nib

Standard Hospital Policy document

Contents

Wishing you the best of health

Thank you for trusting nib to insure your good health. You want the best of healthcare, and our Standard Hospital policy is designed to help you achieve it.

Read this policy carefully

This policy document explains how your policy works, how to make a claim, what we do and do not cover, and your responsibilities.

The documents that make up your Contract of Insurance

This policy document is one of a number of documents that together form your Contract of Insurance. These are (in descending order if they say slightly different things):

1. the Acceptance Certificate or Renewal Certificate (whichever is most recent)
2. this *policy* document (or any subsequent documents that replace this document)
3. the Prosthesis Schedule
4. any applications completed by the policyowner and all the insured persons covered under the policy – for example, your smoker status and chosen excess.

Read the information carefully so that you know what you are covered for, what you need to tell us, how to make a claim and the other terms and conditions of your policy.

ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance.
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance.
ⓘ	*Prosthesis Schedule* The list of maximum costs for *prostheses* as published on our website at **nib.co.nz**

Helpful hints for understanding your policy

Always check with us before you have any *health service* (see Seeking pre-approval for treatment or benefits on page 14).

Unless specified, this policy document only describes the terms and conditions of the nib Standard Hospital policy that apply when the document was issued.

How your Standard Hospital policy usually works

Here is a quick overview of how your policy works. To understand your policy completely, read this document and the other documents in your Contract of Insurance.

1. You usually see a *registered specialist* or *GP*. They refer you for a *health service*, or perform it themselves.
2. If they refer you for a *health service*, you request pre-approval from us.
3. If accepted, you have the *health service*.
4. You make a claim (or your *recognised provider* may make a claim for you).
5. We pay the claim, up to the limit of the benefit for that *health service*.
6. Payments are less any excess on your policy.

(If the benefit you're claiming doesn't relate to *health services* – for example, you want to suspend your cover – you come straight to us.)

ⓘ	*Excess* The amount each insured person must pay towards the cost of *health services* that they receive each policy year, that would otherwise be covered under the policy. The policyowner sets the excess amount. It is on the Acceptance Certificate or Renewal Certificate – whichever is most recent.

Words with special meanings in this policy

Some words in this document have a specific meaning which applies to your nib Standard Hospital policy only.

Meanings of insurance terms we use frequently are listed below.

Meanings of less common insurance terms are explained on the page where they appear.

Medical terms are printed in italics, and are defined in Meanings of medical terms on page 36.

Meanings of insurance terms

ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance.
ⓘ	*Benefit* or *benefits* An amount of money payable from nib either to, or on behalf of, an insured person, for approved expenses for their *health service* — in accordance with their Contract of Insurance.
ⓘ	*Benefit limit* or *benefit limits* The maximum amount nib will pay for each benefit for each insured person every policy year.
ⓘ	*Claim* or *Claims* or *Claiming* A request from an insured person for payment of benefits, or a confirmation of future payment of benefits, which complies with this policy document.
ⓘ	*Cover* or *covers* The defined group of benefits we can pay to an insured person under their chosen level of health insurance which comply with the policy document.
ⓘ	*Insured person* or *insured persons* or *person insured* Anyone named as an insured person on the Acceptance Certificate or Renewal Certificate – whichever is most recent. This may include the policyowner.
ⓘ	*Lifetime limit* The maximum amount we will pay for each benefit for each insured person over the lifetime of the insured person.
ⓘ	*nib, us, our, we* nib nz limited
ⓘ	*Policy* or *policies* This contractual agreement between the policyowner and nib as governed by the Contract of Insurance.
ⓘ	*Policyowner* A person who administers the Policy and whose name is listed on the Acceptance Certificate or Renewal Certificate – whichever is most recent – as 'policyowners'. This means all policyowners if there is more than one.
ⓘ	*Premium* The amount of money the policyowner needs to pay us for a specified period of cover for the policy.
ⓘ	*You* or *your* Anyone named as an insured person on the Acceptance Certificate or Renewal Certificate – whichever is most recent. This may include the policyowner.

Headings don't form part of the cover

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

How to contact nib

The my nib portal provides 24 hour access to your policy and claims details – go to **nib.co.nz/portal**.

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

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

How to get financial statements

You can get a copy of nib nz limited's financial statements for the last reported financial year. Email us at **contactus@nib.co.nz**.

Always contact us before you seek treatment

Always get in touch with us before you seek a *health service*, to make sure it's covered by your policy.

The benefits this policy covers are in What we cover on page 22. Also read What we do not cover on page 33.

You will find more about seeking cover for *treatment* in Seeking pre-approval for treatments and benefits on page 14.

What you agreed with us when you applied for Standard Hospital

You agree that you have disclosed what we need to know

All the information that the policyowner and all insured persons, or anyone on their behalf, have given us must be correct and complete.

You have a legal duty of disclosure – you must tell us everything you knew, or should have known, which would have influenced a prudent insurer's decision to accept your application, and on what terms.

Anyone insured under this policy must have told us about any changes to the information they gave us before any commencement date, effective date or join date of this policy – whichever applies.

Otherwise, we can cancel this policy retrospectively from the commencement date, effective date or join date – whichever applies – and not pay any claims after those dates.

We may keep all the premiums paid. And we may recover any claims we have paid from the policyowner or the insured person.

ⓘ	*Commencement date* The start date of your policy that is shown as the original policy commencement date on the Acceptance Certificate, or Renewal Certificate – whichever is most recent.
ⓘ	*Effective date* The date any changes made to the policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* The date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.

You agree we will communicate online

The policyowner and insured people must give us valid email addresses and always tell us immediately when addresses change.

Wherever this policy refers to a notice in writing such as a certificate, we mean a written notice sent electronically.

You agree to receiving and sending documents online

- We will send you all communications about this policy electronically – through email or through the my nib portal.
- We will send communications to the email address that the policyowner gives us when they apply, or when they tell us it has changed. That email address will be our first point of contact.
- Information we will send online includes policy documents and notices.
- You agree to send us all communications to us about this policy through email or through the my nib portal, **nib.co.nz/portal**.

How we work together with you under this policy

As your insurer, these are our promises

We will value you as customers

We will:

- deal with feedback and complaints quickly and responsibly
- make every possible effort to resolve complaints to the policyowner's and the relevant insured person's satisfaction, whenever we can
- provide a 14-day free-look period on all health cover sales, as long as you have made no claims during that time.

We will keep you informed

We will:

- answer your questions promptly and accurately at the first point of contact, whenever we can
- give you detailed health policy information and help you understand what you are covered for.

We will handle transactions smoothly

We will:

- provide timely and accurate pre-approval, whenever possible
- keep you informed about the process of your claim whenever we can
- give at least 30 days' written notification of any changes to cover or premium increases
- meet the terms of our direct debit authority.

We will respect your privacy

We will:

- treat your personal information with respect and in total accordance with the Privacy Act 1993 and Health Information Privacy Code 1994.

We ask that you honour these promises to us

Please comply with this policy in full

We ask you to:

- be accurate and truthful in your health insurance application and claims (see You agree that you have disclosed what we need to know on page 6)
- understand waiting periods, so you know when you can start claiming – if you are unsure, just ask us.

Please keep us informed

We ask you to:

- provide all information that we reasonably require that is relevant to the policy
- keep your premiums up to date to ensure you remain covered
- meet the terms outlined in our direct debit authority
- tell us as soon as you can of any change that may affect your policy, and if unsure – just ask us.

Please get a referral for a relevant service or treatment

Provide a referral letter if needed – if a specific *health service* needs a referral from a *GP* or *registered specialist*. The account or receipt that you give us for payment must show the referring practitioner's name.

We cover people who are eligible for health services

This policy covers any insured person who is eligible to receive *health services* funded under the New Zealand Public Health and Disability Act 2000 (or its replacement if the law changes).

We may ask for originals or certified copies of each insured person's documents (including visas or work permits in their passports, birth certificates or driver's licences).

We may cancel the policy or the relevant insured person's cover if they no longer meet the criteria (see Reasons we will cancel your policy on page 13).

You can include dependent children under age 18 on your policy

A dependent child under age 18 must be accompanied on the policy by at least one adult aged 18 or older who is the policyowner. This can be the child's parent or legal guardian.

Unless otherwise approved by us, a person under age 18 years is not eligible to be a policyowner.

A dependent child will be charged adult premium rates on the policy anniversary date after they reach age 21.

We will automatically continue to cover them on this policy as an adult insured person. We will deduct the additional premium based on their age, gender, smoking status and excess for the cover, from the same payment source and at the same frequency as this policy, unless you tell us otherwise.

If we don't know their smoking status, we will charge the smoker premium.

