Standard Hospital

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 *(continued on the next page)*

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.

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

Base Cover

- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*
- Skin Lesion Surgery Benefit
- GP Surgery Benefit
- Foot Surgery Benefit

I need to stay in hospital for surgery or treatment

Base Cover

- Surgical Benefit
- Non-Surgical Benefit
- Cancer Treatment Benefit
- Cancer Treatment at Home Benefit
- Travel and Accommodation Benefit
- Parent Accommodation Benefit
- Ambulance Transfer Benefit
- ACC Treatment Injury Benefit

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

I'm recovering from a stay in hospital

Base Cover

- Physiotherapy Benefit
- Follow-up Investigations for Cancer Benefit
- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

Cover Overview *(continued)*

* This benefit may be used across multiple stages.

I need financial support

Base Cover

- Funeral Support Benefit
- ACC Top-Up Benefit
- Waiver of Premium Benefit
- Loyalty – Suspending your Cover Benefit

I want to be proactive about my health

Base Cover

- Loyalty – Gym and Sports Benefit

This policy document explains what you're covered for. You should read this along with your latest Acceptance or Renewal Certificate. 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
- when your cover started

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

Note that you're not covered for any 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.

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**

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).

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?

You can have an unlimited number of **diagnostic investigations** during this time, 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?

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 related biopsies.

How much am I covered for?

Up to $2,500 per **insured person** every **policy year**, up to the **benefit limit** remaining this **policy year** on your Surgical Benefit*.

What else do I need to know?

In addition to any general exclusions that may apply, we also don't cover laser therapy, cryotherapy, pulse light therapy or photodynamic therapy under this benefit.

GP Surgery Benefit

What am I covered for?

We'll pay for **surgery** performed by a **GP**, as well as one **consultation** before and after **surgery** and any related biopsies.

How much am I covered for?

Up to $750 per **insured person** every **policy year**, up to the **benefit limit** remaining this **policy year** on your Surgical Benefit*.

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**, up to the **benefit limit** remaining this **policy year** on your Surgical Benefit*.

What else do I need to know?

In addition to any 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

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 surgeon** or **maxillo-facial surgeon**
- the removal of four 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 $300,000 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 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 $200,000 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 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 general exclusions that may apply, we also don't cover suites in a **private hospital** under this benefit

Cancer Treatment at Home Benefit

What am I covered for?

If you need cancer treatment, we'll pay for the costs of chemotherapy medicines that are prescribed for use at home and are funded by **PHARMAC** at the time of your treatment.

How much am I covered for?

Up to $10,000 per **insured person** every **policy year**, up to the **benefit limit** remaining this **policy year** on your Non-Surgical 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 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

Parent Accommodation Benefit

What am I covered for?

If an **insured person** aged 20 or younger is being treated in a **private hospital**, we'll cover the cost of accommodation for the accompanying parent or legal guardian while they're in hospital.

How much am I covered for?*

- up to $200 per night
- up to a **benefit limit** of $1,000 per **insured person** every **policy year**

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.

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 general exclusions that may apply, we also don't cover ambulance memberships under this benefit.

ACC Treatment Injury Benefit

What am I covered for?

If you become injured during a **health service** that we've paid for, we'll pay for the **surgery** or treatment needed to treat or repair your injury that is not covered by **ACC**.

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?

- to claim on this benefit, you'll need to provide evidence of an **ACC** treatment injury claim being submitted to **ACC**
- if **ACC** declines to pay for the treatment, we may request an **ACC** review on your behalf
- if we've paid for your treatment and **ACC** reimburses you, you must forward this money to us

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).

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?

Up to $500 per **insured person** every **policy year**, deducted from 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.

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
- investigations 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

Funeral Support Benefit

What am I covered for?

If you die between the ages of 16 and 64 (inclusive), we'll pay a contribution towards your funeral costs.

How much am I covered for?

$3,000 for each deceased **insured person**.

What else do I need to know?

- you don't need to pay an excess on this benefit
- the payment will be made to the **policyowner** or the estate of the deceased **insured person** after we receive a copy of the death certificate

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 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.

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

I want to be proactive about my health

BASE COVER

Loyalty – Gym and Sports Benefit

What am I covered for?

If you're 21 or older, and haven't made any claims in two years, we'll reimburse you towards the following:

- sports or gym memberships; or
- sports or fitness gear bought from a retailer recognised by us

How much am I covered for?

Up to $150 per **insured person** after every two years of continuous cover.

When will I be covered?

After two years of continuous cover following your **join date** with no claims made.

What else do I need to know?

- you need to provide us with receipts
- you must use this benefit in the year that you're entitled to it, it can't be accumulated
- if you suspend your cover, the suspension period doesn't count towards the two years
- when a **dependent child** turns 21, and if they continue to stay on this policy, they'll become eligible for this benefit. Well pay this benefit to them after two years of continuous cover – the two years starts from the **policy anniversary date** that follows their 21st birthday

03.

