Ultimate Health Max™

Policy document

nib

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Introduction

01 SECTION

Thank you for trusting nib to insure your good health. This Policy document explains what your Policy covers. It should be read in conjunction with all the documents that form part of your Contract of Insurance.

It is important you read the information carefully to ensure you know what you are covered for, what you need to tell us, how to make a Claim and any other terms and conditions of your Policy. However you should always make enquiries with nib before undergoing any Health Service (see Claims on page 17).

Unless specified, this Policy document only describes nib Ultimate Health Max Cover as at the date of issue of this Policy document. Each nib Cover can be amended from time to time in accordance with its terms.

Contract of insurance

Your Contract of Insurance consists of:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document);
- the Prosthesis Schedule; and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

Words in capitals

Some words in this document start with a capital letter, indicating a specific meaning which applies to Ultimate Health Max Cover only (see Glossary of important terms on page 72).

This is an important document

Please keep this Policy document and the other documents that form part of your Contract of Insurance in a secure place for future reference.

How to contact nib

Call us on **0800 123 nib** (0800 123 642)
Fax us on **0800 345 134**
Email us for general enquiries at **contactus@nib.co.nz**
Email us for claims at **claims@nib.co.nz**
nib nz limited
PO Box 91630
Victoria Street West
Auckland 1142

Go to **nib.co.nz**

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

My nib portal provides 24 hour access to your Policy and Claims details. This information can be found by visiting **nib.co.nz/portal**

General terms of Ultimate Health Max cover

02 SECTION

Applying for an nib cover

All applications for nib Cover must be accompanied by proof of identity and any other relevant information we require. We may at our discretion, refuse to accept an application until all necessary information has been provided or until the Premiums for the minimum period as determined by nib, have been paid.

Subject to the terms of this Policy document we may, at our discretion, refuse an application to join nib as an Insured Person, as described below:

- We have the right to refuse an application to join a Cover that has been closed for sale.
- We have the right to refuse an application to combine a Cover currently for sale with a Cover that has been closed for sale.
- We have the right to refuse an application to move a Cover that has been closed for sale to a Cover currently for sale.
- We have the right to refuse an application to move to another nib Cover.
- If we refuse an application, we will provide a reason for the refusal to the applicant.

Duty of disclosure

The Policyowner and all Insured Persons had a legal duty to disclose everything they knew (or ought to have known) which would have influenced the decision of a prudent insurer whether to accept the Policyowner's application, and if so, on what terms. For example, an Insured Person must have disclosed any medical condition or any sign, symptom, treatment or surgery of any medical condition they had at the time of applying, or have had in the past.

All information given by, or on behalf of, the Policyowner or any Insured Person must be true, correct and complete. The Insured Person must have told us about any changes to the information given to us before any Commencement Date, Effective Date or Join Date (as applicable) of this Policy. If the Insured Person failed to do so, or if any of the above information was not disclosed to us or was not true, correct and complete, we can cancel this Policy or alter the terms and conditions of Cover provided under this Policy from the Commencement Date, Effective Date or Join Date (as applicable) and not pay any Claims after those dates. We may retain all the Premiums paid, and any Claims paid by us after those dates may be recovered from the Policyowner or the Insured Person.

Financial Statements

The Policyowner or any Insured Person can obtain a copy of nib nz limited's financial statements for the last reported financial year by writing to nib nz limited, PO Box 91630, Victoria Street West, Auckland 1142.

Period of cover

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

14-day free-look period

A 14-day free-look period applies to all nib Covers.

The Policyowner can receive a full refund of Premiums if they decide to cancel the Policy within the first 14 days – providing no Claims have been made during that time, and that the cancellation is requested in writing. This period starts three days after we send you your Contract of Insurance. During this time, should you decide the Policy doesn't meet your needs, please send written confirmation to us and we will cancel the Policy and refund the full Premiums paid, providing no Claims have been made.

Health cover reviews

It is the Policyowner and all Insured Persons' responsibility to understand what is covered and what is not covered by their health insurance Policy. We recommend you review your health insurance at least once each year. We are happy to discuss your Cover – you are welcome to call us on **0800 123 nib** (0800 123 642).

nib recognised providers

Claims are only eligible for Health Services carried out by an nib Recognised Provider. We will pay for Benefits under the Ultimate Health Max Cover, if the Insured Person attends an nib Recognised Provider, who must:

- meet all the minimum criteria outlined by us relating to their education, qualifications and active membership of any governing body specified by us;
- be in Private Practice; and
- be recognised by nib.

In the rare instance that we do not recognise a provider, for example in the case of suspected fraud, you are required to co-operate fully with our review process, which may include providing authority to our legal representative and providing us with any relevant information. This process and our success or failure in it, will not result in you having Out-of-Pocket Expenses for otherwise eligible expenses.

Prosthesis Schedule

For Surgery requiring Prosthesis, we will pay up to the maximum amount as defined in the Prosthesis Schedule available on our website at **nib.co.nz**

This schedule is reviewed annually and the Policyowner and all Insured Persons must refer to the most up-to-date list, to understand what they are covered for and the limits that apply.

Key information found on nib's website and my nib portal

Our website

Our website provides key information such as our Prosthesis Schedule and Claim forms. All the relevant information and forms can be found by visiting **nib.co.nz**

My nib portal

Our portal provides 24 hour access to:

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

Our portal can be found by visiting **nib.co.nz/portal**

Who is covered

This Policy provides Cover for an Insured Person who is eligible to receive Health Services funded under the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation) at all times.

We may request to see originals or certified copies of each relevant Insured Person's documents (including visas or work permits in the Insured Person's passports, birth certificates or driver's licences).

We reserve the right to cancel the relevant Insured Person's Cover if the relevant person no longer meets the criteria (see Cancelling the policy or cover on page 14).

Dependent children

A Dependent Child will become subject to adult Premium rates on the next Policy Anniversary Date after they reach age 21. We will automatically continue to cover that person on this Policy as an adult Insured Person and deduct the additional Premium based on their age, gender, smoking status and Excess for the Cover, from the same payment source and at the same frequency as this Policy, unless you advise us otherwise. If the smoking status is not known, smoker Premiums will apply.

Unless otherwise approved by us, a person under 18 years of age is not eligible to be a Policyowner. A Dependent Child under age 18 must be accompanied on the Policy by at least one adult aged 18 or older as the Policyowner, or have his or her parent or legal guardian as the Policyowner.

Who can view and change the policy

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

The Policyowner must give us at least 30 days' prior notice in writing or by email before any changes can be made. The Policyowner may add or remove an Insured Person from the Policy, and may add or remove any nib optional Cover, at a Policy Anniversary Date (see Adding or removing an option on page 11).

If we agree to any other change, we will make the requested change to this Policy on the same (or nearest equivalent) date in the month that corresponds to the date in the month of the Policy Anniversary Date, immediately after you request this change. For example, if the Policy Anniversary Date is 30 September and you request a change on 15 June, the Effective Date of the change will be 30 June. If we make the change on any other date, we will let you know.

Adding an insured person

The Policyowner can add a Partner, Dependent Child, parent or grandchild onto their Policy, providing the Insured Person meets the eligibility criteria (see Who is covered on page 10) and the Insured Person (or their parent or legal guardian if under 16 years old) consents to be added, including providing privacy consent. The person being added to a Policy will be required to serve any applicable Waiting Period from the Commencement Date, Effective Date or Join Date (as applicable). The Policyowner and any new Insured Person added must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details.

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

A new Insured Person added to this Policy from the Join Date (as applicable) is shown on the Acceptance Certificate or Renewal Certificate (whichever is applicable).

Removing an insured person

We will remove an Insured Person from this Policy:

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

Changes in contact details

The Policyowner must notify us of all changes in contact details of the Insured Persons covered under the Policy. Where possible, they must provide an email address. The Policyowner can advise us in writing, including by email.

Changing the insured person's smoking status

If the smoking status is not known, smoker Premiums will apply. If any Insured Person (aged 21 years or over) changes their smoking status (including any tobacco or any other substance), they must complete an nib smoking status questionnaire and send the completed questionnaire to us. We will require at least 30 days' prior notice before this change will be applied on the Policy.

Adding or removing an option

The Policyowner can add an option(s) to the Policy and/or a Cover for an Insured Person for an additional Premium, by following the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application must be completed fully and accepted by us before the Cover on the option(s) can start.

We will charge any additional Premium for each Insured Person's additional option(s). The Premium will be adjusted from the next available billing date to reflect this change. The added optional Cover will start from the Effective Date or Join Date (as applicable) shown on the Acceptance Certificate or the Renewal Certificate (whichever is the later).

The Policyowner can only remove an option at the next Policy Anniversary Date. The Policyowner must give us at least 30 days' prior notice in writing before the option(s) can be removed.

We will process the change

Once we have accepted the changes, we will send the Policyowner a new Acceptance Certificate or Renewal Certificate (as applicable) that will show the changes.

Commencement of cover

Any Insured Person will be able to Claim for the Benefits and/or Health Services provided by the Cover once Waiting Periods have been served and provided that all Premiums have been paid up-to-date.

Waiting period

Waiting Period means a period of time after the Commencement Date, Effective Date or the Join Date (as applicable), for which no Claim will be paid for anything that happens during this period.

The following Waiting Periods apply to each Insured Person for this Policy:	
Base Cover – Oral Surgery for extraction of unerupted or impacted teeth	12 months
Serious Condition Financial Support Option – Serious Conditions as specified	90 days
GP Option	90 days
Dental and Optical Option	Six months
Proactive Health Option	Six months

Waiting periods when changing cover

For any change in Cover, the Policyowner must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application process must be completed fully and accepted by nib before the new Cover can start.

We recognise Waiting Periods already served on a Cover comparable to the Ultimate Health Max Cover only.

For Insured Persons changing their Cover with nib, the following Waiting Period rules apply:

New Benefits and/or Health Service	**No change in Benefits and/or Health Service**
The Waiting Period will apply from the Effective Date.	The Waiting Period applies from the Commencement Date, Effective Date or Join Date (as applicable) prior to the change.

Transfer to a new policy

If for any reason an Insured Person needs to transfer to a new Policy with the same level of Cover, the Waiting Period applies from the Commencement Date, Effective Date or Join Date (as applicable) of the original Policy.

Excess

- The Excess amount is detailed on the Acceptance Certificate or Renewal Certificate (whichever is the later) for each Insured Person, and applies to each Insured Person every Policy Year.
- The Excess will be deducted from eligible Claim payments for each Insured Person from the Commencement Date or Join Date (as applicable) until the Excess amount is reached.
- The Excess will be deducted from any eligible Claim payments for each Insured Person from every Policy Anniversary Date thereafter.
- The Excess is not payable by nib, and cannot be met by withdrawing from any other Benefits on your Policy.

For example: The Excess amount is $500, the Insured Person submits an eligible Claim for $250. No payment is made by nib to the Insured Person. The Insured Person then submits an eligible claim for $500. $250 is paid out to the Insured Person. Any further eligible Claims submitted after the Excess amount had been reached will be paid in line with Benefit Limits until the next Anniversary Date, when the Excess amount is then deductible again.

Changing your excess

The Policyowner can request to increase or decrease the Excess for any Insured Person within six weeks prior to the Policy Anniversary Date.

If the new Excess is lower than the previous Excess, the Policyowner and all the affected Insured Persons must follow the relevant application process. Please call us on **0800 123 nib** (0800 123 642) for more details. The application must be completed fully and accepted by us before the new Excess can start. Any new Excess will commence from the Policy Anniversary Date and it will be noted on the Acceptance Certificate.

Maintaining continuous cover

It is important to maintain continuous Cover with nib to ensure you are able to continue to Claim Benefits and to avoid having to re-assess all the Insured Persons' health and to re-serve Waiting Periods if they decide to re-join later (see Contract of Insurance on page 7).

- If the Policy falls into arrears of Premium, no Insured Persons on the Policy will be able to Claim.
- After 90 days of non-payment the Policy will be cancelled (see Cancelling the policy or cover on page 14).
- It will be at nib's discretion to determine whether the Insured Persons will be covered for any Claims for Health Services carried out during a period of non-payment.

Resuming your policy or cover from suspension

- If the Policy or Cover for an Insured Person has been suspended under the Loyalty – Suspension of Cover Benefit it must be resumed within 90 days of the suspension end date, otherwise the Policy or Cover will be cancelled.
- If the same Cover is resumed before the suspension period ends, we will reinstate the Cover without enquiring into the affected Insured Person's health.
- If Waiting Periods have not been fully served, the remainder of the Waiting Periods must be served once the Policy or Cover is resumed.

- If the Policy or Cover for an Insured Person is not reinstated at the end of the suspension period, we will write to the Policyowner at their last known address and give them 90 days within which to pay any arrears of Premium. If they do not pay the arrears within the 90 days the Policy or Cover for the affected Insured Persons will end.

Cancelling the policy or cover

Unless otherwise permitted by us, any cancellation of a Policy and/or Cover for an Insured Person must be authorised in writing by the Policyowner. The Policyowner must give us at least 30 days' notice of the cancellation.

