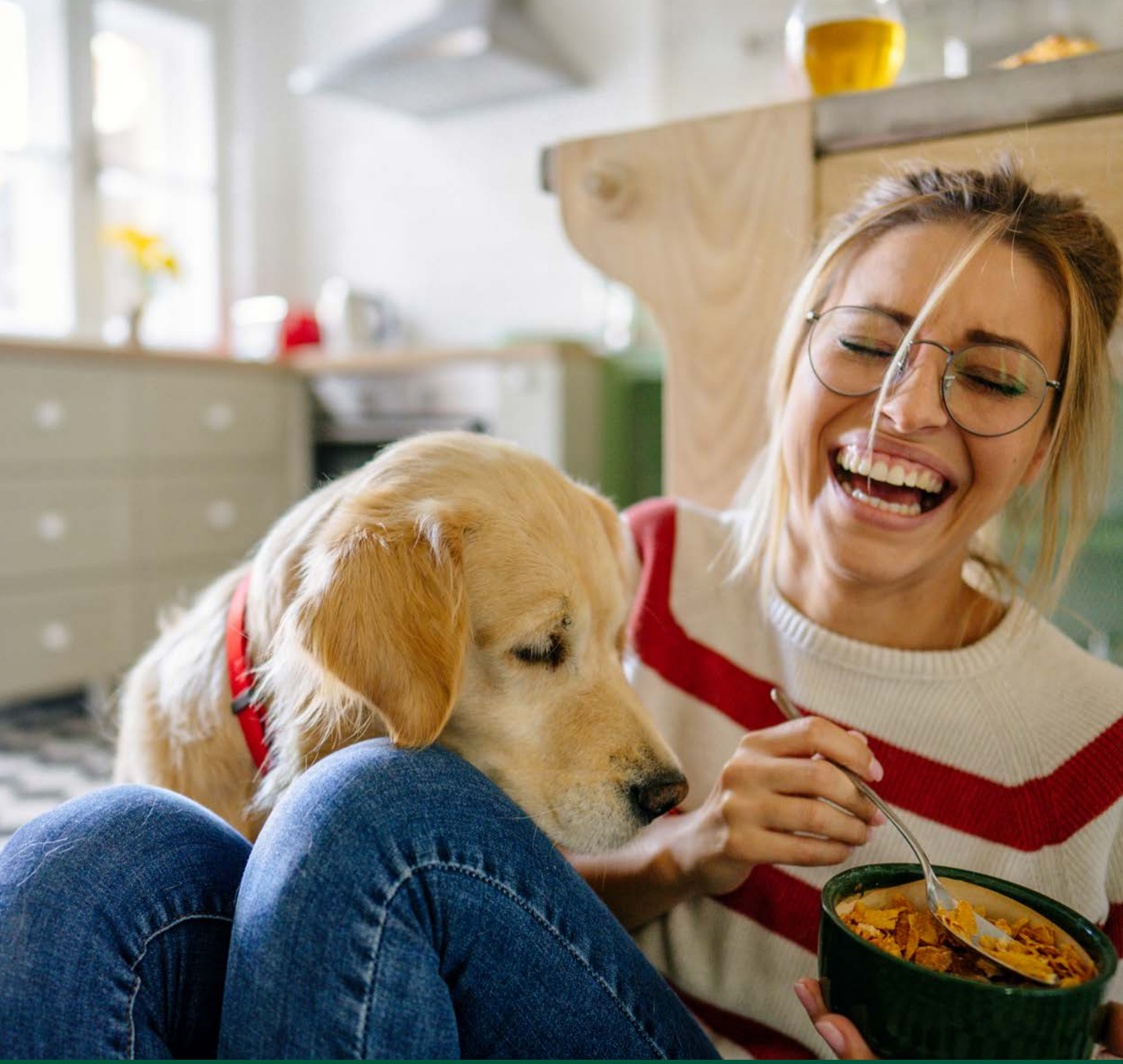

Hospital Cover

nib

Policy Document

Welcome to nib

We're your partner in health and wellbeing. Our key purpose is to help Kiwis and their families live healthier and happier lives. We want to make your cover easy to use and empower you with the right tools to put your health into your hands.

Wherever your health journey takes you, we'll be here to support you.

Contents

01.

How this document works

Your policy document provides information about your Base Cover and the Options you can add.

BASE COVER

A standard set of benefits that every **insured person** on your policy is covered for.

OPTIONS

An additional set of benefits you can add to your policy to provide extra cover for an **insured person**.

Cover Overview

To make it easy to find what you're covered for, we've grouped the benefits under the different situations where you may need to use them. Under each of these categories, you'll find the related benefits that you can claim for. Some benefits can be used in multiple categories. Some benefits are only available to you if you've added the Option with those benefits to your policy.

* This benefit may be used across multiple stages.
^ The Premium Payback Benefit is only available if you've chosen it.

I've been referred for tests, or to see a health professional for consultation or treatment

Base Cover

- General Diagnostic Investigations Benefit
- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*
- Skin Lesion Surgery Benefit
- Minor Surgery Benefit
- Foot Surgery Benefit
- Loyalty – Sterilisation Benefit

I need to stay in hospital for surgery or treatment

Base Cover

- Surgical Benefit
- Non-Surgical Benefit
- Cancer Treatment Benefit
- Travel and Accommodation Benefit
- Ambulance Transfer Benefit
- Overseas Treatment Benefit

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

I'm recovering from a stay in hospital

Base Cover

- Specialist Consultations During Cancer Treatment Benefit
- Physiotherapy Benefit
- Home Care Benefit
- Follow-up Investigations for Cancer Benefit
- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

I need financial support

Base Cover

- ACC Top-Up Benefit
- Waiver of Premium Benefit
- Loyalty – Suspending your Cover Benefit
- Premium Payback Benefit^

This policy document explains what you're covered for. You should read this along with your latest Acceptance or Renewal Certificate, and the Diagnostics Schedule. Together, they are your policy.

Your policy document tells you:

- what you're covered for
- what you're not covered for (general exclusions that apply)
- any other important information you need to know about your cover

Your Acceptance or Renewal Certificate tells you:

- who's the **policyowner**
- who's covered by your policy
- whether you have selected any Options, which are an additional set of benefits you can add to provide extra cover
- how much your policy costs
- what your excess is
- when your cover started
- any special conditions, which can include:
  - personal exclusions. These are usually **pre-existing conditions** that an **insured person** has, which they won't be covered for.
  - loadings. These are additional costs that are added to your premium due to you, or someone else on your policy, having a specific health risk.

If there's any inconsistency between your policy document and your **Acceptance or Renewal Certificate**, your **Acceptance or Renewal Certificate** takes priority.