Options

Your **Acceptance or Renewal Certificate** specifies any Option(s) 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

OPTION

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)
- Hyperhidrosis, Rectus divarication repair

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 implants
- breast reductions
- Gynaecomastia
- revision of breast reconstruction

Reproductive Health

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

Sexual Health

- contraception
- erectile dysfunction
- sterilisation or reversal of sterilisation

Mental Health

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

Congenital, Genetic, or Hereditary

- **congenital** or chromosomal disorders (for example: a birth defect)
- **congenital** kyphosis, **congenital** scoliosis, cystic fibrosis, or pectus excavatum
- Marfan's syndrome
- gene therapy
- genetic testing
- hereditary or genetic **conditions**

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

- vision enhancement (for example: for myopia, hypermetropia, presbyopia, astigmatism, radial keratotomy and photorefractive keratectomy)
- Blepharoplasty

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

Allergies

- treatment for allergies or allergic disorders (for example: desensitisation or patch testing)

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

Pre-existing

- **pre-existing conditions** except where it is expressly specified in this document

Risk Management

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

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
- providers who don't meet our criteria
- services provided by a family member (for example: **health services**, travel costs, or accommodation)
- services provided by someone who is not recognised by the Medical Council of New Zealand
- technologies that we haven't approved that we consider novel or experimental or that are more expensive than an alternative treatment which will provide a similar outcome.

Costs outside the terms of your policy

- additional **surgery** or treatment that isn't covered under your policy
- claims that don't meet the terms of your policy
- expenses recoverable from a third party (for example: another insurer, company, or person)
- **health services** provided during a waiting period
- **health services** after the applicable **benefit limit** has been reached
- **health services** not covered under your policy
- your excess on any claim

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)
- being admitted to hospital for observation only
- 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)

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 the three year waiting period?

After three years of continuous cover following your **join date**, we'll cover your eligible **pre-existing conditions**. Some **pre-existing conditions** are never covered.

What pre-existing conditions are never covered?

Cardiovascular condition:

We don't pay for any **health services** relating to any pre-existing:

- Congenital or acquired cardiovascular **conditions**; or
- Cardiovascular **conditions** where any of the following risk factors applied to you at your **start date** or **join date**:
  - Diabetes of over 10 years' duration
  - Diabetes of any duration if associated with either of the following risk factors:
    - Laboratory proven HbA1C of 64mmol/mol or higher on two or more consecutive tests, with one or more of the following:
      - hypertension
      - dyslipidaemia
      - obesity
      - chronic kidney disease
  - BMI (Body Mass Index) score of 30 or over at any time during the three-year period before your application
  - Laboratory and clinically confirmed hypercholesterolemia

Cancer:

We don't pay for any **health services** relating to any pre-existing cancers. For example, this includes melanoma, leukaemia, lymphoma and invasive cancer of the cervix.

We do cover pre-malignant, pre-existing cancers if there's been appropriate treatment from a **specialist** or **GP** who's qualified to carry out that treatment. Examples of cancers we'd cover in those circumstances are:

- HGIL
- CIN-2 or CIN-3 of the cervix
- polyps of the bowel
- melanoma in situ
- basal cell carcinoma
- squamous cell carcinoma

If treatment hasn't been undertaken, the pre-malignant pre-existing cancer won't be covered.

Hip or knee condition:

We don't pay for any **health services** relating to any pre-existing hip or knee **conditions**, including any degenerative **condition**, disease of, or injury to hip(s) and/or knee(s). The following are also not covered:

- the cost of any prostheses due a **pre-existing condition** of either hip or knee
- any corrective or revision **surgery**, including **surgery** to replace earlier joint replacements

Back condition:

We don't pay for any **health services** relating to any **pre-existing condition** of, or injury to, the back. This includes any condition relating to:

- the spinal cord or spinal vertebrae from the cervical spine (neck) to the lumbosacral spine (lower back)
- vertebrae (bones)
- soft tissues (the nerves, ligaments, tendons, discs and muscles)
- the joints of the spine

We also don't cover any corrective or revision **surgery**, including previous back **surgery**.

Transplant surgery:

We don't pay for any **health services** relating to any transplant **surgery**, or any follow-up **health services** or complications of the **surgery**.

Reconstructive or reparative surgery:

We don't pay for any **health services** relating to any reconstructive or reparative **surgery** performed before your **join date**. This includes repairing scars and treating complications from the previous **surgery**.

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 get **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. The excess is the amount you've selected to pay towards the cost of **health services** you receive. You can find out more about how your excess 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. 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.

If an excess applies to your claim, you'll need to pay your excess 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?

The **policyowner** can apply to have the following people added to your policy; a partner, a **dependent child**, a parent and a grandchild.

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 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?

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

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 you make a claim for a condition that existed before you decreased your excess, the old excess will be applied to that claim.

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 a term 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**.

How do I change my smoking or vaping status?

If you're aged 21 or over and you start or stop smoking or vaping, you'll need to let us know as it may affect your premiums.

To change your smoking status, you'll need to complete our smoking status declaration and provide it to us. You need to have stopped smoking or vaping for at least 12 months for us to be able to change your smoking status to non-smoker.

Any change to your premiums will take effect from your policy's next billing date.

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**.

Changes to your premiums or benefits

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

Premium increases apply to all **insured person(s)** on your policy. 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 increase your premiums as you get older.

We may also 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

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, smoking status, and chosen excess.

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 of 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.

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 exists at birth. These can be hereditary, or result from an action or exposure occurring either during pregnancy or at birth, or a combination of these factors.

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**.

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).

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.

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 contact us on:

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

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