We reserve the right to cancel the Policy and/or Cover for an Insured Person, if:

- the Premiums are in arrears by more than 90 days after the due date for payment; or
- the Policy is not resumed following a suspension; or
- an Insured Person is no longer entitled to receive Health Services funded under the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation); or
- the last Insured Person covered by this Policy dies; or
- any Insured Person breaches the terms of the Policy; or
- any information provided by, or on behalf of the Policyowner or any Insured Person when arranging this Policy or when making any changes to it, is not true, correct and complete; or
- an Insured Person covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, whether for themselves or for any other Insured Person, to which they are not entitled under this Policy document; or
- an Insured Person has engaged in offensive or intimidating behaviour towards employees of nib.

If we cancel this Policy or Cover for an Insured Person, any Premiums paid may be retained by us. If we have already made any Claims payments we may recover these from the Policyowner.

Your premiums

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

- Where the Premium rate change takes effect during the Policy Year, the change will not come into effect until the next Premium falls due.
- Premiums can be paid in advance for up to a maximum of 12 months.

Available payment methods and frequency

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

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

nib payment service agreement

We will give the Policyowner at least 30 days' notice in writing if there are changes to the details of the direct debit terms and conditions.

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

It is the Policyowner's responsibility to:

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

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

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

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

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

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

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

If the Policyowner has a direct debit inquiry, or believes a debit has been made incorrectly, please contact us immediately on **0800 123 nib** (0800 123 642) or write to:

nib nz limited
PO Box 91630
Victoria Street West
Auckland 1142

Important information about your premiums and benefits

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

The Premiums automatically increase when an Insured Person reaches a specified age. Any changes to the Premium rates and age related steps apply across all Insured Persons with this Policy.

No changes will be made to your individual Policy alone, based upon the individual claims experience of your Policy.

The Premiums for this Policy are not guaranteed. We may alter the Premium rates (including any policy fee and/or the age related steps) during the life of the Policy, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

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

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

We want to ensure your valuable cover continues if a premium deduction advice is returned to us as gone/no address. In these circumstances, we will continue to make deductions in accordance with our Premium rates until we are advised otherwise and the Policyowner authorises us to stop the deductions.

Guaranteed Benefits and Future Upgrades

The Benefits (including terms of the Cover, 'What is not covered' and 'Glossary of important terms') for this Policy are guaranteed, subject to the permitted changes set out below. We may only alter the Benefits or other terms of the Cover (except for Premium rates) during the life of the Policy if:

- the law that applies to the Policy changes (including changes in taxation); or
- the Policyowner and/or Insured Person failed to disclose information to us (see Duty of Disclosure on page 8); or
- new Benefits or increases to existing Benefits are added to the Policy.

If we add new Benefits or increase existing Benefits, these changes will only apply to relevant Health Services received where the treatment date is after the date of the relevant change.

Claims

Benefits will only be paid for Claims which meet nib criteria.

- All Claims are subject to your Contract of Insurance (on page 7) and What is not covered (on page 65).
- All Claims must relate to an Insured Person.
- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to the Policy or law.
- It will be at nib's discretion to determine whether the Insured Person will be covered for any Claims for Health Services carried out during a period of non-payment.
- Claims are only eligible for Health Services carried out by Recognised Providers.
- Any Claims must have all the relevant information submitted with the Claim form (see Supporting documentation for Pre-approval and Claims on page 18).

How to make a claim

- Visit our portal at **nib.co.nz/portal** to submit a Claim.
- Visit our website at **nib.co.nz** for a Claim form.
- Call us on **0800 123 nib** (0800 123 642).
- Email us at **claims@nib.co.nz**
- The Policy number must be quoted for all Claims.

Pre-approval

- We strongly recommend any Insured Person should seek Pre-approval prior to undertaking any Health Service to understand what is covered under your Policy.
- Our aim is to process the Pre-approval within five working days from the date the request is received by us, unless further information is required or insufficient information was initially supplied.
- If we issue a Pre-approval for a Claim, we will notify the Policyowner or the Insured Person and send the Policyowner a Pre-approval advice.
- All Claim and Pre-approval forms are available on our portal at **nib.co.nz/portal**, our website at **nib.co.nz** or by contacting us:
  - Call us on **0800 123 nib** (0800 123 642). Our opening hours are Monday to Friday 8.00am to 5.30pm. We are closed on public holidays.
  - Fax us on **0800 345 134**
  - Email us at **claims@nib.co.nz**

The confirmation of the Pre-approval is valid for three months from the date of issue recorded on the correspondence, unless the Cover is cancelled with effect from a date on or prior to the treatment date.

If the Cover is cancelled with effect from a date prior to the treatment date, the Pre-approval will not be valid.

Supporting documentation for Pre-approval and Claims

Supporting documentation for Pre-approval or Claims must:

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

We recommend all Claims be submitted within 12 months of the Health Service date, as no inflation adjustments apply.

Novel, experimental or more expensive treatments or procedures

We will not approve any novel, experimental or more expensive treatment or procedure, where a conventional or less expensive treatment or procedure is available that will provide the same, or a similarly acceptable, medical outcome.

This means novel or experimental treatments, procedures or equipment are not likely to be covered unless, in nib's opinion, they provide a superior outcome at a reasonable cost.

Medical report or assistance

All costs of completing the Claim form, including providing a medical report if required by us, will be at the Policyowner's expense. If we require further information in order to assess the Claim or Pre-approval, all requests must be complied with. If we request additional information, this will be at our expense.

Rapid refund and method

Our aim is to process the Pre-approval or Claims within five working days, unless further information is required. Reimbursement must be to a Recognised Provider, Policyowner or Insured Person, regardless of whether any other person has paid the invoice.

In cases where the Insured Person is deceased, Claim payment can only be made to the Recognised Provider, remaining Policyowner or the deceased Insured Person's estate.

In cases where we are refunding the Policyowner or Insured Person by direct credit, please ensure your banking details are accurate on the Claim form. If we pay to an incorrect account due to an Insured Person's error, no replacement payment can be issued until the original payment has been returned to us.

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

Usual, Customary and Reasonable Charges (UCR Charges)

All costs incurred under a Benefit will be compared to our UCR Charges. This allows nib to manage the costs of Claims. Where the actual costs incurred vary significantly from our UCR Charges, we will negotiate with the Recognised Provider concerned. This process, and our success or failure in it, will not affect what we pay under this Policy.

Medications provided in hospitals or at home

The Policy will meet the cost of medications that are registered and approved by Medsafe, that meet the associated funding criteria, and that are prescribed by the treating Registered Specialist. If a medication is not listed under section A to H of the PHARMAC pharmaceutical schedule, the treating Registered Specialist must provide a recommendation letter detailing the reasons for the medication(s).

Any administration and/or associated costs paid to administer the medications are also covered.

Additional terms

- Benefits are not payable for any medications charged in a Public Hospital.
- Benefits are not payable for any medications that are listed as pending review by Medsafe.
- Benefits are not payable for any medications prescribed or administered outside of the Medsafe guidelines and associated criteria.

ACC

03 SECTION

ACC review

If we believe that ACC should cover your Health Service(s), you are required to co-operate fully with our review process, which may include providing authority to our legal representative and providing us with copies of the ACC declined letter, the case summary and any other relevant information.

ACC treatment injury

In the rare instance of treatment Injury during Surgical or medical treatment, cover is payable for any additional costs involved under the ACC treatment Injury Benefit (see ACC Treatment Injury Benefit on page 40).

What is covered

04 SECTION

Base Cover

This section lists and defines the Benefits we provide under the Ultimate Health Max base Cover, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Claims are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

If the Policyowner has chosen an Excess for an Insured Person's Cover, this will apply to that Insured Person every Policy year (see Excess on page 13).

1. Hospital Surgical Benefit

This Benefit covers the following for eligible Surgical Claims, upon Admission:

- surgeon's operating fees;
- anaesthetist's fees;
- intensivist's fees;
- Hospital accommodation (e.g. Admitted Patient's bed, a private room) (excludes suites);
- operating theatre fees;
- Surgically implanted Prosthesis (see Prosthesis Schedule on page 9);
- laparoscopic disposables;
- in-Hospital X-ray examination and ECG;
- intensive post-operative care and special in-Hospital nursing;
- in-Hospital post-operative Physiotherapy;
- ancillary Hospital charges (e.g. dressings, sutures, needles, bandages); and
- in-Hospital Pharmaceutical Prescriptions (see Medications provided in hospitals and at home on page 19).

We also cover the costs of alternative, less invasive, procedures which, in our sole opinion, replace Surgery as the most appropriate method of treatment for any Condition that we would have otherwise agreed to accept as a Surgical Claim. Cover is under the Hospital Medical Benefit.

This Benefit also applies to the Cover available under the following Benefits relating to an Admission. Claims paid under these Benefits will be deducted from the balance available in the Hospital Surgical Benefit Limit for the current Policy Year and no further claims will be paid after the Hospital Surgical Benefit Limit has been reached:

- Non-PHARMAC Funded Drugs in Hospital Benefit (see Non-PHARMAC Funded Drugs in Hospital Benefit on page 25);
- Non-PHARMAC Funded Drugs at Home Benefit (see Non-PHARMAC Funded Drugs at Home Benefit on page 26);

- Cancer Treatment Accessories Support Benefit (see Cancer Treatment Accessories Support Benefit on page 26);
- Cancer Treatment Counselling and Support Services Benefit (see Cancer Treatment Counselling and Support Services on page 26);
- Cardiac Counselling and Support Services (see Cardiac Counselling and Support Services on page 27);
- Follow-up Investigations for Cancer Benefit (see Follow-up Investigations for Cancer Benefit on page 28);
- Breast Symmetry Post Mastectomy Benefit (see Breast Symmetry Post Mastectomy Benefit on page 29);
- Major Diagnostics Benefit (see Major Diagnostics Benefit on page 29);
- Hospital Diagnostics Benefit (see Hospital Diagnostics Benefit on page 30);
- Hospital Specialist Consultations Benefit (see Hospital Specialist Consultations Benefit on page 30);
- Hospital Specialist Second Opinion Benefit (see Hospital Specialist Second Opinion Benefit on page 30);
- Travel and Accommodation Benefit (see Travel and Accommodation Benefit on page 31);
- Parent Accommodation Benefit (see Parent Accommodation Benefit on page 32);
- Ambulance Transfer Benefit (see Ambulance Transfer Benefit on page 32);
- Home Nursing Care Benefit (see Home Nursing Care Benefit on page 32);
- Physiotherapy Benefit (see Physiotherapy Benefit on page 33);
- Therapeutic Care Benefit (see Therapeutic Care Benefit on page 33);
- Delayed Care Benefit (see Delayed Care Benefit on page 34);
- Cover in Australia Benefit (see Cover in Australia Benefit on page 34);
- Medical Tourism Benefit (see Medical Tourism Benefit on page 36);
- Pre-existing Cover for Newborns Benefit (see Pre-existing Cover for Newborns Benefit on page 37);
- Specialist Skin Lesions Surgery Benefit (see Specialist Skin Lesions Surgery Benefit on page 38);
- ACC Top-up Benefit (see ACC Top-up Benefit on page 39);
- ACC Treatment Injury Benefit (see ACC Treatment Injury Benefit on page 40);
- Loyalty – Sterilisation Benefit (see Loyalty – Sterilisation Benefit on page 42);
- Loyalty – Bariatric Surgery Benefit (see Loyalty - Bariatric Surgery Benefit on page 43); and
- Loyalty – Bilateral Breast Reduction Benefit (see Loyalty – Bilateral Breast Reduction Benefit on page 44).

Individual limits and terms may apply to each of the Benefits.

Benefit limit

- We will pay up to a total maximum of $600,000 for each Insured Person every Policy Year under this Benefit.

Additional terms

- Benefits are not payable if the Surgery is not performed by a Registered Specialist.

Oral surgery

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

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

Additional terms

- Benefits are not payable for any extraction of teeth other than for unerupted or impacted teeth.
- Benefits are not payable for any other Dental Treatments, including periodontic, endodontal procedures, Orthodontic Treatment and implants, and orthognathic surgery or exposure of teeth.

Specialist micrographic surgery (Mohs)

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

Additional terms

- Benefits are not payable for any cryotherapy, pulse light therapy or photodynamic therapy.
- For any other Skin Lesion Surgery (see Specialist Skin Lesion Surgery Benefit on page 38).

Varicose vein treatment

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

- a Registered Specialist; or
- a Vocational GP; or
- an nib Recognised Health Professional;
  - who is in Private Practice and holds a current annual practising certificate;
  - is registered with the Medical Council of New Zealand; and
  - is a fellow of the Australasian College of Phlebology.

Additional terms

- Benefits are not payable for any cosmetic surgeries or treatment, including but not limited to superficial veins (for example: spider veins).

2. Hospital Medical Benefit

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

- Hospital accommodation (e.g. Admitted Patient's bed, a private room) (excludes suites);
- in-Hospital X-ray examination and ECG;
- intensive post-treatment care and special in-Hospital nursing;
- in-Hospital post-treatment Physiotherapy;
- ancillary Hospital charges (e.g. dressings, bandages); and

- in-Hospital Pharmaceutical Prescriptions (see Medications provided in hospitals and at home on page 19).

