Private Hospital Gold Cover

Policy document

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Contents

Introduction

01 SECTION

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 14).

Unless specified, this Policy document only describes nib Private Hospital Gold 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 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 Private Hospital Gold Cover only (see Glossary of important terms on page 51).

This is an important document

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

How to contact nib

Call us on **0800 123 nib** (0800 123 642)
Email us for general enquiries at contactus@nib.co.nz
Email us for Claims at claims@nib.co.nz
nib nz limited
PO Box 91630
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.

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

General terms of cover

02 SECTION

Applying for an nib cover

All applications for nib Cover must be accompanied by any relevant information we require. We may at our discretion, refuse to accept an application until all necessary information has been provided or until the Premiums for the minimum period as determined by nib, 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.

Electronic communication

The Policyowner and the Insured Person must maintain valid email addresses at all times. They must advise us immediately of any change to their email addresses.

The Policyowner and the Insured Person agree:

- To us sending all communications to them in connection with this Policy electronically, including via email to a single nominated email address, and the my nib portal. This includes Policy documents and notices under this Policy. The single nominated email address will be the email address the Policyowner provides us at time of application, as updated by the Policyowner from time to time.
- To sending to us all communications in connection with this Policy via email or through the my nib portal.
- Any reference to notice in writing in this Policy means written notice sent electronically.

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.

All information given by, or on behalf of, the Policyowner or any Insured Person must be true, correct and complete. 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 or was not true, correct and complete, we can cancel this Policy or alter the terms and conditions of Cover provided under 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 Policyowner or 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 91630, Victoria Street West, Auckland 1142.

Period of cover

Your Cover starts from the Commencement Date, Effective Date or Join Date (as applicable) shown on your Acceptance Certificate or Renewal Certificate (whichever is the later). This is subject to any applicable Waiting Period.

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 the day 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 covered 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 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 the Private Hospital Gold 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;
- be in Private Practice; and
- be recognised by nib.

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.

Prosthesis Schedule

For certain Surgeries requiring Prosthesis, we will pay up to the maximum amount as defined in the Prosthesis Schedule available on our website at **nib.co.nz**

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 and my nib portal

Our website

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

My nib portal

Our portal provides 24 hour access to your Policy details and Claims history. Visit **nib.co.nz/portal**

Who is covered

This Policy provides cover for an Insured Person who is eligible to receive Health Services funded under the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation) at all times.

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 the criteria (see Cancelling the policy or cover on page 12).

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 adult 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.

Adding a newborn to your policy

If you add a Dependent Child within three months of birth, we will cover that child for Pre-existing Conditions, other than a Congenital Condition or the standard Policy exclusions. Refer to What is not covered on page 44 and any limitations set out in your Acceptance Certificate or Renewal Certificate.

Employee benefits

If you have taken out Private Hospital Gold Cover through your employer, your employer may have negotiated additional concessions and/or Benefits to those recorded in this Policy.

If this is the case, details of those concessions and/or Benefits will be recorded on your Acceptance Certificate or Renewal Certificate (whichever is the later).

In the event there is a conflict between the concessions and/or Benefits recorded on your Acceptance Certificate or Renewal Certificate and those recorded in this Policy then the Acceptance Certificate or Renewal Certificate will prevail.

Who can view and change the policy

The Policyowner is the primary account holder and has 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 (including 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 optional Cover, at a Policy Anniversary Date (see Adding or removing an option on page 10).

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 an insured person

The Policyowner can add a Partner or Dependent Child onto their Policy, providing the Insured Person meets the eligibility criteria (see Who is covered on page 8) and the Insured Person (or their parent or legal guardian if under 16 years old) consents to be added, including providing privacy consent. The person being added to a Policy will be required to serve any applicable Waiting Period from the Commencement Date, 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.

The following people cannot be added to this Policy unless we agree:

- an adult Insured Person's parents;
- an adult Insured Person's grandchildren; or
- any other adult.

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

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

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.

Changes in contact details

The Policyowner must notify us of all changes in contact details of the Insured Persons covered under the Policy.

Changing the insured person's smoking status

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

Adding or removing an option

The Policyowner can add an option(s) to the Policy and/or a Cover for an Insured Person 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 Cover on the option(s) can start.

We will charge an additional Premium for each Insured Person's additional option(s). The Premium will be adjusted from the next available billing date to reflect this change. The added optional Cover will start from the Effective Date or Join Date (as applicable) shown on the Acceptance Certificate or the Renewal Certificate (whichever is the later).

The Policyowner can only remove an option at the next Policy Anniversary Date. The Policyowner must give us at least 30 days' prior notice in writing before the option(s) can be removed.

We will process the change

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

Commencement of cover

Any Insured Person will be able to Claim for the Benefits and/or Health Services provided by the Cover once any applicable 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 (as applicable), for which no Claim will be paid for anything that happens during this period.

The following Waiting Periods apply to each Insured Person for this Policy:	
Base Cover – Unerupted or impacted teeth extraction	12 months
GP Lite Option	90 days
GP Option	90 days
Dental and Optical Option	Six months
Serious Condition Financial Support Option – Trauma Conditions as specified	90 days

Waiting periods when changing 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 nib before the new Cover can start.

We recognise Waiting Periods already served on another nib Cover comparable to the Private Hospital Gold Cover only.

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

New Benefits and/or Health Service	No change in Benefits and/or Health Service
The Waiting Period will apply from the Effective Date.	The Waiting Period applies from the Commencement Date, Effective 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

- The Excess amount is detailed on the Acceptance Certificate or Renewal Certificate (whichever is the later) for each Insured Person, and applies to each Insured Person every Policy Year.
- The Excess will be deducted from eligible Claim payments for each Insured Person from the Commencement Date or Join Date (as applicable) until the Excess amount is reached.
- The Excess will be deducted from any eligible Claim payments for each Insured Person from every Policy Anniversary Date thereafter.
- The Excess is not payable by nib, and cannot be met by withdrawing from any other Benefits on your Policy.
- For example: The Excess amount is $500, the Insured Person submits an eligible Claim for $250. No payment is made by nib to the Insured Person. The Insured Person then submits an eligible Claim for $500. $250 is paid out to the Insured Person. Any further eligible Claims submitted after the Excess amount had been reached will be paid in line with Benefit Limits until the next Anniversary Date, when the Excess amount is then deductible again.

Changing your excess

The Policyowner can request to increase or decrease the Excess for any Insured Person within six weeks prior to the Policy Anniversary Date, subject to the terms agreed with your employer (if applicable).

If the new Excess is lower than the previous Excess, 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. Any new Excess will commence from the Policy Anniversary Date and it will be noted on the Acceptance Certificate.

Continuation of cover

Where:

- The Insured Person who is an employee resigns from his or her employment; or
- we or the employer ends the arrangement which this Policy is part of,

this Policy ends immediately. We may offer a replacement Policy determined by us at our discretion in accordance with our transfer rules applying at the time the Insured Person resigns or the arrangement we have with the employer ends. We may review special Benefits and concessions and the Premium payable may be reviewed. We will contact you advising that this Policy has been cancelled and give you the opportunity to continue your Policy and Cover.

Resuming your policy or cover from suspension

- If the Policy or Cover for an Insured Person has been suspended under the Loyalty – Suspension of Cover Benefit 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 for an Insured Person is not reinstated at the end of the suspension period, we will write to the Policyowner at their last known email 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.

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.

We reserve the right to cancel the 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
- the Policy is not resumed following a suspension; or
- an Insured Person is no longer entitled to receive Health Services funded under the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation); or
- the last Insured Person covered by this Policy dies; or
- any Insured Person breaches the terms of the Policy; or
- 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 not true, correct and complete; 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 cancel this Policy or Cover for an Insured Person, any Premiums paid may be retained by us. If we have already made any Claims payments we may recover these from the Policyowner.

Important information about your premiums and benefits

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.

The Policyowner must pay us the Premium at one of the frequencies provided by us. These are payable in advance. 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.

Where the Premium rate change takes effect during the Policy Year, the change will not come into effect until the next Premium falls due.

