgical excision of an entire lung.

Stroke

The suffering of a stroke as a result of a cerebrovascular event.

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

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

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

When does the Trauma Cover end?

This cover ends in relation to an **insured person** at the earliest of the following:

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

New application or alteration to sum insured

If **you** wish to add Module 3: Trauma Cover to **your** policy, or alter the **sum insured** (to a level as set by **us**) after the **commencement date** or **join date**, where an **insured person** is added to this policy, **you** must complete a new application form.

Pre-existing conditions are excluded from cover under this module. The terms of **our** acceptance depend on the information **you** provide **us**. If **we** agree to the addition or alteration, then **we** will issue a new **acceptance certificate** or **renewal certificate** showing the new **sum insured**.

The module will be added to this policy on the same (or nearest equivalent) date in the month that corresponds to the date in the month of **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. An additional premium is payable for this module.

Upgrading an existing policy with Trauma Cover, to Module 3: Trauma Cover

Where there is an upgrade from an existing Trauma Cover to Module 3: Trauma Cover, and where there are new Trauma Conditions covered, there is no cover for any new Trauma Conditions that are in connection in any way with any **pre-existing condition** the **insured person** had prior to the **effective date** of the upgrade.

When we will not pay

We will not pay anything under Module 3: Trauma Cover, or where the **sum insured** has been increased, **we** will not pay the amount of the increase, if within the 90 day period after:

- the **effective date** of this module; or
- an increase in the **sum insured**; or
- where the **insured person** is added to this policy, from their **join date**:

  a) the first symptom of the Trauma Condition appeared; or

  b) the Trauma Condition first occurred; or

  c) the Trauma Condition was first diagnosed; or

  d) Surgery was undertaken relating to the Trauma Condition.

We will not pay anything under this benefit if:

- The **insured person** dies within the 14 day period immediately following the date of diagnosis of the Trauma Condition.
- The Trauma Condition suffered by the **insured person** is in connection in anyway with any **pre-existing condition**.
- The Trauma Condition is not suffered for the first time after the **commencement date** or **effective date** (whichever is the later), or the **join date** where an **insured person** is added to this policy.

We do not pay anything under this benefit if the **insured person's** Trauma Condition is in connection with:

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

If, within the first 90 days following the **commencement date** or **effective date** (whichever is the later) or **join date** where an **insured person** is added to this module, **you** wish to change **your** benefit option, the 90 day period will be revised to commence from the newly declared date of change once **you** have signed and dated the declaration authorising the change and the declaration has been received and approved by **us**.

No benefit will be paid for any other condition other than the listed Trauma Conditions and all claims must meet the definitions of the listed Trauma Condition before payment will be made.

No payment will be made to any **insured persons** under 21 years of age regardless of them being an **insured person**.

No benefit will be paid for loss of independent existence.

How to make a claim

- **You** must follow the requirements of 'Section 3 – How to make a claim' in the Help Section of the Priority Health Business™, Base Cover: Major Surgical Module policy document;
- In addition, if **you** wish to claim under this benefit **you** must:
  - advise **us** as soon as possible, but no later than 30 days after the **insured person** suffers one of the listed Trauma Conditions;
  - provide **us** with an original or certified copy of the **insured person's** birth certificate, driver's licence or passport; and
  - complete and return **our** claim form. **You** can call **us** on 0800 287 642 to request a claim form.
- At **your** own expense:
  - supply medical certificates and any other information that **we** may require from time to time; and
  - obtain a definite diagnosis of the listed Trauma Condition as soon as possible after the **insured person** first becomes aware that he or she might be suffering from one of the listed Trauma Conditions. The diagnosis must be made by an appropriately **registered specialist** (or other **registered specialist** approved by **us**) and the investigations must be based on (but not limited to): clinical, radiological, histological and laboratory evidence acceptable to **us**.

  If required by **us**, the **insured person** must undergo medical examinations and other tests by a **registered specialist** of **our** choice to enable **us** to confirm that the **insured person** is suffering from one of the listed Trauma Conditions. This will be at **our** expense.

  Before **we** pay any amount, **you** and the **insured person** must comply with **your** obligations under this module.

For more information

Call **0800 287 642**
Visit **nib.co.nz**
Email **grouphealth@nib.co.nz**

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Priority Health Business™ Policy

Module 4: General Practitioner (GP) Cover

This document explains the cover provided under Priority Health Business™, Module 4: General Practitioner (GP) Cover.

IMPORTANT – This document must be read in conjunction with:

- the policy document for Priority Health Business™, Base Cover: Major Surgical Module; and
- the **acceptance certificate** or **renewal certificate**.