ⓘ	*Dependent child* an insured person's natural or legally adopted child under 21 years of age.
ⓘ	*Policy anniversary date* the date 12 months after the commencement date and every 12-month anniversary of that date.

You can make changes to your policy

The policyowner can view and change the policy

The policyowner is the primary account holder. They have the full and total authority to make changes to the policy and make claims enquiries about anyone on the policy.

If the policy has more than one policyowner, all must consent to any changes.

Unless we specify, policyowners can make changes at a policy anniversary date. If you seek a change at a different time, we will make the change in alignment with your next billing cycle.

The policyowner must give us at least 30 days' notice in writing, by email, before they want the change to take effect.

If the change results in a change of premium, we will adjust it from the next billing date.

ⓘ	*Policy anniversary date* The date 12 months after the commencement date and every 12-month anniversary of that date.

You can add people to this policy, or remove them

You can add a partner, dependent child, parent or grandchild

The policyowner can add a partner, dependent child, parent or grandchild onto their policy at any time. The insured person must meet the eligibility criteria (see We cover people who are eligible for health services on page 8). The insured person (or their parent or legal guardian if they are under age 18) must agree about the addition to the policy.

The policyowner and anyone to be added must follow our application process.

Cover for the new insured person will start:

- from the effective date or join date – whichever applies – shown on your Acceptance Certificate or Renewal Certificate (whichever is most recent.)
- after any applicable waiting period.

We will charge an additional premium for each insured person added.

ⓘ	*Partner* an insured person's spouse or a person who lives with the insured person in a marital, de facto or civil union relationship.
ⓘ	*Dependent child* an insured person's natural or legally adopted child under 21 years of age.
ⓘ	*Effective date* the date any changes made to the Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* the date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send you a renewal certificate each year, at least 30 days before your policy anniversary date.
ⓘ	*Waiting period* A period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.

You can remove an insured person

An insured person can be removed from this policy:

- if they make a written request or
- if the policyowner makes a written request.

A person removed from the policy can continue insurance with us.

A person who been removed from the policy can arrange a separate policy on terms that we decide, without providing any evidence of their current state of health. This option is available until 30 days after removal.

Waiting periods apply if a person moves to a new policy

If an insured person needs to transfer to a new policy with the same level of cover, a waiting period may apply before they can make a claim. Any waiting period applies from the commencement date, effective date or join date of the original policy – whichever date applies.

ⓘ	*Partner* an insured person's spouse or a person who lives with the insured person in a marital, de facto or civil union relationship.
ⓘ	*Dependent child* an insured person's natural or legally adopted child under 21 years of age.
ⓘ	*Commencement date* the start date of your Policy that is shown as the original policy commencement date on the Acceptance Certificate, or Renewal Certificate – whichever is most recent.
ⓘ	*Effective date* the date any changes made to the Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* the date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send you a renewal certificate each year, at least 30 days before your policy anniversary date.
ⓘ	*Waiting period* A period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.

You can change the details on the policy

You can change your excess amount

The policyowner can ask to increase or decrease the excess for any insured person within six weeks before the policy anniversary date. We will adjust the premium accordingly.

If you decrease the excess for an insured person, they have to re-serve waiting periods from the effective date of the decrease. This only applies for claims relating to *pre-existing conditions* that were present prior to the effective date.

ⓘ	*Waiting period* a period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.

You can add or remove an Everyday cover

The policyowner can add Standard Everyday or Premium Everyday to this policy at any time in the policy year for an additional premium, by making an application.

The added Everyday cover will start from the effective date or join date – whichever applies – shown on the Acceptance Certificate or the Renewal Certificate (whichever is more recent).

And the policyowner can remove an nib Everyday cover at a policy anniversary date. We need you to give us 30 days' notice before we apply the change.

ⓘ	*Effective date* The date any changes made to the Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* The date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send you a renewal certificate each year, at least 30 days before your policy anniversary date.
ⓘ	*Policy anniversary date* The date 12 months after the commencement date and every 12-month anniversary of that date.

You can change an insured person's smoking status

If we don't know whether people 21 or over on your policy smoke, we will charge smoker premiums.

If any insured person aged 21 or over stops or starts smoking (including any tobacco or any other substance), they must send us a completed nib smoking status questionnaire. Download one from **nib.co.nz**.

You can change an insured person's smoking status any time, and we will adjust your premiums. We need at least 30 days' notice before we change the premium.

We will process the change and send you an updated Certificate

Once we have accepted the changes, we will send the policyowner a new Acceptance Certificate or Renewal Certificate – whichever is most recent – that will show the changes.

ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send you a renewal certificate each year, at least 30 days before your policy anniversary date.

You can cancel the policy or cover

As the policyowner, you can cancel the policy or cover for an insured person - unless we permit it without your authorisation. You must tell us in writing. You must give us at least 30 days' notice of the cancellation.

When your cover starts

Your cover starts from the commencement date, effective date or join date – whichever applies – shown on your Acceptance Certificate or Renewal Certificate (whichever is most recent). Waiting periods may apply for particular covers or benefits.

ⓘ	*Commencement date* The start date of your policy that is shown as the original policy commencement date on the Acceptance Certificate, or Renewal Certificate – whichever is most recent.
ⓘ	*Effective date* The date any changes made to the policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* The date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send it to renew your policy once a year, at least 30 days before your policy anniversary date.
ⓘ	*Waiting period* A period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.

You may have a waiting period before you can claim

You can claim for the benefits and *health services* provided by the cover once any waiting periods are over, provided that premiums are paid up to date.

Waiting periods vary for benefits

Waiting periods apply for some benefits – see the table below.

We won't pay a claim during the waiting period for these benefits, for the period after the commencement date, effective date or the join date – whichever applies.

Benefit	Waiting period
Oral surgery — removal of unerupted or impacted teeth	1 year
Pre-existing conditions (we don't cover all *pre-existing conditions* – see page 27)	3 years
Suspension of cover	1 year

Waiting periods may apply if you change your nib hospital cover

You can change your nib hospital cover. The application must be made by the policyowner. We may not accept your application. But if we do, your new cover will start as soon as your application is accepted.

If you change your cover to a policy that offers a higher level of benefits, you may have to serve waiting periods.

But if you change to a policy with comparable cover, we recognise waiting periods that you have already served.

Check with us to find out which covers are comparable.

If you change your nib hospital cover, these waiting period rules apply:

If…	Then…
Your cover has new benefits, *health services*, or *hospital categories*	Waiting periods will apply from the effective date.
There is no change in your cover's benefits , or h*ealth services*, or *hospital categories*	There is no change in your waiting periods – they apply as before the change, from the commencement date, effective date or join date.

ⓘ	*Waiting period* A period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.
ⓘ	*Categories* The areas of the body or the specific *surgical* procedure covered by the policy as detailed on the *Hospital Category List*. It is published on our website at **nib.co.nz**.
ⓘ	*Commencement date* The start date of your policy that is shown as the original policy commencement date on the Acceptance Certificate, or Renewal Certificate – whichever is most recent.
ⓘ	*Effective date* The date any changes made to the policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Join date* The date when cover starts for an insured person. This date is shown on the Acceptance Certificate or Renewal Certificate – whichever is most recent.

To avoid new waiting periods, maintain continuous cover

You must maintain continuous cover with nib to:

- ensure you can continue to claim benefits
- avoid having to re-assess all the insured persons' health
- avoid having to serve the waiting periods again if anyone on your policy decides to re-join later.

If you don't maintain continuous cover, you may lose advantages like discounts and concessions. When you resume cover, check your Acceptance Certificate or Renewal Certificate – whichever applies.

ⓘ	*Waiting period* A period of time after the commencement date, effective date or the join date, during which we won't pay a claim for that specific benefit.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send it to renew your policy once a year, at least 30 days before your policy anniversary date.

Reasons we will cancel your policy

We have the right to cancel the policy or cover for an insured person, if:

The policy ends

- The premiums are unpaid more than 90 days after the due date – then none of the insured persons will be able to claim.
- The policyowner does not resume the policy after suspending it.

An insured person becomes ineligible

- An insured person is no longer entitled to receive *health services* funded under the New Zealand Public Health and Disability Act 2000 (or its replacement if the law changes).
- The last insured person covered by this policy dies.

You breach the terms of the policy

- Any insured person breaches the terms of the policy.

- Any information provided by, or on behalf of, the policyowner or any insured person when arranging or changing this policy is not true, correct and complete.
- An insured person has achieved, or tried to achieve an advantage, financial or not, for themselves or for anyone else on the policy, that they are not entitled to under this policy.
- An insured person has behaved offensively to or intimidated nib employees.

If we cancel this policy or cover for an insured person, we may keep any premiums you have paid. And if we have paid any claims, we may require you to pay them back to us.

