Hospital and Specialist Cover

Policy Document

Warehouse Money

Contents

Introduction

Thank you for trusting a Warehouse Money product 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 contact us before undergoing any Health Service (see Claims on page 9-11).

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

Who offers this Cover

Hospital and Specialist Cover is administered and underwritten by nib nz limited. Only nib can approve and accept your Policy, and will be responsible for the administration of your Policy.

nib is solely responsible for all Claims under this Cover, and in no circumstances will TW Financial Services Operations Limited (including its related companies) be liable if nib refuses to pay a claim.

In this policy, "we", "us" and "our" means nib nz limited.

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 documents that replace 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 (including capitalised terms) have a specific meaning which applies to Hospital and Specialist Cover only (see Glossary of important terms on page 25-27).

Headings

The headings in this document are for your guidance only – these don't form part of your Cover.

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 us

WM Health Connect provides 24 hour access to your Policy and Claims details at **wmhealth.co.nz/portal**

Email us for general enquiries at **contactus@wmhealth.co.nz**

Email us for claims at **claims@wmhealth.co.nz**

Go to **warehousemoney.co.nz**

Call us on **0800 801 810**

Our opening hours are **Monday to Friday 8.00am to 5.30pm.** We are closed on public holidays.

General terms of Hospital and Specialist Cover

Applying for a Warehouse Money health insurance Cover

All applications for a Warehouse Money health insurance Cover must meet the criteria stated under 'Who is covered' on page 5.

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

Subject to the terms of this Policy document and the Health Funds Association of New Zealand Inc. Health Insurance Industry Code we may, at our discretion, refuse an application to purchase a Warehouse Money health insurance Cover as an Insured Person, as described below.

- We have the right to refuse an application to join a Cover until the Premiums for the minimum period relevant to the application(s) have been paid.
- 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(s) to move to another Warehouse Money or 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 WM Health Connect. 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 WM Health Connect.

Any reference to notice in writing in this Policy means written notice sent electronically.

If you do not agree to receive Policy communications electronically, we can send paper copies of communications to you. There may be an administration fee for this service. Please contact us for more details.

Duty of disclosure

The Policyowner and all Insured Persons have 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.

Code of practice

This Policy complies with the Health Funds Association of New Zealand Inc. Health Insurance Industry Code. The Policyowner or any Insured Person can obtain a copy of nib's financial statements for the last reported financial year by submitting a request via WM Health Connect or by sending an email to **contactus@wmhealth.co.nz**

Period of cover

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

14-day free-look period

A 14-day free-look period applies to all Warehouse Money health insurance 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 email confirmation to us at **contactus@wmhealth.co.nz** 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 submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810.**

Recognised providers

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

We will pay for Benefits under Hospital and Specialist Cover, if the Insured Person attends a 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 us.

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 Surgery requiring Prosthesis, we will pay up to the maximum amount as defined in the Prosthesis Schedule available at **warehousemoney.co.nz**

Efficient Market Prices (EMP) schedule

For treatment or procedures covered under Hospital and Specialist Cover, we will pay up to the maximum amount as stated in the EMP schedule, as published on our website. If for any reason the EMP schedule is not available, the EMP provision does not apply but the rest of the contract remains in force. See Efficient Market Price on page 11.

Key information found on WM Health Connect and on the Warehouse Money website

WM Health Connect

WM Health Connect provides 24 hour access to:

- submit and track your Pre-approvals and Claims;
- view your Claims history;
- view your Policy details; and
- send a quick request to update your details or make enquiries about your Policy.

WM Health Connect can be found by visiting **wmhealth.co.nz/portal**

The website provides key information, including the Prosthesis Schedule and Claim forms. All the relevant information can be found by visiting **warehousemoney.co.nz**

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 all relevant documents (including proof of identity, visas or work permits in the Insured Person's passports, birth certificates or driver's licences) for each Insured Person.

We reserve the right to cancel the Policy or the relevant Insured Person's Cover if the relevant person no longer meets the criteria (see Cancelling the policy or cover on page 8).

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. A Dependent Child under age 18 must be accompanied on the Policy by at least one adult aged 18 or older as the Policyowner, or have his or her parent or legal guardian as the Policyowner.

Who can view and change the policy

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

Unless specified otherwise, changes can be made at a Policy Anniversary Date, or on the nearest equivalent date in the month that corresponds with the Policy Anniversary Date, depending on the change request being made.

Before any changes can be made, the Policyowner must give us at least 30 days' prior notice by email before the relevant date as specified above.

An Insured Person can request to have themselves removed from the Policy (see Removing an Insured Person on page 6) or to have their smoking status changed (see Changing the Insured Person's smoking status on page 6). Before any changes can be made, the Insured Person must give us at least 30 days' prior notice by email before the relevant date as specified above. Email communications can be sent to us at **contactus@wmhealth.co.nz**

If the change results in a change of Premium, this will be adjusted from the next billing date.

Adding a partner, dependent child, parent or grandchild

The Policyowner can add a Partner, Dependent Child, parent or grandchild onto their Policy at any time, providing the Insured Person meets the eligibility criteria (see Who is covered on page 5) and the Insured Person (or their parent or legal guardian if under 16 years old) consents to be added.

The Policyowner and any new Insured Person to be added must follow the relevant application process. Please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810** for more details.

Cover for a new Insured Person added will start from the Effective Date or Join Date (as applicable) shown on your Acceptance Certificate or Renewal Certificate (whichever is the later), subject to any applicable Waiting Periods.

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

Removing an insured person

An Insured Person can be removed from this Policy:

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

Changing the insured person's smoking status

If the smoking status is not known for any Insured Person, smoker Premiums will apply.

If any Insured Person (aged 21 years or over) changes their smoking status (including any tobacco or any other substance), please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810.**

An Insured Person's smoking status can be changed at any time during the Policy Year, and your Premiums will be adjusted accordingly. We will require at least 30 days' prior notice before the change will be applied.

