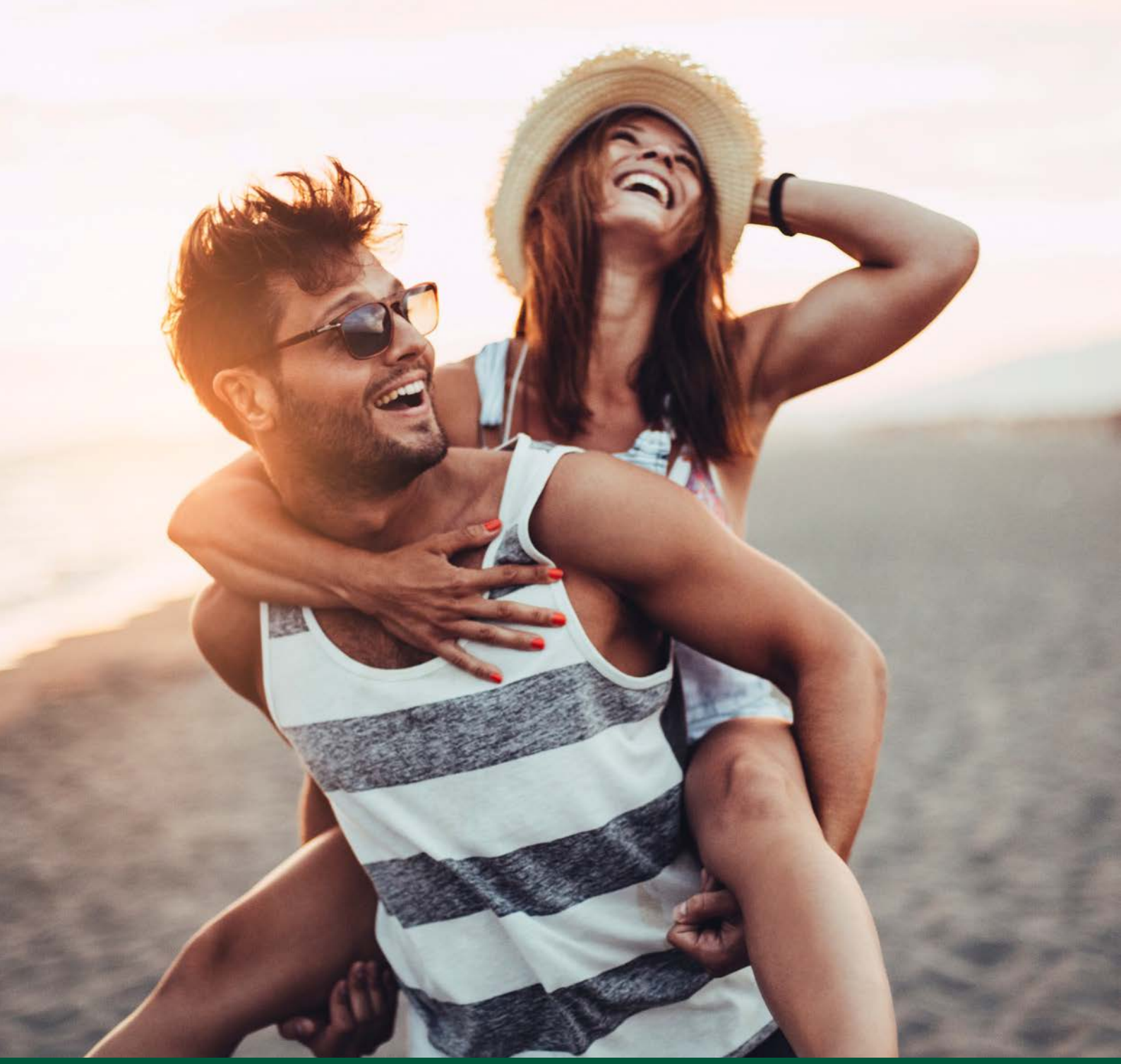

Easy Health

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**. Each Option provides you with additional cover.