The Diagnostics Schedule tells you:

- which **diagnostic investigations** don't have a co-payment. We'll pay 100% of the cost of these, up to the **benefit limit** remaining in the same **policy year** on the relevant benefit

Important words

Some words in this policy document are in bold text. This means they have a specific meaning in relation to your policy. You can find the meaning of these words at the end of this document.

In addition to this, where we use the words:

- "**Acceptance or Renewal Certificate**", we're referring to the most recent version you have
- "us", "our", "we" or "nib", we're referring to nib nz limited
- "you", "your" or "yourself", we're referring to an **insured person** – an **insured person** may also be a **policyowner**

Note that you're not covered for any personal or general exclusions that may apply, and you only have cover for the benefits in this policy document if you're an **insured person**.

If you need to contact us, you can visit our Help Centre.

02.

Your Base Cover

I've been referred for tests, or to see a health professional for consultation or treatment

BASE COVER

*Claims for this benefit are paid from the **benefit limit(s)** remaining this **policy year** on your Surgical or Non-Surgical Benefit (whichever applies).

General Diagnostic Investigations Benefit

What am I covered for?

We'll pay for any **diagnostic investigations** and radiology procedures that you need, for example:

- x-rays
- ultrasound
- MRI
- CT
- colonoscopy
- ECG
- CT angiogram

How much am I covered for?

We'll pay 80% of your eligible costs, unless your **diagnostic investigation** is listed on the Diagnostics Schedule.

If the **diagnostic investigation** is listed on the Diagnostics Schedule, we'll pay 100% of your eligible costs.

We'll pay either:

- up to $5,000 per **insured person** every **policy year**; or

General Diagnostic Investigations Benefit *(continued)*

- if the **diagnostic investigations** result in you being **admitted** to a **private hospital** or having cancer treatment within six months of this investigation, we'll pay up to the amount remaining on your Surgical, Non-Surgical or Cancer Treatment Benefit*.

What else do I need to know?

To claim on this benefit, you'll need a referral from a **GP** or **specialist**.

Hospital Diagnostic Tests Benefit

What am I covered for?

We'll pay for any **diagnostic investigations** you need up to six months before and after you're **admitted** to a **private hospital**.

How much am I covered for?

We'll pay 80% of your eligible costs for **diagnostic investigations** during this time, unless your **diagnostic investigation** is listed on the Diagnostics Schedule.

If the **diagnostic investigation** is listed on the Diagnostics Schedule, we'll pay 100% of your eligible costs.

In each case, you can have an unlimited number of **diagnostic investigations**, up to your overall **benefit limit***.

What else do I need to know?

To claim on this benefit, you'll need to have already had a related claim paid by us under your Surgical or Non-Surgical Benefit.

Hospital Specialist Consultations Benefit

What am I covered for?

We'll pay for any **consultations** you need with a **specialist** or **vocational GP** up to six months before and after you're **admitted** to a **private hospital**.

How much am I covered for?

We'll pay 80% of your eligible costs for **consultations** during this time. You can have unlimited **consultations** during this time, up to your overall **benefit limit***.

What else do I need to know?

To claim on this benefit, you'll need:

- a referral from a **GP** or **specialist**; and
- a related claim already paid by us under your Surgical or Non-Surgical Benefit

Skin Lesion Surgery Benefit

What am I covered for?

We'll pay for skin lesion **surgery** by a **specialist**, as well as one related **specialist consultation** before or after your **surgery**.

How much am I covered for?

Up to $6,000 per **insured person** every **policy year**.

What else do I need to know?

In addition to any personal or general exclusions that may apply, we also don't cover any of the following under this benefit:

- laser therapy, cryotherapy, pulse light therapy or photodynamic therapy
- **consultations** that don't relate to the skin lesion being removed

Minor Surgery Benefit

What am I covered for?

We'll pay for minor **surgery** performed by a **specialist** or **vocational GP**.

How much am I covered for?

Up to $6,000 per **insured person** every **policy year**.

What else do I need to know?

To claim on this benefit, you'll need a referral from a **GP** or **specialist**.

In addition to any personal or general exclusions that may apply, we also don't cover any of the following under this benefit:

- cryotherapy, pulse light therapy or any similar treatments
- intravitreal injections
- **consultations** or **diagnostic investigations**
- pharmaceutical prescriptions, including medicines and medical devices

Foot Surgery Benefit

What am I covered for?

We'll pay for **surgery** by a **podiatric surgeon** under local anaesthetic, as well as one **consultation** before and after your **surgery**, including any related x-rays.

How much am I covered for?

Up to $6,000 per **insured person** every **policy year**.

What else do I need to know?

In addition to any personal or general exclusions that may apply, we also don't cover the following under this benefit:

- any **diagnostic investigations**, other than x-rays
- removal of corns or calluses

Loyalty – Sterilisation Benefit

What am I covered for?

We'll pay for sterilisation (a procedure to prevent pregnancy) by a **GP** or **specialist** as a form of contraception.

How much am I covered for?

Up to $1,000 per **insured person** over the life of this policy.

When will I be covered?

After two years of continuous cover following your **join date**.

What else do I need to know?

- each **insured person** can only claim on this benefit once
- you don't need to pay an excess on this benefit
- if you suspend your cover, the suspension period doesn't count towards the two years
- in addition to any personal or general exclusions that may apply, we also don't cover any procedures to reverse sterilisation under this benefit

I need to stay in hospital for surgery or treatment

BASE COVER

*Claims for this benefit are paid from the **benefit limit(s)** remaining this **policy year** on your Surgical or Non-Surgical Benefit (whichever applies).

Surgical Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for **surgery**, we'll pay for your treatment including your hospital stay, your **surgical** and anaesthetist costs, and any required prosthesis. We'll also pay for related costs that are charged for your treatment while you're in hospital, such as **physiotherapy**, tests , and medications administered (see "What medications can I claim for?" for more information).

This benefit also covers the following specific **surgeries** and treatments:

- oral **surgery**, if it's performed by a registered **oral** or **maxillo-facial surgeon**
- the removal of unerupted or impacted teeth by an **oral surgeon**, **dental practitioner**, or **maxillo-facial surgeon**. You'll be covered for this after one year of continuous cover following your **join date**.
- Specialist micrographic **surgery** (also known as Mohs)
- Varicose vein treatment if it's performed by an appropriate **specialist** or a Phlebologist who is a Fellow of the Australasian College of Phlebology, in private practice and holds a current practising certificate.

How much am I covered for?

Up to $600,000 per **insured person** every **policy year**.

Surgical Benefit *(continued)*

What else do I need to know?

Some other benefits on your policy are also paid out of this **benefit limit,** as they relate to your **surgery**. You'll find details of this under the "How much am I covered for?" section of each applicable benefit.