Changes in contact details

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

To update your details at any time, please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810.**

We will process the change

Once we have accepted the changes, we will send the Policyowner a new Acceptance Certificate or Renewal Certificate (whichever is the later) 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 Waiting Periods have been served and provided that all Premiums have been paid up-to-date.

Waiting periods

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.

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

The following Waiting Periods apply to each Insured Person:	
Removal of unerupted or impacted teeth	12 months
Pre-existing Conditions This excludes Pre-existing Conditions that are never covered (see Loyalty Benefit – Pre-existing Conditions on page 19).	3 years

Waiting periods when changing hospital covers

For any change in Cover, the Policyowner must follow the relevant application process. Please call us on **0800 801 810** for more details. The application process must be completed fully and accepted by nib before the new Cover can start.

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

New Benefits and/or Health Services and/or increase in Benefit Limits	No change in Benefits and/or Health Services and/or decrease in Benefit Limits
Waiting Periods will apply from the Effective Date.	Waiting Periods apply from the Commencement Date, Effective Date or Join Date (as first 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, Waiting Periods apply 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 is not payable by nib, and cannot be met by withdrawing from any other Benefits on your Policy.
- 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.

For example: The Excess amount is $500.

1. The Insured Person submits an eligible Claim for $200. No payment is made by nib to the Insured Person. Instead, the Excess balance is reduced by $200, with $300 remaining before the Excess amount is reached.
2. The Insured Person then submits another eligible Claim for $400. This time, $300 is not paid by nib, but this eliminates the remaining Excess balance; and $100 is paid to the Insured Person.
3. Any further eligible Claims submitted after the Excess amount has been reached will be paid in line with Benefit Limits until the next Anniversary Date, when the Excess amount is deducted again from eligible Claims.

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.

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

For a decrease in Excess, Waiting Periods must be re-served from the Effective Date of the decrease, but only in respect of Claims relating to Pre-existing Conditions that were present prior to the Effective Date.

Maintaining continuous cover

It is important to maintain continuous Cover with nib to ensure you are able to continue to Claim Benefits and to avoid having to re-assess all the Insured Persons' health and to serve the Waiting Periods again if they decide to re-join later. See your Acceptance Certificate or Renewal Certificate (whichever applies).

- If the Policy falls into arrears of Premium, all Insured Persons on the Policy will be unable to Claim.
- After 90 days of non-payment of Premium the Policy will be terminated (see Termination of the policy or cover on page 8).
- Once the Policy has been terminated all Insured Persons listed on the Policy will have to re-serve Waiting Periods if they decide to re-join later.
- It will be at nib's discretion to determine whether the Insured Persons listed on the Policy will be covered for any Claims requested under the Policy during a period of non-payment.

Resuming your policy or cover from suspension

- If the Policy or Cover for an Insured Person has been suspended under the Loyalty Benefit – Suspension of Cover 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 the 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 cancellation of Cover for an Insured Person must be authorised by the Policyowner. The Policyowner must give us at least 30 days' notice of the cancellation by email.

An Insured Person can request to have themselves removed from the Policy (see Removing an Insured Person on page 6). The Insured Person must give us at least 30 days' notice before any changes can be made.

Termination of the policy or cover

We reserve the right to terminate a Hospital and Specialist Cover Policy and/or Cover for an Insured Person:

- if the Premiums are in arrears by more than 90 days after the due date for payment; or
- 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
- if the last Insured Person covered by this Policy dies; or
- if any Insured Person breaches the terms of the Policy; or
- if any information provided by, or on behalf of the Policyowner or any Insured Person when arranging this Policy, or when making any changes to it, is false, incorrect or incomplete; or
- an Insured Person covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, whether for the Insured Person 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 our employees.

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

Your premiums

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

- Where the Premium rate change takes effect during the Policy Year, the change will be applied at your next Policy Anniversary Date.
- Premiums can be paid in advance for up to a maximum of 12 months.

Available payment methods and frequency

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

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

nib direct debit service agreement

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

It is the Policyowner's responsibility to:

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

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

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

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

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

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

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

If the Policyowner has a direct debit inquiry, or believes a debit has been made incorrectly, please contact us immediately by submitting a request through WM Health Connect, emailing us on **contactus@wmhealth.co.nz** or calling us on **0800 801 810.**

Important information about your premiums and benefits

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

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 and/or Benefits and/or the terms of cover (including 'What is not covered' and 'Glossary of important terms') during the life of the Policy, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

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

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

We want to ensure your valuable cover continues if a deduction advice is returned to us 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

- Benefits will only be paid for Claims which meet nib's criteria.
- For any Pre-existing Conditions, see Loyalty Benefit – Pre-existing Conditions on page 19.
- All Claims are subject to your Contract of Insurance and What is not covered on page 21-22.
- 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 submitted with the Claim form (see Supporting documentation for pre-approval and claims on page 9-10).
- No Claim payment will be greater than 100% of the EMP (see Efficient Market Price on page 11).
- If we require further information in order to assess the Pre-approval request or Claim, all necessary requests must be complied with.
- We recommend all Claims be submitted within 12 months of the Health Service date, as no inflation adjustments apply to any Claim payments.
- The Claim must relate to an Insured Person. Reimbursement must be made to a Recognised Provider, Policyowner or Insured Person, regardless of whether any other person has paid the account or bill.
- In cases where the Insured Person is deceased, Benefits can only be made to the Recognised Provider, remaining Policyowner or the deceased Insured Person's estate.
- The Policyowner and each Insured Person must comply with this Policy in full before any Claim is paid.

Always call us before going to hospital

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

Pre-approval

The Insured Person must seek Pre-approval prior to undertaking any Health Services, to understand what is covered under your Policy.

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

We aim to process the Pre-approval within two working days from the date the request is received by us, unless further information is required or insufficient information was initially supplied.

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 notification. 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 in which case the Pre-approval notification will not be valid.

If we do not accept the Pre-approval request, we will let the Policyowner or the Insured Person know.