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

- Diagnostic Investigations Benefit
- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*
- Skin Lesion Surgery Benefit
- GP Surgery Benefit
- Foot Surgery Benefit
- Eye Injections Benefit
- High-Risk Pregnancy Benefit
- Loyalty – Sterilisation Benefit

I need to stay in hospital for surgery or treatment

Base Cover

- Surgical Benefit
- Non-Surgical Benefit
- Cancer Treatment Benefit
- Non-PHARMAC Cancer Treatment Benefit
- Travel and Accommodation Benefit
- Parent Accommodation Benefit
- Ambulance Transfer Benefit
- Cover in Australia Benefit
- Overseas Treatment Benefit

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

I'm recovering from a stay in hospital

Base Cover

- Physiotherapy Benefit
- Therapeutic Care Benefit
- Home Care Benefit
- Follow-up Investigations for Cancer Benefit
- Breast Symmetry Post Mastectomy 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

- Public Hospital Payment
- Funeral Support Benefit
- Medical Misadventure Benefit
- ACC Top-Up Benefit
- Waiver of Premium Benefit
- Loyalty – Suspending your Cover Benefit

Serious Condition Lump Sum Option

Serious Condition Benefit

I want to be proactive about my health

Base Cover

- Loyalty – Check Up Benefit

Proactive Health Option

Screening Benefit

Allergy Testing and Vaccinations Benefit

Dietitian or Nutritionist Consultations Benefit

Stay Active Benefit

Loyalty – Health Check 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).

Diagnostic Investigations Benefit

What am I covered for?

We'll pay for you to have the following **diagnostic investigations** if your **GP** or **specialist** refers you for them:

- Arthroscopy
- Capsule endoscopy
- Colonoscopy
- Colposcopy
- CT scan
- CT angiogram
- Cystoscopy
- Gastroscopy
- MRI scan
- Myelogram
- PET scan (including PET/CT scan)

How much am I covered for?

You can have an unlimited number of tests, up to your overall **benefit limit***.

What else do I need to know?

In addition to any general exclusions that may apply, we also don't cover any related **consultations** under this benefit.

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 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 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

GP Surgery Benefit

What am I covered for?

We'll pay for minor **surgery** by a **GP**.

How much am I covered for?

Up to $1,500 per **insured person** every **policy year**.

What else do I need to know?

In addition to any general exclusions that may apply, we also don't cover any **consultations** or biopsies relating to your **surgery** under this 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**.

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

Eye Injections Benefit

What am I covered for?

We'll pay for intravitreal eye injections that are administered by a **specialist**.

How much am I covered for?

Up to $3,000 per **insured person** every **policy year**.

What else do I need to know?

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

High-Risk Pregnancy Benefit

What am I covered for?

We'll pay for treatment by an **obstetrician** to assess and monitor recognised risk factors with your pregnancy. This might include, for example, gestational diabetes, preeclampsia, and anaemia.

How much am I covered for?

Up to $2,000 for each pregnancy.

What else do I need to know?

- we don't consider IVF to be a risk factor
- to claim on this benefit you'll need a referral from your **GP** or **specialist**

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

- Caesarean sections
- treatment of ectopic pregnancies
- any related **conditions** arising after the end of your pregnancy
- pregnancies conceived before your **join date**
- treatment in a public hospital

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** per procedure.

When will I be covered?

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

What else do I need to know?

- 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 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 $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

Non-PHARMAC Cancer Treatment Benefit

What am I covered for?

If you need treatment for cancer, we'll pay for the costs of chemotherapy or immunotherapy medicines that are administered in a **private hospital** and aren't funded by **PHARMAC** at the time of your treatment.

How much am I covered for?

Up to $20,000 per **insured person** every **policy year**, deducted from your overall **benefit limit***.

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:

- medicines that are administered or charged for in a public hospital
- medicines that aren't approved by **Medsafe**

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 medical 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 $3,000 per **insured person** per hospitalisation

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.

Cover in Australia Benefit

What am I covered for?

We'll pay for your **surgery** or treatment in Australia for all the benefits under your policy, except for:

- Travel and Accommodation Benefit
- Overseas Treatment Benefit
- ACC Top-up Benefit
- Ambulance Transfer Benefit
- any cover provided under an Option

How much am I covered for?

The maximum amount we'll pay is the **Efficient Market Price** that would have been payable in New Zealand for the same **surgery** or treatment, up to your overall **benefit limit***.

For more information on the **Efficient Market Price**, see "Choosing a recognised provider" section.

Cover in Australia Benefit *(continued)*

What else do I need to know?