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 Premium deduction advice is returned to us due to a failure to deliver to the nominated email 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, Claiming and payment.

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

- All Claims are subject to your Contract of Insurance on page 5 and What is not covered on page 44.
- All Claims must relate to an Insured Person.
- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to the Policy or law.
- It will be at nib's discretion to determine whether the Insured Person will be covered for any Claims for Health Services carried out during a period of non-payment.
- Claims are only eligible for Health Services carried out by Recognised Providers.
- Any Claims must have all the relevant information and supporting documentation submitted with the Claim form (see Supporting documentation for pre-approval and claims on page 16).

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.

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.

How to make a claim

- Visit our portal at **nib.co.nz/portal** to submit a Claim.
- Visit our website at **nib.co.nz** for a Claim form.
- Call us on **0800 123 nib** (0800 123 642).
- Email us at **claims@nib.co.nz**
- The Policy number must be quoted for all Claims.

Pre-approval

- We strongly recommend any Insured Person should seek Pre-approval prior to undertaking any Health Service to understand what is covered under your Policy.
- 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.
- If we issue a Pre-approval for a Claim, we will notify the Policyowner or the Insured Person and send the Policyowner a Pre-approval advice. If the request has been made by a Recognised Provider we will also notify them.

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 on or prior to the treatment date.

If the Cover is cancelled with effect from a date prior to the treatment date, the Pre-approval will not be valid.

Supporting documentation for pre-approval and claims

Supporting documentation for Pre-approval or Claims must:

- be made in a format approved by nib;
- include a copy of the GP referral letter (if appropriate);
- include a copy of the Registered Specialist Consultation letter (if appropriate); and
- Claims must be supported by Recognised Provider invoices and/or itemised receipts on the Recognised Provider's letterhead showing their GST number.

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

Novel, experimental or more expensive treatments or procedures

We will not approve any novel, experimental or more expensive treatment or procedure, where a conventional or less expensive treatment or procedure is available that will provide the same, or a similarly acceptable, medical outcome.

This means novel or experimental treatments, procedures or equipment are not likely to be covered unless, in nib's opinion, they provide a superior outcome at a reasonable cost.

Medical report or assistance

All costs of completing the Claim form, including providing a medical report if required by us, will be at the Policyowner's expense. If we require further information in order to assess the Claim or Pre-approval, all requests must be complied with. If we request additional information, this will be at our expense.

Refund and method

Reimbursement must be to a Recognised Provider, Policyowner or Insured Person, regardless of whether any other person has paid the invoice.

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.

In cases where we are refunding the Policyowner or Insured Person by direct credit, please ensure your banking details are accurate on the Claim form. If we pay to an incorrect account due to an Insured Person's error, no replacement payment can be issued until the original payment has been returned to us.

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 medications that are listed under Section A to H of the PHARMAC pharmaceutical schedule that meet the associated funding criteria, and that are prescribed by the treating Registered Specialist.

Cover is available for non-PHARMAC, Medsafe approved drugs as part of cancer treatment (see Cancer Treatment in Hospital Benefit on page 21) and intravitreal Injections (see Intravitreal Injections Benefit on page 27).

Benefits are not payable for any medications issued for the sole purpose of use at home or any medications charged in a Public Hospital except where provided for cancer treatment (see Cancer Treatment in Hospital Benefit on page 21).

ACC

03 SECTION

ACC review

If we believe that ACC should cover your Health Service(s), you are required to co-operate fully with our review process, which may include providing authority to our legal representative and providing us with copies of the ACC decline letter, the case summary and any other relevant information.

ACC treatment injury

In the rare instance of treatment Injury during Surgical or medical treatment, cover is payable for any additional costs involved under the ACC Treatment Injury Benefit (see ACC Treatment Injury Benefit on page 28).

What is covered

04 SECTION

Please ensure you have read the Claims section on page 15 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

Base Cover

This section lists and defines the Benefits we provide under the Private Hospital Gold Cover Base Cover, 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 cover on page 6 and What is not covered on page 44).

If the Policyowner has chosen an Excess for an Insured Person's Cover, this will apply to that Insured Person every Policy Year (see Excess on page 11).

We will pay 100% of each eligible cost under the Benefits up to the Benefits Limits less any Excess.

1. Hospital Surgical Benefit

This Benefit covers the following for eligible Surgical Claims, upon Admission:

- 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 8);
- 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 17).

We also cover the costs of alternative, less invasive, procedures which, in our opinion, replace Surgery as the most appropriate method of treatment for any Condition that we would have otherwise agreed to accept as a Surgical Claim. Cover is under the Hospital Medical Benefit.

Benefit limit

- We will pay up to a total maximum of $100,000 for each Insured Person per Surgery.

Additional terms

- Benefits are not payable if the Surgery is not performed by a Registered Specialist.

Oral Surgery

This Benefit covers the cost of oral Surgery performed by a registered oral surgeon or maxillo-facial surgeon in a Recognised Private Hospital.

Additional terms

- Benefits are not payable for any periodontic, endodontal procedures, Orthodontic Treatment and implants, and orthognathic Surgery or exposure of teeth.

Unerupted or impacted teeth extraction

This Benefit covers the cost of removal of unerupted or impacted teeth if a registered oral surgeon, Dental Practitioner or maxillo-facial surgeon performs the Surgery.

Additional terms

- Benefits are not payable for any extraction of teeth other than for unerupted or impacted teeth.
- There is a 12 month Waiting Period for the extraction of unerupted or impacted teeth from the Join Date of each Insured Person.
- Benefits are not payable for any other Dental Treatments, including periodontic, endodontal procedures, Orthodontic Treatment and implants, and orthognathic Surgery or exposure of teeth.

Specialist Micrographic Surgery (Mohs)

This Benefit covers the cost of Mohs Surgery, performed by a Registered Specialist in a Recognised Private Hospital. Includes cover for follow-up Consultations within six weeks of Surgery.

Additional terms

- Benefits are not payable for any cryotherapy, pulse light therapy or photodynamic therapy.
- For any other Skin Lesion Surgery (see Specialist Skin Lesion Surgery Benefit on page 27).

Varicose vein treatment

This Benefit covers the cost of varicose vein treatment if it is performed by either:

- a Registered Specialist; or
- a Vocational GP; or
- an nib Recognised Health Professional;
  - who is in Private Practice and holds a current annual practising certificate;
  - is registered with the Medical Council of New Zealand; and
  - is a fellow of the Australasian College of Phlebology.

Additional terms

- We will cover two varicose vein treatments per leg per lifetime.
- Benefits are not payable for any cosmetic Surgeries or treatment, including but not limited to superficial veins (for example: spider veins).

Cataract Surgery

This Benefit covers the Surgical insertion of a standard monofocal intraocular lens only and any follow-up Consultations within six weeks of Surgery.

Additional terms

- There is no cover for the additional cost of any other type of Surgically implanted intraocular lens for the correction of refractive visual errors.

2. Hospital Medical Benefit

This Benefit covers the following for eligible medical Claims, upon Admission for treatment, convalescence, or observation:

- Hospital accommodation (e.g. Admitted Patient's bed, a private room) (excludes suites);
- in-Hospital X-ray examination and ECG;
- intensive post-treatment care and special in-Hospital nursing;
- in-Hospital post-treatment Physiotherapy;
- Ancillary Hospital charges (e.g. dressings, bandages); and
- in-Hospital Pharmaceutical Prescriptions (see Medications provided in hospitals on page 17).

Benefit limit

- We will pay up to a total maximum of $60,000 for each Insured Person every Policy Year under this Benefit.

Additional terms

- Benefits are not payable when the medical treatment is not managed by a Registered Specialist.
- Benefits are not payable for any medical treatment where the sole or main purpose of the medical treatment is administration of an Injection. For example, without limitation: pain management Injections (except where the contrary is expressly specified in the Policy).
- Benefits are not payable unless the Condition or treatment requires Admission as supported by medical evidence.
- Benefits are not payable if the drug is not listed under Section A to H of the PHARMAC pharmaceutical schedule.
- Benefits are not payable for Psychiatric hospitalisation (see Psychiatric Hospitalisation Benefit on page 23).