Please visit **warehousemoney.co.nz** for our Prosthesis Schedule which details the maximum costs that we will pay for any individual Prosthesis (see Prosthesis Schedule on page 5).

How to make a claim or pre-approval

- Submit your Claim through WM Health Connect: **wmhealth.co.nz/portal**
- Visit **warehousemoney.co.nz** for a Claim and Pre-approval form.
- Email us at **claims@wmhealth.co.nz**
- Call us on **0800 801 810.**

The Policy number must be quoted for all Claims.

Supporting documentation for pre-approval and claims

Supporting documentation for Pre-approval or Claims must:

- be made in a format approved by nib;
- be submitted with a fully completed Claim and Pre-approval form;
- include a copy of the GP referral letter (if appropriate);
- include a copy of the Registered Specialist Consultation letter (if appropriate);
- Claims must be supported by Recognised Provider invoices and/or itemised receipts on the Recognised Provider's letterhead showing their official stamp and GST number; and
- Pre-approvals must be supported by an estimate of the cost on the Recognised Provider's letterhead showing their official stamp and GST number.
- Please retain the originals as we retain the right to request to view the originals at any time.

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

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

If the Policyowner or an Insured Person needs assistance to complete the Claim form, or we request a medical report with the Claim form, these will be at the Policyowner's expense.

If we request additional information in order to assess the Claim, this will be at our expense.

Rapid refund and method

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

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.

Efficient Market Price (EMP)

Subject to the Benefit Limits in this Policy, the most we will pay under any Benefit covered by this policy is the EMP for the Health Service provided. Any charges, costs or fees that exceed the EMP will be Out-of-Pocket Expenses that must be paid by the Policyowner or the Insured Person. Accordingly, the Policyowner and all Insured Persons should ensure they understand all the potential costs before undertaking any Health Services. If for any reason the Efficient Market Price schedule is not available, the EMP provision does not apply but the rest of the contract remains in force.

We determine EMP based on our ongoing review of:

- Recognised Providers' charges for a particular service; and
- nib's own claims statistics; and
- nib's experience of the New Zealand health market; and
- international benchmarks of the relative value of the service, determined by the American Medical Association (or any successor).

The Efficient Market Price schedule will be reviewed annually and the Policyowner and all Insured Persons must refer to it to understand what they are covered for and the limits that apply.

We may at our sole discretion:

- contact the Recognised Provider and obtain an estimate of the costs associated with the medical treatment or procedure;
- negotiate the proposed costs; and
- request that the Insured Person obtains a second opinion if the proposed costs are greater than 100% of the EMP.

When a functional treatment is combined with appearance based treatments, or non-approved treatments and the functional treatment was an incidental find, the functional treatment will be defined as a secondary procedure and we will not cover primary costs such as, but not limited to set-up costs, accommodation costs, recovery costs.

If your procedure or treatment is not listed under the Efficient Market Price schedule, please submit a request via WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810** for further details.

Medications provided in hospitals

The Policy will meet the cost of the medications prescribed by the treating Registered Specialist listed under Section A to H of the PHARMAC pharmaceutical schedule (except where provided for under the Non-PHARMAC Cancer Treatment Benefit).

Additional terms

- Benefits are not payable for any medications issued for the sole purpose of use at home (except where provided for under the Cancer treatment at home benefit on page 13 or under the Non-PHARMAC Cancer Treatment Benefit on page 14).
- Benefits are not payable for any medications charged in a Public Hospital.

ACC review

We are happy to assist, where appropriate, with the review of a declined ACC claim. This must be in relation to a Claim that is eligible under this Cover. The Insured Person must provide us with a copy of the ACC declinature letter and the case summary, and co-operate fully with our review process.

What is covered

This section lists and defines the Benefits we provide under this Cover, and should be read in conjunction with all other parts of your Contract of Insurance. All Claims are subject to our general terms (see General terms of Hospital and Specialist Cover on page 4-12 and What is not covered on page 21-22).

Benefit limits

Overall benefit limits

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

We will pay up to a total maximum of $200,000 f or each Insured Person every Policy Year, less any Excess for all the non-Surgical (Hospital medical) and cancer related Benefits under this Cover.

Individual limits may apply to each of the Benefits.

If an Excess has been chosen, it is applied to each Insured Person every Policy Year (see Excess on page 7) for all applicable Benefits.

1 Hospital Surgical Benefit

1.1 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 5);
- 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 12).

Benefit limit

- We will pay up to a total maximum of $300,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable if the Surgery is not performed by a Registered Specialist.
- Benefits are not payable as a substitute to ACC.

1.2 Oral surgery in hospital

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

We will only cover the cost of removal of unerupted or impacted teeth if a registered oral surgeon, Dental Practitioner or maxillofacial surgeon performs the Surgery.

A 12-month Waiting Period from the Join Date for each Insured Person applies to the extraction of unerupted or impacted teeth.

Benefit limit

- We will cover the cost of extraction of four impacted or unerupted teeth for each Insured Person for the lifetime of the Policy.

Additional terms

- Benefits are not payable for any Dental Treatment other than impacted or unerupted teeth. For example: periodontic, endodontic or orthodontic treatments and/or implants, or orthognathic surgery.

1.3 Melanoma surgery in hospital

This Benefit covers the cost of melanoma Surgery, performed by a Registered Specialist in a Recognised Private Hospital.

Additional terms

- Benefits are not payable for any cryotherapy, pulse light therapy or photodynamic therapy.
- For any other Skin Lesion Surgery see Registered Specialist Skin Lesion Surgery Benefit on page 17.

2 Hospital Medical Benefit

This Benefit covers the following for eligible medical Claims upon Admission:

- 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 12).

This Benefit covers Hospital medical treatment as an alternative, less invasive procedure to Surgery.

Benefit limit

- We will pay up to a total maximum of $200,000 for each Insured Person every Policy Year.

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: pain management Injections or intravitreal Injection (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.