All medical facilities, providers, and health professionals that you use must have accreditation and/or registration that would be acceptable for New Zealand standards, and the **surgery** or treatment must comply with Australian law.

We only pay for any medications that would be covered in New Zealand (see "What medications can I claim for?" for more information.

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 to the **health service** provider

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

- **surgery** or treatment that relates to an injury which would be covered under **ACC** if it had happened in New Zealand
- medication that isn't funded by **PHARMAC** in New Zealand at the time of your treatment
- any ambulance costs
- a claim for the same **surgery** or treatment under the Overseas Treatment Benefit – we'll pay under the benefit with the higher cover amount

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 $20,000 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 general exclusions that may apply, we also don't cover the following under this benefit:

- desensitisation, vaccinations, immunology, or allergies
- any costs you've already claimed for under the Cover in Australia Benefit

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 $750 per **insured person** per hospitalisation 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.

Therapeutic Care Benefit

What am I covered for?

We'll pay for the following treatments for up to six months after you've been discharged from a **private hospital**:

- **Osteopathic treatment**
- **Chiropractic treatment**
- **Sports Physician treatment**
- **Speech Therapy**
- **Occupational Therapy**
- **Dietitian consultations**

How much am I covered for?

Up to $250 per **insured person** per hospitalisation, 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 treatment 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 $150 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 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
- 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.

Breast Symmetry Post Mastectomy Benefit

What am I covered for?

If you've had a mastectomy covered under this policy, we'll pay for one or both of the following:

- reconstruction of the breast you had removed
- reduction of the other breast to achieve symmetry

We'll also pay for any related **consultations**, **diagnostic investigations**, or further treatment that is and related to this **surgery**.

How much am I covered for?

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

What else do I need to know?

You'll need to provide us with a medical report from your **specialist** before any **surgery**.

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

Public Hospital Payment

What am I covered for?

If you're **admitted** to a public hospital, we'll pay a benefit from the third night onwards.

How much am I covered for?

Up to $300 per night, to a total maximum of $3,000 per **insured person** every **policy year**.

What else do I need to know?

- you don't need to pay an excess under this benefit
- you can claim on this benefit once you've been in a public hospital for three or more nights in a row
- to claim on this benefit, you'll need to provide us with the discharge summary from the public hospital. It needs to include the reason for your stay and the dates you arrived and left the public hospital
- we'll only pay this benefit if you would have been able to claim under the Surgical Benefit, Non-Surgical Benefit, or Cancer Treatment Benefit in a **private hospital**

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

- any stays in the private wing of a public hospital
- any admission related to an **acute condition**

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?

$5,000 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

Medical Misadventure Benefit

What am I covered for?

If you die due to an error, negligence, oversight, or failure of a **health professional** to follow expected or usual standards during treatment or **surgery** that we're paying for, we'll provide compensation. We refer to this as medical misadventure.

How much am I covered for?

$30,000 per **insured person**.

What else do I need to know?

- you don't need to pay an excess under this benefit
- a copy of your death certificate will need to be provided to us

In addition to any general exclusions that may apply, we also won't pay under this benefit if any of the following apply:

- the death doesn't occur within 14 days of the medical misadventure
- the cause of death has not been confirmed by a coroner's inquest
- the medical misadventure is not the main cause of death
- the medical misadventure happens during treatment or **surgery** that isn't covered by this policy
- the death occurs as a result of treatment or **surgery** provided outside of New Zealand

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.

OPTIONS

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

Serious Condition Lump Sum Option

Serious Condition Benefit

I want to be proactive about my health

BASE COVER

Loyalty – Check Up Benefit

What am I covered for?

If you're 21 or older, we'll pay for you to have a wellness check by a **GP**. For example, this could include:

- laboratory tests
- ECG
- blood pressure check
- breast examinations
- mole mapping
- cervical smears
- prostate examinations

How much am I covered for?

Up to $100 per **insured person**, after every three years of continuous cover.

When will I be covered?

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

What else do I need to know?

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

OPTIONS

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

Proactive Health Option

Screening Benefit
Allergy Testing and Vaccinations Benefit
Dietitian or Nutritionist Consultations Benefit
Stay Active Benefit
Loyalty – Health Check Benefit

03.

Options

Your **Acceptance or Renewal Certificate** specifies any Option(s) that an **insured person(s)** has selected. These are the Options that are available to you:

Non-PHARMAC Plus Option

Proactive Health Option

Serious Condition Lump Sum 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.