3. Cancer Treatment in Hospital Benefit

This Benefit covers the following for eligible Claims upon Admission:

- non-PHARMAC chemotherapy;
- Chemotherapy;
- Radiotherapy;
- Brachytherapy;
- Hospital accommodation (e.g. Admitted Patient's bed, a private room) (excludes suites);
- in-Hospital X-ray examination and ECG;
- intensive post-treatment care and special in-Hospital nursing;
- in-Hospital post-treatment Physiotherapy;
- ancillary Hospital charges (e.g. dressings, needles, bandages);

- at home chemotherapy Pharmaceutical Prescriptions; and
- in-Hospital Pharmaceutical Prescriptions (see Medications provided in hospitals on page 17).

Benefit limit

- We will pay up to a total maximum of $60,000 for each Insured Person every Policy Year. This includes up to $10,000 for non-PHARMAC funded, Medsafe approved and indicated chemotherapy drugs for cancer per Insured Person every Policy Year.

Additional terms

- Costs relating to a cancer Surgery are covered under the Hospital Surgical Benefit (see Hospital Surgical Benefit on page 19).

4. General Diagnostics Benefit

This Benefit covers the cost of the following diagnostics, after referral by a GP or a Registered Specialist.

- X-rays
- Mammography
- Ultrasounds
- Nuclear Scanning
- Myocardial perfusion scan
- Computed Axial Tomography (CT Scan)
- Magnetic Resonance Imaging (MRI Scan)
- Positron Emission Tomography/Computed Axial Tomography (PET/CT)

Benefit limit

- We will pay up to a total maximum of $60,000 for each Insured Person every Policy Year.

Additional terms

- A GP or a Registered Specialist referral is not required for diagnostics directly related to Podiatric Surgery (see Podiatric Surgery Benefit on page 27).

5. Hospital Diagnostics Benefit

This Benefit covers the cost of diagnostics, not listed under General Diagnostics Benefit, up to six months before and after Admission, after referral by a GP or Registered Specialist.

Benefit limit

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

6. Hospital Cardiac Tests Benefit

This Benefit covers the cost of cardiac tests, not listed under General Diagnostics Benefit, up to six months before and after Admission, after referral by a GP or Registered Specialist.

Benefit limit

- We will pay up to a total maximum of $5,000 for each Insured Person every Policy Year.

7. Hospital Specialist Consultations Benefit

This Benefit covers Registered Specialist or Vocational GP Consultations up to six months before and after Admission, after a referral from a GP or a Registered Specialist.

Benefit limit

- We will pay up to a total maximum of $5,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for Podiatric Surgery (see Podiatric Surgery Benefit on page 27.)

8. Psychiatric Hospitalisation Benefit

This Benefit covers the cost of an Admission, referred by and under the care of a Psychiatrist in Private Practice for treatment, convalescence or observation.

The Benefit includes reimbursement for hospital accommodation and ancillary hospital charges.

Benefit limit

- We will pay for the cost of psychiatric hospitalisation up to $330 per day or night up to a total maximum of $1,650 per Admission. This includes up to $200 for the cost of drugs and/or ancillary hospital charges incurred during Admission.

9. Hospital Dietitian Consultations Benefit

This Benefit covers the cost of Dietitian Consultations up to six months after being discharged from a Recognised Private Hospital, where the Consultation directly relates to that medical Condition, after referral by the treating Registered Specialist.

Benefit limits

- We will pay up to $100 per Consultation.
- We will pay up to a total maximum of $500 for each Insured Person every Policy Year.

10. Speech and Language Therapy Benefit

This Benefit covers the cost of Speech and Language Therapy up to six months after being discharged from a Recognised Private Hospital, where the therapy directly relates to that medical Condition, after referral by the treating Registered Specialist.

Benefit limits

- We will pay up to $70 per treatment.
- We will pay up to a total maximum of $350 for each Insured Person every Policy Year.

11. Post Mastectomy Grant to Achieve Breast Symmetry

This Benefit covers the cost relating to Surgery to achieve breast symmetry post mastectomy including any Consultations, diagnostics and subsequent treatments relating to this unilateral breast reduction Surgery.

Grant limit

- We will pay up to a Lifetime Limit of $2,500 for each Insured Person.

Additional terms

- Grants are only payable if the Insured Person has had a mastectomy covered under this Policy.

12. Hospice Benefit

This Benefit provides a payment to the Hospice when an Insured Person is admitted to a Hospice.

Benefit limits

- Adult
  - We will pay $50 per night and up to $500 per admission.
  - We will pay up to a total maximum of $2,400 for each Insured Person every Policy Year.
- Child:
  - We will pay $25 per night and up to $250 per admission.
  - We will pay up to a total maximum of $1,200 for each Insured Person every Policy Year.

Additional terms

- The Excess does not apply to this Benefit.
- To Claim under this Benefit, you must provide a discharge summary from the Hospice stating the reason and the date of the admission.

13. Travel and Accommodation Benefit

This Benefit covers the travel and accommodation costs incurred when Surgery or medical treatment recommended by a Registered Specialist is not available through a Recognised Private Hospital within 100 kilometres from the Insured Person's usual residence.

Where a Registered Specialist has recommended a support person for the Surgery or medical treatment, the support person must travel together with the Insured Person to and from the Recognised Private Hospital.

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; or
- car: mileage for road travel at the amount determined by nib; or
- rail or bus: a return rail or bus trip within New Zealand for the Insured Person and the accompanying support person; and
- 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.

Accommodation

We will cover the cost of accommodation incurred by the support person whilst the Insured Person is an Admitted Patient.

Benefit limit

- We will pay up to a total maximum of $500 for each Insured Person every Policy Year.

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit, Hospital Medical Benefit or Cancer Treatment in Hospital Benefit (whichever applies).

- Benefits are not payable for any costs incurred when travelling outside New Zealand.
- Benefits are not payable for any costs relating to vehicle hire.
- Benefits are not payable for any costs relating to travel insurance.

14. Parent Accommodation Benefit

This Benefit covers the cost of accommodation incurred by a parent or legal guardian accompanying an Insured Person aged 20 or under, where they are being treated in a Recognised Private Hospital.

Benefit limits

- We will pay up to $100 each night.
- We will pay up to a total maximum of $500 for each Insured Person per Admission.

15. Home Nursing Care Benefit

This Benefit covers the cost of home nursing care up to six months after being discharged from a Recognised Private Hospital where the home nursing directly relates to a medical Condition, and the Insured Person requires assistance with any of the Activities of Daily Living.

The home nursing care must be recommended by the Insured Person's GP or Registered Specialist and provided by a Registered Nurse or a Nurse Practitioner.

This Benefit provides cover for up to six months following each Admission as long as assistance is still required for the Activities of Daily Living.

Benefit limits

- We will pay up to $175 a day.
- We will pay up to a total maximum of $2,800 for each Insured Person every Policy Year.

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit, Hospital Medical Benefit, or Cancer Treatment Benefit (whichever applies).
- Benefits are not payable for any cost in relation to providing domestic duties/house keeping or childcare.

16. Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy up to six months after being discharged from a Recognised Private Hospital where the Physiotherapy directly relates to that medical Condition, after a referral by the treating Registered Specialist.

Benefit limits

- We will pay up to $60 per visit.
- We will pay up to a total maximum of $300 for each Insured Person every Policy Year.

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit, Hospital Medical Benefit, or Cancer Treatment Benefit (whichever applies).

17. Overseas Treatment Benefit

This Benefit covers the cost of an overseas Surgical or medical treatment that cannot be performed at all in New Zealand, where an application has been submitted to the Ministry of Health for funding under the 'Medical Treatment Overseas Scheme', and the Ministry of Health has declined funding.

We cover the reasonable travel cost, including return economy airfares for the Insured Person requiring treatment and a support person, plus the cost of the treatment performed overseas, up to the Benefit Limit.

Benefit limit

- We will pay up to a total maximum of $10,000 for each Insured Person every Policy Year.