3 Cancer Treatment Benefit

3.1 Cancer treatment in hospital benefit

This Benefit covers the following for eligible cancer Claims upon Admission:

- 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); and
- Hospital Pharmaceutical Prescriptions (see Medications provided in hospitals on page 12).

Benefit limit

- The maximum we will pay is included in the Hospital Medical Benefit Limit.

Additional terms

- For cancer Surgery see Hospital Surgical Benefit on page 12.
- Benefits are not payable for any medication charged in a Public Hospital.

3.2 Cancer treatment at home benefit

This Benefit covers the cost of PHARMAC funded Chemotherapy drugs for the treatment of cancer for the sole purpose of use outside a Hospital.

Benefit limit

- We will pay a maximum of $10,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Medical Benefit Limit.

Additional terms

- Benefits are not payable for any medication charged in a Public Hospital.

4 Non-PHARMAC Cancer Treatment Benefit

This Benefit covers the cost of Chemotherapy drugs that are Medsafe approved for the treatment of cancer.

Benefit limit

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

- The maximum we will pay is included in the Hospital Medical Benefit Limit.

Additional terms

- Benefits are not payable for any medication charged in a Public Hospital.

5 Follow-up Investigations for Cancer Benefit

This Benefit covers the cost of follow-up care at the completion of cancer treatment or Surgery covered under this Policy, we cover one Registered Specialist Consultation and relevant investigation(s) relating to that cancer each Policy Year for up to five years. This Benefit commences after the active phase of cancer treatment has been completed.

Benefit limit

- We will pay a maximum of $3,000 for each Insured Person every Policy Year.
- We will pay this Benefit for up to five consecutive Policy Years for each Insured Person.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- This Benefit is only effective from the end of your treatment phase (Chemotherapy, Brachytherapy, Radiotherapy or Surgery).
- For Consultations or investigations of signs or symptoms see Registered Specialist Consultations Benefit, or CT, MRI and PET Scans Benefit, or Diagnostic Investigations Benefit (whichever applies) on page 14.

6 Registered Specialist Consultations Benefit

This Benefit covers Registered Specialist Consultations for eligible Claims, whether the Consultation results in Admission or not.

Benefit limit

- For cancer treatment related Registered Specialist Consultations, there is no limit on the number of Registered Specialist Consultations during the cancer treatment phase (Chemotherapy, Brachytherapy, Radiotherapy or Surgery).
- For other Registered Specialist Consultations (including pre- and post-cancer treatment phase), we will pay for up to 12 Registered Specialist Consultations for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or the Hospital Medical Benefit Limit (whichever applies).

Additional terms

- For Registered Specialist Consultations following a cancer Surgery or treatment where there are no signs or symptoms, see Follow-up Investigations for Cancer Benefit on page 14.

7 CT, MRI and PET Scans Benefit

This Benefit covers the cost of CT, MRI and PET scans after referral by a GP or Registered Specialist.

Benefit limit

- We will pay a maximum of $5,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- For any other Diagnostic Investigations see Diagnostic Investigations Benefit on page 14.

8 Diagnostic Investigations Benefit

This Benefit covers Diagnostic Investigations when the Diagnostic Investigation has been requested by a GP or Registered Specialist, whether the Diagnostic Investigation results in Admission or not.

Benefit limit

- For cancer treatment related Diagnostic Investigations, there is no limit on the number of Diagnostic Investigations during the cancer treatment phase (Chemotherapy, Brachytherapy, Radiotherapy or Surgery).
- For other Diagnostic Investigations (including pre and post cancer treatment phase), we will pay a maximum of $15,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or the Hospital Medical Benefit Limit (whichever applies).

Additional terms

- For all Claims relating to CT scans, MRI scans and PET scans, see CT, MRI and PET Scans Benefit on page 14.
- For Diagnostic Investigations following a cancer Surgery or treatment where there are no signs or symptoms, see Follow-up Investigations for Cancer Benefit on page 14.

9 Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy up to six months after an Admission.

Benefit limit

- We will pay a maximum of $750 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

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

10 Therapeutic Care Benefit

This Benefit covers the cost of the following, up to six months after an Admission, after referral by the treating Registered Specialist:

- Osteopathic treatment;
- Chiropractic treatment;
- Speech Therapy;
- Occupational Therapy; and
- Dietitian Consultations.

Benefit limit

- We will pay up to a maximum of $250 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

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

11 Home Nursing Benefit

This Benefit covers the cost of home nursing care up to six months after an Admission, when the Insured Person requires assistance with any of the Activities of Daily Living.

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

Benefit limit

- We will pay up to a maximum of $150 a day, up to a maximum of $6,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable whilst the Insured Person requires assistance for any of the Activities of Daily Living.
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- Benefits are not payable for any cost in relation to providing domestic duties, housekeeping or childcare.

12 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 provided treatment for the Insured Person for at least 24 hours as an Admitted Patient.

Benefit limit

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

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).
- Benefits are not payable on any ambulance society subscriptions.
- Benefits are not payable for any other ambulance transfers apart from carriage between medical providers as approved by us.

13 Travel and Accommodation Benefit

This Benefit covers the travel and accommodation costs incurred when an Insured Person's treatment covered under the Hospital Surgical Benefit or Hospital Medical Benefit is not available within 100km of the Insured Person's usual residence.

Where a Registered Specialist has recommended a support person for Admission, 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; or
- **taxi:** taxi fares on Admission and discharge from the Recognised Private Hospital 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

- **Surgery and medical treatment:** we will pay up to a maximum of $2,000 for travel for each Insured Person every Policy Year. We will pay up to $200 each night for support person accommodation, up to a maximum of $3,000 for each Insured Person every Policy Year.
- **Cancer treatment:** we will pay up to $200 a night for support person accommodation, up to a maximum of $5,000 for both travel and accommodation for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- The treatment must be recommended by a Registered Specialist.
- The treatment must take place in the nearest Recognised Private Hospital to the Insured Person's usual residence.
- Benefits are not payable when no associated Claim has been paid under the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- Benefits are not payable for any costs incurred when travelling outside New Zealand.
- Benefits are not payable for any costs that do not relate to an Admission.
- Benefits are not payable for any costs relating to vehicle hire or insurance.
- 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, when they are being treated in a Recognised Private Hospital.