In addition to any personal or general exclusions that may apply, we also don't cover the following under this benefit:

- any **surgery** that isn't performed by a **specialist**
- tooth extractions, except for unerupted or impacted teeth
- any other dental treatments, including periodontic and endodontic treatment, orthodontic treatment and implants, and orthognathic **surgery** or exposure of teeth
- cryotherapy, pulse light therapy, or photodynamic therapy as part of your Mohs **surgery**

Non-Surgical Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for treatment that doesn't involve **surgery**, we'll pay for your treatment including your hospital stay and your **specialist** costs. We'll also pay for related costs that are charged for your treatment while you're in hospital, such as **physiotherapy**, tests, and medications administered (see "What medications can I claim for?" for more information).

How much am I covered for?

Up to $300,000 per **insured person** every **policy year**.

What else do I need to know?

Some other benefits on your policy are also paid out of this **benefit limit**, as they relate to your hospitalisation. You'll find details of this under the "How much am I covered for?" section of each applicable benefit.

In addition to any personal or general exclusions that may apply, we also don't cover the following under this benefit:

- any treatment that isn't managed by a **specialist**
- any treatment where the main purpose, or only purpose, is to receive an injection (for example, a pain management injection)

Cancer Treatment Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for chemotherapy, immunotherapy, radiotherapy or brachytherapy, we'll pay for your treatment including your accommodation, tests, **physiotherapy**, and medications administered while you're in hospital (see "What medications can I claim for?" for more information).

How much am I covered for?

Up to the **benefit limit** remaining this **policy year** on your Non-Surgical Benefit*.

What else do I need to know?

- Any costs relating to cancer **surgery** are covered under your Surgical Benefit.
- in addition to any personal or general exclusions that may apply, we also don't cover suites in a **private hospital** under this benefit.

Travel and Accommodation Benefit

What am I covered for?

If you need **surgery** or treatment and it can't be provided by a **private hospital** within 100km of where you usually live, we'll cover your travel and accommodation costs to have your treatment at another **private hospital**.

We'll also pay for a support person to travel and stay with you during your treatment. We'll cover the accommodation costs for you and your support person the night before your treatment, and also for your support person while you're in hospital.

What type of travel costs am I covered for?

We'll pay for the following travel costs for you and a support person:

- air: return economy flights within New Zealand and return taxi fares between the hospital and airport; or
- rail or bus: a return rail or bus trip within New Zealand and return taxi fares between the hospital and railway/bus station; or
- car: mileage for road travel at the amount set by us

How much am I covered for?*

Accommodation:

- up to $300 per night in total

Travel:

- for **surgery** or treatment: up to $3,000 per **insured person** every **policy year**
- for cancer treatment: up to the **benefit limit** remaining this **policy year** on your Surgical or Non-Surgical Benefit

What else do I need to know?

To claim on this benefit, you'll need:

- a recommendation from a **specialist**; and
- a related claim already paid by us under your Surgical or Non-Surgical Benefit

In addition to any personal or general exclusions that may apply, we also don't cover the following under this benefit:

- vehicle hire and parking costs
- travel insurance
- costs incurred when travelling outside New Zealand

Ambulance Transfer Benefit

What am I covered for?

We'll cover the cost of ambulance transfers by road, either:

- from a public hospital to a **private hospital**
- between **private hospitals**

How much am I covered for?

Up to the **benefit limit** remaining this **policy year** on your Surgical or Non-Surgical Benefit*.

What else do I need to know?

The transfer must be:

- to the closest **private hospital**; and
- recommended by a **specialist** who has cared for you for at least 24 hours while you were in hospital

To claim on this benefit, you'll need to have already had a related claim paid by us under your Surgical or Non-Surgical Benefit.

In addition to any personal or general exclusions that may apply, we also don't cover ambulance memberships under this benefit.

Overseas Treatment Benefit

What am I covered for?

If you require **surgery** or treatment that can't be performed in New Zealand, we'll pay for this **surgery** or treatment to be done overseas.

We also pay for the reasonable travel costs, including accommodation, for you and a support person.

How much am I covered for?

Up to $30,000 per **insured person** for each overseas **surgery** or treatment.

What else do I need to know?

- to claim on this benefit, the Ministry of Health needs to have declined your application for funding under the 'High-Cost Treatment Pool' (or its replacement). You'll need to provide us with a copy of the letter declining your application
- all medical facilities, providers, and health professionals that you use must have accreditation and/or registration that would be acceptable for New Zealand standards
- we'll only pay for economy airfares

Payments:

- any **benefit limits** or excess on this benefit are in New Zealand Dollars
- we'll use the exchange rate on the day we pay your claim to calculate the payment amount
- payments will only be made to the selected New Zealand bank account of the **policyowner** or **insured person** and won't be paid directly to the **health service** provider

The treatment must meet all of the following criteria:

- be a type that can't be performed in New Zealand
- be recommended by the **specialist** who is treating you
- be approved by us
- comply with the local laws

In addition to any personal or general exclusions that may apply, we also don't cover the following under this benefit:

- desensitisation, vaccinations, immunology, or allergies

OPTIONS

You may also have cover available under the following Option if you have added this to your policy:

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit

I'm recovering from a stay in hospital

BASE COVER

*Claims for this benefit are paid from the **benefit limit(s)** remaining this **policy year** on your Surgical or Non-Surgical Benefit (whichever applies).

Specialist Consultations During Cancer Treatment Benefit

What am I covered for?

We'll pay for **specialist consultations** that you need during a cycle of cancer treatment that is being paid for by us. This includes **consultations** during chemotherapy, immunotherapy, radiotherapy or brachytherapy.

How much am I covered for?

Up to the amount remaining this **policy year** on your Non-Surgical Benefit.

What else do I need to know?

- to claim on this benefit, you'll need a referral from a **GP** or **specialist**
- we'll only pay for **consultations** during a cycle of cancer treatment

Physiotherapy Benefit

What am I covered for?

We'll pay for your **physiotherapy** treatment for up to six months after being discharged from a **private hospital**.

How much am I covered for?

You can have unlimited **physiotherapy** treatments during this time, up to your overall **benefit limit***.

What else do I need to know?

To claim on this benefit, you'll need:

- a referral from the **specialist** who treated you while you were in hospital; and
- a related claim already paid by us under your Surgical or Non-Surgical Benefit (whichever applies)

The **physiotherapy** must relate directly to the **condition** you were in hospital for.

Home Care Benefit

What am I covered for?

We'll pay for you to have home care by a **registered nurse**, **nurse practitioner** or **healthcare assistant** for up to six months after you're discharged from a **private hospital**.

How much am I covered for?