Payment method and currency

- Payment will be direct credited into your nominated New Zealand bank account in New Zealand dollars.
- All payments, Excess and Benefit Limits under this Benefit are in New Zealand dollars.
- Payments can only be made to the Policyowner or Insured Person.
- We do not pay the Health Service provider concerned.
- The exchange rate will be calculated by nib as at the date of Health Services.

Additional terms

- The treatment must be a type that cannot be performed in New Zealand.
- The treatment must be recommended by the Insured Person's treating Registered Specialist.
- The Surgery or medical treatment are subject to nib approval, at nib's sole discretion.
- You must provide a copy of the Ministry of Health's decision regarding funding to nib.
- All medical facilities/treatment providers/health professionals must have an equivalent accreditation/registration as per New Zealand standards approved by nib.
- Surgical or medical treatment must comply with the local legislation and applicable law.
- Benefits are not payable for any accommodation costs.
- Benefits are not payable for any desensitisation, vaccinations, immunology or allergies.

18. Public Hospital Cash Benefit

This Benefit provides a payment when an Insured Person is admitted to a Public Hospital overnight.

Benefit limits

- We will pay $50 per night.
- We will pay up to a total maximum of $2,400 for each Insured Person every Policy Year.

Additional terms

- The Excess does not apply to this Benefit.
- Benefits are not payable if an Insured Person is admitted to the private wing of a Public Hospital.

- Benefits are only payable if an Insured Person would have been able to Claim under the Hospital Surgical Benefit, Hospital Medical Benefit or Cancer Treatment in Hospital Benefit under the Base Cover.
- To Claim under this Benefit, you must provide a discharge summary from the Public Hospital stating the reason and the date of the admission as well as the date of the discharge to support your Claim.

19. Intravitreal Injections Benefit

This Benefit covers the cost of intravitreal Injections administered by a Registered Specialist, on referral by a GP or Registered Specialist.

Benefit limit

- We will pay up to a total maximum of $100,000 for each Insured Person per Injection.

Additional terms

- Benefits are payable for any medications listed under Section A to H of the PHARMAC pharmaceutical schedule.
- Benefits for medications approved by Medsafe but not in PHARMAC pharmaceutical schedule A to H are limited to $100 per Injection.

20. Specialist Skin Lesion Surgery Benefit

This Benefit covers the cost of Skin Lesion Surgery performed by a Registered Specialist in Private Practice under local anaesthetic.

Benefit limit

- We will pay up to a total maximum of $7,500 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any laser therapy, cryotherapy, pulse light therapy and photodynamic therapy.
- Benefits are not payable for Mohs Surgery. Mohs Surgery will be paid under Hospital Surgical Benefit (see Hospital Surgical Benefit on page 19).

21. Podiatric Surgery Benefit

This Benefit covers the cost of Surgery performed by a Podiatric Surgeon under local anaesthetic, including up to one pre and one post Consultation and x-rays.

Benefit limits

- We will pay up to a total maximum of $6,000 for each Insured Person every Policy Year.
- This Benefit maximum includes the cost of any Surgically implanted Prosthesis (see Prosthesis Schedule on page 8).

Additional terms

- Costs relating to diagnostics other than x-ray are covered under the General Diagnostics Benefit (See General Diagnostics Benefit on page 22).
- Benefits are not payable for removal of corns and callouses.

22. GP Minor Surgery Benefit

This Benefit covers the cost of Surgery performed by a GP.

Benefit limit

- We will pay up to a total maximum of $450 for each Insured Person per Surgery.

Additional terms

- Benefits are not payable for any GP Consultation or biopsy relating to the Surgery. Cover may be available under the GP option if the Policyowner has selected that option.

23. ACC Top-up Benefit

This Benefit covers the difference between costs payable by ACC for an Injury and the actual costs for the Surgery or medical treatment.

Benefit limit

- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- When Claiming for this Benefit, evidence of the amount payable by ACC must be provided to nib.
- Benefits are not payable for any cosmetic aspect of the ACC approved Surgery or medical treatment.

24. ACC Treatment Injury Benefit

This Benefit covers the costs of Surgery or medical treatment for any Injury which occurred during an Insured Person's Health Service for an eligible Claim.

If ACC declines the Claim for treatment Injury where an Injury has occurred, an ACC review will be requested (see ACC on page 18).

Benefit limit

- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- When Claiming for this Benefit, evidence of a claim being submitted to ACC must be provided.
- Any ACC reimbursement payment must be made to nib.
- Benefits are not payable for any cosmetic aspect of the ACC approved treatments.

25. Premium Waiver Benefit

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

Benefit limit

- We will pay the Premiums for two years.

Additional terms

- The Excess does not apply to 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 by all the remaining Insured Persons.
- Benefits are not payable for any additional Insured Person(s) and/or option(s) added to the Policy during the Premium waiver timeframe.

26. Loyalty – Suspension of Cover Benefit

After 12 months of continuous cover under the Base Cover for an Insured Person, the Policyowner can apply to suspend the Policy and/or Cover for the Insured Person, for reasons of unemployment (including Redundancy), overseas travel or employer approved parental leave.

Unemployment/Redundancy

If the Policyowner or the Insured Person is registered as unemployed (including as a result of Redundancy), this Policy 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, their Cover can be suspended for a minimum of 90 days up to a maximum of 24 months.

Parental leave

If the Policyowner or the Insured Person is on employer approved parental leave, this Policy can be suspended for a minimum of 90 days up to a maximum of 12 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 must be paid up-to-date before the Policy or Cover can be suspended.
- While the Policy or Cover for an Insured Person is suspended, Premiums and Benefits are not payable.
- The Policy or Cover for an Insured Person cannot be suspended for more than 24 months in any 10 year period.
- For unemployment (including Redundancy) 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 (including Redundancy), the Policy will automatically be resumed after six months.

27. Loyalty – Sterilisation Benefit

After two years of continuous cover under the Base Cover for an Insured Person, this Benefit will cover the costs of sterilisation as a means of contraception for the Insured Person, performed by a GP or Registered Specialist.

Benefit limits

- We will pay for a maximum of one sterilisation Surgical procedure for each Insured Person over the lifetime of the Policy.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit.

Additional terms

- Any Registered Specialist Consultations relating to the Sterilisation procedure will be covered under the Hospital Specialist Consultations Benefit.
- Benefits are only payable once for each Insured Person.
- Benefits are not payable for sterilisation reversal procedures.

28. Loyalty – Obstetrics Benefit

After three years' continuous cover under this Policy, we will reimburse the cost of the obstetrics care carried out by an Obstetrician.

Benefit limit

- We will pay up to a total maximum of $1,500 for each Policy every Policy Year.

29. Loyalty – Bilateral Breast Reduction Grant

After three years' continuous cover under the Base Cover, an Insured Person is covered for the cost of bilateral breast reduction Surgery including the costs of the related Consultations and diagnostics when the following criteria have been met:

- At least two of the following symptoms have been present for a minimum of 12 months (non Injury related):
  - pain in the upper back, neck or shoulders;
  - headaches (secondary to neck or back pain);or
  - pain, discomfort or ulceration from bra straps cutting into shoulders (not just imprints of straps); or
  - associated skin disorders that have not responded to conservative medical treatment.
- Bra cup size is over DD;
- Medical examination confirms macromastia;
- The amount of breast tissue to be removed is estimated to be at least 350 grams per breast; and
- If the Insured Person is over 30 years, no suspicious lesions were found on a mammogram completed within 12 months of the date of Surgery.

Grant limit

- We will pay up to a Lifetime Limit of $5,000 for each Insured Person.

Additional terms

- To Claim under this Grant, the Insured Person must submit the medical report by a Registered Specialist prior to the Surgery that demonstrates that the criteria are met.
- Grants are not payable for any subsequent treatment relating to the breast reduction Surgery.
- The Grant for a bilateral breast reduction will not pay for breast reduction via tumescent liposuction.