Benefit limit

- We will pay up to $200 a night, up to a maximum of $3,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are not payable when no associated Claim has been paid under the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

15 Obstetrics Benefit

This Benefit covers the cost of treatment by an Obstetrician, after a referral by a GP or Registered Specialist for assessment and monitoring of recognised risk factor(s).

Benefit limit

- We will pay a maximum of $2,000 for each pregnancy.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or the Hospital Medical Benefit Limit (whichever applies).

Additional terms

- IVF is not regarded as a risk factor by nib.
- Benefits are payable at the end of an Insured Person's pregnancy upon receipt of evidence of the costs incurred.
- Benefits are not payable for any caesarean sections or treatment of ectopic pregnancies.
- Benefits are not payable if an Insured Person is admitted to a Public Hospital.
- Benefits are not payable in relation to a pregnancy that is conceived prior to the Commencement Date, Join Date or Effective Date (as applicable).
- Benefits are not payable for any Conditions arising post-birth.

16 Pre-existing Cover for Newborns Benefit

This Benefit covers the cost of treatment for Pre-existing Conditions for a Dependent Child if the Dependent Child is added to this Policy within four months of birth.

Benefit limit

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

Additional terms

- All other Policy terms apply (for example: Congenital conditions) (see What is not covered on page 21-22).

17 GP Surgery Benefit

This Benefit covers the cost of Surgery performed by a GP and includes one pre- and one post-treatment Consultation and related biopsies.

Benefit limit

- We will pay a maximum of $750 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit.

18 Registered Specialist Skin Lesion Surgery Benefit

This Benefit covers the cost of Skin Lesion Surgery performed by a Registered Specialist, including (but not limited to) Mohs Surgery (other than melanoma) and related biopsies.

Benefit limit

- We will pay a maximum of $6,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit.

Additional terms

- Benefits are not payable for any laser therapy, cryotherapy, pulse light therapy or photodynamic therapy.
- For melanoma Surgery see Hospital Surgical Benefit on page 12.
- For Registered Specialist Consultations relating to Skin Lesion Surgery see Registered Specialist Consultations Benefit on page 14.

19 Varicose Veins Benefit

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

- a Registered Specialist; or
- a 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,

on recommendation from a GP or Registered Specialist.

Benefit limit

- The maximum we will pay is included in the Hospital Surgical Benefit Limit.

Additional terms

- Benefits are not payable if a GP or Registered Specialist does not recommend the Surgical procedure.
- Benefits are not payable for any cosmetic treatments.
- Benefits are not payable for any treatments of telangiectasia/spider veins.
- Pre-approval must be obtained for this Benefit, and imaging studies will be required to complete the Pre-approval process.

20 Intravitreal Eye Injections Benefit

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

Benefit limit

- We will pay up to a maximum of $3,000 for each Insured Person every Policy Year.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are not payable for any medications not listed under Section A to H of the PHARMAC pharmaceutical schedule.

21 ACC Top-up Benefit

This Benefit covers the difference between costs payable by ACC for a physical Injury and the EMP costs relating to an Admission.

Benefit limit

- The maximum we will pay is included in the applicable Benefit Limits 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 for your treatment must be provided to nib.

- Benefits are not payable for any Injury that occurred on or prior to the Commencement Date, Effective Date or the Join Date (as applicable).
- Benefits are not payable for any cosmetic aspect of the ACC approved Surgery or medical treatment.
- Benefits are not payable for any Out-of-Pocket Expenses, regardless of the Benefit limit in this Hospital and Specialist Cover Policy document.

22 ACC Treatment Injury Benefit

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

If ACC declines the Claim for treatment Injury where an Injury has occurred, an ACC review will be requested (see ACC review on page 12).

Benefit limit

- The maximum we will pay is included in the applicable Benefit Limits 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.
- Benefits are not payable when an ACC treatment Injury Claim has not been submitted to ACC.

23 Funeral Support Benefit

This Benefit is provided if an Insured Person dies between the age of 16 and 64.

Benefit limit

- We will pay $3,000 to the Policyowner or the deceased Insured Person's estate in respect of the Insured Person.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- No Excess will be deducted from this Benefit.
- Benefits are not payable for any Pre-existing Conditions (see What is not covered on page 21-22).
- When Claiming for this Benefit, a certified copy of the Insured Person's original death certificate must be provided.

24 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.

Benefit limit

- Benefits are not payable for any Pre-existing Conditions (see What is not covered on page 21-22).
- We will pay the Premiums:
  - for two years; or
  - until any of the remaining Insured Persons turn 65 years old,
  - whichever occurs first.
- The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- No Excess will be deducted from this Benefit.
- When Claiming for this Benefit, a certified copy of the Insured Person's original death certificate must be provided.
- 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 Cover(s) added to the Policy during the Premium waiver timeframe.

25 Loyalty Benefit – Suspension of Cover

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

- **Unemployment/redundancy**
  If the Policyowner is registered as unemployed (including Redundancy), this Cover can be suspended for up to a maximum of six months.
- **Overseas travel/residence**
  If an 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 is on parental leave, this Cover 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 reoccurring 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.

26 Loyalty Benefit – Sterilisation

After two years of continuous cover from the Commencement Date, Join Date or Effective Date (as applicable) under this 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 limit

- The Lifetime Limit for this Benefit is $1,000 for each Insured Person.

Additional terms

- No Excess will be deducted from this Benefit.
- Benefits are not payable for any sterilisation reversal procedures.

27 Loyalty Benefit – Pre-existing Conditions

After three years of continuous cover from the Commencement Date, Effective Date or Join Date (as applicable), this Benefit covers costs relating to treatment or Surgery for some Pre-existing Conditions for all Benefits listed under Hospital and Specialist Cover.