Up to $300 per day, to a total maximum of $6,000 per **insured person** every **policy year**, deducted from your overall **benefit limit***.

What else do I need to know?

The care must meet all of the following criteria:

- be recommended by a **GP** or **specialist**
- be for **activities of daily living**
- directly relate to the **condition** you were in hospital for

To claim on this benefit, you'll need to have already had a related claim paid by us under your Surgical or Non-Surgical Benefit (whichever applies).

In addition to any personal or general exclusions that may apply, we also don't cover any housekeeping or childcare costs under this benefit.

Follow-up Investigations for Cancer Benefit

What am I covered for?

If you've had cancer **surgery** or cancer treatment paid for by us under this policy, we'll also pay for your related follow-up investigations for up to five consecutive years.

You're covered for both:

- an annual **specialist consultation** relating to your cancer
- an annual investigation relating to your cancer

How much am I covered for?

Up to $3,000 per **insured person** every **policy year**, deducted from your overall **benefit limit***.

What else do I need to know?

This benefit starts once your cancer treatment has ended.

ADDITIONAL COVER

You may also have cover under the following Base Cover benefits, or Option if you have added this to your policy:

Base Cover

Hospital Diagnostic Tests Benefit

Hospital Specialist Consultations Benefit

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit

I need financial support

BASE COVER

ACC Top-Up Benefit

What am I covered for?

If your **ACC** claim payments don't fully cover the cost of the **surgery** or medical treatment you're having for a physical injury, we'll pay the difference.

How much am I covered for?

Up to the **benefit limit** remaining this **policy year** on your Surgical or Non-Surgical Benefit.

What else do I need to know?

You'll need to provide us with confirmation of how much **ACC** is paying.

In addition to any personal or general exclusions that may apply, we also don't cover any injuries that occurred before your **join date** under this benefit.

Waiver of Premium Benefit

What am I covered for?

We won't charge any premiums if a **policyowner** dies before the age of 70.

How long will my premiums be waived for?

We won't charge any premiums from the next billing date after the death of the **policyowner**, until the first of these happens:

- two years have passed
- any remaining **insured person** turns 70 years old

After this, your premium payments will resume.

Waiver of Premium Benefit *(continued)*

What else do I need to know?

- you don't need to pay an excess on this benefit
- a copy of the death certificate will need to be provided to us
- premiums won't be waived for any new **insured person(s)** or Option(s) added to your policy after we started waiving the premiums

Loyalty – Suspending your Cover Benefit

What am I covered for?

You can apply to put your policy or cover on hold for an **insured person** due to any of the following:

- unemployment/redundancy
- overseas travel/residence
- parental leave

You don't have to pay premiums for any cover that is on hold, and we won't pay any claims for suspended cover during this time.

How long can I put my cover on hold?

- unemployment/redundancy: for up to six months
- overseas travel/residence: for at least three months, up to a maximum of 24 months
- parental leave: for at least three months, up to a maximum of 12 months

You can only suspend your cover for a total of 24 months in any 10-year period.

When can I use this benefit?

After one year of continuous cover following your **join date**.

What else do I need to know?

- you need to provide us with supporting documentation as part of your application to suspend your policy or cover
- your premiums must be up-to-date before you can suspend your policy or cover
- once your suspension period ends, your policy or cover will resume on the next available billing date
- while your policy or cover for an **insured person** is suspended, the suspension period doesn't count towards any waiting periods on your policy. Any waiting periods that have not ended will need to be completed when the cover restarts
- if your policy has renewed while it's on hold, an increase in your premium may apply.

Premium Payback Benefit

If your **Acceptance or Renewal Certificate** shows that you've chosen the 'Premium Payback' option, you're eligible to receive the Premium Payback Benefit and Premium No Claims Discount.

Premium Payback

What am I covered for?

After your policy has been in force for 15 consecutive years, you'll be eligible for a benefit of either 50% or 100% of the Premium Payback amount, depending on the age of the youngest insured adult on your policy. The Premium Payback amount is only paid once over the life of the policy.

How is my Premium Payback calculated?

We'll pay 50% or 100% of all premiums paid by you minus:

- Goods and services tax (GST); and
- any policy frequency fees (the additional amount added to your premium when you don't pay annually)
- the total amount of all benefits paid by us during the life of this policy.

We calculate the Premium Payback amount at the policy anniversary date that it becomes payable or the date that your policy is cancelled by you and it becomes payable (as applicable).

How much do I receive back?

100% Premium Payback

You become eligible to receive 100% of the Premium Payback once:

- the policy has been in force for at least 15 consecutive years; and
- the youngest insured adult on the policy has already turned 60 years old prior to the **policy anniversary** marking 15 consecutive years

Once this benefit has been paid, your policy will continue without the Premium Payback and your premium will be adjusted to reflect that.

If the policy has been in force for at least 15 consecutive years and the youngest insured adult on this policy has not already turned 60 years old before this anniversary, you can choose to do the following:

- cancel your entire policy to receive a 50% Premium Payback; or
- wait until the **policy anniversary** following the 60th birthday of the youngest insured adult on this policy to receive a 100% Premium Payback

50% Premium Payback

You become eligible to receive a 50% Premium Payback:

- if the policy has been in force for at least 15 consecutive years; and
- the youngest insured adult on the policy has not turned 60 years old yet; and
- the policy is cancelled for any reason

03.

Options

Your **Acceptance or Renewal Certificate** specifies any Option that an **insured person(s)** has selected. The following Option is available to you:

Non-PHARMAC Plus Option

Non-PHARMAC Plus Option

This section outlines what is covered under the Non-PHARMAC Plus Option.

If you have selected this Option, the **Acceptance or Renewal Certificate** will specify your **benefit limit**.

When will I be covered?

You're covered for this benefit from your **join date** on this Option.

What else do I need to know?

- we pay 100% of eligible costs under this benefit up to your available **benefit limit**
- you don't need to pay an excess on this Option
- we don't pay for any hospital services under this Option

OPTIONS

Non-PHARMAC Plus Benefit

What am I covered for?

After referral from a **specialist**, we'll cover the cost of medicines that meet all of the following criteria:

- approved by **Medsafe**
- reason for use is within **Medsafe** approval
- not funded by **PHARMAC** at the time of your treatment

The medicines must be either:

- used in a **private hospital**; or
- used at home for up to six months after you're **admitted** to a **private hospital** for treatment – this treatment must be approved by nib and the medicines must relate to it

We also cover any costs to administer the medicines.

How much am I covered for?

We'll pay up to your **benefit limit** per **insured person** every **policy year**.

What else do I need to know?

The medicine must relate to a claim that we've accepted under your Hospital Surgical Benefit, Non-Surgical Benefit, or your Cancer Treatment Benefit.