30. Loyalty – Gastric Banding or Bypass Grant

After three years' continuous cover under this Policy, an Insured Person is covered for the cost of gastric banding or bypass Surgery including the costs of the related Consultations and diagnostics when the following criteria have been met.

- In the case of severe obesity being diagnosed, defined as one of the following:
  - body mass index (BMI) of 40 or greater; or
  - body mass index (BMI) of 35 or greater when at least one of the following Conditions is also present:
    i. coronary disease;
    ii. type 2 diabetes mellitus;
    iii. clinically significant obstructive sleep apnoea (proven by sleep studies);
    iv. osteoarthritis of weight bearing joints, e.g. hips and knees (radiological evidence required); or
    v. blood pressure greater than 140/90 despite optimal medical management defined as maximal dose of three or more anti-hypertensive medications have been tried and remain ineffective even when sufficient time has elapsed for a response.
- Physical growth is complete.
- Previous attempts at weight loss in the past have not resulted in successful long-term weight reduction.

Grant limit

- We will pay up to a Lifetime Limit of $7,500 for each Insured Person.

Additional terms

- To Claim under this Grant, the Insured Person must submit the medical report by a Registered Specialist prior to the Surgery demonstrates that the above criteria are met.
- Grants are not payable for any subsequent treatment relating to the gastric banding or bypass Surgery.

Specialist Option

05 SECTION

Please ensure you have read the Claims section on page 14 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of cover on page 6 and What is not covered on page 44).

1. What is covered under this option

We will refund 80% or 100% of each eligible cost incurred up to the Benefit Limits. Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

The Excess does not apply to this option.

2. What is not covered under this option

The Specialist option does not cover any Hospital related services.

3. Specialist Consultations Benefit

This Benefit covers the cost of Registered Specialist or Vocational GP Consultations, after referral by a GP or Registered Specialist.

Benefit limit

- We will pay up to a total maximum of $5,000 for each Insured Person every Policy Year.

Additional terms

- If the Consultations result in an Admission within six months, it will be covered under the Hospital Specialist Consultation Benefit in the Base Cover (see Hospital Specialist Consultations Benefit on page 23).

4. Diagnostic Tests Benefit

This Benefit covers the cost of diagnostic tests after referral by a GP or Registered Specialist.

Benefit limit

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

Additional terms

- If the diagnostic tests result in an Admission within six months, it will be covered under the Hospital Diagnostics Benefit in the Base Cover (see Hospital Diagnostics Benefit on page 22).

5. Cardiac Tests Benefit

This Benefit covers the cost of cardiac tests after referral by a GP or Registered Specialist.

Benefit limit

- We will pay up to a total maximum of $5,000 for each Insured Person every Policy Year.

Additional terms

- If the cardiac tests result in an Admission within six months, it will be covered under the Hospital Cardiac Tests Benefit in the Base Cover (see Hospital Cardiac Tests Benefit on page 22).

6. Ear Care Benefit

This Benefit covers the cost of audiometric tests and Audiology Treatment after referral by a GP or Registered Specialist.

Benefit limits

- We will pay up to a total maximum of $210 for audiometric tests for each Insured Person every Policy Year.
- We will pay up to a total maximum of $210 for Audiology Treatment for each Insured Person every Policy Year.

7. Allergy Testing Benefit

This Benefit covers cost of allergy testing by a Registered Specialist, GP or Registered Nurse.

Benefit limit

- We will pay up to a total maximum of $175 for each Insured Person every Policy Year.

8. Laboratory Tests Benefit

This Benefit covers the cost of laboratory tests provided by a Recognised Private Hospital, community based or regional referral laboratory, approved by International Accreditation New Zealand.

Benefit limit

- We will pay up to a total maximum of $70 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable if the test is funded by a government agency.

9. Dietitian Consultations Benefit

This Benefit covers the cost of Dietitian Consultations after referral by a GP or Registered Specialist.

Benefit limits

- We will pay up to $100 per Consultation.
- We will pay up to a total maximum of $500 for each Insured Person every Policy Year.

Additional terms

- If the Consultation occurs after an Admission within six months, it will be covered under the Hospital Dietitian Consultations Benefit in the Base Cover (see Hospital Dietitian Consultations Benefit on page 23).

10. Psychiatric Consultations Benefit

This Benefit covers the cost of Consultations by a Psychiatrist.

Benefit limit

- We will pay up to a total maximum of $200 for each Insured Person every Policy Year.

GP Lite Option

06 SECTION

Please ensure you have read the Claims section on page 14 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms cover on page 6 and What is not covered on page 44).

1. What is covered under this option

We will refund 80% or 100% of the applicable Benefits maximums for each Benefit. Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

The Excess does not apply to this option.

2. What is not covered under this option

The GP Lite Option does not cover any Hospital related services.

3. Prescriptions Benefit

This Benefit covers the cost of Pharmaceutical Prescriptions.

Benefit limit

- We will pay up to a total maximum of $100 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any Pharmaceutical Prescriptions that are not prescribed by a GP, Registered Specialist or Nurse Practitioner.
- To Claim under this Benefit, you must submit receipts.

4. Annual Flu Vaccination Benefit

This Benefit covers the cost of a flu vaccination administered by a Medical Practitioner or Registered Specialist.

Benefit limit

- We will pay for one vaccination up to $100 for each Insured Person every year.

5. Medical Consultations Benefit

This Benefit covers the cost of GP, Registered Nurse or Nurse Practitioner visits.

Benefit limit

- We will pay up to a total maximum of $200 for each Insured Person every Policy Year.

GP Option

07 SECTION

Please ensure you have read the Claims section on page 14 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of cover on page 6 and What is not covered on page 44).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

We will refund 100% of each eligible cost incurred under the Benefits up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The GP option does not cover any Hospital related services.

3. General Practitioner Benefit

This Benefit covers the cost of GP visits.

Benefit limits

- We will pay up to $50 for each GP visit.
- We will pay up to $75 for each home visit or after hours visit.

4. Prescriptions Benefit

This Benefit covers the cost of Pharmaceutical Prescriptions.

Benefit limit

- We will pay up to a total maximum of $600 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any Pharmaceutical Prescriptions that are not prescribed by a GP, Registered Specialist or Nurse Practitioner.
- To Claim under this Benefit, you must submit receipts.

5. Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy.

Benefit limits

- We will pay up to $50 each visit.
- We will pay up to a total maximum of $250 for each Insured Person every Policy Year.

Additional terms

- Physiotherapy within six months after an Admission will be covered under the Physiotherapy Benefit in the Base Cover (see Physiotherapy Benefit on page 25).

6. Registered Nurse and Nurse Practitioner Benefit

This Benefit covers the cost of visits to/by an Registered Nurse or Nurse Practitioner.

Benefit limit

- We will pay up to $22 for each visit.

7. Nutritionist Consultation Benefit

This Benefit covers the cost of Nutritionist Consultations.

Benefit limit

- We will pay up to a total maximum of $300 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any food including vitamin supplements, videos, books or DVDs.

8. Chelation Therapy Benefit

This Benefit covers the cost of Chelation Therapy performed by a GP or Registered Specialist.

Benefit limit

- We will pay up to $40 per treatment.

9. Clinical Psychologist Benefit

This Benefit covers the cost of Clinical Psychologist Consultations.

Benefit limit

- We will pay up to a total maximum of $300 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any educational, industrial or sport psychology.

10. 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.

Benefit limit

- We will pay up to a total maximum of $180 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable on any ambulance society subscriptions.

11. Acupuncture Benefit

This Benefit covers the cost of acupuncture treatment performed by a GP.

Benefit limit

- We will pay up to $40 for each treatment.

12. Chiropractic Benefit

This Benefit covers the cost of Chiropractic treatment, medicine and related X-rays.

Benefit limits

- We will pay up to $50 for each treatment.
- We will pay up to a total maximum of $250 for each Insured Person every Policy Year.

13. Osteopath Benefit

This Benefit covers the cost of Osteopathic treatment, medicine and related X-rays.

Benefit limits

- We will pay up to $50 for each treatment.
- We will pay up to a total maximum of $250 for each Insured Person every Policy Year.