You can resume your policy or cover after suspension

If you have suspended the policy or cover for an insured person under the Loyalty benefit – Suspension of Cover, you must resume it within 90 days of the suspension end date. Otherwise, we will cancel the policy or cover. See Suspending your Cover – Loyalty benefit on page 30.

If you resume the same cover before the suspension period ends, we will reinstate the cover without asking about that insured person's health.

If you haven't served the waiting periods, you must serve the rest of the waiting periods once the policy or cover restarts. The suspension period does not count towards the waiting period.

If you don't resume the policy or cover for an insured person at the end of the suspension period, we will write to the policyowner at their last known email address. We will give them 90 days to bring premium payments up to date. If they do not, the policy or cover will end.

ⓘ	*Waiting period* A period of time after the commencement date, effective date or join date, during which we won't pay a claim for that specific benefit.

Seeking pre-approval for treatment or benefits

Before you have any *health service*, you must seek pre-approval, to make sure it is covered under your policy.

ⓘ	*Pre-approval* or *Pre-approve* Our advanced confirmation that we will accept an insured person's claim.

How to seek pre-approval

You can seek pre-approval in several ways.

Check if your *recognised provider* has access to the nib First Choice portal – **nibfirstchoice.co.nz/portal**. If so, ask them to request pre-approval on your behalf. Then they can send us the subsequent claim, on your behalf. You can seek pre-approval in these ways:

- Submit your pre-approval by visiting our customer portal (my nib) at **nib.co.nz/portal**.
- If you can't use the portal, email us at **claims@nib.co.nz**

Always quote your policy number.

How we process pre-approvals

Pre-approval will usually take up to five working days from the date we get your request, unless we need more information from you.

You cover any costs for submitting a claim. If you need assistance to complete the pre-approval form, or we ask for a medical report, you need to pay any cost for providing them.

If we ask for more information to assess the pre-approval, we will pay to get it.

We have the right to decline any claim that has not been pre-approved.

Supporting documents for pre-approval

Supporting documents for pre-approvals must:

- be in a format approved by nib
- include a copy of the *GP* referral letter (if appropriate)
- include a copy of the *registered specialist consultation* letter (if appropriate)
- be supported by an estimate of the cost on the *recognised provder's* letterhead, showing their official stamp and GST number.

If we need information to assess your pre-approval, you must give it to us.

We will tell you if we have pre-approved your treatment or health service

If we issue a pre-approval for your claim, we will tell the policyowner or the insured person and send the policyowner notification of the pre-approval.

If the request has been made by a *recognised provider*, we will also tell them.

The pre-approval is valid for three months from the date of issue, recorded on the notification. That is unless the cover is cancelled on or before the *treatment* date. In that case the pre-approval notification will be invalid.

Always seek pre-approval before seeking treatment or a health service

Always contact us for pre-approval before going to *hospital* or seeking a *health service*. You must check that we will cover what you want to claim.

We have the right to decline any claim that has not been pre-approved.

If you have pre-approval and then fall behind with your premiums, we may decide not to cover your claim.

If we don't accept the pre-approval request, we will tell the policyowner or the insured person.

If your *treatment* involves a *prosthesis*, check the Prosthesis Schedule on our website, **nib.co.nz**. The schedule tells you the maximum costs that we will pay for individual *prostheses*.

ⓘ	*Prosthesis Schedule* The list of maximum costs for *prostheses* as published on our website at **nib.co.nz**

We may refuse approval for an experimental, novel, or more expensive treatments or procedures

We are unlikely to cover experimental or novel *treatments*, procedures or equipment unless we consider that they provide a better outcome at a reasonable cost.

We will approve a conventional or less expensive procedure that will give the same, or a similarly acceptable, medical outcome.

You must choose an nib recognised provider

You will only get pre-approval for *health service*s carried out by an nib *recognised provider*. The provider must:

- meet all the minimum criteria we have outlined relating to their education, qualifications and active membership of any governing body that we specify
- be in *private practice*
- be recognised by us.

If, occasionally, we don't recognise a provider because of, say, overcharging or suspected fraud, we will tell you we do not cover *treatment* with them. If we usually cover the *treatment*, we will be able to pre-approve *treatment* with another *recognised provider*.

Making a claim

For us to pay your claim, the policyowner and each insured person must comply with this policy in full.

Meeting the requirements of your policy

All claims must meet the requirements of your Contract of Insurance, and What we do not cover on page 33.

- You must give us all relevant information (see Supporting documents for claims on page 16).
- The claim must relate to an insured person. We will only pay the claim to a *recognised provider*, policyowner or insured person, even if someone else has paid the account or bill.

ⓘ	*Contract of Insurance* means the following documents together: ▪ the Acceptance Certificate or Renewal Certificate that we send you in subsequent years – whichever is most recent ▪ this policy document (or any subsequent document that replaces it) ▪ the Prosthesis Schedule ▪ any applications that have been made by the policyowner or insured person to join the policy. If there are differences, the documents apply in descending order.

Pre-existing conditions and deceased claimants

- For any *pre-existing conditions*, see Pre-existing Conditions – Loyalty benefit on page 27.
- If the insured person is deceased, we can only pay benefits to the *recognised provider*, remaining policyowner, or the deceased insured person's estate.

When we can't pay claims

- When premiums are not being paid, we have the right to decide whether we will cover the insured person for any claims for *health services*.
- You can only claim for *health services* carried out by *recognised providers*.
- If you have claimed for *health services*, and then fall behind with your premiums, we may decide not to cover your claim.

We have the right to recover any money that we pay by mistake, or you obtain by fraud. We also have the right to recover money you obtain by contravening the policy or breaking the law.

Submit your claim within a year

We recommend that you send us all claims within 12 months of having the *health service*. We don't adjust claims payments for inflation.

Key information on nib's website

Our website and portal provide key information such as our Prosthesis Schedule. All the relevant information can be found by visiting **nib.co.nz** and **nib.co.nz/portal**

Supporting documents for claims

Supporting documents for claims must:

- be in a format approved by nib
- include a copy of the *GP* referral letter (if appropriate)
- include a copy of the *registered specialist consultation* letter (if appropriate).

If we need more information to assess your claim, you must give it to us.

Claims must be supported by *recognised provider* invoices or itemised receipts on the *recognised provider's* letterhead. The paperwork must show their official stamp and GST number.

Where possible, we process claims within 5 working days

Where possible, we will process your request for claim within five working days of receiving your form, unless we need more information.

You cover any costs for submitting a claim.

If you need help to complete the claim, or we ask for a medical report, you need to pay any cost for providing them.

If we ask for more information to assess the claim, we will pay to get it.

We have the right to decline any claim that has not been pre-approved.

Who we pay

Your claim must relate to a person who's insured on this policy.

Everyone covered by this policy must comply with it before we will pay any claim.

Usually we refund the *recognised provider* directly.

If we are refunding you by direct credit, please make sure your banking details are correct. If we pay to the wrong account because of your error, we can't make a replacement payment until the original payment is returned to us.

We will only refund to a nominated New Zealand bank account in New Zealand dollars.

Choosing your provider, and what we pay

The amount that we pay for your cover may depend on who provides your *health service* and where. For *health services* provided by an nib First Choice provider, we will cover 100% of the cost, up to your benefit limit, less any excess.

ⓘ	*nib First Choice network* and *nib First Choice providers* The *recognised providers* whose charges for *health services* are currently within our First Choice price range. This is subject to change from time to time. If your *health service* is provided by an nib First Choice provider, we will pay you 100% of the cost, less any excess.
ⓘ	*First Choice price range* If a *recognised provider's* charges for a *health service* currently falls within our First Choice price range, we include them in the nib First Choice network.
ⓘ	*Efficient Market Price (EMP)* The maximum that we will pay for a *health service* where the First Choice network applies to that *health service*. We pay up to the EMP if you go to a provider for *health services* affected by the network, and the provider is not an nib First Choice provider.
ⓘ	*Gap payment* Any payment needed to make up the difference between the EMP and the total cost of the *health service*, if your *recognised provider* is not an nib First Choice provider. You are responsible for making the gap payment.
ⓘ	*Pre-approval* or *Pre-approve* Our advanced confirmation that we will accept an insured person's claim.
ⓘ	*Excess* The amount each insured person must pay towards the cost of *health services* that they receive each policy year, that would otherwise be covered under the policy. The policyowner sets the excess amount. It is on the Acceptance Certificate or Renewal Certificate – whichever is most recent.

The differences between nib First Choice providers and other providers

If you choose an nib First Choice provider, we will cover 100% of your eligible costs up to your benefit limit, less any excess.

If you choose a *recognised provider* that is not an nib First Choice provider, the maximum we will pay is the Efficient Market Price (EMP). You must pay any gap payment to make up the full cost of the *health service*. We will tell you how much we will pay when we give you pre-approval.