This Benefit also applies to the Cover available under the following Benefits relating to an Admission. Claims paid under these Benefits will be deducted from the balance available in the Hospital Medical Benefit Limit for the current Policy Year and no further claims will be paid after the Hospital Medical Benefit Limit has been reached:

- Cancer Treatment in Hospital Benefit (see Cancer Treatment in Hospital Benefit on page 25);
- Non-PHARMAC Funded Drugs in Hospital Benefit (see Non-PHARMAC Funded Drugs in Hospital Benefit on page 25);
- Non-PHARMAC Funded Drugs at Home Benefit (see Non-PHARMAC Funded Drugs at Home Benefit on page 26);
- Cancer Treatment Accessories Support Benefit (see Cancer Treatment Accessories Support Benefit on page 26);
- Cancer Treatment Counselling and Support Services Benefit (see Cancer Treatment Counselling and Support Services Benefit on page 26);
- Follow-up Investigations for Cancer Benefit (see Follow-up Investigations for Cancer Benefit on page 28);
- Major Diagnostics Benefit (see Major Diagnostics Benefit on page 29);
- Hospital Diagnostics Benefit (see Hospital Diagnostics Benefit on page 30);
- Hospital Specialist Consultations Benefit (see Hospital Specialist Consultations Benefit on page 30);
- Hospital Specialist Second Opinion Benefit – see Hospital Specialist Second Opinion Benefit on page 30);
- Travel and Accommodation Benefit (see Travel and Accommodation Benefit on page 31);
- Parent Accommodation Benefit (see Parent Accommodation Benefit on page 32);
- Ambulance Transfer Benefit (see Ambulance Transfer Benefit on page 32);
- Home Nursing Care Benefit (see Home Nursing Care Benefit on page 32);
- Physiotherapy Benefit (see Physiotherapy Benefit on page 33);
- Therapeutic Care Benefit (see Therapeutic Care Benefit on page 33);
- Delayed Care Benefit (see Delayed Care Benefit on page 34);
- Cover in Australia Benefit (see Cover in Australia Benefit on page 34);
- Medical Tourism Benefit (see Medical Tourism Benefit on page 36);
- Pre-existing Cover for Newborns Benefit (see Pre-existing Cover for Newborns Benefit on page 37);
- ACC Top-up Benefit (see ACC Top-up Benefit on page 39); and
- ACC Treatment Injury Benefit (see ACC Treatment Injury Benefit on page 40).

Individual Benefit Limits and terms may apply to each of the Benefits.

Hospital medical Cover as an alternative, less invasive procedure to Surgery is covered under this Benefit.

Benefit limit

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

Additional terms

- Benefits are not payable when the medical treatment is not managed by a Registered Specialist.
- Benefits are not payable for any medical treatment where the sole or main purpose of the medical treatment is administration of an Injection. For example: pain management Injections or intravitreal Injection (except where the contrary is expressly specified in the Policy).
- Benefits are not payable unless the Condition or treatment requires Admission as supported by medical evidence.
- Benefits are not payable if the drug is not approved by Medsafe.

3. Cancer Treatment in Hospital Benefit

This Benefit covers the following for eligible Claims upon Admission:

- Chemotherapy;
- Radiotherapy;
- Brachytherapy;
- Hospital accommodation (e.g. Admitted Patient's bed, a private room) (excludes suites);
- in-Hospital X-ray examination and ECG;
- intensive post-treatment care and special in-Hospital nursing;
- in-Hospital post-treatment Physiotherapy;
- ancillary Hospital charges (e.g. dressings, needles, bandages); and
- in-hospital Pharmaceutical Prescriptions (see Medications provided in hospitals or at home on page 19).

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Medical Benefit Limit.

Additional terms

- Costs relating to a cancer Surgery are covered under the Hospital Surgical Benefit (see Hospital Surgical Benefit on page 21).

4. Non-PHARMAC Funded Drugs in Hospital Benefit

This Benefit covers the costs of drugs that are Medsafe approved for use in a Recognised Private Hospital (see Medication provided in hospital or at home on page 19).

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- For drugs issued for the sole purpose of use at home after Admission (see Non-Pharmac Funded Drugs at Home Benefit below).
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical

Benefit (whichever applies).

- Benefits are not payable if the drug is not approved by Medsafe.

5. Non-PHARMAC Funded Drugs at Home Benefit

This Benefit covers the costs of drugs that are Medsafe approved up to six months after Admission approved by us (see Medication provided in hospitals or at home on page 19).

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- For drugs issued during Admission (see Non-Pharmac Funded Drugs in Hospital Benefit above).
- Benefits are only payable providing the drug are Medsafe approved and is directly relate to that Admission.
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).

6. Cancer Treatment Accessories Support Benefit

This Benefit covers the costs of a wig, hat, scarf or mastectomy bras during or within six months after a cancer Surgery or Cycle of cancer treatment approved by us.

Benefit limits

This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Scarf/hat

- The maximum we will pay for this Benefit is $50 for each eligible cancer Condition.

Wig/Mastectomy bras

- The maximum we will pay for this Benefit is $500 for each eligible cancer Condition.

Additional terms

- Benefits are only payable upon receipt of evidence of the costs incurred.
- Benefits are only payable providing the cost of the scarf, hat, wig or mastectomy bras relate directly to the eligible cancer Condition.
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).

7. Cancer Treatment Counselling and Support Services Benefit

This Benefit covers the cost of Counselling and support services that occur within six months after an Admission for a cancer Surgery or Cycle of cancer treatment approved by us.

Claims must be received with the treating GP or Registered Specialist's

written recommendation for the Counselling and/or support service. The recommended service must relate to the cancer Surgery or Cycle of treatment for cancer approved by us.

The Counselling services covered under this Benefit are:

- Grief Counselling;
- Illness crisis Counselling;
- Anxiety Counselling;
- Depression Counselling; and
- Anger management.

The support services covered under this Benefit are:

- Stop smoking;
- Drug addiction;
- Alcohol addiction;
- Gambling addiction;
- Relationship guidance;
- Budgeting advice;
- Career advice; and
- Small business advice.

Benefit limits

This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Counselling services

- The maximum we will pay for this Benefit is $400 for each eligible cancer Condition.

Support services

- The maximum we will pay for this Benefit is $300 for each eligible cancer Condition.

Additional terms

- Benefits are only payable if the Counselling service is provided by a GP, Clinical Psychologist, Psychiatrist or Psychologist, and is approved by nib prior to receiving the service.
- Benefits are only payable if the support service is provided by an expert within their field, and is approved by nib prior to receiving the service.
- Benefits are only payable upon receipt of evidence of the costs incurred.
- Benefits are not payable to any family members, friends, associates or those who do not meet the criteria as determined by us.
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).

8. Cardiac Counselling and Support Services Benefit

This benefit covers the cost of Counselling and support services that occur within six months after an Admission for a heart Surgery approved by us.

Claims must be received with the treating GP or Registered Specialist's written recommendation for the Counselling and/or support service. The recommended service must relate to the heart Surgery approved by us.

The Counselling services covered under this Benefit are:

- Grief Counselling;
- Illness crisis Counselling;
- Anxiety Counselling;
- Depression Counselling; and
- Anger management.

The support services covered under this Benefit are:

- Stop smoking;
- Drug addiction;
- Alcohol addiction;
- Gambling addiction;
- Relationship guidance;
- Budgeting advice;
- Career advice; and
- Small business advice.

Benefit limits

This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Counselling services

- The maximum we will pay for this Benefit is $400 for each eligible heart Surgery.

Support services

- The maximum we will pay for this Benefit is $300 for each eligible heart Surgery.

Additional terms

- Benefits are only payable if the Counselling service is provided by a GP, Clinical Psychologist, Psychiatrist or Psychologist, and is approved by nib prior to receiving the service.
- Benefits are only payable if the support service is provided by an expert within their field, and is approved by nib prior to receiving the service.
- Benefits are payable upon receipt of evidence of the costs incurred.
- Benefits are not payable to any family members, friends, associates or those who do not meet the criteria as determined by us.
- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).

9. Follow-up Investigations for Cancer Benefit

Following a cancer Surgery or treatment approved by us, we cover one Registered Specialist Consultation and relevant investigation(s) relating to that cancer every Policy Year for up to five years.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We will pay a total maximum of $3,000 for each Insured Person every Policy Year.

- We will pay up to five consecutive Policy Years.

Additional terms

- This Benefit is only effective from the end of your treatment phase (Chemotherapy, Radiotherapy, Brachytherapy or Surgery).

10. Breast Symmetry Post Mastectomy Benefit

Following a mastectomy covered under this Policy we will cover:

- the cost of reconstruction of the affected breast and/or
- unilateral breast reduction Surgery of the unaffected breast,

to achieve breast symmetry.

This benefit includes cover for any Consultations, diagnostics and subsequent treatments relating to breast reconstruction or unilateral breast reduction Surgery.

Following the initial breast reconstruction or unilateral breast reduction we will not cover any subsequent treatment that is not Medically Necessary.

Benefit limits

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit.

Additional terms

- To claim under this Benefit, the Insured Person must submit a medical report by a Registered Specialist prior to the Surgery.
- This Benefit is only payable if Insured Person has had a mastectomy covered under this Policy
- No excess will be deducted from this Benefit.

11. Major Diagnostics Benefit

This Benefit covers the cost of the following Diagnostic Investigations after referral by a GP or Registered Specialist.

- arthroscopy
- capsule endoscopy
- colonoscopy
- colposcopy
- CT scan
- CT angiogram
- cystoscopy
- gastroscopy
- MRI scan
- myelogram
- PET scan (including PET/CT scan)

Benefit limits

- There is no limit to the number of Diagnostic Investigations for each Insured Person every Policy Year.
- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

If the Diagnostic Investigation results in an Admission within six months, it will be covered under the Hospital Diagnostics Benefit (see Hospital Diagnostic Benefit on page 30).

12. Hospital Diagnostics Benefit

This Benefit covers Diagnostic Investigations up to six months before and after Admission.

Benefit limits

- There is no limit to the number of Diagnostic Investigations during the specified timeframe.
- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies). Cover may be available under the Specialist Option if the Policyowner has selected that option.

13. Hospital Specialist Consultations Benefit

This Benefit covers Registered Specialist or Vocational GP Consultations up to six months before and after Admission, after a referral from a GP or a Registered Specialist.

Benefit limits

- There is no limit to the number of Registered Specialist or Vocational GP Consultations during the specified timeframe.
- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies). Cover may be available under the Specialist Option if the Policyowner has selected that option.

14. Hospital Specialist Second Opinion Benefit

This Benefit covers the costs of a second opinion from another Registered Specialist or Vocational GP for the Admission.

This Benefit covers the costs of Registered Specialist or Vocational GP Consultations for a second opinion, up to six months before and after Admission.

Benefit limits

- There is no limit on the number of Registered Specialist or Vocational GP Consultations for a second opinion, for each Insured Person every Policy Year.
- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Specialist Consultations Benefit (see above).
- For Diagnostic Investigations requested by another Registered Specialist (see Hospital Diagnostic Investigations Benefit on page 30 and Major Diagnostics Benefit on page 29).

15. Travel and Accommodation Benefit

This Benefit covers the travel and accommodation costs incurred when Surgery or medical treatment recommended by a Registered Specialist is not available through a Recognised Private Hospital within 100 kilometres from the Insured Person's usual residence.

Where a Registered Specialist has recommended a support person for the Surgery or medical treatment. The support person must travel together with the Insured Person to and from the Recognised Private Hospital.

Travel

This Benefit covers the following where applicable:

- air: a return economy class flight within New Zealand for the Insured Person and the accompanying support person; or
- car: mileage for road travel at the amount determined by nib; or
- rail or bus: a return rail or bus trip within New Zealand for the Insured Person and the accompanying support person; and
- taxi: taxi fares on Admission and discharge from the Recognised Provider to/from the airport or railway station for the Insured Person and the accompanying support person.

Accommodation

We will cover the cost of accommodation incurred by the support person whilst the Insured Person is an Admitted Patient.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- Surgery and medical treatment: the maximum we will pay for travel is $3,000 for each Insured Person every Policy Year. We will pay up to $300 each night for accommodation costs.
- Cancer treatment: the maximum we will pay for travel is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies). We will pay up to $300 each night for accommodation costs.

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).
- Benefits are not payable for any costs incurred when travelling outside New Zealand.
- Benefits are not payable for any costs relating to vehicle hire.
- Benefits are not payable for any costs relating to travel insurance.

16. Parent Accommodation Benefit

This Benefit covers the cost of accommodation incurred by a parent or legal guardian accompanying an Insured Person aged 20 or under, where they are being treated in a Recognised Private Hospital.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We will pay up a total maximum of $3,000 for each Insured Person every Policy Year.
- We will pay a maximum of $300 each night.

Additional terms

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

17. Ambulance Transfer Benefit

This Benefit covers the cost of road ambulance transfer from a Public Hospital or Recognised Private Hospital to the closest Recognised Private Hospital. The road ambulance transfer must be recommended by a Registered Specialist who has cared for the Insured Person for at least 24 hours as an Admitted Patient.

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).
- Benefits are not payable on any ambulance society subscriptions.

18. Home Nursing Care Benefit

This Benefit covers the cost of home nursing care up to six months after being discharged from a Recognised Private Hospital where the home nursing directly relates to a medical Condition, and the Insured Person requires assistance with any of the Activities of Daily Living.