14. Podiatry Benefit

This Benefit covers the cost of Podiatry Treatment.

Benefit limits

- We will pay up to $35 for each treatment.
- We will pay up to a total maximum of $175 for each Insured Person every Policy Year.

Additional terms

- This Benefit does not include Podiatric Surgery (see Podiatric Surgery Benefit on page 27).

15. Dental Consultation Benefit

This Benefit covers the cost of Dental Practitioner Consultations only.

Benefit limit

- We will pay up to a total maximum of $100 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for Consultations for Dependent Children covered under the school dental service or general dental benefit scheme.

16. Eye Care Benefit

This Benefit covers the Consultation cost of Optometrist and the examination cost of Orthoptist.

Benefit limits

- We will pay up to $50 for each Optometrist Consultation.
- We will pay up to a total maximum of $200 for each Orthoptist examination for each Insured Person every Policy Year.

Dental and Optical Option

08 SECTION

Please ensure you have read the Claims section on page 14 for details in relation to the nib First Choice Network which applies to the Benefits under this Policy.

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of cover on page 6 and What is not covered on page 44).

1. What is covered under this option

We will refund 80% of each eligible cost incurred under the Benefits up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The Dental and Optical Option does not cover any Hospital related services.

3. Dental Care Benefit

This Benefit covers the cost of Consultations and Dental Treatment, including Consultation, cleaning, scaling, fillings, associated X-rays, crowns and removal of teeth.

Benefit limit

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

Additional terms

- Benefits are not payable for any treatment for Dependent Children covered under the school dental service or general dental benefit scheme.
- Benefits are not payable for any cost of gold or other exotic materials.

4. Optical Appliance Benefit

This Benefit covers the cost of Optical Appliances when these are required as a result of change of vision.

Benefit limit

- We will pay up to a total maximum of $500 for each Insured Person every Policy Year.

Additional terms

- To Claim under the Optical Appliance Benefit, a written confirmation from the Insured Person's Recognised Health Professional that the Consultation, examination or Optical Appliance is required as a result of change in vision.
- Benefits are not payable for any Optical Appliances acquired for fashion reasons.
- Benefits are not payable on costs of tinting or transition lenses.

Serious Condition Financial Support Option

09 SECTION

This section lists and defines Trauma Conditions we provide Benefit for under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of cover on page 6 and What is not covered on page 44).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

The Serious Condition Financial Support Option pays the Sum Insured shown in the Acceptance Certificate or Renewal Certificate as a lump sum.

Only one Sum Insured is paid for each Insured Person covered by the Serious Condition Financial Support Option.

If the Insured Person suffers one of the Trauma Conditions (summarised in section 2 and defined in section 3 in this option) for the first time on or after the Effective Date and before or on the end date of the Serious Condition Financial Support Option (refer to section 5 of this option), we will pay you the Sum Insured that applies at that time.

The Insured Person's medical Condition must come exactly within the Trauma Condition definition in section 3 in this option.

Waiting period

If any of the highlighted Conditions summarised in section 2 below occur, or symptoms leading to any of those Trauma Conditions occur, within the first 90 days after:

- the Effective Date of the Serious Condition Financial Support Option; or
- the Effective Date of the Serious Condition Financial Support Option being reinstated; or
- you increasing the Sum Insured,

we will not pay the Sum Insured or the amount by which the Sum Insured increased (whichever is applicable), and there is no cover under this option for any subsequent reoccurrence of that same Trauma Condition at any time.

2. Trauma Conditions

The Trauma Conditions are summarised as follows:

Heart and circulation

- Aortic Surgery
- Coronary Artery Bypass Grafting Surgery
- Major Heart Attack (Myocardial Infarction)
- Heart Valve Surgery

Cancer

- Cancer – Life Threatening

Functional Loss/Neurological

- Benign Tumour of the Brain or Spinal Cord
- Paralysis (including):
  - Hemiplegia
  - Diplegia
  - Paraplegia
  - Quadriplegia
  - Tetraplegia
- Stroke

Organs

- Chronic Liver Failure
- Chronic Lung Failure
- Chronic Renal Failure
- Major Organ Transplant
- Pneumonectomy

If the Trauma Condition is a Surgical procedure, then that Surgical procedure must be the usual treatment in respect of the Trauma Condition.

3. Definitions of the Trauma Conditions

Aortic Surgery

The undergoing of Medically Necessary Surgery 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.

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 Functions 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 of the arteries or veins of the brain, haematoma and tumours of the pituitary gland.

Cancer – Life Threatening

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

The following are not included:

- Tumours showing the malignant changes of Carcinoma in Situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant, unless it results directly in the removal of the entire organ*.
- Melanomas which are less than 1.5mm depth of invasion using the Breslow method and less than Clark level 3, as determined by histological examination.
- All non-melanoma skin cancers, unless there is evidence of metastases.
- Prostatic cancers which are histologically described as TNM Classification T1 and Gleason score of 5 or less, unless it results directly in the removal of the entire organ*.
- 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.

Chronic Liver Failure

End stage liver failure with permanent jaundice, ascites or encephalopathy. This does not include liver disease related to alcohol use or drug abuse.

Chronic Lung Failure

End stage respiratory failure requiring extensive, continuous and permanent oxygen therapy and

- with FEV 1 test results of consistently less than one litre; or
- the Insured Person is constantly and permanently unable to perform at least one of the Activities Of Daily Living without the physical assistance of another person.

Chronic Renal Failure

End stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which regular renal dialysis is instituted or renal transplantation performed.

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)

Means the Insured Person has had 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%.

Major Organ Transplant

Means either:

- the undergoing of; or
- upon the advice of a Registered Specialist being on a waiting list of a Transplantation Society of Australia or New Zealand recognised transplant unit for at least four weeks for

the Medically Necessary human to human transplant from a donor to the Insured Person of one or more of the following complete organs: kidney, liver, heart, lung, pancreas, small bowel or the transplantation of bone marrow.

Paralysis

The permanent and total loss of function of two or more limbs as a result of Injury to, or disease of, the spinal cord or brain as defined below. Limb is defined as the complete arm or the complete leg.

- Hemiplegia: the permanent and total loss of function of one side of the body as a result of Injury to, or disease of, the spinal cord or brain.
- Diplegia: the permanent and total loss of function of both sides of the body as a result of Injury to, or disease of, the spinal cord or brain.
- Paraplegia: the permanent and total loss of function of both legs as a result of Injury to, or disease of, the spinal cord or brain.
- Quadriplegia: the permanent and total loss of function of both arms and both legs as a result of Injury, to or disease of, the spinal cord or brain.
- Tetraplegia: the permanent and total loss of function of both arms and both legs and loss of head movement as a result of Injury to, or disease of, the spinal cord or brain.

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.

4. How to make a claim

Diagnosis

When Claiming under the Serious Condition Financial Support Option, the Insured Person covered must first:

- receive a definite diagnosis of the Trauma Condition. The diagnosis must be by a Registered Specialist based on conventional medical testing acceptable to us; and
- co-operate with any requests we make to confirm diagnosis of that Insured Person's Trauma Condition. For example, undergoing a medical examination by a Registered Specialist of our choice at our expense.

You must:

- advise us as soon as possible but no later than 90 days after that Insured Person is diagnosed with a Trauma Condition;
- give us an original or certified copy of that Insured Person's birth certificate, driver's licence or passport;
- complete and return our Claim form; and
- at your own expense supply medical certificates and any other information that we may require.

Seek treatment

You must obtain, as soon as possible after the Insured Person first become aware that he or she might be suffering from a Trauma Condition, advice and medical treatment from an appropriate Registered Specialist (or other Registered Specialist approved by us) and to follow that advice and medical treatment.

Medical examination

If requested 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 Trauma Conditions. This will be at our expense.

5. When the Serious Condition Financial Support Option ends

The Serious Condition Financial Support Option 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 for the Serious Condition Financial Support Option is paid in respect of that Insured Person; or
- when that Insured Person dies.