Some *health services* may not be affected by the nib First Choice network. We are working to expand the network, and more *health services* will be added.

If the network doesn't apply to the *health service*, you can go to any *recognised provider* and the limit of the EMP does not apply. We will pay your cover up to the limit of your benefit, less any excess.

How to find nib First Choice providers

Find our list of nib First Choice providers on the nib First Choice directory at **nibfirstchoice.co.nz/directory**. Check each provider involved in your *treatment*. For example, if you are going to *hospital*, check both the *hospital* and the treating specialist.

If you have already been referred to a provider who is not on the nib First Choice network, talk to your *GP*. They may be able to give you an alternative.

Your health service may involve more than one provider

Not all your *treatment* for one procedure may be with an nib First Choice provider. Check each provider for each part of your *treatment*.

When we get your claim, we may separate the costs into two components, the *hospital* and the *surgical cost grouping*, and assess each provider separately. Here is an example for a knee operation.

- The *surgical cost grouping*, where the *registered specialist* is an nib First Choice provider
- The *hospital* is not an nib First Choice provider.

You would make a single claim (or the provider would make it for you). We would pay:

- 100% of cover for your costs for the *surgical cost grouping*, up to your benefit limit, less any excess
- Up to the EMP for your *hospital* care. You may need to pay a gap payment to make up the total cost.

If the status of the provider changes

If you have been pre-approved for *treatment* by an nib First Choice provider that then stops being an nib First Choice provider before your *treatment*, we will honour the pre-approval. We will still pay 100% of your cover, up to the limit of your benefit, less any excess. Your pre-approval must be valid – it must have been granted within the last 3 months.

Alternatively, you may get pre-approval for a provider which is not an nib First Choice provider, and then becomes a First Choice provider before your *treatment*. If that happens, we won't limit payment to the EMP. We will pay 100% of your cover, up to your benefit limit, less any excess.

How we calculate the Efficient Maximum Price (EMP)

We calculate the EMP based on:

- health providers' charges for a particular healthcare service
- our own claims statistics
- our experience of the national and regional New Zealand health market.

We may change the EMP from time to time.

We deduct the excess from claim payments

You will find your excess amount on the Acceptance Certificate or Renewal Certificate (whichever is most recent) for each insured person, and it applies to each insured person every policy year.

We don't pay your excess, and you can't pay it by withdrawing from any other benefits on your policy.

We will deduct the excess from eligible claim payments until the total excess amount is reached for the year, from the commencement date or join date – whichever applies.

The excess applies for each insured person.

From every policy anniversary date thereafter, we will deduct the excess from any eligible claim payments for each insured person.

ⓘ	*Excess* The amount each insured person must pay towards the cost of *health services* that they receive each policy year, that would otherwise be covered under the policy. The policyowner sets the excess amount. It is on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send it to renew your policy once a year, at least 30 days before your policy anniversary date.
ⓘ	*Policy year* The 12-month period that begins on the commencement date and ends at 6am on the policy anniversary date – and each following 12-month period from one policy anniversary date to the next.
ⓘ	*Policy anniversary date* The date 12 months after the commencement date and every 12-month anniversary of that date.

An example of how the excess works

The insured person has an excess of $500.

1. They submit an eligible claim for $200. nib does not pay the person their claim; instead we reduce their excess balance by $200. Three-hundred dollars remains before their excess amount is reached.
2. The insured person submits another eligible claim for $400. This time, $300 is not paid by nib, but is taken off their excess.
3. Now, the insured person has paid their excess in full. nib pays them $100 – the remaining value of their $400 claim.
4. If the insured person submits any more eligible claims after the excess amount has been reached, nib will pay their claims in full, up to the limit of each benefit – until the end of the policy year.
5. At the next anniversary date, we again deduct the excess amount from the insured person's eligible claims.

You must pay your premiums on time

You must keep your premiums up to date to keep the policy active. Otherwise, insured persons on the policy may not be able to claim benefits.

If the premium rate changes during the policy year, we will apply the change at your next policy anniversary date.

You can pay your premiums in advance for a maximum of 12 months.

ⓘ	*Policy year* The 12-month period that begins on the commencement date and ends at 6am on the policy anniversary date – and each following 12-month period from one policy anniversary date to the next.
ⓘ	*Policy anniversary date* The date 12 months after the commencement date and every 12-month anniversary of that date.

Your payment options depend on payment frequency

Your payment options are below. You must pay in advance, unless we have specifically told you otherwise:

Direct debit

If you pay your premiums by direct debit from a bank, building society, or credit union account, you can pay weekly, fortnightly, monthly, quarterly, half-yearly or yearly.

Credit card

If you pay your premiums by credit card payment from a MasterCard or Visa, you can pay monthly, quarterly, half-yearly or yearly.

Our agreement with you

We will give the policyowner at least 30 days' notice in writing if the amount of the direct debit is increased as a result of a premium rate change.

We will keep any information about the nominated account confidential, except when we need to complete direct debits with the financial institution.

When the due date is not a working day, we will debit the account on the first working day after the due date.

We have the right to cancel direct debit arrangements if the financial institution dishonours direct debits. We will arrange a different payment method with the policyowner.

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

Your agreement with us

It is the policyowner's responsibility to:

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

You can change the direct debit arrangements

The policyowner may cancel or stop a direct debit with their financial institution. They must give instructions in writing.

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

Contact us if you have an enquiry or problem about direct debits

If the policyowner has a direct debit enquiry, or believes a debit has been made incorrectly, let us know immediately.

Email us at **contactus@nib.co.nz**

If we can't reach you, we will continue your cover by making deductions

We want to ensure your valuable cover continues, if a premium deduction advice is returned to us as gone / no address. We will continue to make premium deductions until the policyowner tells us to stop the deductions.

Your premiums are based on your benefits, and increase with age

Your premiums are calculated according to the rates that apply from time to time for the policy selected.

Premiums automatically increase when an insured person reaches a specified age. The same changes to the premium rates and age-related steps apply to everyone insured under this policy.

We may change premiums and benefits if general circumstances change

We will make no changes to your individual policy alone, regardless of your claims history.

However, depending on wider circumstances we may change the:

- premium rates (including age-related steps) benefits
- terms of cover (including 'What is not covered' and words defined in this policy) during the life of the policy.

We will only make changes in the circumstances below, and only to compensate for the particular circumstances that apply.

- The law that applies to the policy changes (including tax changes).
- Our costs increase as a result of medical inflation – as we determine.
- To increase the level of cover under a benefit or to add a new benefit.
- To allow for an unexpected and significant increase in the type or level of claims under the policy, which are unsustainable long term and threaten its commercial viability.
- To align this policy with a newer version of the same type of policy we offer later, with similar premiums or benefits.
- To take into account unexpected, severe public health threats, such as a pandemic.

We will let you know when premiums increase

We will give the policyowner 30 days' written notice of any change in premiums.

The policyowner has the right to cancel this policy at any time.

What we cover

This section lists the benefits you can claim for under this Standard Hospital policy. It explains what you're covered for, and what you aren't. And it tells you how much we will pay as a benefit for each covered *health service*.

Read it together with all other parts of your nib Contract of Insurance.

Make sure you read about claiming on page 16 for details about the nib First Choice network of health providers of services covered by our benefits.

Benefit limits

Overall total benefit limits each year

The total maximum we pay for surgery-related benefits each year

We pay each person insured up to a total maximum of $300,000 every policy year – less any excess. Any benefits we pay you for *surgery*-related *health services* will be deducted from this total maximum *benefit limit*.

The total maximum we pay for non-surgical medical treatment in hospital, and cancer-related benefits

We pay each person insured up to a total maximum of $200,000 every policy year – less any excess. Any benefits we pay you for non-*surgical* and cancer-related *health services* will be deducted from this total maximum *benefit limit*.

Benefits have individual limits

Individual limits may apply to each of the benefits.

Some we pay out of the benefit limit for the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Others are capped separately.

ⓘ	*Excess* The amount each insured person must pay towards the cost of *health services* that they receive each policy year, that would otherwise be covered under the policy. The policyowner sets the excess amount. It is on the Acceptance Certificate or Renewal Certificate – whichever is most recent.
ⓘ	*Acceptance Certificate* The most recent document titled Acceptance Certificate sent to the policyowner by nib as part of the Contract of Insurance. (Also see Renewal Certificate.)
ⓘ	*Renewal Certificate* The most recent document entitled Renewal Certificate that we send to the policyowner as part of the Contract of Insurance. We send it to renew your policy once a year, at least 30 days before your policy anniversary date.
ⓘ	*Policy year* The 12-month period that begins on the commencement date and ends at 6am on the policy anniversary date – and each following 12-month period from one policy anniversary date to the next.
ⓘ	*Policy anniversary date* The date 12 months after the commencement date and every 12-month anniversary of that date.