This Benefit does not cover any Pre-existing Conditions for the first three years and some Pre-existing Conditions are never covered. It is important that you are aware of these limitations.

Pre-existing conditions are not covered for the first three years

We will not pay a Claim for any Health Services occurring within the first three years after the Commencement Date, Effective Date or Join Date (as applicable) that is connected in any way with a Pre-existing Condition.

Additional terms

Pre-existing conditions that are never covered
We will never pay a Claim for any Health Services relating to any of the following Pre-existing Conditions:

27.1 Cardiovascular condition

This includes, but is not limited to, any sign, symptom or Condition that relates to Congenital or acquired diseases/disorders of the Cardiovascular System.

This also includes, where any of the following medical circumstances applied to the Insured Person at the Commencement Date, Effective Date, or the Join date (as applicable):

- Diabetes Mellitus
  - Type 1 Diabetes Mellitus of over 10 years' duration; or
  - Type 2 Diabetes Mellitus of any duration, in combination with either of the following risk factors:
    - high blood pressure greater than 160/100 (the average recording taken over the three year period preceding application); or
    - total blood cholesterol of 7 mmol/L or above (the average of tests taken over the three year period preceding application).
- BMI (Body Mass Index) score of 30 or over at any time during the three year period preceding application; or
- Abnormal blood lipids where the average of tests taken over the three year period preceding application is:
  - total blood cholesterol of 7mmol/L or above; or
  - HDL ratio of 5.5 or above.

27.2 Cancer

This includes, but is not limited to, melanoma, leukaemia, lymphoma or invasive cancer of the cervix.

This does not apply to pre-malignant pre-existing cancers – for example, but not limited to, HIGIL, CIN-2 or CIN-3 of the cervix, polyps of the bowel, melanoma in situ, basal cell carcinoma, squamous cell carcinoma – if there has been appropriate treatment from a Registered Specialist who is suitably qualified to carry out that treatment. If treatment has not been undertaken, investigations of and treatment for pre-malignant pre-existing cancers are not covered.

27.3 Hip or knee condition

This includes, but is not limited to, any degenerative condition or disease of, or Injury to, either hip or either knee.

Any revision Surgery, including but not limited to previous joint replacement Surgery, is also not covered.

27.4 Back condition

This includes, but is not limited to, any sign, symptom or Condition of, or Injury to, the spinal cord or spinal vertebrae, soft tissues and the joints of the spine.

Any revision Surgery, including but not limited to previous back (spinal) Surgery, is also not covered.

27.5 Transplant surgery

This includes any transplant Surgery, and/or any follow-up Health Services for, or complications of, transplant Surgery.

27.6 Reconstructive or reparative surgery

This includes, but is not limited to, any scar revision or complications relating to Surgeries performed before the Commencement Date, Effective Date or Join Date (as applicable).

Benefit limit

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

What is not covered

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

- Providers who do not meet our criteria.
- Health Services not stated in this Policy document.
- Health Services provided during a Waiting Period.
- Health Services provided after the Benefit Limit(s) or Lifetime 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: Health Services, accommodation and travel costs).
- Expenses recoverable from any third party (for example: any other person, company or insurer).
- Services provided outside of New Zealand.
- Goods purchased outside of New Zealand (for example: goods ordered on the internet which are from another country).
- Acute Medical Conditions.
- Organ/tissue transplants or donation (for example: organ transplant and/or stem cell transplant).
- Specialised transfusions (for example: transfusion of blood, blood products and derivatives and dialysis of any type).
- HIV and AIDS.
- Any Injury covered by ACC (except where provided for under the ACC Top-up Benefit or ACC Treatment Injury Benefit).
- Vision enhancement (for example: myopia, hypermetropia, presbyopia, astigmatism, radial keratotomy and photorefractive keratectomy).
- Revision of breast reconstruction, breast implants, breast reduction, or gynaecomastia.
- Cosmetic procedures or reconstruction, and complications of these procedures.
- Blepharoplasty, hyperhidrosis, abdominoplasty or rectus divarication repair.
- Weight loss/Bariatric investigations and treatment (for example: gastric banding, sleeve and bypass), or weight loss investigations or treatment used in order to treat other health conditions (for example: diabetes or cardiovascular conditions).
- Sleep problems and disorders (for example: snoring, insomnia and sleep apnoea).
- Allergies or allergic disorders (for example: allergy testing and desensitisation).
- Any form of risk management (except where provided for under the Follow-up Investigations for Cancer Benefit).
- Pregnancy (for example: ectopic, healthy or termination of), caesarean section, sterilisation or reversal of (except where provided for under the Obstetrics Benefit or under the Loyalty Benefit – Sterilisation).
- Contraception, hormone therapy or intrauterine devices.
- Infertility, assisted reproduction or erectile dysfunction.
- Any Pre-existing Conditions, except:
  - any medical Condition declared on the application form and accepted by nib; or
  - where provided for under the Pre-existing Cover for Newborns Benefit and the Loyalty Benefit – Pre-existing Conditions Benefit.
- Any Congenital, hereditary, or genetic condition or chromosomal disorder (for example: birth defect), Marfan's syndrome, kyphosis, scoliosis, cystic fibrosis or pectus excavatum.
- Gene therapy and genetic testing.
- Health Services resulting from concerns of familial risk or familial predisposition only, in the absence of signs or symptoms that a Condition exists.
- Psychiatric, psychological, behavioural, or developmental condition (for example: depression, ADD, ADHD and eating disorders).
- Gender reassignment and/or gender dysphoria.
- Substance misuse (for example: misuse of alcohol and misuse of drugs).
- Self-inflicted injuries of any type.
- Any act or omission that results in charges under the Crimes Act (for example: any medical condition which is related in any way to the Insured Person being involved in an incident which results in the Insured Person being charged under the Crimes Act).
- Continuous care (for example: geriatric care, palliative, respite, rehabilitation, Long-term Care, convalescence and disability, support services costs, senile condition and dementia).
- Wars, riots or acts of terrorism.
- Any medical treatment, investigations or admission that is not Medically Necessary.