The home nursing care must be recommended by the Insured Person's GP or Registered Specialist and provided by a Registered Nurse or a Nurse Practitioner.

This Benefit provides Cover for up to six months following each Admission as long as assistance is still required for the Activities of Daily Living.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit

Limit (whichever applies).

- We will pay up to a total maximum of $6,000 for each Insured Person every Policy Year.
- We will pay up to $300 a day.

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).
- Benefits are not payable for any cost in relation to providing domestic duties/house keeping or childcare. Cover may be available under the GP Option if the Policyowner has selected this option.

19. Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy up to six months after being discharged from a Recognised Private Hospital where the Physiotherapy directly relates to that medical Condition, after a referral by the treating Registered Specialist.

Benefit limits

- There is no limit to the number of Physiotherapy treatments during the specified timeframe.
- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- Benefits are only payable when an associated Claim has been paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies). Cover may be available under the GP Option if the Policyowner has selected that option.

20. Therapeutic Care Benefit

This Benefit covers the cost of the following:

- Osteopathic treatment;
- Chiropractic treatment;
- Speech Therapy;
- Occupational Therapy;
- Dietitian Consultations; and
- Sports Physician Treatments

up to six months after being discharged from a Recognised Private Hospital, where the therapeutic care directly relates to that medical Condition, after referral by the treating Registered Specialist.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We will pay up to a total maximum of $1,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are only payable when an associated Claim has been

paid under the Hospital Surgical Benefit or Hospital Medical Benefit (whichever applies).

- Cover may be available under the Specialist Option, GP Option and Dental and Optical Option if the Policyowner has selected these options.

21. Delayed Care Benefit

This Benefit covers the costs of Surgery or medical treatment that takes place overseas where the Surgery or medical treatment is privately available in New Zealand but cannot be provided as a direct result of insufficient medical resources, for a period of six months or more.

This Benefit covers the costs of economy flights for the Insured Person and one support person to and from the destination, including transfers.

This Benefit also covers the costs of accommodation for the Insured Person and one support person as agreed by nib prior to departure.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We will pay UCR costs that would be payable in New Zealand for the same Surgery or medical treatment.

Payment method and currency

- All payments, Excess and Benefit Limits under this Benefit are in New Zealand dollars and will be direct credited into your nominated New Zealand bank account in New Zealand dollars. Payments can only be made to the Policyowner or Insured Person. We do not pay the Health Service provider concerned.
- The exchange rate will be calculated by nib as at the date of Health Services.

Additional terms

- Relevant Diagnostic Investigations and histology must be performed prior to departure.
- Destination, travel and accommodation details are subject to nib approval, at nib's sole discretion.
- All medical facilities/treatment providers/health professionals must have an equivalent accreditation/registration as per New Zealand standards approved by nib.
- Benefits are not payable when Surgery or medical treatment is not available in New Zealand.
- Benefits are not payable for any Surgery or medical treatment that is claimable under the overseas treatment Benefit.
- Benefits are not payable for any Surgery or medical treatment not performed in an overseas private hospital.

22. Cover in Australia Benefit

This Benefit covers the costs incurred by the Insured Person for a Surgical or medical treatment in Australia for all the Benefits listed under this base Cover with the exception of:

- Travel and Accommodation Benefit;
- Overseas Treatment Benefit;
- Delayed Care Benefit;

- ACC Top-up Benefit;
- ACC Treatment Injury Benefit; and
- Ambulance Transfer Benefit

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We will reimburse up to the UCR Charges which would have been payable in New Zealand.

Payment method and currency

- All payments, Excess and Benefit Limits under this Benefit are in New Zealand dollars and will be direct credited into your nominated New Zealand bank account in New Zealand dollars. Payments can only be made to the Policyowner or Insured Person. We do not pay the Health Service provider concerned.
- The exchange rate will be calculated by nib as at the date of Health Services.

Additional terms

- Benefits are not payable for any Surgical or medical treatment undertaken relating to an Injury which would be covered under ACC in New Zealand if the Injury had occurred in New Zealand.
- All medical facilities/treatment providers/health professionals must have an equivalent accreditation/registration as per New Zealand standards approved by nib.
- Surgical or medical treatment must comply with the Australian legislation.
- Benefits are not payable for any type of ambulance costs.
- Claims cannot be submitted for both Cover in Australia Benefit and Overseas Treatment Benefit for the same Surgical or medical treatment. If both Benefits are eligible we will pay the higher Benefit Limit.
- Benefits for any medications are only provided if the medications would be covered in New Zealand (see Medications provided in hospital on page 19).

23. Overseas Treatment Benefit

This Benefit covers the cost of an overseas Surgical or medical treatment that cannot be performed at all in New Zealand, where an application has been submitted to the Ministry of Health for funding under the 'Medical Treatment Overseas Scheme', and the Ministry of Health has declined funding.

We cover the reasonable travel cost, including return economy airfares for the Insured Person requiring treatment and a support person, plus the cost of the treatment performed overseas, up to the Benefit Limit.

Benefit limit

- We will pay up to a maximum of $30,000 for every overseas Surgical or medical treatment for each Insured Person.

Payment method and currency

- All payments, Excess and Benefit Limits under this Benefit are

in New Zealand dollars and will be direct credited into your nominated New Zealand bank account in New Zealand dollars. Payments can only be made to the Policyowner or Insured Person. We do not pay the Health Service provider concerned.

- The exchange rate will be calculated by nib as at the date of Health Services.

Additional terms

- The treatment must be a type that cannot be performed in New Zealand.
- The treatment must be recommended by the Insured Person's treating Registered Specialist.
- The Surgery or medical treatment are subject to nib approval, at nib's sole discretion.
- You must provide a copy of the Ministry of Health's decision regarding funding to nib.
- All medical facilities/treatment providers/health professionals must have an equivalent accreditation/registration as per New Zealand standards approved by nib.
- Surgical or medical treatment must comply with the local legislation and applicable law.
- Benefits are not payable for any accommodation costs.
- Benefits are not payable for any desensitisation, vaccinations, immunology or allergies.

24. Medical Tourism Benefit

This Benefit covers the cost of overseas Surgical or Medical treatment in the country of the Insured Person's choice, provided the treatment is recommended by a Registered Specialist in New Zealand and can be provided in New Zealand within a period of six months.

This Benefit only covers costs that would be covered under the Hospital Surgical Benefit, Hospital Medical Benefit, Cancer Treatment in Hospital Benefit, non-PHARMAC Funded Drugs in Hospital Benefit or non-PHARMAC Funded Drugs at Home Benefit.

Notwithstanding the references to any other Benefits in the Hospital Surgical Benefit and Hospital Medical Benefit, this Medical Tourism Benefit does not apply to cover costs under any Benefit in this Policy except the five Benefits listed above.

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).
- We pay up to 75% of the Usual, Customary and Reasonable Charges that would have been payable in New Zealand.

Payment method and currency

- All payments, Excess and Benefit Limits under this Benefit are in New Zealand dollars and will be direct credited into your nominated New Zealand bank account in New Zealand dollars. Payments can only be made to the Policyowner or Insured Person.

We do not pay the Health Service provider concerned.

- The exchange rate will be calculated by nib as at the date of Health Services.

Additional terms

- Pre-approval must be obtained for this Benefit
- The Surgical or medical treatment must be a type that can be performed in New Zealand and must be recommended by the Insured Person's treating Registered Specialist.
- All medical reports and receipts in relation to the Surgery and medical treatment must be provided to nib in English, at your own cost.
- All medical facilities/treatment providers/health professionals must have an equivalent accreditation/registration as per New Zealand standards approved by nib.
- Benefits are not payable for costs associated with any complications and/or ongoing treatment that may arise as a direct or indirect result of the treatment.
- Claims cannot be submitted for both the Medical Tourism and Cover in Australia Benefit.
- Benefits for any medications are only provided if the medications would be covered in New Zealand.

25. Obstetrics Benefit

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

Benefit limit

- We will pay a maximum of $4,000 for each pregnancy.

Additional terms

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

26. Pre-existing Cover for Newborns Benefit

This Benefit provides cover for any Pre-existing Conditions for all Benefits listed under the base Cover, for a Dependent Child when added to this Policy within four months of birth.

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the applicable Benefit Limit.

Additional terms

- All Claims are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8, What is not covered on page 65 and your Contract of Insurance on page 7).
- Benefits are not payable for any Congenital conditions.

27. Public Hospital Cash Benefit

This Benefit provides a payment when an Insured Person is admitted to a Public Hospital for three or more consecutive nights.

Benefit limits

- We will pay up to a total maximum of $3,000 for each Insured Person every Policy Year.
- We will pay $300 each night for the third and each subsequent night.

Additional terms

- The Excess does not apply to this Benefit.
- Benefits are not payable if an Insured Person is admitted to the private wing of a Public Hospital.
- Benefits are only payable if an Insured Person would have been able to Claim under the Hospital Surgical Benefit, Hospital Medical Benefit or cancer treatment in Hospital Benefit under the base Cover.
- To Claim under this Benefit, you must provide a discharge summary from the Public Hospital stating the reason and the date of the admission as well as the date of the discharge to support your Claim.

28. Hospice Care Benefit

This Benefit provides a payment to the Hospice when an Insured Person is admitted to a Hospice for three or more consecutive nights.

Benefit limits

- We will pay up to a total maximum of $3,000 for each Insured Person every Policy Year.
- We will pay $300 each night for the third and each subsequent night.

Additional terms

- To Claim under this Benefit, you must provide a discharge summary from the Hospice stating the reason and the date of the Admission as well as the discharge summary to support your Claim.

29. Intravitreal Eye Injections Benefit

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

Benefit limit

- We will pay up to a total maximum of $3,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any medications not approved by Medsafe.

30. Specialist Skin Lesion Surgery Benefit

This Benefit covers the cost of Skin Lesion Surgery performed by

a Registered Specialist.

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit. **Additional terms**
- Any Registered Specialist Consultations relating to the Skin Lesion Surgery will be covered under the Specialist Consultations Benefit, whether or not the Insured Person is an Admitted Patient.
- Benefits are not payable for any Registered Specialist Consultation that does not relate to the excised Skin Lesion(s).
- Cover may be available under the Specialist Option if the Policyowner has selected that option.
- Benefits are not payable for any laser therapy, cryotherapy, pulse light therapy and photodynamic therapy.

31. GP Minor Surgery Benefit

This Benefit covers the cost of Surgery performed by a GP.

Benefit limit

- We will pay a total maximum of $5,000 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any GP Consultation or biopsy relating to the Surgery.
- Cover may be available under the GP Option if the Policyowner has selected that option.

32. Podiatric Surgery Benefit

This Benefit covers the cost of Surgery performed by a Podiatric Surgeon under local anaesthetic, including up to one pre and one post Surgery Consultation and related x-rays.

Benefit limit

- We will pay a total maximum of $6,000 for each Insured Person every Policy Year.
- This benefit maximum includes the cost of Surgically implanted Prosthesis (see Prosthesis Schedule on page 9).

Additional terms

- Costs relating to Diagnostics other than x-ray are covered under the Major Diagnostics Benefit (See Major Diagnostics Benefit on page 29).
- Benefits are not payable for removal of corns and callouses.

33. ACC Top-up Benefit

This Benefit covers the difference in costs payable by ACC for a physical Injury and the actual costs for the Surgery or medical treatment.

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- When Claiming for this Benefit, evidence of the amount payable by ACC must be provided to nib.
- Benefits are not payable for any Injury that occurred prior to the

Commencement Date, Effective Date or the Join Date (as applicable).

- Benefits are not payable for any cosmetic aspect of the ACC approved Surgery or medical treatment.

34. ACC Treatment Injury Benefit

This Benefit covers the costs of Surgical treatment for any Injury which occurred during an Insured Person's Health Service for an eligible Claim.

If ACC declines the Claim for treatment Injury where an Injury has occurred, an ACC review will be requested (see ACC on page 20).

Benefit limit

- The maximum we will pay is the balance available for the Policy Year in the Hospital Surgical Benefit Limit or Hospital Medical Benefit Limit (whichever applies).

Additional terms

- When Claiming for this Benefit, evidence of a claim being submitted to ACC must be provided.
- Any ACC reimbursement payment must be made to nib.
- Benefits are not payable for any cosmetic aspect of the ACC approved treatments.
- Benefits are not payable when an ACC treatment Injury Claim has not been submitted.

35. Medical Misadventure Benefit

This Benefit is payable if an Insured Person dies as a direct consequence of any erroneous or negligent action, omission or failure to observe reasonable and customary standards by a Recognised Health Professional, provided the death occurred within 14 days of such a recorded and proven incident.

Benefit limit

- We will pay $30,000 for each Insured Person.

Additional terms

- No Excess will be deducted for this Benefit.
- When Claiming for this Benefit, please provide a certified copy of the original death certificate.
- Benefits are not payable when the cause of death has not been confirmed by a coroner's inquest.
- Benefits are not payable when medical misadventure is not the sole or primary cause of death.
- Benefits are not payable when the medical misadventure occurs during a surgery or treatment that is not covered by this Policy.
- Benefits are not payable in relation to the Medical Tourism Benefit.

36. Funeral Support Benefit

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

Benefit limit

- We will pay $10,000 to the Policyowner or the deceased Insured Person's estate in respect of the Insured Person.