What is not covered

10 SECTION

Benefits and/or Grants 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.
- Health Services not stated in this Policy document.
- Health Services provided after the Benefit Limit(s) has been reached.
- Incomplete Claims, Policy applications or Claims where false or inaccurate information is supplied.
- Any services provided by a family member or relative (for example, without limitation: Health Services, accommodation and travel costs).
- Expenses recoverable from any third party (for example, without limitation: any other person, company or insurer).
- Services provided outside of New Zealand (except where expressly specified in this Policy document).
- Goods purchased outside of New Zealand (for example, without limitation: goods ordered on the internet which are from another country).
- Acute Medical Conditions.
- Organ/tissue transplants or donation (for example, without limitation: organ transplant and/or stem cell transplant) (except where expressly specified in the Policy document).
- Specialised transfusions (for example, without limitation: transfusion of blood, blood products and derivatives and dialysis of any type).
- HIV and AIDS.
- Revision of breast reconstruction, breast implants, breast reduction or gynaecomastia (except where expressly specified in the Policy document).
- Cosmetic procedures or reconstruction.
- Abdominoplasty, rectus divarication repair, embolisation or Surgery for cerebral vascular abnormality including aneurysm, percutaneous aortic valve replacement and transcatheter aortic valve implantation/replacement.
- Weight loss/bariatric investigations and treatment (for example, without limitation: gastric banding, sleeve or bypass), or weight loss treatment intended to treat other medical Conditions such as, but not limited to, diabetes or cardiovascular Conditions except where expressly specified in this Policy document.
- Sleep problems and disorders (for example, without limitation: snoring, insomnia and sleep apnoea).
- Allergies or allergic disorders (for example, without limitation: allergy testing and desensitisation), (except where provided for under the Specialist Option).

- Vision enhancement (for example, without limitation: myopia, hypermetropia, presbyopia, astigmatism, radial keratotomy and photorefractive keratectomy), (except where provided for under the Dental and Optical Option).
- Any Congenital condition and/or chromosomal disorder (for example, without limitation: birth defect).
- Hereditary Conditions or genetic Conditions, in the absence of signs or symptoms.
- Gene therapy or genetic testing.
- Pregnancy (for example, without limitation: ectopic, healthy or termination of, caesarean section, sterilisation or reversal of) (except where expressly specified for under the Loyalty – Sterilisation Benefit or Loyalty – Obstetrics Benefit).
- Contraception, hormone therapy or intrauterine devices (except where expressly specified for under the Loyalty Benefit – Sterilisation).
- Infertility, assisted reproduction or erectile dysfunction.
- Psychiatric, psychological, behavioural or developmental Condition (for example, without limitation: depression, ADD, ADHD and eating disorders), (except where expressly specified in the Policy document).
- Gender reassignment and/or gender dysphoria.
- Substance misuse (for example, without limitation: misuse of alcohol and/or misuse of drugs).
- Self-inflicted injuries of any type.
- Charges under the Crimes Act (for example, without limitation: 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.
- Wars, riots or act of terrorism.
- Continuous care (for example, without limitation: geriatric care, palliative, respite, rehabilitation, convalescence and disability, support services costs, senile Condition and dementia) (except where expressly specified in this Policy document).
- Any Injury covered by ACC (except where provided for under the ACC top-up Benefit or ACC treatment Injury Benefit).
- Any Pre-existing Conditions, except
  - any medical Condition declared on an application form and accepted by nib (if applicable); or
  - where Dependent Child is added to this Policy within three months of birth; or
  - where it is noted on the Acceptance Certificate or Renewal Certificate that Pre-existing Conditions are covered, but subject to the other exclusions in this Policy and any special terms on the Acceptance Certificate or Renewal Certificate.
- Any medical treatments, investigations, Admissions or associated costs that are not Medically Necessary.
- Any experimental, unproven or unconventional medical treatments, procedures or technologies that have not been pre-approved by nib.

- Any treatment or procedure that nib considers is novel or experimental or more expensive than an available alternative treatment or procedure, which will provide the same, or a similarly acceptable, medical outcome.
- Polycystic kidney, Loeys-Dietz syndrome, spina bifida, pectus carinatum, pectus excavatum, Marfan's syndrome, kyphosis, scoliosis or cystic fibrosis.
- Vaccinations (except where provided for under the GP Lite Option).

Benefits and/or Grants are not payable for any costs that are related to the following:

- Alternative or complementary medicines or therapies (for example, without limitation: massage therapy, homeopathy and natural therapy).
- Costs associated to additional Surgery or treatment performed that is not covered by the Contract of Insurance.
- Mechanical tools, aids and/or appliances of any type as determined by nib (for example, without limitation: insulin pumps, C-PAP equipment, cochlear implants, pacemakers, electrodes, nerve stimulators, crutches and/or artificial limbs).
- Drugs that do not meet the funding criteria on the PHARMAC pharmaceutical schedule under section A to H (except where provided under the Cancer Treatment in Hospital Benefit and Intravitreal Injections Benefit).
- Any periodontics, orthodontics and endodontic procedures, dentures, implants, orthognathic Surgery or tooth exposure (except where provided for under the Dental and Optical Option).
- GP and out-of-Hospital prescription charges (except where provided for under the GP Option or GP Lite Option).
- Any Health Services that are provided by health professionals not recognised by the Medical Council of New Zealand unless otherwise specified.
- Any medical Condition not registered with the Ministry of Health as a disease entity.
- Claims that do not meet our general terms (see General terms of cover on page 6).

Contact us before commencing Health Services (see How to contact nib on page 5). We can check what will be covered and help you understand the best ways to avoid potential Out-of-Pocket Expenses.

nib's obligations

SECTION 11

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.
- Make every possible effort to resolve complaints to the Policyowner's and the relevant Insured Person's satisfaction (whenever possible).
- Provide timely and accurate Pre-approval (whenever possible).
- Keep the Policyowner and the Insured Persons informed regarding the process of their Claim (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

SECTION 12

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.
- Keep their health insurance Premiums up-to-date to ensure they remain covered if applicable.
- Meet the terms outlined in our direct debit authority if applicable.
- Provide all information reasonably required by us in relation to 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 referring practitioner must be shown on the account or receipt presented to us for payment.
- Notify us as soon as reasonably possible of any change that may affect their Policy, and if unsure – ask us.
- Comply with the duty of disclosure (see Duty of disclosure on page 6).
- Maintain valid email addresses at all times. They must advise us immediately of any change to their email addresses, and agree to:
  - Us sending all communications to them in connection with this Policy electronically, including via email to a single nominated email address or the nib portal. This includes Policy documents and notices under this Policy. The single nominated email address will be the email address the Policyowner provides us at time of application, as updated by the Policyowner from time to time.
  - Sending to us all communications in connection with this Policy via email or through the nib portal.

nib's privacy policy

13 SECTION

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

14 SECTION

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** or **claims@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 or Claim, or to talk to a Team Leader or Manager.

Alternatively, you can write to the nib Complaints Committee:
nib nz limited
PO Box 91630
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.

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

Glossary of important terms

15 SECTION

"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 24 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 Recognised Private Hospital. For the purpose of this Cover, 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 Surgery or medical treatment. For the purpose of this Cover, an Insured Person having treatment in the emergency room of a Recognised Private Hospital is not an admitted patient.

"Audiologist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Audiological Society (or its successor).

"Audiology Treatment" means treatment that is provided by an Audiologist.

"Benefit" or **"Benefits"** 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 Contract of Insurance.

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

"Brachytherapy" means radiation therapy in which the source of radiation (seeds) is implanted internally close to or in the site being treated.

"Carcinoma in situ" means a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues."Invasion" means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The diagnosis of carcinoma in situ must be based on histological examination of tissue. A clinical or radiological diagnosis will not be sufficient.

"Chelation Therapy" means the injecting of substances into the blood stream to relieve blood vessel blockages.

"Chemotherapy" means a medication and its administration for the treatment of cancer that is listed on the PHARMAC pharmaceutical schedule under Section A to H and meets the PHARMAC funding criteria.

"Chiropractic" means treatment that is provided by a Chiropractor.