How we've listed the benefits

We have listed and grouped the benefits in alphabetical order.

ACC benefits

1 ACC Top-up benefit

This benefit covers the difference in costs between what *ACC* has paid to treat a physical *injury* and the actual costs relating to *admission* for the *treatment*.

When you claim for this benefit, you must give us evidence of the amount *ACC* is paying for your *treatment*.

Benefit limit

We don't pay benefits for any *injury* that occurred on or prior to the commencement date, effective date or the join date – whichever applies.

We don't pay benefits for any cosmetic aspect of the *ACC*-approved *surgery* or *treatment*.

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

2 ACC Treatment Injury benefit

If you are *injured* while being treated under a claim that we have covered, this benefit covers the costs of reparative *treatment*.

However, to qualify for this benefit you must first go to *ACC* and submit an *ACC* Treatment Injury Claim. You must give us evidence of your submission.

If *ACC* declines the claim for *treatment injury*, we will request a review of *ACC*'s decision. For us to do this, you must give us a copy of the *ACC* letter declining your claim and their case summary. And you must co-operate fully with our review process.

Further terms

If *ACC* pays reimbursement for the *treatment injury*, it must be paid to us. That means, if we are involved in the claim, we negotiate the refund with *ACC* directly. If they pay the reimbursement direct to you, you must pass it on to us. Benefits are not payable for any cosmetic aspect of the *ACC* approved *treatments*.

Benefit limit

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Ambulance transfer

3 Ambulance Transfer benefit

This benefit covers the cost of road ambulance transfer from a *public hospital* or a *recognised private hospital*, to another *recognised private hospital*. It must be the nearest *recognised private hospital*.

The transfer must be recommended by a *registered specialist* who has treated you as an *admitted patient* for at least 24 hours.

We only pay a benefit when we have paid an associated claim under the Hospital Surgical benefit or Hospital Medical benefit – whichever applies.

Benefit limits

- We don't pay this benefit for any ambulance society subscriptions.
- We don't pay this benefit for transfers apart from transfers between medical providers that we have approved.
- The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Cancer

4 Cancer Treatment benefit

4.1 Cancer treatment in hospital benefit

This benefit covers the following *treatments*, supplies, and services for eligible cancer claims when an insured person is admitted to a *recognised private hospital*:

- *chemotherapy*
- *radiotherapy*
- *brachytherapy*
- *hospita*l accommodation (for example, the *admitted patient's* bed, a private room – but not a suite)
- in-*hospital* X-ray examination and ECG
- intensive post-*treatment* care and special in-*hospital* nursing
- in-*hospital* post-*treatment physiotherapy*
- required *hospital* supplies (such as dressings, needles, bandages)
- *hospital pharmaceutical prescriptions* (see Medications on page 35).

For cancer *surgery* see Hospital Surgical benefit on page 29.

We don't pay benefits for any medication charged in a *public hospital*.

Benefit limit

The benefit we will pay will be deducted from the Hospital Medical benefit limit.

4.2 Cancer treatment at home benefit

This benefit covers the cost of *PHARMAC*-funded *chemotherapy* drugs for treating cancer outside a *hospital*.

We don't pay a benefit for any medication charged in a *public hospital*.

Benefit limit

- We will pay a maximum of $10,000 for each person insured, every policy year.
- The benefit we will pay will be deducted from the Hospital Medical benefit limit.

5 Melanoma Surgery in Hospital benefit

This benefit covers the cost of melanoma *surgery*, performed by a *registered specialist* in a *recognised private hospital*.

For any other *skin lesion surgery,* see the Registered Specialist Skin Lesion Surgery benefit on page 30.

We don't pay a benefit for cryotherapy, pulse light therapy or photodynamic therapy.

Benefit limit

- The benefit we will pay will be deducted from the Hospital Surgical benefit limit.

6 Follow-up Investigations for Cancer benefit

Following *surgery* or *treatment* for cancer that we have approved, we cover you for one *consultation* with a *registered specialist* a year, and relevant investigations relating to the cancer, each policy year for up to 5 years.

This benefit only applies from the end of your *treatment* phase (*chemotherapy, brachytherapy, radiotherapy* or *surgery*).

For investigations related to signs or symptoms, see Hospital Registered Specialist Consultations benefit and Hospital Diagnostic Investigations benefit on page 25.

Benefit limit

- We will pay a maximum of $3,000 for each person insured, every policy year.
- We will pay this benefit for up to 5 consecutive policy years following the end of your *treatment* phase for each person insured.
- The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Diagnostics

7 Hospital Diagnostic Investigations benefit

This benefit covers *diagnostic investigations* up to 6 months before *admission* and up to 6 months *after* discharge from a *recognised private hospital*. That is provided the *diagnostic investigation* relates to the medical *condition* for which the *GP* or *registered specialist* referred you to that *recognised private hospital*.

We only pay a benefit when we have paid an associated claim under the Hospital Surgical benefit or Hospital Medical benefit – whichever applies. For *diagnostic investigations* following a cancer *surgery* or *treatment* where there are no signs or symptoms, see the Follow-up Investigations for Cancer benefit on page 24.

Benefit limit

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Funeral support and Premium waiver

8 Funeral Support benefit

We provide this benefit if an insured person dies between the age of 16 and 64.

We won't deduct an excess from this benefit.

When you claim for this benefit, you must provide a certified copy of the insured person's original death certificate.

Benefit limit

We will pay $3,000 to the policyowner or the deceased person's estate.

9 Premium Waiver benefit

If the policyowner dies before the age of 65, from any cause, this benefit covers the costs of premiums for the remaining people insured on the policy.

We won't deduct an excess from this benefit.

When you claim for this benefit, you must provide a certified copy of the insured person's original death certificate.

The benefit starts from the next premium payment date following the policyowner's death.

When the benefit period ends, the remaining people insured are to resume paying premiums.

Benefit limits

We will pay the premiums:

- for 2 years, or
- until any of the remaining insured persons turn 65 years old,

whichever happens first.

We won't pay benefits for any new people you add to the policy, or for or any further cover you take out, during the Premium waiver timeframe.

Hospital medical treatment

10 Hospital Medical benefit

This benefit covers medical *treatment* – not *surgical treatment* – in a *recognised private hospital*.

We cover these following *treatments*, supplies, and services for eligible medical claims when you're admitted to a *recognised private hospital*:

- *hospital* accommodation (for example, the *admitted patient's* bed, a private room – but not a suite)
- in-*hospital* X-ray examination and ECG
- intensive post-*treatment* care and special in-*hospital* nursing
- in-*hospital* post-*treatment physiotherapy*
- required *hospital* supplies (such as dressings and bandages)
- in-*hospital pharmaceutical prescriptions* (see Medications on page 35).

Benefit limit

We will pay up to a total maximum of $200,000 for each person insured, every policy year.

When we won't pay a benefit

We don't pay a benefit:

- when the medical *treatment* is not managed by a *registered specialist*
- when the only or main purpose of the medical *treatment* is administration of an *injection*. Examples are pain management *injections* or intravitreal *injections*
- unless there is medical evidence to support the need for *admission* for the *treatment* or *condition*
- for any drug that is not listed under Section A to H of the *PHARMAC* pharmaceutical schedule

Cover for newborns

11 Pre-existing Cover for Newborns benefit

This benefit covers the cost of *treatment* for *pre-existing conditions* for a dependent child if the child is added to this policy within 4 months of birth.

We don't pay benefits for any *congenital conditions* (see What we do not cover on page 33).

Benefit limit

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

No Claims benefit

12 Gym and Sports Bonus

We will reimburse you towards sports or gym membership, or sports or fitness gear, if you make no claims for 24 months starting on the policy anniversary date after you are aged 21 or older.

You become eligible for this benefit after 24 months' continuous cover, and at the end of every 24-month period after under this Standard Hospital policy, provided you make no claims in that period. As an insured person aged 21 or older, we'll reimburse you towards:

- membership of a gym or sports club, or
- sports or fitness equipment bought from a sporting retailer that we recognise.

The 24 months of continuous cover will be based on the effective date or join date (as applicable).

Benefit limit

The maximum we will pay for this benefit is $150 for each person insured aged 21 or over, after each 24 months of continuous cover on this policy.

Further terms

- You must give us evidence you have paid your membership fees.
- You must take this benefit in the policy year after you're entitled to it.
- You can't accumulate this benefit over following years.
- On the policy anniversary date after a dependent child turns 21, they become eligible for this benefit. If they then make no claims for the next 24 months, they can claim the Gym and Sports Bonus.
- If the cover has been suspended (see Taking a break from your cover, page 30), the suspended period is not included when calculating the 24 months' continuous cover.