Additional terms

- No Excess will be deducted for this Benefit.

- When Claiming for this Benefit, please provide a certified copy of the original death certificate.

37. Premium Waiver Benefit

This Benefit covers the costs of Premiums due on this Policy for the remaining Insured Persons if a Policyowner dies before the age of 70 from any cause covered under this Policy, or at the end of the Premium waiver extension Benefit.

Benefit limit

We will pay the Premiums:

- for two years; or
- until any of the remaining Insured Persons turn 70 years old,

whichever occurs first.

Additional terms

- No Excess will be deducted for this Benefit.
- When Claiming for this Benefit, please provide a certified copy of the original death certificate.
- The Benefit starts from the next Premium payment date following the death of the Policyowner or at the end of the Premium waiver extension Benefit or at the end of the Premium waiver extension Benefit.
- When the Benefit period ends, the Premiums will be payable by all the remaining Insured Persons.
- Benefits are not payable for any additional Insured Person(s) and/or option(s) added to the Policy during the Premium waiver timeframe.
- Benefits are not payable if the Policyowner dies after 70 years old.

38. Premium Waiver Extension Benefit

This Benefit extends the Premium Waiver Benefit by up to six months upon diagnosis of a terminally ill Condition if the Policyowner is diagnosed before the age of 70. Premium Waiver Benefit will automatically commence after the last payment of the Premium Waiver Extension Benefit, unless it has already been initiated.

Benefit limit

We will pay the Premiums:

- for six months; or
- until the Policyowner dies

whichever occurs first.

Additional terms

- No Excess will be deducted from this Benefit.
- When Claiming for this Benefit, please provide Registered Specialist's Consultation letters and a confirmation of terminally ill diagnostic note.
- Benefits are not payable retrospectively i.e. after the Policyowner has died.
- The Benefit starts from the next Premium payment date following the Claim submission date.

- When the Benefit period ends, the Premiums will be payable for all the remaining Insured Persons, unless the Premium Waiver Benefit is initiated.
- Benefits are not payable for any additional Insured Person(s) and/or option(s) added to the Policy during the Premium Waiver and/or Premium Waiver Extension timeframe.

39. Loyalty – Suspension of Cover Benefit

After 12 months of continuous cover under the Ultimate Health Max base Cover for an Insured Person, the Policyowner can apply to suspend the Policy and/or Cover for the Insured Person, for reasons of unemployment (including Redundancy), overseas travel or employer approved parental leave.

Unemployment/Redundancy

If the Policyowner or the Insured Person is registered as unemployed (including as a result of Redundancy), this Policy can be suspended for up to a maximum of six months.

Overseas travel/residence

If the Insured Person lives or travels outside New Zealand for longer than 90 consecutive days, their Cover can be suspended for a minimum of 90 days up to a maximum of 24 months.

Parental leave

If the Policyowner or the Insured Person is on employer approved parental leave, this Policy can be suspended for a minimum of 90 days up to a maximum of 12 months.

Additional terms

- All relevant documentation in support of the application to suspend the Policy and/or Cover for an Insured Person must be supplied to us as required.
- All Premiums must be paid up-to-date before the Policy or Cover can be suspended.
- While the Policy or Cover for an Insured Person is suspended, Premiums and Benefits are not payable.
- The Policy or Cover for an Insured Person cannot be suspended for more than 24 months in any 10 year period.
- For unemployment (including Redundancy) suspensions, the suspension ends on the date nominated by the Policyowner or at the end of the six month maximum suspension period, whichever occurs first.
- If the Policy is suspended for unemployment (including Redundancy), the Policy will automatically be resumed after six months.

40. Loyalty – Sterilisation Benefit

After two years of continuous cover under the Ultimate Health Max base Cover for an Insured Person, this Benefit will cover the costs of sterilisation as a means of contraception for the Insured Person, performed by a GP or Registered Specialist.

Benefit limits

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit.

- We will pay for a maximum of one sterilisation Surgical procedure for each Insured Person over the lifetime of the Policy.

Additional terms

- No Excess will be deducted from this Benefit.
- Any Registered Specialist Consultations relating to the Sterilisation procedure will be covered under the Hospital Specialist Consultations Benefit.
- Benefits are only payable once for each Insured Person.
- Benefits are not payable for sterilisation reversal procedures.

41. Loyalty – Bariatric Surgery Benefit

After 36 months of continuous cover under the Ultimate Health Max base Cover for an Insured Person, this Benefit will cover the costs of sleeve gastrectomy, gastric banding or bypass Surgery including the costs of the related Consultations and diagnostics for the Insured Person when the following criteria have been met.

- Severe obesity, defined as one of the following:
  - body mass index (BMI) of 40 or greater; or
  - body mass index (BMI) of 35 or greater when at least one of the following Conditions is also present:
    i. coronary heart disease;
    ii. type 2 diabetes mellitus;
    iii. clinically significant obstructive sleep apnoea (proven by sleep studies);
    iv. moderate or severe osteoarthritis of weight bearing joints, e.g. hips and knees (radiological evidence required); or
    v. blood pressure greater than 140/90 despite optimal medical management defined as maximal dose of three or more anti-hypertensive medications have been tried for 6 months or more and remain ineffective even when sufficient time has elapsed for a response.
- Physical growth is complete.
- Previous attempts at weight loss in the past have not resulted in successful long-term weight reduction.

Benefit limit

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit.
- We will pay up to a Lifetime Limit of $10,000 for each Insured Person.

Additional terms

- To Claim under this Benefit, the Insured Person must submit the medical report by a Registered Specialist prior to the Surgery that demonstrates the above criteria are met.
- We only pay for the bariatric treatment specified above and do not pay for other treatment under this Benefit, including but not limited to banded gastroplasty (stomach stapling)
- Benefits are not payable for any subsequent treatment or complications relating to sleeve gastrectomy, gastric banding or gastric bypass Surgery.

42. Loyalty – Bilateral Breast Reduction Benefit

After 36 months of continuous cover under the Ultimate Health Max base Cover for an Insured Person, this Benefit will cover the costs of bilateral breast reduction Surgery including the costs of the related Consultations and diagnostics for the Insured Person when the following criteria have been met:

- At least two of the following symptoms have been present for a minimum of 12 months (non-injury related):
  - pain in the upper back, neck or shoulders;
  - headaches (secondary to neck or back pain); or
  - pain, discomfort or ulceration from bra straps cutting into shoulders (not just imprints of straps); or
  - associated skin disorders that have not responded to conservative medical treatment.
- Bra cup size is over DD;
- Medical examination confirms macromastia;
- The amount of breast tissue to be removed is estimated to be at least 350 grams per breast; and
- If the Insured Person is over 30 years, no suspicious lesions were found on a mammogram completed within 12 months of the date of Surgery.

Benefit limit

- This Benefit is paid from the balance available for the Policy Year in the Hospital Surgical Benefit Limit.
- We will pay up to a Lifetime Limit of $10,000 for each Insured Person.

Additional terms

- To Claim under this Benefit, the Insured Person must submit the medical report by a Registered Specialist prior to the Surgery that demonstrates the criteria are met.
- Benefits are not payable for any subsequent treatment relating to the breast reduction Surgery.
- The Benefit for a bilateral breast reduction will not pay for breast reduction via tumescent liposuction.

43. Loyalty – Wellness Benefit

After 36 months of continuous cover under the Ultimate Health Max base Cover and every subsequent period of 36 consecutive months for an Insured Person, this Benefit covers the costs of a medical examination by a GP, for example, the cost of laboratory tests, ECG, blood pressure checks, breast examinations, mole map, cervical smears and prostate examinations.

This Benefit is only available for any Insured Person aged 21 or over.

Benefit limit

- We pay up to $100 each Insured Person aged 21 or over, after each 36 months of continuous cover.

Additional terms

- The Excess does not apply to this Benefit.

- We will advise you when an Insured Person is eligible to take up this Benefit.
- Benefits are not available to Dependent Children.
- Once a Dependent Child reaches age 21, this Benefit is available to him or her and the period of 36 months of continuous cover begins on the Policy Anniversary date, on or immediately after that Insured Person reaches age 21, if that Insured Person remains on this Policy.
- This Benefit must be taken in the Policy Year after entitlement and cannot be accumulated over subsequent years.
- If cover is suspended, the suspended period is not included in calculating the 36 months of continuous cover.
- Where an Insured Person is added to this base Cover on this Policy, each period runs from that Insured Person's Join Date.

Specialist Option

05 SECTION

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

We will refund 100% of each eligible cost incurred up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The Specialist Option does not cover any Hospital related services.

3. Specialist Consultations Benefit

This Benefit covers the cost of Registered Specialist or Vocational GP Consultations, after referral by a GP or Registered Specialist.

Benefit limit

- There is no limit on the number of Registered Specialist or Vocational GP Consultations for each Insured Person every Policy Year.

Additional terms

- If the Consultation results in an Admission within six months, it will be covered under the Hospital specialist Consultation Benefit in the base Cover (see Hospital Specialist Consultations Benefit on page 30).

4. Specialist Second Opinion Benefit

This Benefit covers the cost of another Registered Specialist or Vocational GP Consultation for a second opinion, after referral by a GP or Registered Specialist.

Benefit limit

- There is no limit on the number of Registered Specialist or Vocational GP Consultations for each Insured Person every Policy Year.

Additional terms

- If the treatment results within six months after an Admission, it will be covered under the Hospital Specialist Consultations Benefit in the base Cover (see Hospital Specialist Consultations Benefit on page 30).

5. Specialist Sports Physician Benefit

This Benefit cover the costs incurred for Sport Physician Treatment after referral by a GP or Registered Specialist.

Benefit limit

- The maximum we will pay for this Benefit is $500 for each Insured Person every Policy Year.

Additional terms

- If the treatment results within six months after an Admission, it will be covered under the Therapeutic Care Benefit in the base Cover (see Therapeutic Care Benefit on page 33).
- Benefits are not payable for any GP Consultations. Cover may be available under the GP Option if the Policyowner has selected that option.

6. General Diagnostics Benefit

This Benefit covers the cost of Diagnostic Investigations after referral by a GP or Registered Specialist. For example: X-rays, arteriogram, ultrasound, scintigraphy, mammogram and visual field tests.

Benefit limit

- The maximum we will pay for this Benefit is $3,000 for each Insured Person every Policy Year.

Additional terms

- If the Diagnostic Investigation results in an Admission within six months, it will be covered under the Hospital diagnostics Benefit in the base Cover (see Hospital Diagnostics Benefit on page 30).

7. Cardiac Investigations Benefit

This Benefit covers the cost of cardiac Diagnostic Investigations after referral by a GP or Registered Specialist. This includes treadmills, holter monitoring, ambulatory blood pressure monitoring, cardiovascular ultrasound, echocardiography and myocardial perfusion scans.

Benefit limit

- The maximum we will pay for this Benefit is $60,000 for each Insured Person every Policy Year.

Additional terms

- If the cardiac Diagnostic Investigation results in an Admission within six months, it will be covered under the Hospital diagnostics Benefit in the base Cover (see Hospital Diagnostics Benefit on page 30).

8. Pre-existing Cover for Newborns Benefit

This Benefit provides cover for any Pre-existing Conditions for all Benefits listed under the Specialist Option, for a Dependent Child when added to this Policy within four months of birth.

Benefit limit

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

Additional terms

- Benefits are not payable for any Congenital conditions.

Proactive Health Option

06 SECTION

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

A six-month Waiting Period applies to this option (see Waiting Period on page 12).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover you have selected for each Insured Person.

1. What is covered under this option

We will refund 80% of each eligible cost incurred up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The Proactive Health Option does not cover any Hospital related services.

3. Health Screening Benefit

This Benefit covers the cost of the following health Screening tests.

- bone Screening
- bowel Screening
- breast Screening
- cervical Screening
- heart Screening
- prostate Screening
- eye tests and/or visual field tests
- hearing tests
- mole mapping

Benefit limit

- The maximum we will pay for this Benefit is $750 for each Insured Person every Policy Year.

Additional terms

- If the tests result in an Admission within six months, it will be covered under the Hospital Diagnostics Benefit in the base Cover (see Hospital Diagnostics Benefit on page 30).

4. Allergy Testing and Vaccinations Benefit

This Benefit covers the cost of allergy testing and vaccinations, administered by a Recognised Health Professional.

Benefit limit

- The maximum we will pay for this Benefit is $100 for each Insured Person every Policy Year.

Additional terms

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

5. Dietitian or Nutritionist Consultation Benefit

This Benefit covers the cost of Dietitian or Nutritionist Consultations.

Benefit limit

- The maximum we will pay for this Benefit is $300 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any food items, vitamins, supplements, videos, books, or DVDs.
- If the Consultation occurs after an Admission within six months, it will be covered under the Therapeutic care Benefit in the base Cover (see Therapeutic Care Benefit on page 33).

6. Stay Active Benefit

This Benefit covers the cost of gym memberships, weight-loss management programmes or quit smoking programmes to assist the Insured Person to stay healthy.

Benefit limit

- The maximum we will pay for this Benefit is $100 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any food items, vitamins, supplements, videos, books, or DVDs.
- Benefits are not payable for any activity related garments, protective items, footwear or equipment of any type.