All examples of the above exclusions are indicative only and are not an exhaustive list of what is excluded.

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

- Any excess.
- Any services or treatment not normally conducted by a GP or Registered Specialist, and/or not recognised by the Medical Council of New Zealand or Ministry of Health.
- Any Health Services that are provided by health professionals not recognised by the Medical Council of New Zealand.
- Any medical condition not registered with the Ministry of Health as a disease entity.
- 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.
- Alternative or complementary medicines or therapies (for example: massage therapy, homeopathy and natural therapy).
- Costs associated with 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: insulin pumps, C-PAP equipment, cochlear implants, pacemakers, electrodes, nerve stimulators and/or crutches and artificial limbs).
- Any costs that are not Medically Necessary (for example: car parking, newspapers, take-out meals, alcohol, toiletries, TV rental, fax charges, overtime, cancellation charges, prioritisation fees and ambulance society prescriptions).
- Medications that are not approved by Medsafe.
- Drugs that do not meet the funding criteria on the PHARMAC pharmaceutical schedule under section A to H (except where provided for under the Non-PHARMAC Cancer Treatment Benefit).
- Any periodontics, orthodontics, or endodontic procedures, dentures, implants, orthognathic surgery or tooth exposure.
- GP and out-of-hospital prescription charges (except where provided for under the GP Surgery Benefit or the Cancer treatment at home Benefit).
- Claims that do not meet our general terms (see General terms of Hospital and Specialist Cover on page 4).

All examples of the above exclusions are indicative only and are not an exhaustive list of what is excluded.

Before going to Hospital, call us on **0800 801 810.**

We can check what will be covered and help you understand the best ways to avoid potential Out-of-Pocket Expenses.

nib's obligations

We will:

- Treat Insured Persons as valued 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).
- Comply with all aspects of the Health Funds Association of New Zealand Inc. Health Insurance Industry Code.
- Provide at least 30 days' written notification of Cover changes and at least 30 days' written 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 and Health Information Privacy Code 1994.

Policyowner and insured person's obligations

By taking out a Warehouse Money health insurance Policy with nib, 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.
- Meet the terms outlined in our direct debit authority.
- 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 4).
- 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, and WM Health Connect. 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 WM Health Connect.

nib's privacy policy

We are committed to protecting the privacy and security of the personal information we collect. We have implemented measures to comply with our obligations under the Health Funds Association of New Zealand Inc. Health Insurance Industry Code and the Privacy Act 1993, including the Health Information Privacy Code 1994.

Our privacy policy explains how we may collect, use and disclose personal information. In addition to the parties listed in our privacy policy, nib may also disclose information provided by you, and any other information collected by nib as underwriter of the insurance policies, to TW Financial Services Operations Limited. However, in no circumstances will nib disclose any of your health information to TW Financial Services Operations Limited.

To read our current privacy policy, please go to **nib.co.nz/about-us/privacy-policy**

Feedback and complaints

Any questions? More information?

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

How to contact us:

- Submit a request through WM Health Connect **wmhealth.co.nz/portal**
- Email **contactus@wmhealth.co.nz**
- Go to **warehousemoney.co.nz**
- Call us on **0800 801 810**, Monday to Friday 8:00am – 5.30pm.

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 email the Complaints Committee: complaints@wmhealth.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 email a letter of "deadlock" which gives you the option to take your complaint to the Insurance & Financial Services Ombudsman (IFSO):

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

Need help?

- Submit a request through WM Health Connect by visiting **wmhealth.co.nz/portal**
- Email **contactus@wmhealth.co.nz**
- Go to **warehousemoney.co.nz**
- Call us on **0800 801 810,** Mon to Fri: 8:00am – 5.30pm

Glossary of important terms

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

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

"Activities of Daily Living" means any of the following:
- bathing and showering; or
- dressing and undressing (including grooming and fitting artificial limbs); or
- eating and drinking; or
- using a toilet to maintain personal hygiene; or
- moving to or from place to place by walking, wheelchair or walking aid.

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

"Admission" means to have followed an administration process to become an Admitted Patient for treatment of a sign, symptom or Condition as a private patient in a 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.

"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 sources of radiation (seeds) are implanted internally close to or in the site being treated.

"Cardiovascular System" means the heart (all anatomical structures) and great vessels (aorta, inferior vena cava, superior vena cava, pulmonary artery, pulmonary vein and carotid arteries).

"Chemotherapy" means a medication and its administration for the treatment of cancer.

"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 under any subsequent legislation).

"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.

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

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

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

"Consultation" or **"Consultations"** means a necessary face-to-face meeting with a Recognised Health Professional for discussion or the seeking of advice, or conferring to evaluate the medical case and any treatment. A consultation does not include the treatment itself. This does not include 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; and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

"Cover" 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 under any subsequent legislation).

"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.

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

"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 under any subsequent legislation).

"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).

"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).

"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 under any subsequent legislation).

"Health Service" or **"Health Services"** means Consultation, assessment, Diagnostic Investigation or treatment of a sign, symptom or Condition provided by a Recognised Health Professional.

"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).

"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 not a "mental injury" as defined in the Accident Compensation 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 for each Insured Person over the lifetime of the Insured Person.

"Long-term Care" means Public Hospital and private Hospital-based services provided on an ongoing regular basis where a medical Condition has been or is likely to be present for more than 14 nights.

"Medically Necessary" means a service or supply provided by a Registered Specialist 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 Registered Specialist;
- those goods, services or supplies furnished mainly for the comfort or convenience of the Insured Person; and
- those goods, services or supplies that do not relate to the medical treatment being provided (for example alcohol, toiletries, pay TV, car parking and take away meals).

"Medsafe" means the 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.

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

"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 under any subsequent legislation).

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

"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 under any subsequent legislation).