Your **specialist** needs to provide us with a recommendation letter which explains the reasons for prescribing the non-PHARMAC medication to you.

04.

What we don’t cover

WHAT WE DON'T COVER

There are some things we aren't able to provide cover for. We've grouped these into categories to make it easier for you to read and understand.

Unless specifically covered under a benefit or Option, we don't pay any claims that are related to and/or are consequences of any of the following:

Cosmetic

- anything cosmetic or reconstructive that is not **medically necessary** regardless of whether it's done for physical, functional, psychological, or emotional reasons (for example: treatment that improves, changes, or enhances your appearance)

Weight Loss

- weight loss or bariatric investigations or treatment (for example: gastric banding, sleeve, and bypass), even if the purpose is to treat other health **conditions** (for example: diabetes or cardiovascular **conditions**)

Breast

- breast reductions
- Gynaecomastia

Reproductive Health

- childbirth including caesarean sections
- hormone therapy
- infertility
- pregnancy (for example: normal pregnancy, ectopic, or termination of)

Sexual Health

- contraception
- erectile dysfunction
- sterilisation or reversal of sterilisation

Gender

- gender reassignment
- any treatment or procedures that are related to gender dysphoria

Mental Health

- psychiatric, psychological, behavioural, or developmental **conditions** (for example: depression, ADHD, and eating disorders)
- injuries that are self-inflicted

Congenital, Genetic, or Familial Risk

- **congenital conditions**
- gene therapy
- genetic testing
- genetic **conditions**, in the absence of signs or symptoms that a **condition** exists at your **join date**.
- concerns of familial risk or familial predisposition, in the absence of signs or symptoms that a **condition** exists

Emergency and Injury

- any **acute** medical **conditions** or **acute** care
- ambulance society subscriptions
- injuries that are covered by **ACC**

Rehabilitation and Mobility

- aids that assist with rehabilitation and mobility (for example: crutches, toilet frames, artificial limbs)
- continuous care (for example: geriatric, palliative, rehabilitation)
- mechanical tools or appliances (for example: insulin pumps, CPAP machines and equipment, pacemakers)

Transfusions or Transplants

- organ or tissue transplants or donations (for example: organ transplants)
- specialised transfusions (for example: transfusion of blood, blood products and derivatives, and dialysis of any type)

Dental

- dentures
- dental implants
- Orthognathic **surgery**
- Periodontics, orthodontics, and endodontic procedures
- tooth exposure

Vision

- myopia, hypermetropia, presbyopia, radial keratotomy, and photo-refractive keratectomy
- glasses, sunglasses or contact lenses

Crime or Conflict

- any treatment for a **condition** relating to crime committed by you
- **conditions** or treatment relating to wars, riots, or terrorism

Immune System Disease

- HIV or AIDS

Not funded or registered

- medicines that aren't funded by **PHARMAC** under the latest **PHARMAC** Pharmaceutical Schedule
- **conditions** not registered with the Ministry of Health as a disease entity

Pre-existing

- **pre-existing conditions** (unless the **condition** was declared at application and was accepted by us)

Screening

- any form of risk management (for example: **screening**, preventative, or prophylactic **health services**)
- health surveillance testing

Sleep

- sleep problems or disorders (for example: snoring, insomnia, or sleep apnoea)

Care that isn't standard practice

- alternative or complementary medicine or therapy (for example: homoeopathy and natural therapy)
- experimental, unproven, or unconventional treatments or procedures
- services provided by someone who is not recognised by the Medical Council of New Zealand

Costs outside the terms of your policy

- additional **surgery** or treatment that isn't covered under your policy
- expenses recoverable from a third party (for example: another insurer, company, or person)
- **health services** not covered under your policy

Other general exclusions

- anything that isn't **medically necessary** (for example: alcohol, toiletries, car parking, visitor meals, or administration costs)
- **GP** and out-of-hospital charges (including prescriptions)
- services or goods that were received or purchased outside of New Zealand (for example: goods bought online from another country)
- false or inaccurate information provided for a policy application or claim request
- substance misuse (for example: misuse of alcohol or drugs)
- dementia

05.

Using your cover

Pre-existing Conditions

What is a pre-existing condition?

Any sign, symptom, treatment, or **surgery** of any **condition** that happened on or before the **insured person's join date** that the **policyowner(s)** or another **insured person**:

- were aware of; or
- had an indication that something was wrong; or
- sought investigation or medical advice for; or
- would cause a reasonable person to seek diagnosis, care, or treatment

When are pre-existing conditions covered?

In the first three years following your **join date**, we won't pay any claims that directly or indirectly relate to any **pre-existing conditions**.

What is covered after three years?

After three years of continuous cover from your **join date**, we'll cover any **pre-existing conditions** you have unless a general or personal exclusion applies.

If your cover is cancelled and then reinstated, the three years will be counted from the date your cover is reinstated.

Who can I see for treatment?

When choosing who to see, keep in mind that we only pay claims for **health services** that are carried out by **recognised providers** in New Zealand, except where benefits specifically provide cover overseas.

We recommend that you apply for **pre-approval** using 'my nib' ahead of your treatment, to give you peace of mind that you'll be covered.

Choosing a recognised provider

You can choose to see any **recognised provider** in New Zealand. We have a selected group of **recognised providers** for some specific **health services**, called the First Choice Network, who help us deliver value for our members.
A directory of First Choice Network providers can be found here.

If you choose a recognised provider that *is* part of the First Choice Network:

We'll cover 100% of your eligible costs when you make a claim (up to your **benefit limit**), less any excess and/or co-payment. The excess is the amount you've selected to pay towards the cost of **health services** you receive.
A co-payment is the portion of a claim that you pay for some benefits. You can find out more about how your excess and co-payment works in the "How much do I pay towards health services?" section of this policy document.

If you choose a recognised provider that *isn't* part of the First Choice Network:

You may need to make a gap payment (in addition to any applicable excess and/or co-payment). This is because the amount your **recognised provider** may charge is more than the maximum amount we'll pay for that service. The gap payment is the difference between what your **recognised provider** (who isn't part of the First Choice Network) charges, and the **Efficient Market Price** (the maximum amount we'll pay for a service by a **recognised provider** who isn't part of the First Choice Network).

We determine the **Efficient Market Price** based on:

- what healthcare providers charge for a particular **health service**
- our own claims data
- our experience with New Zealand's national and regional health market

How we apply the **Efficient Market Price**:

If you have a pre-approval

We'll use the **Efficient Market Price** that applied on your **pre-approval** date.

If you don't have a pre-approval

We'll use the **Efficient Market Price** that applied on your treatment date.

We can make changes to the **Efficient Market Price** at our discretion.