7. Loyalty – Health Check Benefit

After 24 months' continuous cover under this option, and at the end of every 24 months thereafter, this Benefit will cover the costs of a medical examination by a GP, for example, a full health test. The 24 months of continuous cover will be based on the Effective Date or Join Date (as applicable) of this option.

Benefit limit

- The maximum we will pay for this Benefit is $150 each Insured Person, after each 24 months of continuous cover.

Additional terms

- This Benefit must be taken in the same Policy Year of entitlement and cannot be accumulated over subsequent years.
- Benefits are not payable while the Policy and/or Cover is suspended.
- If Cover is suspended, the suspended period is not included in calculating the 24 months of continuous cover.

Serious Condition Financial Support Option

07 SECTION

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

This option pays the Sum Insured shown in the Acceptance Certificate or Renewal Certificate (whichever applies) as a lump sum payment.

The maximum we will pay is one Sum Insured for each Insured Person covered by this option, except for

- Paralysis Assistance Benefit (see sub-section 6 on page 57)
- Children's Benefit (see sub-section 7 on page 57).

The Insured Person's medical Condition must meet the Serious Condition definition (see Definitions of the Serious Conditions Covered on page 51).

Waiting period

If the following Serious Conditions occur, or any sign or symptoms of that Serious Condition occurs, within the first 90 days after the Effective Date of this option, we will not pay the Sum Insured or the amount by which the Sum Insured increased (whichever is applicable), and there is no Cover under this option for any subsequent reoccurrence of that Serious Condition.

The following Serious Conditions have a 90-day Waiting Period from the Effective Date of this option:

- Aortic Surgery
- Benign tumour of the brain or spinal cord
- Cancer – life threatening
- Cardiac arrest – out of Hospital
- Cardiomyopathy
- Coronary artery angioplasty – three vessels or more
- Coronary artery bypass grafting Surgery
- Heart valve Surgery
- Primary pulmonary hypertension
- Myocardial infarction (heart attack) – major
- Major organ transplant
- Stroke

2. What is not covered under this option

This option does not cover any Serious Conditions if the Insured Person or the Insured Person's Child dies within the 14-day period immediately following the date of diagnosis of the Serious Condition.

3. When does this option end

This option ends in relation to an Insured Person at the earliest of the following:

- at the Policy Anniversary Date immediately after that Insured Person's 70th birthday; or
- when the Sum Insured for the Serious Condition Financial Support Option is paid in respect of that Insured Person; or
- when that Insured Person dies,

whichever occurs first.

4. How to make a claim under this option

4.1 Diagnosis

When Claiming under this option:

- the Insured Person must first receive a definite diagnosis of the Serious Condition. The diagnosis must be made by a Registered Specialist based on conventional medical testing acceptable to us; and
- nib may require that the Insured Person undergoes a medical examination by an independent Registered Specialist.

4.2 Information to be provided

You must:

- advise us as soon as possible but no later than 12 months after the Insured Person is diagnosed with a Serious Condition;
- provide us with an original or certified copy of that Insured Person's birth certificate, driver's licence or passport;
- complete and return our Claim form; and
- at your own expense supply medical certificates and any other information that we may require.

Claim forms are available on our website at **nib.co.nz** or you can email us at **claims@nib.co.nz** or call us on **0800 123 nib** (0800 123 642) to request a Claim form.

5. Definitions of the Serious Conditions covered

5.1 Advanced dementia (including Alzheimer's disease)

Alzheimer's disease or other dementia resulting in permanent irreversible failure of brain function and significant cognitive impairment for which no other recognisable cause can be identified. Significant cognitive impairment means a deterioration or loss of intellectual capacity that results in a requirement for a permanent caregiver.

5.2 Aortic surgery

The undergoing of Medically Necessary Surgery to:

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

For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

5.3 Aplastic anaemia

Bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia requiring treatment over a period of at least two months with at least one of the following:

- blood product transfusion; or
- marrow stimulating agents; or
- immunosuppressive agents; or
- bone marrow transplantation.

5.4 Benign tumour of the brain or spinal cord

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

- Medically Necessary Surgery to remove the tumour; or
- neurological deficit causing: at least 25% impairment of Whole Person Functions that is permanent; or
- the Insured Person to be constantly and permanently unable to perform at least one of the Activities of Daily Living without the physical assistance of another person.

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

5.5 Cancer – life threatening

The presence of one or more malignant tumours including leukaemia, lymphomas and Hodgkin's disease. The malignant tumour is to be characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue.

The following are not included:

- Tumours showing the malignant changes of Carcinoma in Situ* (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant, unless it results directly in the removal of the entire organ*.
- Melanoma which are less than 1.5mm depth of invasion using the Breslow method and less than Clark level 3, as determined by histological examination.
- All non-melanoma skin cancers, unless there is evidence of metastases.
- Prostatic cancers which are histologically described as TNM Classification T1 and Gleason score of 5 or less, unless it results directly in the removal of the entire organ*.
- Chronic Lymphocytic Leukaemia less than Rai Stage 1.

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

5.6 Cardiac arrest – out of hospital

Cardiac arrest which has occurred outside of Hospital, and is not caused by or associated to any medical procedure. This must be documented by an electrocardiogram and be due to:

- ventricular fibrillation; or
- cardiac asystole.

5.7 Cardiomyopathy

Impaired ventricular function of variable aetiology, caused by primary disease of the heart muscle, causing permanent and irreversible physical impairment to the degree of at least Class 3 of the New York Heart Association Classification of cardiac impairment.

5.8 Chronic liver failure

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

5.9 Chronic lung failure

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

- FEV 1 test results of consistently less than one litre; or
- the Insured Person to be constantly and permanently unable to perform at least one of the Activities of Daily Living without the physical assistance of another person.

5.10 Chronic renal failure

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

5.11 Coma

A state of unconsciousness with no reaction to external stimuli or internal needs, resulting in either:

- continuous mechanical ventilation by means of tracheal intubation for three or more consecutive days (24 hours per day); or
- admission for at least five or more consecutive days (24 hours per day) in an authorised intensive care unit of an acute care Hospital, on the recommendation of an appropriate Registered Specialist.

5.12 Coronary artery angioplasty – three vessels or more

The actual undergoing of coronary artery angioplasty that is considered Medically Necessary to correct or treat a narrowing or blockage of three or more coronary arteries during the same procedure.

5.13 Coronary artery bypass grafting surgery

The undergoing of Medically Necessary coronary artery bypass grafting Surgery to correct or treat coronary artery disease.

5.14 Deafness

The complete and irrecoverable loss of hearing of both ears (whether aided or unaided) as a result of a Condition and confirmed as still present after 90 days.

5.15 Encephalitis resulting in functional loss

The severe inflammatory disease of the brain resulting in neurological deficit causing either:

- at least 25% impairment of Whole Person Functions, that is permanent; or
- the Insured Person to be constantly and permanently unable to perform at least one of the Activities of Daily Living without the physical assistance of another person.

5.16 Heart valve surgery

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

5.17 Intensive care

Means that a Condition has resulted in the Insured Person requiring:

- continuous mechanical ventilation by means of tracheal intubation for three or more consecutive days (24 hours per day); or
- admission for at least five consecutive days (24 hours per day) in an intensive care unit of an acute care Hospital, on the recommendation of an appropriate Registered Specialist.

5.18 Loss of independent existence

As a result of a Condition whereby the Insured Person is totally and permanently unable to perform (whether aided or unaided) at least two of the five Activities of Daily Living, or suffers cognitive impairment that results in the Insured Person requiring permanent and constant supervision.

5.19 Loss of limbs and/or sight

The total and irrecoverable:

- loss of two or more limbs; or
- loss of sight of both eyes; or
- loss of one limb and the sight of one eye.

The loss of sight of an eye means the complete and irrecoverable loss of sight (whether aided or unaided).

For this Serious Condition only, the loss of a limb means complete loss of the use of an entire hand or entire foot.

5.20 Loss of speech

The complete and irrecoverable loss of speech (whether aided or unaided) as a result of a Condition.

5.21 Major head trauma resulting in functional loss

Head trauma resulting in permanent neurological deficit causing either:

- at least 25% impairment of Whole Person Functions that is permanent; or
- the Insured Person to be constantly and permanently unable to perform at least one of the Activities of Daily Living without the physical assistance of another person.

5.22 Myocardial infarction (heart attack) – major

Means the Insured Person has had a myocardial infarction (other than as a direct result of cardiac or coronary intervention) with the following criteria being satisfied:

- a diagnostic rise and fall in either Troponin I in excess of 2.0ug/L or Troponin T in excess of 0.6ug/L; and
- ECG showing new changes indicative of ischaemia.

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

5.23 Major organ transplant

Means either:

- the undergoing of; or
- being on a waiting list of a Transplantation Society of Australia or New Zealand recognised transplant unit

for at least four weeks for the Medically Necessary human to human transplant from a donor to the Insured Person of one or more of the following complete organs: kidney, liver, heart, lung, pancreas, small bowel or the transplantation of bone marrow (excluding stem cells).

5.24 Medically acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) to the Insured Person, where in nib's opinion the infection arose from one of the following Medically Necessary events:

- transfusion with blood products; or
- organ transplant to the Insured Person; or
- assisted reproductive techniques; or
- a medical procedure or operation performed by a Recognised Health Professional.

Notification and proof that the infection is medically acquired will be required via a statement from the recognised statutory health authority. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of HIV.

Infection in any other manner, including infection as a result of sexual activity or intravenous drug use is excluded. We must have open access to all blood results and/or blood samples and be able to obtain independent testing of such blood samples.

5.25 Motor neurone disease

The unequivocal diagnosis of motor neurone disease.

5.26 Multiple sclerosis resulting in functional loss

Multiple sclerosis with significant persistent neurological deficit resulting in either:

- at least 25% impairment of Whole Person Functions, that is permanent; or
- the Insured Person to be constantly and permanently unable to perform at least one of the Activities of Daily Living without the physical assistance of another person; or
- a restriction of at least 7.5 as measured by the Expanded Disability Status Score (EDSS).

5.27 Muscular dystrophy

The unequivocal diagnosis of muscular dystrophy.

5.28 Occupationally acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where HIV was acquired as a result of an accident, or a malicious act of another person, during the course of carrying out normal occupational duties with sero-conversion to HIV infection occurring within six months of the incident. Any incident giving rise to a potential Claim must be reported to us within 90 days of the incident and be supported by a negative HIV antibody test taken by the Insured Person, taken within seven days after the incident. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of HIV.

Infection in any other manner, including infection as a result of sexual activity or intravenous drug use is excluded. We must have open access to all blood results and/or samples and be able to obtain independent testing of such blood samples.

5.29 Paralysis

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

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

For this Serious Condition only, limb is defined as the complete arm or the complete leg.

5.30 Parkinson's disease

The unequivocal diagnosis of degenerative idiopathic Parkinson's disease as characterised by the clinical manifestation of one or more of the following:

- rigidity; or
- tremor; or
- akinesia

resulting in the degeneration of the nigrostriatal system.

All other types of Parkinsonism are excluded (e.g. secondary to medication).

5.31 Pneumonectomy

The Surgical excision of an entire lung.

5.32 Primary pulmonary hypertension

Primary pulmonary hypertension with substantial right ventricular enlargement, established by investigations including cardiac catherisation.

5.33 Severe burns

Tissue injury caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least:

- 20% of the body surface area as measured by 'The Rule of Nines' or the Lund & Browder Body Surface Chart (or similar means of measurement as determined by us); or
- 50% of both hands and requiring Surgical debridement and/or grafting; or
- 25% of the face and requiring Surgical debridement and/or grafting.

5.34 Stroke

The suffering of a stroke as a result of a cerebrovascular event.

This requires clear evidence or similar appropriate scan that a stroke has occurred and shows:

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

This does not include transient ischaemic attacks, migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye, optic nerve or vestibular functions.

5.35 Total and permanent blindness

The complete and irrecoverable loss of the sight of both eyes to the extent that:

- visual acuity is less than 6/60 vision, in both eyes after correction; or
- field vision is constricted to 10 degrees or less; or
- combined visual defects result in the same degree of visual impairment as that occurring in either of the above two points.

6. Paralysis Assistance Benefit

6.1 What we cover

This Benefit covers an additional amount equal to the amount of the Sum Insured, if the Insured Person suffers from one of the paralysis Serious Conditions (defined on page 56).

Benefit limit

- We only pay one Claim under the paralysis assistance Benefit for each Insured Person.

7. Children's Benefit

7.1 What we cover

This Benefit covers the Insured Person's Child if he or she suffers from one of the Serious Conditions (defined on page 51) for the first time on or after the Effective Date of this option being added and before or on the end date of this option being removed.

Benefit limit

- We will pay the Insured Person 50% of the Sum Insured, provided the Insured Person's Child is aged between two and 20 years when he or she first suffers the Serious Condition.

Additional terms

- The maximum we will pay is one Claim under this Children's Benefit for each Insured Person's Child. This payment does not reduce the Sum Insured.
- We only make one payment across all nib policies, in respect of a Serious Condition, for each Insured Person's Child. The highest Sum Insured is applicable.
- The Waiting Period for this option applies to the Insured Person's Child with effect from the Insured Person's Effective Date for this option.