"Chiropractor" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of The Chiropractic Board of New Zealand (or its successor).

"Claim" or **"Claims"** 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.

"Clinical Psychologist" means a Recognised Health Professional who:

- has the Postgraduate Diploma in Clinical Psychology;
- is in Private Practice and holds a current annual practising certificate;
- is a member of New Zealand Psychologists Board (or its successor).

"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, and:

- any sign or symptom of the condition existed on or before the:
  - Commencement Date; or
  - Effective Date; or
  - Join Date,

  whichever is applicable; or
- diagnosed within three months of birth whether it is inherited or due to external or environmental factors such as drugs or alcohol. Umbilical hernias, inguinal hernias, undescended testes, hydroceles, ankyloglossia, phimosis and squint are not considered as congenital conditions.

"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 any virtual consultations.

"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 Prosthesis Schedule;
- 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" or **"Covers"** means the defined group of Benefits which are payable to an Insured Person under their chosen level of health insurance which comply with the Policy document.

"Dental Practitioner" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dental Council of New Zealand (or its successor).

"Dental Treatment" means treatment that is provided by a Dental Practitioner.

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

"Dietitian" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dietitian Board in New Zealand (or its successor).

"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 Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Medical Council of New Zealand (or its successor).

"Grant" or **"Grants"** means the maximum amount we will pay for each Insured Person over the lifetime of the Insured Person.

"Health Service" or **"Health Service**s" means Consultation, assessment, diagnostic investigation or treatment of a sign, symptom or Condition provided by a Recognised Health Professional.

"Hospice" means a Recognised Provider which is:

- a health care facility providing palliative care services for terminally ill patients; and
- a member of Hospice New Zealand (or its successor).

"Hospital" means premises that come within part (a) of the definition of 'hospital care' in the Health and Disability (Safety) Act 2001 (or its successor under any subsequent legislation).

"Hospitalisation" means Admission in New Zealand to a Recognised Private Hospital for the purposes of:

- undergoing a Surgical procedure; or
- receiving medical treatment or Chemotherapy or Radiotherapy treatment.

"Injection" or **"Injections"** means the act of forcing a liquid or pharmaceutical into any part of the body, using a needle, cannula or other introducer.

"Injury" or **"Injuries"** means a "physical injury, but excluding "mental injury "as defined in the Accident Corporation Act 2001 (or its successor under any subsequent legislation).

"Insured Person" or **"Insured Persons"** 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. This date is shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

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

"Medically Necessary" means a service or supply provided by a Recognised Health Professional that nib deems on reasonable grounds is necessary for the diagnosis, care or treatment of the disease or illness involved. Under no circumstances will the following goods, services or supplies be considered medically necessary:

- those goods, services or supplies that do not require the skills or services of a Recognised Health Professional; or
- those goods, services or supplies furnished mainly for the comfort or convenience of the Insured Person; or
- those goods, services or supplies that do not relate to the medical treatment being provided (for example, without limitation: alcohol, toiletries, pay TV, car parking and take away meals).

"Medsafe" means New Zealand Medicines and Medical Devices Safety Authority, a Business unit of the Ministry of Health established by the Medicines Act 1981 and the Medicines Regulations 1984 (or its successor under any subsequent legislation).

"Mohs" or **"Micrographic Surgery"** means a specialised Surgical technique for the removal of skin cancers (carcinomas) which allows precise tissue removal assisted by frozen section and microscopic viewing with minimal damage to healthy tissue.

"Nurse Practitioner" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate as a nurse practitioner; and
- a member of the Nursing Council of New Zealand (or its successor).

"Nutritionist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Nutrition Society of New Zealand (or its successor).

"Obstetrician" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (or its successor).

"Ophthalmologist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Royal Australian and New Zealand College of Ophthalmologist (or its successor).

"Optical Appliances" means spectacles or contact lenses used to correct sight which have been approved by nib and prescribed by an Optometrist, Optician or Ophthalmologist.

"Optometrist" or **"Optician"** means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Optometrists and Dispensing Opticians board of New Zealand (or its successor).

"Orthodontic Treatment" means treatment performed by an Orthodontist.

"Orthodontist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dental Council of New Zealand (or its successor).

"Orthoptist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Orthoptic Society Inc (or its successor).

"Osteopath" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Osteopathic Council of New Zealand (or its successor).

"Osteopathic" means treatment provided by a registered Osteopath.

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

"Out-of-Pocket Expenses" means any costs not covered by nib that are billed by the 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, Dental Practitioner or Nurse Practitioner for the preparation and administration of a medicine (pharmaceutical), dispensed by a registered Pharmacy and listed under sections A to H of the Ministry of Health PHARMAC pharmaceutical schedule (or its successor under any subsequent legislation).

"Pharmacy" means Recognised Provider who is:

- in Private Practice and holds a current annual practicing certificate; and
- a member of the Pharmacy Council of New Zealand (or its successor).

"Physiotherapist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of The Physiotherapy Board of New Zealand (or its successor).

"Physiotherapy" means treatment provided by a Physiotherapist.

"Podiatric Surgeon" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Podiatrists Board of New Zealand (or its successor); and
- vocationally registered and recognised as a podiatric surgeon.

"Podiatrist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Podiatrists Board of New Zealand (or its successor).

"Podiatry Treatment" means treatment that is provided by Podiatrist.

"Policy" 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.

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

"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.

"Pre-approval" or **"Pre-approve"** means our advanced confirmation of the eligibility of an Insured Person's Claim.

"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.

"Prostheses" or **"Prosthesis"** means an artificial implant used for functional reasons to:

- replace a joint or body part that has been removed; or
- support a body structure

due to disease or Injury and is approved and listed by nib.

"Prosthesis Schedule" means the list of Prostheses maximum costs as published on our website at **nib.co.nz** .

"Psychiatrist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate;
- a member of the Royal Australian and New Zealand College of Psychiatrist (or its successor) and has Medical Council of New Zealand vocational registration in psychiatry.

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

"Radiotherapy" means a specified number of fractions (sequentially administered doses) of radiation where:

- the radiation is administered at prescribed intervals within a planned timeframe; and
- the radiation is prescribed by a Registered Specialist and administered in a licensed facility in New Zealand.

"Recognised Health Professional" means:

- a 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);
- 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, Registered Specialist, Recognised Private Hospital or other medical facility that is recognised by nib.

"Redundancy" means a situation where employment has been terminated by the employer due to the position held is no longer necessary for the employer. This will exclude the following situations:

- fixed term agreement ends; or
- voluntary redundancy; or
- seasonal work changes; or
- performance management dismissal; or
- result of extended leave which lasts longer than three months (with or without pay); or
- when the employer is a relative to the Policyowner or an Insured Person.

"Registered Nurse" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate as a registered nurse; and
- a member of the Nursing Council of New Zealand (or its successor).

"Registered Specialist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate;
- a member of an appropriately recognised specialist college and has Medical Council of New Zealand vocational registration in that speciality (or its successor); and
- recognised 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 and reproductive health, general practice, medical administration, or public health medicine.

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

"Skin Lesion" means an abnormal change to any one or all of the three skin layers caused by disease or Injury.

"Speech and Language Therapy" means treatment that is provided by a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Speech Language Therapists Association (or its successor).

"Sum Insured" means the total dollar value covered under the Serious Condition Financial Support Option as shown on the Acceptance Certificate or Renewal Certificate (whichever is the later) for an Insured Person.

"Surgery" or **"Surgical"** or **"Surgically"** 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. For the purpose of this Cover, 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.

"Trauma Condition" means the medical Conditions as defined under the Serious Condition Financial Support Option (see Definitions of the Trauma Conditions covered on page 40).

"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 a period of time after the Commencement Date, Effective Date or the Join Date, during which no Claim will be paid for that specific Benefit.

"Whole Person Function" means a loss of use, or derangement of any body part, organ system, or organ function, that is well established and unlikely to change substantially in the next 12 months, with or without further medical treatment.

"You" or **"Your"** means an Insured Person.

nib
it's worth it

Need help?

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