"Occupational 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 Occupational Therapy Board of New Zealand (or its successor under any subsequent legislation).

"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 under any subsequent legislation).

"Osteopathic" means treatment provided by a registered Osteopath.

"Out-of-Pocket Expenses" means any costs not covered by nib that are billed by the provider for which the Insured Person will be liable.

"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 Prescriptions" 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).

"Physiotherapist" means a Recognised Health Professional who is:
- in Private Practice and holds a current annual practicing certificate; and
- a member of The Physiotherapy Board of New Zealand (or its successor under any subsequent legislation).

"Physiotherapy" means treatment provided by a Physiotherapist.

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

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

"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, or any Condition:
  - which the Policyowner or the Insured Person was first aware of; or
  - for which the Insured Person first sought Diagnostic Investigation or medical advice; or
  - that would cause a reasonable person in the circumstances to first seek Diagnostic Investigation or medical advice;

  or
- any Condition, the presence of which was evident (even if the Insured Person was not made aware of it) when the Insured Person sought Diagnostic Investigation, medical Screening or medical advice;

  or
- any treatment of any Condition which the Insured Person underwent, on or before the earliest of the following that applies to the Insured Person:
  - Commencement Date; or
  - Effective Date; or
  - Join Date.

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

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

"Prophylactic" means any Surgery or medical treatment performed to prevent the risk of a Condition developing in the future in the absence of current signs or symptoms of that Condition.

"Prosthesis" or **"Prostheses"** means an artificial implant approved and listed by nib, 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.

"Prosthesis Schedule" means the list of Prostheses maximum costs as published on **warehousemoney.co.nz/health**

"Public Hospital" 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, 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;
- voluntary redundancy;
- seasonal work changes;
- performance management dismissal;
- result of an extended leave which last 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 under any subsequent legislation).

"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 (or its successor under any subsequent legislation) vocational registration in that speciality.

For the purposes of this definition it will not include those holding vocational registration for accident and medical practice, emergency medicine, family planning, sexual health and reproductive health, general practice, medical administration, or public health medicine or sports medicine.

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

"Screening" means an investigation carried out in the absence of any sign or symptom of a Condition, for example: testing due to a family history of cancer.

"Skin Lesion" or **"Skin Lesions"** means an abnormal change to any one or all of the three skin layers (epidermis, dermis and subcutaneous) caused by disease or Injury.

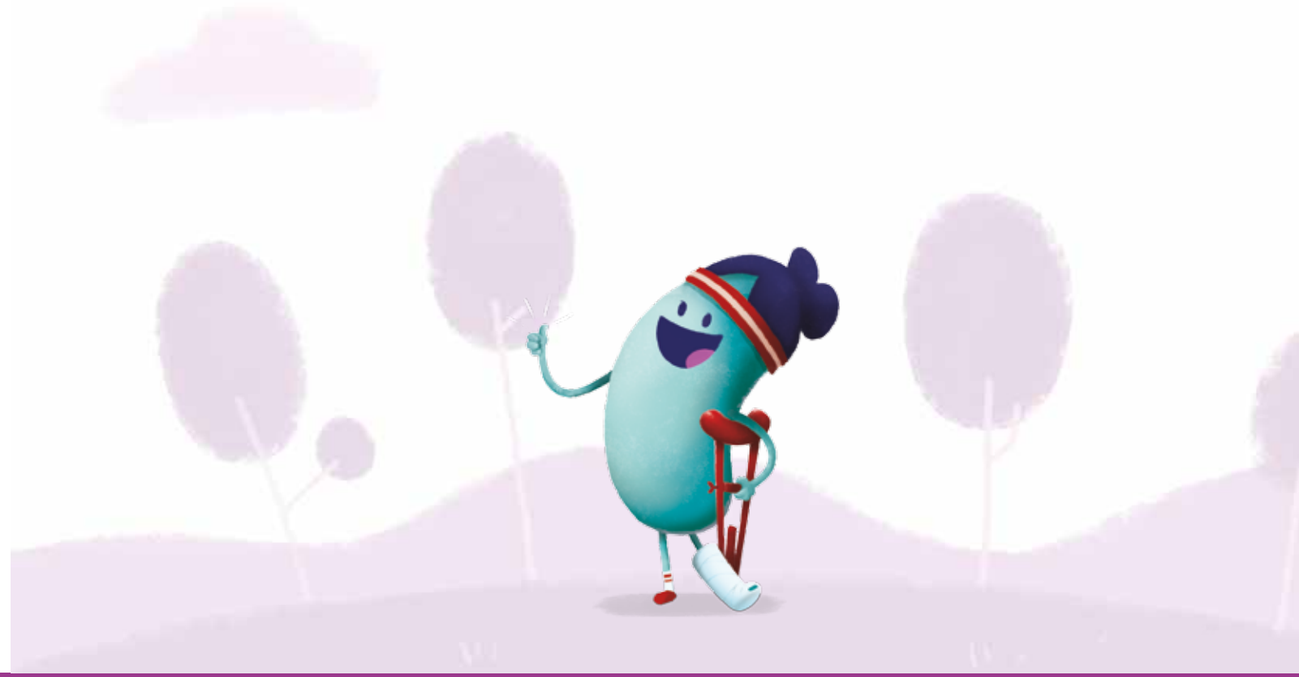
"Speech Therapy" means treatment that is provided by a Recognised Health Professional who is:
- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Speech Language Therapists Association (or its successor under any subsequent legislation).

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

"Waiting Period" or **"Waiting Periods"** 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.

"WM Health Connect" means the online portal where the Policyowner (s) can access information about the Policy. At the date of this document, the address is www.wmhealth.co.nz/portal. This may be updated from time to time.

"you" or **"your"** means an Insured Person.



For credit cards and other insurance

Take a look online at **warehousemoney.co.nz** or just give us a call.

→ **Travel Insurance**
0800 801 811

→ **Credit Cards**
0800 801 808

warehousemoney.co.nz

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