Proactive Health Option

This section outlines the benefits that are covered under the Proactive Health Option.

When will I be covered?

Unless specified otherwise under a benefit, you're covered by these benefits six months following your **join date** on this Option.

What else do I need to know?

- we'll pay 80% of eligible costs under each 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

Screening Benefit

What am I covered for?

We'll pay for the following **screening** tests:

- bone **screening**
- bowel **screening**
- breast **screening**
- cervical **screening**
- heart **screening**
- prostate **screening**
- eye tests
- visual field tests
- hearing tests
- mole mapping

How much am I covered for?

Up to $750 per **insured person** every **policy year**.

Allergy Testing and Vaccinations Benefit

What am I covered for?

We'll pay for allergy testing and vaccinations administered by a **health professional**.

How much am I covered for?

Up to $100 per **insured person** every **policy year**.

Dietitian or Nutritionist Consultations Benefit

What am I covered for?

We'll pay for **dietitian** or **nutritionist consultations**.

How much am I covered for?

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

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:

- food, vitamins, or supplements
- videos, books, or DVD

Stay Active Benefit

What am I covered for?

We'll pay for the following:

- gym memberships
- weight-loss programmes
- quit smoking programmes

How much am I covered for?

Up to $100 per **insured person** every **policy year**.

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:

- food, vitamins, or supplements
- videos, books, or DVDs
- active wear, protective items, footwear, or equipment

Loyalty – Health Check Benefit

What am I covered for?

We'll pay for a medical check by a **GP** or **nurse practitioner**.

How much am I covered for?

$150 per **insured person** after every two years of continuous cover on this Option.

When will I be covered?

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

What else do I need to know?

- this benefit can't be accumulated, you must use it in the year that you're entitled to it
- if you suspend your cover, the suspended period doesn't count towards the two years

Serious Condition Lump Sum Option

This section outlines the cover that is provided under the Serious Condition Lump Sum Option.

If you have selected this Option, the **Acceptance or Renewal Certificate** will specify your sum insured, which is the lump sum amount we'll pay if you meet the definition of a serious **condition** outlined in this section

OPTIONS

Serious Condition Benefit

We pay this benefit if you suffer one of the serious **conditions** listed and defined below. The diagnosis must be by a **specialist** based on testing we approve. We may require you to have a medical examination by an independent **specialist** at our expense.

We only pay the sum insured once per **insured person** covered under this Option.

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

- any claim if you die within 14 days of being diagnosed with a listed serious **condition**
- any claim related to a **pre-existing condition**.

When will I be covered?

You will be covered for the following serious **conditions** three months after your **join date** on this Option. If any of these serious **conditions** occur, or you have any signs or symptoms of that serious **condition** in this three-month period, you won't have cover for that serious **condition** under this Option:

- Aortic **surgery**
- Benign tumour of the brain or spinal cord
- Cancer – life-threatening
- Coronary artery bypass grafting **surgery**
- Heart valve **surgery**
- Myocardial infarction (heart attack) – major
- Major organ transplant
- Stroke

You can claim for any other serious **conditions** outlined below from your **join date** on this Option.

When does this Option end for you?

This Option ends for you when the first of these things occurs:

- the **policy anniversary date** after your 70th birthday
- we pay you the sum insured for a **condition** under this benefit
- you die

How do I claim?

You must tell us of your serious condition within 12 months of being diagnosed.

You need to provide us with all of the following:

- a copy of your birth certificate, driver's licence, or passport
- a completed claim form
- any medical certificates and information we need, at your own expense

Serious Condition Definitions

Aortic surgery

The undergoing of **medically necessary surgery** to:

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

For the purpose of this definition, aorta means the thoracic and abdominal aorta but not its branches.

Benign tumour of the brain or spinal cord

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

- **medically necessary surgery** to remove the tumour; or
- neurological deficit causing:
  - documented functional loss that is deemed permanent; or
  - you being constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

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

Cancer – life-threatening

The presence of one or more malignant tumours including leukaemia, lymphomas, and Hodgkin's disease. The malignant tumour is to be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue. The following are not included:

- Tumours showing the malignant changes of Carcinoma in Situ* (including cervical dysplasia CIN-1, CIN-2, and CIN-3) or which are histologically described as pre-malignant, unless it results directly in the removal of the entire organ*.
- Stage 1 and stage 2 melanoma
- All non-melanoma skin cancers, unless there is evidence of metastases.
- Prostatic cancers which are histologically described as TNM Classification T1 and T2 and Gleason score of 5 or less, unless they result directly in the removal of the entire organ*.
- Chronic Lymphocytic Leukaemia less than Rai Stage 1.