What if there is a change in my recognised provider's First Choice Network status?

Recognised providers are included in the First Choice Network for specific **health services**.

If there's a change in your **recognised provider's** First Choice status between your **pre-approval** (our agreement to pay for a **health service**) and your treatment date, then:

Who is your pre-approval for?

A recognised provider who is part of our First Choice Network

We'll honour the original terms of the **pre-approval**, regardless of whether they are still a First Choice **recognised provider** on the treatment date.

A recognised provider who is not part of our First Choice Network, but has been added to it on or before your treatment date

We'll recognise the change when assessing your claim. The **Efficient Market Price** limit will no longer apply.

What medications can I claim for?

When you make a claim, we'll pay towards the cost of medications that meet all the following requirements:

- are registered and approved by **Medsafe**
- are prescribed and administered within **Medsafe** guidelines.
- are prescribed by the treating **specialist** or **GP**
- are funded by **PHARMAC** for the treatment you need at the time of your treatment (unless your benefit or Option says it covers non-**PHARMAC** medicines as well)

If the cost of your medication isn't fully funded by **PHARMAC** and meets the criteria listed above, we'll pay the difference up to your relevant **benefit limit**.

We'll also cover any costs to administer these medications.

We don't cover the costs for any medications that are:

- issued for the sole purpose of use at home (except if this is covered under a specific benefit)
- prescribed in a public hospital
- used for a purpose that is not funded by **PHARMAC** (except if this is covered under your policy)

When will nib pay for health services?

We'll pay for **health services** that are covered under your policy. You can only claim for these **health services** if:

- you're an **insured person**
- your premium payments are up to date, and
- any relevant waiting period has ended

Claims can be made by you or by the **recognised provider** on your behalf. It is important we receive all information we request through the claims process. We may decide not to approve a claim until all requested information is provided.

When you make a claim, you need to provide an invoice or receipt on your **recognised provider's** letterhead showing their name and GST number.

If your premium payments are overdue, or not currently being paid for other reasons, the payment of any claim is at our discretion.

If any claims have been paid out by mistake, or any money has been obtained by fraud or in another unlawful way, or in a way that breaches the terms of your policy, we may recover this money.

You should submit your claim within 12 months of your **health service**, as claim payments aren't adjusted for inflation.

When can I start claiming?

While you can use most benefits from your **join date** some benefits require you to wait a specified period before you can start using them. This is called a waiting period. You can find information about any applicable waiting periods under each benefit in this policy document.

Any waiting periods will begin on your **join date**.

You can't claim for any **health services** that happened before your **join date**.

If you make a change to your cover which means you have new benefits or Options, any applicable waiting period will apply from the **join date** on these new benefits or Options.

How much do I pay towards health services?

The **policyowner** can choose to have an excess (an amount you pay towards an approved claim) on your policy, which will reduce the premium. If you have an excess, it will be shown on your **Acceptance or Renewal Certificate**. The excess applies once per **insured person**, each **policy year** you have a claim accepted by us.

Some benefits may require a co-payment, which is the portion of a claim that you pay. Where this applies, you'll need to pay a percentage of the eligible cost.

If an excess and co-payment both apply to your claim, the co-payment will be applied to the eligible cost of your claim first, and then your excess will be deducted from the part of the claim we pay.

For example, if a covered procedure like a CT scan costs $2,000, a 20% co-payment will be applied first – that's $400. The remaining $1,600 is then subject to your excess, if you have one. If your excess is $500, this will be deducted next. So, you'll pay a total of $900 toward the cost of the CT scan, and we'll cover the remaining $1,100.

If an excess and/or co-payment applies to your claim, you'll need to pay your excess and/or co-payment directly to your **recognised provider**, along with any costs that aren't covered by us, and any gap payments that may apply if you've chosen a provider who isn't in the First Choice Network.

What happens if ACC won't cover me?

The Accident Compensation Corporation (**ACC**) provides cover for many **health services** but can decline cover in some situations. If we believe that the **ACC** should pay for a **health service** you need, rather than it being covered by us, we may ask the **ACC** to review their decision on your behalf. You'll be required to cooperate fully with this process.

This might include:

- giving our legal representative the authority to act for you with the **ACC**
- providing us with your case summary and a copy of the letter the **ACC** has sent you declining your cover
- providing us with any other relevant information

06.

Making changes to your policy

Who can view and change my policy?

The **policyowner** can ask about claims for any **insured person(s)**.

- If there is more than one **policyowner** all **policyowners** must request any changes that impact multiple **insured persons**.
- If changes only impact a **dependent child**, only one **policyowner** needs to request the changes.
- If the changes impact only one **insured person** and don't increase the premium, that **insured person** can request the changes.

Any requests to change your policy need to be made in writing and can be made through our Help Centre. If the change is agreed by us, it will take effect from your policy's next billing date, which is the date your next premium is charged.

If you'd like to remove an Option, but have claimed under it this **policy year**, you'll need to wait until your next **policy anniversary date** to remove it.

Who can I add to my policy?

If you have not selected the Premium Payback option, or you have already claimed it:

- a **policyowner** can apply to have a partner or **dependent child** added to your policy

If you have selected the Premium Payback option:

- a **policyowner** can apply to have a **dependent child** added to your policy

The first child born after your **start date** will be covered under your policy for four months after birth, at no additional cost. If you want to continue cover for this child after four months, you'll need to apply to add them to your policy. Once accepted, a premium will be charged for them.

If a **dependent child** is added to your policy within four months of birth, we'll cover their **pre-existing conditions** under the Base Cover. Any personal or general exclusions will still apply, including those for **congenital conditions**.

An additional premium will apply for each **insured person** that is added, and this will be shown on your **Acceptance or Renewal Certificate**.

How do I remove someone from my policy?

If you have not selected the Premium Payback option, or you have already claimed it:

- to remove an **insured person** from your policy we'll need a request from either:
  - the **policyowner(s)**; or
  - the **insured person** who wants to be removed. If they're under 16, the **policyowner** will need to request this

If you have selected the Premium Payback option and have not claimed it:

- to remove an **insured person** from your policy we'll need a request from both:
  - the **policyowner(s)**; or
  - the **insured person** who wants to be removed. If they're under 16, the **policyowner(s)** will need to request this

When we receive the request we'll remove the **insured person** from your policy's next billing date, which is the date your next premium is charged.

If you pay quarterly, half-yearly, or annually, we'll make the change on the same day of the month as your regular billing date, the month after your request is accepted.

The **insured person** who has been removed can choose to arrange a separate policy of their own (as long as they're aged 16 or older) on terms determined by us, within 30 days of their removal, without needing to provide us with evidence of their current state of health. If the **insured person** is under 16 years old, a person who is 16 or older can arrange this for them and must be the **policyowner** of their new policy.