Pre-existing conditions

13 Pre-existing Conditions – Loyalty benefit after we've covered you for 3 years

This benefit covers costs relating to *treatment* or *surgery* for some *pre-existing conditions* for all benefits listed under Standard Hospital. You become eligible after 3 years of continuous cover from the commencement date, join date or effective date under this cover – whichever applies.

However, there are some *pre-existing conditions* that we never cover (see below).

Benefit limit

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Pre-existing conditions that we never cover

We will never pay a claim for any *health services* relating to any of the following *pre-existing conditions*:

13.1 Pre-existing cardiovascular conditions

We do not cover pre-existing cardiovascular *conditions*. This includes any signs, symptoms or *conditions* that relate to *congenital* or acquired diseases and disorders of the *cardiovascular system*:

Diabetes mellitus

Type 1 diabetes mellitus of over 10 years' duration, or

Type 2 diabetes mellitus of any duration, in combination with either of the following risk factors:

- high blood pressure over 160/100, or
- total blood cholesterol of 7 mmol/L or above.

We look at the average of tests taken over the 3-year period before your application.

Body Mass Index over 30

BMI (Body Mass Index) score of 30 or over at any time during the 3 years before your application.

Abnormal blood lipids

Abnormal blood lipids where the average of tests taken over the 3 years before your application was:

- total blood cholesterol of 7mmol/L or above, or
- HDL ratio of 5.5 or above.

13.2 Pre-existing cancer

We do not cover pre-existing cancer. This includes melanoma, leukaemia, lymphoma or invasive cancer of the cervix.

However, we do cover pre-malignant, pre-existing cancers if there has been appropriate *treatment*. It must have been from a *registered specialist* who is suitably qualified to carry out that *treatment*. Examples of cancers we would 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 you have not been treated, investigation and *treatment* of pre-malignant, pre-existing cancers is not covered.

13.3 Pre-existing hip or knee conditions

We do not cover pre-existing hip or knee *conditions*. This includes any degenerative *condition* or disease of, or *injury* to, hips and knees.

Any corrective *surgery*, including *surgery* to replace earlier joint replacements is also not covered.

13.4 Pre-existing back conditions

We do not cover pre-existing back *conditions*. This includes any sign, symptom or *condition*, or *injury* in the:

- spinal cord
- spinal vertebrae
- soft tissues
- joints of the spine.

Any corrective *surgery* to previous back *surgery* is also not covered.

13.5 Transplant surgery or follow-up care

We do not cover transplant *surgery* or follow-up care. This includes any transplant *surgery*, and any follow-up *health services* for, or complications of, transplant *surgery*.

13.6 Reconstructive or reparative surgery following pre-existing surgery

We do not cover reconstructive or reparative *surgery* following pre-existing *surgery*. This includes repairing scars and treating complications relating to *surgery* performed before your commencement date, effective date or join date – whichever applies.

Specialist consultations

14 Hospital Registered Specialist Consultations benefit

This benefit covers *consultations* with *registered specialists* or *vocational GPs* up to 6 months before *admission* and up to 6 months after discharge from a *recognised private hospital*. That is provided the *consultation* relates to the medical *condition* for which the *GP* or *registered specialist* referred you to that *recognised private hospital*.

We only pay a benefit when we have paid an associated claim under the Hospital Surgical benefit or Hospital Medical benefit – whichever applies.

For *registered specialist consultations* following a *treatment* or *surgery* for cancer, where there are no signs or symptoms, see the Follow-up Investigations for Cancer benefit on page 24.

Benefit limit

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Surgery

15 Hospital Surgical benefit

15.1 Surgical benefit

This benefit covers the following for eligible *surgical* claims, when you're admitted to a *recognised private hospital*:

Hospital surgical and specialist staff, services, and devices:

- in-*hospital* X-ray examination and ECG
- surgeon's operating fees
- anaesthetist's fees
- intensivist's fees
- operating theatre fees
- surgically implanted *prostheses* (see our Prosthesis Schedule, published on our website at **nib.co.nz**)
- laparoscopic disposables.

Accommodation and post-operative care:

- *hospital* accommodation (for example, the *admitted patient's* bed, a private room – but not a suite)
- intensive post-operative care and special in-*hospital* nursing
- in-*hospital* post-operative *physiotherapy*
- required *hospital* supplies (such as dressings, sutures, needles, and bandages)
- in-*hospital pharmaceutical prescriptions* (see Medications on page 35).

Benefit limit

We will pay up to a total maximum of $300,000 for each person insured, every policy year.

When we won't pay a benefit

- If the *surgery* is not performed by a *registered specialist*, we won't pay a benefit.
- We won't pay a benefit for *treatment* that *ACC* would otherwise pay for.

15.2 Oral Surgery in Hospital benefit

This benefit covers the cost of oral *surgery* performed by a registered oral surgeon or maxillo-facial surgeon in a *recognised private hospital*.

There's a 12-month waiting period from the join date for each person insured before we will cover the extraction of impacted or unerupted teeth.

We won't pay a benefit for any *dental treatment* other than impacted or unerupted teeth. For example, we do not cover periodontic, endodontic or orthodontic *treatments* or implants, or orthognathic *surgery*.

Benefit limit

There is a *lifetime limit* of the cost of extraction of four impacted or unerupted teeth.

ⓘ	*Lifetime limit* The maximum amount we will pay for each benefit for each insured person over the lifetime of the insured person.

16 Registered Specialist Skin Lesion Surgery benefit

This benefit covers the cost of *skin lesion surgery* performed by a *registered specialist*, including (but not limited to) *Mohs surgery* (other than for melanoma) and related biopsies.

We do not pay benefits for any cryotherapy, pulse light therapy or photodynamic therapy.

For melanoma *surgery*, see Melanoma Surgery in Hospital benefit on page 24.

For *registered specialist consultations* relating to Skin Lesion Surgery, see Hospital Registered Specialist Consultations benefit on page 28.

Benefit limit

- We will pay a maximum of $2,500 for each insured person every policy year.
- The benefit we will pay will be deducted from the Hospital Surgical benefit limit.

17 GP Surgery benefit

This benefit covers the cost of *surgery* performed by a *GP*. It includes one *consultation* before *surgery*, one after, and related biopsies.

Benefit limit

- We will pay a maximum of $750 for each person insured, every policy year.
- The benefit we will pay will be deducted from the Hospital Surgical benefit limit.

18 Podiatric Surgery benefit

This benefit covers the cost of *surgery* performed by a *podiatric surgeon* under local anaesthetic. It includes one *consultation* before *surgery* and one after, and related x-rays.

We cover costs relating to diagnostics other than x-ray under the Hospital Diagnostic Investigations benefit on page 25.

This benefit does not cover removal of corns and callouses.

Benefit limit

- We will pay up to a total maximum of $6,000 for each person insured every policy year.
- This benefit maximum includes the cost of surgically implanted *prostheses* (see Prosthesis Schedule).
- The benefit we will pay will be deducted from the Hospital Surgical benefit limit.

Taking a break from your cover

19 Suspending your Cover – Loyalty benefit after we've covered you for a year

As a benefit for being a loyal customer, the policyowner can apply to suspend the policy for all or some insured persons.

You become eligible for this benefit after 12 months of continuous cover from the commencement date, join date or effective date under this cover (whichever applies).

While the policy is suspended by the policyowner, we won't pay benefits for any of the insured persons.

If the policy is suspended for an insured person, we won't pay benefits to them, but will to the other people on the policy. You can suspend cover for the following reasons.

- **Unemployment / redundancy of policyowner**
  If the policyowner is registered as unemployed (including redundancy), we can suspend this cover for up to a maximum of 6 months. For unemployment and redundancy suspensions, the suspension ends on the date the policyowner nominates, or at the end of the 6-month maximum suspension period – whichever comes first.
- **Overseas travel / residence**
  If a person insured under this policy lives or travels outside New Zealand for longer than 90 consecutive days, their cover can be suspended for a minimum of 90 days up to a maximum of 24 months.
- **Parental leave**
  If the policyowner goes on parental leave, this cover can be suspended for a minimum of 90 days up to a maximum of 12 months.

Further terms

- You must give us all the documents to support your application to suspend the policy or cover.
- You must have paid your premiums up to date before we can suspend the policy or cover.
- You can't suspend your policy or cover for more than 24 months in any reoccurring 10-year period.

Therapeutic treatment

20 Physiotherapy benefit

This benefit covers the cost of *physiotherapy* up to 6 months after a pre-approved *admission* to a *recognised private hospital*.