GP Option

08 SECTION

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

A 90-day Waiting Period applies to this option (see Waiting Period on page 12).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

We will refund 100% of each eligible cost incurred under the Benefits up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The GP Option does not cover any Hospital related services.

3. General Practitioner Benefit

This Benefit covers the cost of GP Consultations and GP Surgery performed in GP rooms under local anaesthetic (including home Consultations, ECG, cervical smears).

Benefit limits

Consultations

The maximum we will pay up to:

- $55 for each GP Consultation, including after hours Consultations.
- $80 for each home Consultation.
- $25 for each ACC top-up Consultation. This cannot be used in conjunction with the $55 or $80 each after hours or home Consultation Benefit.

The maximum we will pay for these Consultations is 12 GP Consultations for each Insured Person every Policy Year. GP minor Surgeries are not included in the 12 Consultations.

GP Surgeries

- The maximum we will pay for the GP Surgical procedure is $200 each procedure. This cannot be used in conjunction with any other GP Consultations Benefit.

4. Prescriptions Benefit

This Benefit covers the cost of Pharmaceutical Prescriptions.

Benefit limits

- We will pay up to $15 for each item.
- The maximum we will pay for this Benefit is $300 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any after hour's fees or any administration costs (for example faxing costs).
- Benefits are not payable for any Pharmaceutical Prescriptions that are not prescribed by a GP, Registered Specialist or Nurse Practitioner.
- Benefits are not payable for any Pharmaceutical Prescriptions not listed under Section A to H of the PHARMAC pharmaceutical schedule.
- To Claim under this Benefit, you must submit receipts detailing:
  - the name of the patient;
  - the prescription number;
  - the name of the medication prescribed;
  - the cost of each item; and
  - the reason for the Pharmaceutical Prescriptions must be stated on the Claim form.

5. Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy treatment after referral by a GP or Registered Specialist.

Benefit limits

We will pay up to:

- $40 each treatment/visit.
- $15 each ACC treatment. This cannot be used in conjunction with the $40 each treatment/visit Benefit Limit.
- The maximum we will pay for this Benefit is $400 for each Insured Person every Policy Year.

6. Nurse Practitioner Benefit

This Benefit covers the cost of visits of a Nurse Practitioner.

Benefit limits

- We will pay up to $30 for each visit.
- The maximum we will pay for this Benefit are six visits for each Insured Person every Policy Year.

7. Pre-existing Cover for Newborns Benefit

This Benefit provides cover for any Pre-existing Conditions for all Benefits listed under the GP Option, for a Dependent Child when added to this Policy within four months of birth.

Benefit limit

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

Additional terms

- Benefits are not payable for any Congenital conditions.

8. Loyalty – Active Wellness Benefit

After 24 months' continuous cover under the GP Option, and at the end of every 24 months thereafter, providing the Claims for Benefits that occurred within the preceding 24 month period under the GP Option are less than $150 for an Insured Person, the Insured Person (aged 21 or older) will receive a reimbursement towards the following:

- membership of a gym or sports club; or
- sports/fitness equipment purchased from a sporting retailer,

recognised by nib.

If you have submitted a Claim for treatment within the preceding 24 month period after this Benefit has been paid, we will deduct the amount paid to you for this Benefit from the Claim.

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 Insured Person (aged 21 or over), after each 24 months of continuous cover under the GP Option.

Additional terms

- Evidence or receipt of paid membership fees must be submitted.
- This Benefit must be taken within the Policy Year after entitlement and cannot be accumulated over subsequent years.
- Benefits are not payable to any Dependent Children.
- Once a Dependent Child reaches age 21, this Benefit will be available to him or her and the period of 24 months of continuous cover begins on the Policy Anniversary Date, on or immediately after that Insured Person reaches age 21 if that Insured Person remains on this Policy.
- If the Cover has been suspended, the suspended period is not included when calculating the 24 months' continuous cover.
- Benefits are not payable while the Policy and/or Cover is suspended.

Dental and Optical Option

09 SECTION

This section lists and defines the Benefits we provide under this option, and should be read in conjunction with all other parts of your nib Contract of Insurance. All Benefits are subject to our general terms (see General terms of Ultimate Health Max Cover on page 8 and What is not covered on page 65).

A six-month Waiting Period applies to this option (see Waiting Period on page 12).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the type of optional Cover selected for each Insured Person.

1. What is covered under this option

We will refund 80% of each eligible cost incurred under the Benefits up to the Benefit Limits.

The Excess does not apply to this option.

2. What is not covered under this option

The Dental and Optical Option does not cover any Hospital related services.

3. Dental Care Benefit

This Benefit covers the cost of Dental Treatment, including examination, cleaning, scaling, fillings, associated X-rays, removal of teeth and crowns.

Benefit limit

- The maximum we will pay for this Benefit is $500 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any treatment for Dependent Children covered under the school dental service or general dental benefit scheme.
- Benefits are not payable for any cost of gold or other exotic materials.
- Benefits are not payable for any Orthodontic Treatment within the first 24 months from the Effective Date or Join Date (whichever applies).

4. Eye Care Benefit

This Benefit covers the cost of Optometrist, Orthoptist and Optician examination fees as well as the cost of Optical Appliances when these are required as a result of change of vision.

Benefit limits

Consultation/examination

- We pay up to $55 for each Consultation/examination.
- The maximum we will pay for these Consultations/examinations

is $275 for each Insured Person every Policy Year.

Optical Appliance

- The maximum we will pay for the Optical Appliance is $330 for each Insured Person every Policy Year.

Additional terms

- To Claim under the Optical Appliance Benefit Limit, a written confirmation from the Insured Person's Recognised Health Professional that the Consultation, examination or Optical Appliance is required as a result of change in vision.
- Benefits are not payable for any Optical Appliances acquired for fashion reasons.
- Benefits are not payable on costs of tinting or transition lenses.

5. Ear Care Benefit

This Benefit covers the cost of audiometric tests and audiology treatment after referral by a Registered Specialist.

Benefit limits

- The maximum we will pay for audiometric tests is $250 for each Insured Person every Policy Year.
- The maximum we will pay for audiology treatment is $250 for each Insured Person every Policy Year.

6. Acupuncture Benefit

This Benefit covers the cost of Acupuncture treatment, after referral from a GP or Registered Specialist.

Benefit limits

We will pay up to:

- $40 each visit.
- $15 each ACC visit. This cannot be used in conjunction with the $40 each visit Benefit.
- The maximum we will pay for this Benefit is $250 for each Insured Person every Policy Year.

7. Spinal Care Benefit

This Benefit covers the cost of Chiropractic treatment and related X-rays after referral from a GP or Registered Specialist.

Benefit limits

Chiropractic treatment

We will pay up to:

- $40 each visit.
- $15 each ACC visit. This cannot be used in conjunction with the $40 each visit Benefit Limit.
- The maximum we will pay for the visits are $250 for each Insured Person every Policy Year.

X-rays

- The maximum we will pay for the X-rays are $80 for each Insured Person every Policy Year.

8. Joint Care Benefit

This Benefit covers the cost of Osteopathy treatment and related X-rays after referral by a GP or Registered Specialist.

Benefit limits

Osteopathy treatment

We will pay up to:

- $40 each visit.
- $15 each ACC visit. This cannot be used in conjunction with the $40 each visit Benefit Limit.
- The maximum we will pay for visits is $250 for each Insured Person every Policy Year.

X-rays

- The maximum we will pay for X-rays are $80 for each Insured Person every Policy Year.

9. Foot Care Benefit

This Benefit covers the cost of Podiatry Treatment after referral by a GP or Registered Specialist.

Benefit limits

- We will pay up to $40 each visit.
- The maximum we will pay for this Benefit is $250 for each Insured Person every Policy Year.

10. Speech, Occupation and Eye Therapy Benefit

This Benefit covers the cost of Speech Therapy, Occupational Therapy and/or eye therapy after referral by a GP or Registered Specialist.

Benefit limits

- We will pay up to $40 each visit.
- The maximum we will pay for this Benefit is $300 for each Insured Person every Policy Year.

11. Pre-existing Cover for Newborns Benefit

This Benefit provides cover for any Pre-existing Conditions for all Benefits listed under the Dental and Optical Option, when a Dependent Child is added to this Policy within four months of birth.

Benefit limit

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

Additional terms

- Benefits are not payable for any Congenital conditions.

12. Loyalty – Orthodontic Treatment Benefit

After 24 months of continuous cover under the Dental and Optical Option, the Dental care Benefit will be extended to cover Orthodontic Treatment.

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 is included in the Benefit Limit for the Dental Care Benefit of $500 for each Insured Person every Policy Year.

Additional terms

- If the Cover has been suspended, the suspended period is not included when calculating the 24 months continuous cover.

What is not covered

10 SECTION

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

- Providers who do not meet our criteria.
- Health Services not stated in this Policy document.
- Health Services provided after the Benefit Limit(s) has been reached.
- Incomplete Claims, Policy applications or Claims where false or inaccurate information is supplied.
- Any services provided by a family member or relative (for example: Health Services, accommodation and travel costs).
- Expenses recoverable from any third party (for example: any other person, company or insurer).
- Services provided outside of New Zealand (except where expressly specified in this Policy document).
- Goods purchased outside of New Zealand (for example: goods ordered on the internet which are from another country) (except where expressly specified in this Policy document).
- Acute Medical Conditions.
- Organ/tissue transplants or donation (for example: organ transplant and/or stem cell transplant).
- Specialised transfusions (for example: transfusion of blood, blood products and derivatives and dialysis of any type).
- HIV and AIDS (except where provided under the Serious Condition Financial Support Option).
- Revision of breast reconstruction, breast implants, breast reduction or gynaecomastia (except where expressly specified under the Breast Symmetry Post Mastectomy Benefit).
- Cosmetic procedures or reconstruction that are not Medically Necessary (except where expressly specified under the Breast Symmetry Post Mastectomy Benefit).
- Blepharoplasty, hyperhydrosis, abdominoplasty or rectus divarication repair.
- Weight loss/bariatric investigations and treatment (for example: gastric banding, sleeve and bypass), or weight loss investigations or treatment used in order to treat other health conditions (for example: diabetes or cardiovascular conditions) (except where expressly specified in this Policy document).
- Sleep problems and disorders (for example: snoring, insomnia and sleep apnoea).
- Allergies or allergic disorders (for example: allergy testing and desensitisation) (except where provided under the Proactive Health Option).

- Vision enhancement (for example: myopia, hypermetropia, presbyopia, astigmatism, radial keratotomy and photorefractive keratectomy) (except where provided under the Dental and Optical Option).
- Any Congenital, chromosomal disorder (for example: birth defect), Marfan's syndrome, kyphosis, scoliosis, cystic fibrosis or pectus excavatum.
- Hereditary conditions or genetic conditions, in the absence of signs or symptoms that a Condition exists from the Join Date or Effective Date (whichever is applicable) (except where provided under the Proactive Health Option).
- Gene therapy or genetic testing.
- Pregnancy (for example: ectopic, healthy or termination of), caesarean section, sterilisation or reversal of (except where expressly specified under the Obstetrics Benefit).
- Contraception, hormone therapy or intrauterine devices (except where expressly specified under the Loyalty Benefit - Sterilisation).
- Infertility, assisted reproduction or erectile dysfunction.
- Psychiatric, psychological, behavioural, or developmental condition (for example: depression, ADD, ADHD and eating disorders) (except where expressly specified under the Cancer Treatment Counselling and Support Services Benefit and Cardiac Counselling and Support Services Benefit).
- Gender reassignment and/or gender dysphoria.
- Substance misuse (for example: misuse of alcohol and misuse of drugs).
- Self-inflicted injuries of any type.
- Charges under the Crimes Act (for example: any medical condition which is related in any way to the Insured Person being involved in an incident which results in the Insured Person being charged under the Crimes Act).
- Any form of risk management (except where expressly specified in this Policy document).
- Wars, riots or acts of terrorism.
- Continuous care (for example: geriatric care, palliative, respite, rehabilitation, Long-term Care, convalescence and disability, support services costs, senile condition and dementia) (except where expressly specified in this Policy document).
- Any Injury covered by ACC (except where provided under the ACC top-up Benefit or ACC treatment Injury Benefit).
- Any Pre-existing Conditions, except
  - any medical condition declared on the application form and accepted by nib; or
  - where provided for under the Proactive Health Option or Pre-existing Cover for Newborns Benefit.
- Any medical treatment, investigations or admission that is not Medically Necessary (except where provided under the Proactive Health Option).

- Any experimental, unproven or unconventional medical treatments, procedures or technologies that have not been pre-approved by nib.
- Any treatment or procedure that nib considers is novel or experimental or more expensive than an available alternative treatment or procedure, which will provide the same, or a similarly acceptable, medical outcome.