Can I change my excess amount?

Yes – **policyowner(s)** can ask us to increase or decrease your excess at any time. The request needs to be made in writing and can be made through our Help Centre. This will result in a change to your premium.

If you'd like to decrease your excess, you may need to complete a new application and have this accepted by us. This could result in some additional terms being added to your policy. We'll let you know if you need to do this when you request a decrease in excess.

If we accept the request, we'll change the excess from your policy's next billing date, which is the date your next premium is charged.

If you pay quarterly, half-yearly, or annually, we'll make the change on the same day of the month as your regular billing date, the month following your request being accepted.

How do I cancel my policy?

If you'd like to cancel your policy, all **policyowner(s)** will need to tell us in writing, which can be done through our Help Centre, at least 30 days before you want the policy to end.

Can nib cancel my policy?

Yes. We may cancel the entire policy immediately and let you know if any of the following applies:

- your premium payment is overdue by more than 90 days
- the last remaining **insured person** on your policy has died
- you've breached the terms of your policy
- information provided by you, or on your behalf (when arranging or making changes to your policy) is not true, correct, and complete
- you or another **insured person's** claim is fraudulent in any way
- you behave in an offensive or intimidating way towards an nib employee

We may cancel the cover for an **insured person** if that person is no longer entitled to receive **health services** that are funded under the New Zealand Public Health and Disability Act 2000 (or legislation that takes its place).

If we cancel your policy or your cover for any reason, including fraud, we may keep any premiums that have been paid to us. If we've already made claim payments that were submitted fraudulently, we may recover the money from the **policyowner**.

07.

Conditions of your policy

Who can be a policyowner?

You need to be at least 16 years old to be a **policyowner**. If you're under 16, you'll need to have at least one person aged 16 or older, or your parent or legal guardian, as the **policyowner**.

Your responsibilities

As a **policyowner** or **insured person**, you must do the following:

- comply completely with your policy
- read your policy documents and ask us if you're unsure about what you're covered for
- be truthful, correct and complete when making a claim
- provide us with a relevant referral letter for any **health service** that requires a referral from a **GP** or **specialist**
- ensure your premiums are paid on time so you remain covered
- let us know if your contact details, or any details that might affect your cover, change
- provide us with any information we ask for if it is reasonable and related to your policy. The information must be true, correct, and complete at the time it's provided to us. You'll also need to tell us about any changes to the information you've provided as soon as possible.

If you don't provide us with true, correct, and complete information (that you know, or should know), when you apply for insurance, change your policy or make a claim, depending on the individual facts of any situation, we can do all or any of the following:

- cancel your policy with immediate effect
- change the terms and conditions of cover provided under your policy, and apply these changes back to your **start date** or **join date**, whichever is more recent
- not pay any claims after your **start date** or **join date**, whichever is more recent
- keep any premiums that have been paid to us
- recover any claim payments that we have already made

08.

About your premiums and benefits

Managing your payments

To keep your policy active so you can make claims, you'll need to make sure that payments for your premiums are up to date. Your premium includes any applicable policy fee.

If we send you communications about your premiums and they cannot be delivered, we'll keep making deductions until you tell us to stop.

You can pay your premiums up to 12 months in advance from your **policy anniversary date**.

How do my premiums work?

Your Base Cover premiums are based on the type of cover you've selected, your excess and any Options. Your Base Cover premium is based on who is on your policy:

- **single adult**: based on your age
- **couple**: based on the age of the youngest insured person
- **one parent family**: based on the age of the insured parent
- **two parent family**: based on the age of the youngest insured parent

If you've added the Non-PHARMAC Plus Option, your premium for that Option will be based on the age, gender and smoking status of each **insured person** with that Option.

Changes to your premiums or benefits

The premiums and benefits on your policy may change from time to time and aren't guaranteed.

We won't make changes to your premiums because of any individual claims that have been made under your policy.

When can nib change my premiums or benefits?

We may make changes to your premiums, benefits, or the terms of your policy for any of the following reasons:

- a law that applies to your policy has changed (including tax changes)
- our costs have increased due to an increase in the cost and/or use of medical treatments
- we want to increase the level of cover under a benefit or add a new benefit to your policy
- we need to allow for an unexpected and significant increase in the type and/or amount of claims made under a product, which aren't sustainable long-term or commercially viable
- we want to align your policy with a newer version of the same type of policy that has similar, (but not necessarily the same), premiums and/or benefits
- unexpected and severe public health threats, such as a pandemic

If we need to make changes to your premiums or benefits, we'll let you know at least 30 days before the change(s) take effect.

Premiums for children

If you have not selected Premium Payback, or you have already claimed it:

When a **dependent child** who's insured on your policy turns 21 years of age, they'll be charged adult premiums from the next **policy anniversary date**.

We'll automatically continue their cover as an adult and charge additional premiums based on their age, gender and chosen excess.

Alternatively, they can apply for a policy of their own on our current on-sale product within 30 days of the **policy anniversary date** after they turn 21, without needing to provide us with evidence of their current state of health except their smoking status. Any special terms, exclusions or loadings they have will be carried over to the new policy. The Premium No Claims Discount will not be carried over to the new policy.

If you have the Premium Payback Benefit:

When a **dependent child** who's insured on your policy turns 21 years of age, their cover ends on the **policy anniversary** following their 21st birthday. They can apply for a policy of their own on our current on-sale product within 30 days of their cover ending, without needing to provide us with evidence of their current state of health except their smoking status. Any special terms, exclusions or loadings they have will be carried over to the new policy. The Premium Payback Cover and Premium No Claims Discount will not be carried over to the new policy.

Premium No Claims Discount

If your **Acceptance or Renewal Certificate** shows that this policy includes 'Premium Payback', you're eligible to receive the Premium No Claims Discount.

If we haven't paid a claim on this policy for three consecutive **policy years**, you'll receive a 15% no claim discount on your future premiums. The discount will be applied from the first **policy anniversary** following this three-year period.

What happens when I make a claim?

If we pay a claim while you're receiving the 15% no claim discount, we'll remove this discount at the next **policy anniversary** after this claim has been paid.

We don't count a Premium Payback Benefit payment as a claim for the purpose of checking your eligibility for the Premium No Claims Discount.

Will the discount be applied again?

The discount will start again on the next **policy anniversary** date after we haven't paid a claim on this policy for three consecutive **policy years**.

09.

Important Words

IMPORTANT WORDS

Some words in this policy document are in bold, which means they have a specific meaning. This specific meaning also applies to all words that are derived from that word. For example, the specific meaning for claim also applies to claims and claiming. All Acts of Parliament referenced here include any Act of Parliament that is a replacement or substitute. The meanings of these words are outlined below:

ACC

The Accident Compensation Corporation or any "Accredited Employer" as defined in the Accident Compensation Act 2001 (or its replacement).