We only pay benefits when you have made an associated claim under the Hospital Surgical benefit limit or Hospital Medical benefit limit – whichever applies.

Benefit limit

- We will pay a maximum of $500 for each person insured, every policy year.
- The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Travel and accommodation

21 Travel and Accommodation benefit

This benefit covers the travel and accommodation costs involved when the *treatment* covered by the Hospital Surgical benefit or Hospital Medical benefit is not available within 100km of your usual home.

The *registered specialist* may recommend for a support person to accompany you. The support person must travel together with you, to and from the *recognised private hospital*.

Travel

This benefit covers the following where relevant:

- air – a return economy class flight within New Zealand for you and your support person
- car – mileage for road travel at the amount we determine
- rail or bus – a return rail or bus trip within New Zealand for you and your support person
- taxi – taxi fares on *admission* and discharge from the *recognised private hospital* to and from the airport or railway station for you and your support person.

Accommodation for a support person

We will cover the cost of accommodation for your support person while you are admitted as a patient.

Further terms for the Travel and Accommodation benefit

- The *treatment* that requires the travel must be recommended by a *registered specialist*.
- The *treatment* must take place in the *recognised private hospital* that is nearest to your usual home.
- We only pay a benefit when we have paid an associated claim under the Hospital Surgical benefit limit or Hospital Medical benefit limit – whichever applies.
- We only pay benefits that relate directly to an *admission*.
- We do not pay benefits relating to the cost of vehicle hire or insurance.
- We do not pay benefits relating to travel insurance.

Benefit limit

- *Surgery* and medical *treatment*: we will pay up to a maximum of $2,000 for travel for each person insured every policy year. We will pay up to $200 a night for a support person's accommodation, up to a maximum of $3,000 for each person insured every policy year.
- Cancer *treatment*: we will pay the accommodation costs for a support person and / or the insured person. We will pay up to $200 a night, up to a maximum of $5,000 for both travel and accommodation for each insured person every policy year.
- The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

22 Parent Accommodation benefit

This benefit covers the cost of accommodation for a parent or legal guardian accompanying an insured person who is aged 20 or under, when they are being treated in a *recognised private hospital*.

We only pay benefits when we have paid an associated claim under the Hospital Surgical benefit limit or Hospital Medical benefit limit – whichever applies.

Benefit limit

- We will pay up to $200 a night, up to a maximum of $1,000, for each person insured every policy year.

The benefit we pay will be deducted from the Hospital Surgical benefit limit or the Hospital Medical benefit limit – whichever applies.

Varicose veins

23 Varicose Veins benefit

This benefit covers the cost of varicose vein *treatment*. To qualify for the benefit, the *treatment* must have been recommended by a *GP* or a *registered specialist*.

You must get pre-approval for *treatment* of varicose veins, otherwise we will reject the claim. To complete the pre-approval process, we will need you to provide imaging studies at your own cost.

We won't pay a benefit for cosmetic *treatment*, or for telangiectasia / spider veins.

The *treatmen*t must be performed by one of these three kinds of practitioner:

- a *registered specialist*
- a *vocational GP*
- a *recognised health professional.*

They must be in *private practice*, hold a current annual practising certificate, and be registered with the Medical Council of New Zealand. They must also be a fellow of the Australasian College of Phlebology.

Benefit limit

The benefit we will pay will be deducted from the Hospital Surgical benefit limit.

What we do not cover

We do not cover the *health services, treatments* and costs listed in this section.

Contact us before you go to *hospital*. We can check what we will cover, and help you consider the best ways to avoid potential out-of-pocket expenses.

Health services we do not cover

We do not pay benefits for any of the following *health services* and *treatments* that relate to or result from any of the *conditions* or situations below.

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

Coverage relating to your policy or claim

Any excess

Claims if you've given us false or inaccurate information when you made your claim or applied for your policy

Health services and *treatments* not mentioned in this policy document

Providers who do not meet our criteria

Health services and *treatments* you get after you have reached your policy benefit limits or *lifetime limits*

Health services and *treatments* you get during a waiting period, between taking out a policy with us, and the date you can start claiming

Incomplete claims

Services provided by others

Any services provided by a family member, such as accommodation, travel, *health services*, or *treatments*

Expenses you could recover from a third party, such as another person, a company or an insurer

Services outside New Zealand

Services you've received outside New Zealand

Items you have bought outside New Zealand, such as items you ordered on the internet from another country

Blood and organ conditions

Organ or tissue transplants or donations, such as kidney transplants or stem cell transplants

Specialised transfusions, such as transfusions of blood, blood products and derivatives, or dialysis of any type

HIV and AIDS

Acute conditions and observation

Acute medical conditions – this means symptoms or *conditions* that need *hospital admission* for *treatment* or monitoring either immediately or within 48 hours

Admission for observation only to a *recognised private hospital*

Any form of risk management, such as *screening* and *prophylactic*, except where provided for under the Follow-up Investigations For Cancer benefit

Injuries covered by ACC

Any *injury* covered under *ACC*, except where cover is provided under the ACC Top-up benefit or ACC Treatment Injury benefit

Elective treatment

Vision enhancement, such as myopia, hypermetropia, presbyopia, astigmatism, radial keratotomy and photorefractive keratectomy

Breast reconstruction or reduction, gynaecomastia, and revision of breast implants, unless we approve the *treatment*

Cosmetic procedures, blepharoplasty, hyperhidrosis and rectus divarication repair

Repair of a *treatment injury*, except where provided for under the ACC Treatment Injury benefit

Any periodontic, endodontic or orthodontic *treatments* or implants, or orthognathic *surgery*

Treatment for weight loss and *obesity*, such as gastric banding, sleeve and by-pass

Sleep problems and disorders, such as snoring, insomnia and sleep apnoea

Allergies and allergic disorders, such as allergy testing and desensitisation

Screening where there is no sign or symptom of a *condition*

Preventative *treatment* where there are no signs or symptoms of an illness, disease or medical *condition*

Genetic testing for any purpose

Fertility treatment

Family planning, such as infertility, termination of pregnancy, reversal of sterilisation, contraception, caesarean section, hormone replacement therapy and erectile dysfunction

Pregnancy

Sterilisation

Pre-existing conditions, and *conditions* that run in families

A *pre-existing condition* except where cover is provided under the Pre-existing Cover for Newborns benefit and the Pre-existing Conditions benefit

Any *congenital*, hereditary or genetic *condition*, such as a birth disorder, chromosomal disorder, familial predisposition, or familial risk

Investigation of any *congenital*, hereditary or genetic *condition*, such as gene therapy or genetic testing

Mental and psychiatric conditions

Psychiatric, behavioural, psychological or developmental *conditions*, such as depression, ADD, ADHD or eating disorders

Substance misuse such as misuse of alcohol or drugs

Self-inflicted *injuries*

Continuous care such as geriatric care, palliative care, respite care, *long-term care*, convalescence and disability care, costs for support services costs, if, for example, you become senile or develop dementia

Crime, riot and war

Anything you do or don't do as a result of any medical *condition*, that results in your being charged under the Crimes Act

Cover for care during a riot or war

Costs we do not cover

We do not pay benefits for any of the costs below.

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

Costs our contract says we don't cover

Costs for additional *surgery* or *treatment* that isn't covered by your Contract of Insurance

Claims that do not meet the terms of this policy

Unrecognised treatments and practitioners

Any services or *treatments* that are not normally provided by a *GP* or *registered specialist*, or that are not recognised by the Medical Council of New Zealand or the Ministry of Health

Health services provided by health professionals who are not recognised by the Medical Council of New Zealand

Medical *conditions* that are not registered with the Ministry of Health

Unproven or unconventional medical *treatment*s, procedures or technologies that we have not pre-approved

Experimental techniques or technologies that we have specifically excluded

Treatments or procedures that nib consider novel or experimental

Treatment that is more expensive than another available *treatment* or procedure, and that will provide a medical outcome that's the same, or acceptably similar

Alternative or complementary medicines or therapies such as massage therapy, homeopathy or natural therapy

Consultations that are not face to face

Devices

Mechanical tools, aids or appliances of any type as we determine when you claim, such as insulin pumps, C-PAP equipment, cochlear implants, pacemakers, electrodes, nerve stimulators, crutches, and artificial limbs

Extra expenses

Any incidental costs such as car parking, newspapers, takeaway meals, alcohol, toiletries and TV rental

Administration costs such as fax charges, after-hours costs, overtime, cancellation charges and prioritisation fees

Ambulance society subscriptions

GP and out-of-*hospital* prescription charges, except where they're provided for under the GP Surgery benefit

Medications

Medications that are not approved by *Medsafe*

Medications that are not on the *PHARMAC* pharmaceutical schedule under section A to H.