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

Chronic liver failure

End-stage liver failure with permanent jaundice, ascites, or encephalopathy.

Chronic lung failure

End-stage respiratory failure requiring extensive, continuous, and permanent oxygen therapy and must result in either:

- FEV1 <40% of predicted and/or arterial blood gases showing a PaO2 < 7.3kPa; or
- you being constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Chronic renal failure

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

Coronary artery bypass grafting surgery

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

Heart valve surgery

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

Myocardial infarction (heart attack) – major

Means you have had a myocardial infarction (other than as a direct result of cardiac or coronary intervention) with the following documented evidence of myocardial infarction diagnosis:

- laboratory confirmed rise and fall in troponin level
- symptoms of myocardial ischaemia
- ECG changes suggestive of ischaemia

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

Major organ transplant

Means either:

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

for the **medically necessary** human-to-human transplant from a donor to you of one or more of the following complete organs: kidney, liver, heart, lung, pancreas, small bowel, or the transplantation of bone marrow (excluding stem cells).

Paralysis

The permanent and total loss of function of two or more limbs as a result of injury to, or disease of, the spinal cord or brain as defined below.

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

For this serious **condition** only, a limb is defined as the complete arm or the complete leg.

Pneumonectomy

The **surgical** excision of an entire lung.

Stroke

The suffering of a stroke as a result of a cerebrovascular event. This requires clear evidence or a similar appropriate scan that a stroke has occurred and shows:

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

This does not include transient ischaemic attacks, migraine, or cerebral injury resulting from trauma.

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
- Mastopexy

Reproductive Health

- assisted reproduction
- childbirth including caesarean sections
- hormone therapy
- infertility
- normal pregnancy, including termination of

Sexual Health

- contraception
- erectile dysfunction
- sterilisation or reversal of sterilisation

Gender

- gender reassignment

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** or chromosomal disorders (for example: a birth defect)
- 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

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** (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** after the applicable benefit limit has been reached
- **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)
- 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 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 **condition** of the heart, coronary arteries, heart valves or arteries; or
- Cardiovascular **condition** of the heart, coronary arteries, heart valves or arteries 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** per treatment.

If you're **admitted** to **private hospital** for your **condition**, you only pay one excess for all treatments related to that **condition** for six months before being hospitalised and up to six months after being discharged. Any claims outside of this period will be charged another excess.

If you're having cancer treatment paid for by us, you'll only need to pay your excess once for each course of treatment, which is the set number of chemotherapy cycles or radiation fractions prescribed by your specialist for the treatment of cancer. If you need to have related **surgery** within 6 months of your cancer treatment, you won't need to pay your excess again.

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 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**.

How do I change my smoking or vaping status?

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

To change your smoking status, you'll need to complete our Non-Smoker 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 determine that a policy fee needs to increase due to an increase in operational expenses
- 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 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.

Chiropractic treatment

Treatment by a chiropractor who:

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

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**.

Dietitian

A **health professional** who:

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

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

Nutritionist

A **health professional** who:

- is a Registered Clinical Nutritionist registered as a Practitioner Member of the Clinical Nutrition Association in New Zealand or the Nutrition Society of New Zealand (or its successor); and
- is in private practice; and
- holds a current annual practising certificate

This doesn't include anyone registered with the Clinical Nutrition Association on a student membership.

Obstetrician

A **health professional** who:

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

Occupational Therapy

Treatment provided by a **health professional** who:

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

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

Osteopathic treatment

Treatment provided by an osteopath who:

- is a member of the Osteopathic Council of New Zealand (or its replacement); 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

Speech Therapy

Treatment provided by a **health professional** who:

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

Sports Physician Treatment

Treatments provided by a **health professional** who:

- is vocationally registered with the Medical Council of New Zealand (or its replacement) in Sport and Exercise medicine; and
- is in private practice; and
- holds a current annual practising certificate.

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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