Acceptance or Renewal Certificate

The most recent version of your Acceptance or Renewal Certificate.

Activities of daily living

Any of the following:

- washing yourself; or
- getting dressed/undressed; or
- eating or drinking; or
- using a toilet; or
- getting to/from a place by walking, wheelchair, or walking aid

Acute

A sign, symptom, or **condition** that means you need to be hospitalised and treated immediately or within 48 hours.

Admitted

To have followed a process to become an admitted patient for the treatment of a sign, symptom, or **condition** in a **private hospital**.

This doesn't include treatment in the emergency room.

Benefit limit(s)

The maximum we'll pay for a benefit per **insured person** per **policy year**. Benefit limits in this policy include GST.

Condition(s)

Any illness, injury, ailment, disease, sickness, disorder, or disability.

Congenital

A **condition** or trait that is recognised at birth, or diagnosed within four months of birth, whether it is inherited or due to external or environmental factors such as drugs or alcohol.

Consultation(s)

A necessary meeting with a **health professional** for:

- discussion; or
- seeking advice; or
- evaluation of your **condition** and/or treatment.

This doesn't include any diagnostics or the treatment itself.

Dental practitioner

A **health professional** who:

- is a member of the Dental Council of New Zealand (or its replacement); and
- is in private practice; and
- holds a current annual practising certificate.

Dependent child

Your natural or legally adopted child(ren) under the age of 21.

Diagnostic Investigation

An investigative procedure to identify or determine the presence or cause of a sign, symptom, or **condition**.

This doesn't include skin biopsies or any treatment of a sign, symptom or **condition**.

Efficient Market Price

The maximum amount we'll pay for a **health service** provided by a **recognised provider** who isn't part of our First Choice Network.

GP

A **health professional** who:

- is registered with the Medical Council of New Zealand (or its replacement) in General Practice; and
- is in private practice; and
- holds a current annual practising certificate

Health professional

A registered person who:

- holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its replacement); and
- is a member of the appropriate registration body; and
- is recognised by us.

Health service(s)

Consultation, assessment, **diagnostic investigations**, **surgery**, or treatment for a sign, symptom, or **condition** provided by a **health professional**.

Healthcare assistant

A healthcare or care support worker who:

- has a Level 2 or above NZQA Certification in Health and Wellbeing; or
- works for a registered home care provider

Insured person(s)

A person who is named as an 'insured person' on the **Acceptance or Renewal Certificate**.

Join date

The date that cover starts for an **insured person**, which is shown on your **Acceptance or Renewal Certificate**.

Maxillo-facial surgeon

A **health professional** who:

- is vocationally registered with the Medical Council of New Zealand (or its replacement) or the Dental Council of New Zealand (or its replacement) as an Oral & Maxillo-Facial Surgeon; and
- is in private practice; and
- holds a current annual practising certificate.

Medically necessary

A service or supply provided by a **health professional** that we recognise as necessary for the diagnosis, care, or treatment of your **condition**.

This does not include goods, services, or supplies that:

- don't require the skills of a **health professional** recognised by us; or
- are mainly used for comfort or convenience; or
- do not relate to your treatment, for example alcohol, toiletries, TV, car parking and take away meals

Medsafe

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 replacement).

Nurse practitioner

A **health professional** who:

- is a member of the Nursing Council of New Zealand (or its replacement); and
- is in private practice; and
- holds a current annual practising certificate as a nurse practitioner

Oral surgeon

A **health professional** who:

- is vocationally registered with the Dental Council of New Zealand as an Oral Surgeon; and
- is in private practice; and
- holds a current annual practising certificate

PHARMAC

The Pharmaceutical Management Agency, a Crown entity established by the New Zealand Public Health and Disability Act 2000 (or its replacement).

Physiotherapy

Treatment by a physiotherapist who:

- is a member of the Physiotherapy Board of New Zealand (or its replacement)
- is in private practice; and
- holds a current annual practising certificate

Podiatric surgeon

A **health professional** who:

- is vocationally registered and recognised with the Podiatrists Board of New Zealand (or its replacement) as a Podiatric surgeon; and
- is in private practice; and
- holds a current annual practising certificate

Policy anniversary date

The date 12 months after your policy's **start date** and every 12 months after that.

Policy year

The 12-month period starting from your policy's **start date** and ending at 6am on your **policy anniversary date**, and every 12 months after that.

Policyowner(s)

A person who administers and is responsible for the policy and who is listed as 'policyowner(s)' on the **Acceptance or Renewal Certificate**.

This means all policyowners if there is more than one.

Pre-approval

Our advanced confirmation that an **insured person** is eligible to claim.

Pre-existing condition(s)

Any sign, symptom, treatment, or **surgery** of any **condition** that happened on or before the **insured person's join date** that the **policyowner(s)** or another **insured person**:

- were aware of; or
- had an indication that something was wrong; or
- sought investigation or medical advice for; or
- would cause a reasonable person to seek diagnosis, care, or treatment

Private hospital

A private hospital, day **surgery** unit, cancer clinic, or private wing in a public hospital. This must be in New Zealand and recognised by us.

Recognised provider

Any:

- **specialist**,
- **private hospital**,
- **health professional**,
- other medical facility

that is recognised by us.

Registered nurse

A **health professional** who:

- is in private practice; and
- holds a current annual practising certificate; and
- is a member of the Nursing Council of New Zealand (or its replacement)

Screening

A **diagnostic investigation** done where there is no sign or symptom of a **condition**. For example: testing due to a family history of cancer.

Specialist

A **health professional** who:

- has vocational registration with the Medical Council of New Zealand; and
- is in private practice; and
- holds a current annual practising certificate; and
- is a member of an appropriately recognised specialist college.

This doesn't include those holding vocational registration in:

- accident and medical practice; or
- emergency medicine; or
- family planning; or
- sexual health and reproductive health; or
- general practice; or
- medical administration; or
- public health medicine; or
- sport and exercise medicine

Start date

The date your policy started, which is shown on your **Acceptance or Renewal Certificate**.

Surgery / surgical / surgeries

An operation performed under anaesthetic by a **recognised provider**, which requires a surgical incision to remove or repair damaged or diseased tissue.

This doesn't include injections.

us, our, we, nib

nib nz limited.

Vocational GP

A **GP** with a postgraduate qualification in the **health service** they are providing, as recognised by us.

you, your, yourself

An **insured person**, who may also be a **policyowner**.

If you need support, you can get in touch with your adviser, or contact us on:

www.health.nib.co.nz/contact-us
www.mynib.co.nz

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