Check whether your planned treatment is covered

The list gives examples only. Contact us before you go to *hospital*.

We can check what will be covered, and help you to avoid potential expenses.

Meanings of medical terms

ACC

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

Acute medical condition

A sign, symptom or *condition* that needs *hospital admission* for *treatment* or monitoring, immediately or within 48 hours.

Admission

To have followed an administration process to become an *admitted patient* as a private patient in a *recognised private hospital*. The *admission* must be for *treatment* of a sign, symptom or *condition*.*Treatment* in the emergency room of a *recognised private hospital* is not covered as an *admission*.

Admitted patient

An insured person who is formally *admitted* to a *recognised private hospital* for *surgery* or medical *treatment*. However, if they are treated in the emergency room, they are not covered s an *admitted patient*.

Brachytherapy

Radiation therapy in which sources of radiation (seeds) are implanted internally, close to or in the site being treated.

Cardiovascular system

The heart (all anatomical structures) and great vessels (aorta, inferior vena cava, superior vena cava, pulmonary artery, pulmonary vein and carotid arteries).

Categories

The areas of the body or the specific *surgical* procedure covered by the policy as detailed on the *Hospital Category List*. The list is on our website, **nib.co.nz**

Chemotherapy

A medication and its administration for treating cancer.

Condition

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

Congenital

A health anomaly or defect which is present at birth – whether it is recognised or not, and whether it is inherited or caused by external or environmental factors such as drugs or alcohol.

Consultation

A necessary face- to-face meeting with a *recognised health professional*. The purpose must be to evaluate the medical case and any *treatment*. A *consultation* does not include the *treatment* itself. This does not include any virtual *consultations*, such as by phone or Skype.

Dental practitioner

A *recognised health professiona*l who is:

- in *private practice* and holds a current annual practising certificate
- a member of the Dental Council of New Zealand (or its replacement, if the law changes).

Dental Treatment

Treatment provided by a *dental practitioner*.

Diagnostic investigation

An investigative procedure to determine the presence or cause of a sign, symptom or *condition*. For the purpose of this cover, this does not include skin biopsies or *treatment* of any kind, including pain relief.

GP or *General Practitioner*

A *recognised health professional* who is:

- in *private practice* and holds a current annual practising certificate, and
- a member of the Medical Council of New Zealand (or its replacement, if the legislation changes).

Health service or *health services*

Consultation, assessment, *diagnostic investigation* or *treatment* of a sign, symptom or *condition* provided by a *recognised health professional*.

Hospital

Premises that come within part (a) of the definition of 'hospital care' in the Health and Disability (Safety) Act 2001 (or its replacement, if the legislation changes).

Hospital Category List

The list of *categories* as published on our website at **nib.co.nz**. See the definition for *categories* on page 36.

Injection

Forcing a liquid or pharmaceutical into any part of the body, using a needle, cannula or other introducer.

Injury or *injuries*

A '*physical injury*', but not a '*mental injury*' as defined in the Accident Compensation Act 2001 (or its replacement if the legislation changes).

Long-term care

Public hospital and *private hospital*-based services provided on an ongoing regular basis when a medical *condition* has been present for more than 14 nights, or is likely to be.

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 if the legislation changes).

Mohs or *micrographic surgery*

A specialised *surgical* technique for removing skin cancers (carcinomas). It allows precise removal of tissue, assisted by frozen section and microscopic viewing with minimal damage to healthy tissue.

Nurse practitioner

A *recognised health professional* who is:

- in *private practice* and holds a current annual practising certificate as a nurse practitioner
- a member of the Nursing Council of New Zealand (or its replacement if the legislation changes).

Obesity

The World Health Organisation recognised definition of obesity.

PHARMAC

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

Pharmaceutical Prescription

A legally written order by a *registered specialist*, *GP*, d*ental practitioner* or *nurse practitioner* for the preparation and administration of a medicine (pharmaceutical), dispensed by a registered pharmacy. It must be for a medicine that's listed under sections A to H of the Ministry of Health PHARMAC pharmaceutical schedule (or its replacement if the legislation changes).

Physiotherapist

A *recognised health professional* who is:

- in *private practice* and holds a current annual practising certificate, and
- a member of the Physiotherapy Board of New Zealand (or its replacement if the legislation changes).

Physiotherapy

Treatment provided by a *physiotherapist*.

Podiatric Surgeon

A *recognised health professional* who is:

- in *private practice* and holds a current annual practising certificate, and
- a member of the Podiatrists Board of New Zealand (or any replacement), and
- vocationally registered and recognised as a podiatric surgeon.

Pre-existing condition

Any sign or symptom of any *condition*, or any *condition*:

- which the policyowner or the insured person was first aware of, or
- for which the insured person first sought *diagnostic investigation* or medical advice, or
- that would cause a reasonable person in the circumstances to first seek *diagnostic investigation* or medical advice

or

- any *condition*, which was evident (even if the *insured person* was not made aware of it) when they sought *diagnostic investigation*, medical *screening* or medical advice,

or

- any *treatment* of any *condition* which the insured person had, on or before the earliest of the following that applies to the insured person:

before their commencement date, effective date or join date.

Private practice

A practice recognised by nib (whether sole, partnership or group) which receives its main income from the fees it charges to its patients, without subsidy or funding from the public health sector.

Prophylactic

Any *surgery* or medical *treatment* performed to prevent the risk of a *condition* developing in the future.

Prosthesis or *prostheses*

An artificial implant (including stents and metalware) used to replace and / or support a joint or body part to restore function. This does not include spectacles, corrective lenses, appliances or an aid of any kind unless included in this policy).

Public hospital

A *hospital* owned and administered by the publicly funded health sector of the New Zealand Government.

Radiotherapy

A specified number of fractions (sequentially administered doses) of radiation where:

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

Recognised health professional

A person who is:

- registered and holds a current practising certificate that complies with the Health Practitioners Competence Assurance Act 2003 (or its replacement if the legislation changes)
- a member of the appropriate registration body, for example, Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand or the Chiropractic Board in New Zealand
- recognised by nib.

Recognised private hospital

A *private hospital*, day *surgery* unit or private wing in a *public hospital*, within New Zealand that has been recognised by nib. It does not include any other type of medical facility.

Recognised provider

A *recognised health professional*, *recognised private hospital* or other medical facility that is recognised by nib.

Registered specialist

A *recognised health professional* who:

- is in *private practice* and holds a current annual practising certificate
- is a member of an appropriately recognised specialist college
- has vocational registration in that specialty with the Medical Council of New Zealand (or its replacement if the legislation changes).

This definition does not include those holding vocational registration for accident and medical practice, emergency medicine, family planning, sexual health and reproductive health, general practice, medical administration, public health medicine or sports medicine.

Screening

An investigation carried out in the absence of any sign or symptom of a *condition* – for example, testing due to a family history of cancer.

Skin lesion

An abnormal change to any one or all of the three skin layers (epidermis, dermis and subcutaneous) caused by disease or *injury*.

Surgery or *surgical*

An operation performed in a *recognised provider* under an anaesthetic (general, intravenous sedation, local or spinal), requiring a surgical incision to remove or repair damaged or diseased tissue. For the purpose of this cover, this does not include *injections* of any type.

Surgical cost grouping

The overall costs for your *registered specialist*, anaesthetist, and any *prosthesis* costs.

Treatment

A *health service* that involves medical care, therapy, or *surgery*.

Vocational GP

A *general practitioner (GP)* with a relevant post-graduate qualification in the *health service* they are providing, as recognised by us.

Feedback and complaints

Any questions? More information?

Your customer feedback helps to improve the quality of our service.

Get in touch

Go to **nib.co.nz**

Email **contactus@nib.co.nz**

Have you got a complaint? Please let us know

We have a process for making sure complaints are heard and dealt with.

You are welcome to talk to the person who handled your enquiry or claim. Or to talk to a senior team member or team leader.

nib Complaints Committee

Or you can write to the nib Complaints Committee:

Email **complaints@nib.co.nz**

We will do everything we can to resolve complaints to your satisfaction.

If you are not satisfied with the outcome, we will write a 'letter of deadlock' which gives you the option to take your complaint to the Insurance & Financial Services Ombudsman (IFSO):

The Insurance & Financial Services Ombudsman

PO Box 10-845

Wellington 6143

Phone 0800 888 202

Email **info@ifso.nz**

Our privacy policy

We are committed to protecting the privacy and security of the personal information we collect.

We work to comply with our obligations under the Privacy Act 1993, including the Health Information Privacy Code 1994.

Our privacy policy explains how we may collect, use and disclose personal information. Read it at **nib.co.nz/about-us/privacy-policy**

Standard Hospital Policy document

Need help?

Go to **nib.co.nz**
Email us at contactus@nib.co.nz

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