Module 4: General Practitioner (GP) Cover can be added to the Priority Health Business™, Base Cover: Major Surgical Module for an additional premium. If **you** have chosen any additional modules, these are shown on **your acceptance certificate** or **renewal certificate**.

Benefits under Module 4: General Practitioner (GP) Cover apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate** unless stated otherwise in this policy.

Any **excess** chosen on the Base Cover does not apply to this module.

What we pay

We will refund **you** the costs for **GP** visits and prescription medicines up to the benefit maximums.

1. General Practitioners Benefit

We cover the cost of **GP** visits, including home visits and cervical smears.

1.1 Benefit maximums

- **We** pay up to $35 per **GP** clinic visit, including after hours.
- **We** pay up to a total maximum of three **GP** visits per **insured person** per **policy year**.

2. Prescription Benefit

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

2.1 Benefit Maximums

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

2.2 Other terms

After-hours pharmacy fees are excluded.

2.3 Claims under the Prescription Benefit

When submitting claims for prescriptions under this module, **you** must submit pharmacy receipts stating the name of the patient, prescription number, the name of the medication prescribed and the cost of each item. The reason for the medication must be stated on the claim form.

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

For more information

Call **0800 287 642**

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PRBG 06-17
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Priority Health Business™ Policy

Module 5: Specialist and Other Diagnostic Cover

This document explains the cover provided under Priority Health Business™, Module 5: Specialist and Diagnostic Cover.

IMPORTANT – This document must be read in conjunction with:

- the policy document for Priority Health Business™, Base Cover: Major Surgical Module;
- the **diagnostic list** and the **surgical list**; and
- the **acceptance certificate** or **renewal certificate**.

Module 5: Specialist and Other Diagnostic Cover can be added to the Priority Health Business™, Base Cover: Major Surgical Module for an additional premium. If **you** have chosen any additional modules, these are shown on **your acceptance certificate** or **renewal certificate**.

Benefits under Module 5: Specialist and Other Diagnostic Cover apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate** unless stated otherwise in this policy.

Any **excess** chosen on the Base Cover does not apply to this module.

Please ensure **you** have read the Help section in the Priority Health Business™, Base Cover: Major Surgical Module policy document on page 7 for details in relation to the **nib First Choice network** which applies to the Benefits under this policy.

1. Registered Specialist Consultation Benefit

We cover the cost of the **insured person** receiving a New Zealand **registered specialist** or **vocational GP consultation**.

1.1 Benefit maximum

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

2. General Diagnostic Benefit

We cover the cost of **diagnostic procedures** under Module 5: Specialist and Other Diagnostic Cover, after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised** for treatment.

2.1 Benefit maximum

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

3. Specialist Diagnostic Radiology and Imaging Benefit

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

3.1 Benefit maximums are per insured person per policy year

- CT: $2,000.
- MRI: $2,500.
- X-rays: $800.
- Ultrasound: $500.
- Scintigraphy: $400.
- Mammography: $300.

4. Specialist Cardiac Investigations Benefit

We cover the cost of specialist cardiac **diagnostic procedures** under Module 5: Specialist and Other Diagnostic Cover, after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised** for treatment.

4.1 Benefit maximum

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

Claims under Module 5: Specialist and Other Diagnostic Cover

You must submit all invoices stating the name of the patient, the name of the **registered specialist** and / or **diagnostic procedure** and the cost of each item. The reason for the **consultation** and / or the **diagnostic procedure** must be stated on the claim form.

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

For **consultation(s)** and / or **diagnostic procedure** that relate to:

- a pre-approved **surgical procedure** covered under the Base Cover: Major Surgical Module, or Module 1: Other Surgical Cover; or
- pre-approved chemotherapy, radiotherapy, and brachytherapy for cancer or non-surgical **hospitalisation** under Module 2: Cancer and Non-Surgical **Hospitalisation** Cover,

you must submit the **consultation(s)** and **diagnostic procedure** receipts with the details of the pre-approved claim under the relevant module.

Please refer to **your acceptance certificate** or **renewal certificate**, the **diagnostic list** and the **surgical list**, and the relevant policy document(s) for the details of **your** cover.

For **consultation(s)** and / or **diagnostic procedures** that do not relate to:

- pre-approved **surgical procedure** covered under the Base Cover: Major Surgical Module, or Module 1: Other Surgical Cover; or
- pre-approved chemotherapy, radiotherapy, and brachytherapy for cancer or non-surgical **hospitalisation** under Module 2: Cancer and Non-Surgical **Hospitalisation** Cover,

these **consultation(s)** and / or **diagnostic procedure** are covered up to the specific benefit maximums under the Module 5: Specialist and Other Diagnostic Cover.

For more information

Call **0800 287 642**
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