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

- Alternative or complementary medicines or therapies (for example: massage therapy, homeopathy and natural therapy).
- Costs associated to additional surgery or treatment performed that is not covered by the Contract of Insurance.
- Mechanical tools, aids and/or appliances of any type as determined by nib (for example: insulin pumps, C-PAP equipment, cochlear implants, pacemakers, electrodes, nerve stimulators and/or crutches and artificial limbs).
- Any costs that are not Medically Necessary (for example: car parking, newspapers, take-out meals, alcohol, toiletries and TV rental, fax charges, administration costs, overtime, cancellation charges, prioritisation fees and ambulance society subscriptions) (except where provided under the Cancer Treatment Accessories Support Benefit).
- Drugs that are not approved by Medsafe and/or have not met the Therapeutic Indications of Medsafe.
- Drugs that do not meet the funding criteria on the PHARMAC pharmaceutical schedule under section A to H (except where provided under the Non-PHARMAC Funded Drugs in Hospital Benefit, Non-PHARMAC Funded Drugs at Home Benefit and Intravitreal Eye Injections Benefit).
- Any periodontics, orthodontics and endodontic procedures, dentures, implants, orthognathic surgery or tooth exposure (except where expressly specified in this Policy document).
- GP and out-of-hospital prescription charges (except where provided under the GP Option).
- Any Health Services that are provided by health professionals not recognised by the Medical Council of New Zealand (except where expressly specified in this Policy document).
- Any medical condition not registered with the Ministry of Health as a disease entity.
- Claims that do not meet our general terms (see General terms of Ultimate Health Max Cover on page 8).

Before going to hospital, call us on **0800 123 nib** (0800 123 642). We can check what will be covered and help you understand the best ways to avoid potential Out-of-Pocket Expenses.

nib's obligations

SECTION 11

We will:

- Treat Insured Persons as valued nib customers.
- Answer questions promptly and accurately at the first point of contact (whenever possible).
- Provide detailed health Policy information and help the Policyowner and the Insured Persons understand what they are covered for.
- Deal with feedback and complaints in a timely and responsible manner.
- Make every possible effort to resolve complaints to the Policyowner's and the relevant Insured Person's satisfaction (whenever possible).
- Provide timely and accurate Pre-approval (whenever possible).
- Keep the Policyowner and the Insured Persons informed regarding the process of their Claim (whenever possible).
- Provide at least 30 days' written notification of Cover changes and at least 30 days' notification of a Premium increase.
- Meet the terms outlined in our direct debit authority.
- Provide a 14-day free-look period on all health Cover sales (providing no Claims are made during that time).
- Treat personal information with respect and in total accordance with the Privacy Act 1993, including the Health Information Privacy Code 1994.

Policyowner and insured person's obligations

SECTION 12

By taking out a Policy with us, the Policyowner and all Insured Persons agree to:

- Comply with this Policy in full.
- Be accurate and truthful in their health insurance application and Claims.
- Undertake to understand Waiting Periods and what they are covered for, and if unsure – ask us.
- Keep their health insurance Premiums up-to-date to ensure they remain covered.
- Meet the terms outlined in our direct debit authority.
- Provide all information reasonably required by us in relation to the Policy.
- Provide a relevant referral letter where the specific service or treatment must only be performed after referral by a GP or Registered Specialist. The name of the referring practitioner must be shown on the account or receipt presented to us for payment.
- Notify us as soon as reasonably possible of any change that may affect their Policy, and if unsure – ask us.
- Comply with the duty of disclosure (see Duty of disclosure on page 8).

nib's privacy policy

13 SECTION

We are committed to protecting the privacy and security of the personal information we collect. We have implemented measures to comply with our obligations under the Privacy Act 1993, including the Health Information Privacy Code 1994. Our privacy policy explains how we may collect, use and disclose personal information. To read our current privacy policy, please go to nib.co.nz/about-us/privacy-policy

Feedback and complaints

14 SECTION

Any questions? More information?

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

How to contact us

Call nib on **0800 123 nib** (0800 123 642), Monday to Friday 8.00am – 5.30pm
Go to **nib.co.nz**
Email **contactus@nib.co.nz** or **claims@nib.co.nz**

We have a process for dealing with complaints to ensure they are heard.

You are welcome to contact us on the details above to talk to the person who handled your enquiry or Claim, or to talk to a Team Leader or Manager.

Alternatively, you can write to the nib Complaints Committee:
nib nz limited
PO Box 91630
Victoria Street West
Auckland 1142
Email **complaints@nib.co.nz**

We will make every possible effort to resolve complaints to your satisfaction. In the event that you are not satisfied with the outcome, we will issue a "letter of deadlock" which gives you the option to take your complaint to the Insurance & Financial Services Ombudsman:

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

Glossary of important terms

SECTION 15

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

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

"Activities of Daily Living" means any of the following:

- bathing and showering; or
- dressing and undressing (including grooming and fitting artificial limbs); or
- eating and drinking; or
- using a toilet to maintain personal hygiene; or
- moving to or from place to place by walking, wheelchair or walking aid.

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

"Admission" means to have followed an administration process to become an Admitted Patient for treatment of a sign, symptom or Condition as a private patient in a Recognised Private Hospital. For the purpose of this Cover, a treatment in the emergency room of a Recognised Private Hospital is not an admission.

"Admitted Patient" means an Insured Person who is formally admitted to a Recognised Private Hospital for the purposes of Surgery or medical treatment. For the purpose of this Cover, an Insured Person having treatment in the emergency room of a Recognised Private Hospital is not an admitted patient.

"Audiologist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Audiological Society (or its successor).

"Audiology Treatment" means treatment that is provided by an Audiologist.

"Benefit" or **"Benefits"** means an amount of money payable from nib to or on behalf of an Insured Person, in respect of approved expenses incurred by that Insured Person for treatment, in accordance with the Contract of Insurance.

"Benefit Limit" or **"Benefit Limits"** means the maximum amount nib will pay for each Benefit for each Insured Person every Policy Year.

"Brachytherapy" means radiation therapy in which the source of radiation (seeds) is implanted internally close to or in the site being treated.

"Chemotherapy" means a medication and its administration for the treatment of cancer that is provided by Medsafe.

"Chemotherapy Agent" or **"Chemotherapy Agents"** means a chemotherapy drug orally or intravenously administered for the treatment of cancer that is approved by Medsafe.

"Chiropractic" means treatment that is provided by a Chiropractor.

"Chiropractor" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- member of The Chiropractic Board of New Zealand (or its successor).

"Claim" or **"Claims"** or **"Claiming"** means a request from an Insured Person for the payment of Benefits or a confirmation of future payment of Benefits, which complies with this Policy document.

"Clinical Psychiatrist" or **"Psychiatrist"** means a Registered Specialist who is in Private Practice and holds a current annual practicing certificate.

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

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

"Congenital" means a health anomaly or defect which is recognised at birth, or diagnosed within four months of birth, whether it is inherited or due to external or environmental factors such as drugs or alcohol.

"Consultation" or **"Consultations"** means a necessary face-to-face meeting with a Recognised Health Professional for discussion or the seeking of advice, or conferring to evaluate the medical case and any treatment. A consultation does not include the treatment itself. This does not include any virtual consultations.

"Contract of Insurance" means the following:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document);
- the Prosthesis Schedule; and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

"Counselling" means provision of professional assistance and guidance in resolving personal or psychological conditions provided by a GP, Clinical Psychologist, Psychiatrist or Psychologist.

"Cover" or "Covers" means the defined group of Benefits which are payable to an Insured Person under their chosen level of health insurance which comply with the Policy document.

"Cycle" means for

- Chemotherapy treatment: A specified number of sequentially administered doses of Chemotherapy Agent(s) where:
  - the Chemotherapy Agent is administered at prescribed intervals within a planned timeframe;
  - the Chemotherapy Agent is approved by Medsafe; and

- the treating Registered Specialist must provide a recommendation letter detailing the reasons for the Chemotherapy Agent.

- Radiotherapy treatment: A specified number of sequentially administered doses of radiation where:
  - the radiation is administered at prescribed time frame; and
  - the radiation is prescribed by a Registered Specialist and administered in a Recognised Provider in New Zealand.

"Dental Practitioner" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dental Council of New Zealand (or its successor).

"Dental Treatment" means treatment that is provided by a Dental Practitioner.

"Dependent Child" or **"Dependent Children"** means an Insured Person's natural or legally adopted child or children under the age of 21 years.

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

"Dietitian" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dietitian Board in New Zealand (or its successor).

"Disability Support Services" means support services provided that do not include any Surgical or medical treatments.

"Effective Date" means the date any changes made to the Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Excess" means the amount each Insured Person must pay towards the cost of Health Services that they receive each Policy Year that would otherwise be covered under the Policy. The Insured Person's Excess amount is shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"GP" or **"General Practitioner"** means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Medical Council of New Zealand (or its successor).

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

"Hospice" means a Recognised Provider which is:

- a healthcare facility providing palliative care services for terminally ill patients; and
- a member of Hospice New Zealand (or its successor).

"Hospital" means premises that come within part (a) of the definition of 'hospital care' in the Health and Disability (Safety) Act 2001 (or its successor under any subsequent legislation).

"Hospitalisation" means Admission in New Zealand to a Recognised Private Hospital for the purposes of:

- undergoing a Surgical procedure; or
- receiving medical treatment or Chemotherapy or Radiotherapy treatment.

"Injection" or **"Injections"** means the act of forcing a liquid or pharmaceutical into any part of the body, using a needle, cannula or other introducer.

"Injury" or **"Injuries"** means a "physical injury, but excluding "mental injury "as defined in the Accident Corporation Act 2001 (or its successor under any subsequent legislation).

"Insured Person" or **"Insured Persons"** means a person named as an 'Insured Person' on the Acceptance Certificate or Renewal Certificate (whichever is the later), and may, as applicable, include the Policyowner.

"Insured Person's Child" means a natural or legally adopted child of an Insured Person, aged between two and 20 years.

"Join Date" means the date when Cover commences for an Insured Person. This date is shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Lifetime Limit" means the maximum amount we will pay for each Benefit for each Insured Person over the lifetime of the Insured Person and the Policy.

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

"Medically Necessary" means a service or supply provided by a Recognised Health Professional that nib deems on reasonable grounds is necessary for the diagnosis, care or treatment of the disease or illness involved. Under no circumstances will the following goods, services or supplies be considered Medically Necessary:

- those goods, services or supplies that do not require the skills or services of a Recognised Health Professional; or
- those goods, services or supplies furnished mainly for the comfort or convenience of the Insured Person; or
- those goods, services or supplies that do not relate to the medical treatment being provided (for example: alcohol, toiletries, pay TV, car parking and take away meals).

"Medsafe" means New Zealand Medicines and Medical Devices Safety Authority, a Business unit of the Ministry of Health established by the Medicines Act 1981 and the Medicines Regulations 1984 (or its successor under any subsequent legislation).

"Mohs" or **"Micrographic Surgery"** means a specialised surgical technique for the removal of skin cancers (carcinomas) which allows precise tissue removal assisted by frozen section and microscopic viewing with minimal damage to healthy tissue.

"Nurse Practitioner" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate as a nurse practitioner; and
- a member of the Nursing Council of New Zealand (or its successor).

"Nutritionist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Nutrition Society of New Zealand (or its successor).

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

"Obstetrician" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (or its successor).

"Occupational Therapy" means treatment that is provided by a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Occupational Therapy Board of New Zealand (or its successor).

"Ophthalmologist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Royal Australian and New Zealand College of Ophthalmologist (or its successor).

"Optical Appliances" means spectacles or contact lenses used to correct sight which have been approved by nib and prescribed by an Optometrist, Optician or Ophthalmologist.

"Optometrist" or **"Optician"** means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Optometrists and Dispensing Opticians board of New Zealand (or its successor).

"Orthodontic Treatment" means treatment performed by an Orthodontist.

"Orthodontist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dental Council of New Zealand (or its successor).

"Orthoptist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Orthoptic Society Inc (or its successor).

"Osteopath" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Osteopathic Council of New Zealand (or its successor).

"Osteopathic" means treatment provided by a registered Osteopath.

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

"Out-of-Pocket Expenses" means any costs not covered by nib that are billed by the Recognised Provider for which the Insured Person will

be liable.

"Partner" means an Insured Person's spouse or a person who cohabits with the Insured Person in a nature of a marital, de-facto or civil union relationship.

"PHARMAC" means the Pharmaceutical Management Agency being a Crown entity established by the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation).

"Pharmaceutical Prescription" means a legally written order by a Registered Specialist, GP, Dental Practitioner or Nurse Practitioner for the preparation and administration of a medicine (pharmaceutical), dispensed by a registered Pharmacy and approved by Medsafe (or its successor under any subsequent legislation).

"Pharmacy" means Recognised Provider who is:

- in Private Practice and holds a current annual practicing certificate; and
- a member of the Pharmacy Council of New Zealand (or its successor under any subsequent legislation).

"Physiotherapy" means treatment provided by a Physiotherapist.

"Podiatric Surgeon" means 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 its successor); and
- vocationally registered and recognised as a podiatric surgeon

"Podiatrist" means 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 its successor).

"Podiatry Treatment" means treatment that is provided by Podiatrist.

"Physiotherapist" means 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 successor).

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

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

"Policyowner" means a person who administers the Policy and whose name is listed on the Acceptance Certificate or Renewal Certificate (whichever is the later) as 'Policyowner(s)'. This means all Policyowners if there is more than one.

"Policy Year" means the 12-month period that commences on the Commencement Date and ends at 6am on the Policy Anniversary Date, and each successive 12-month period from a Policy Anniversary Date to the next Policy Anniversary Date.

"Pre-approval" or **"Pre-approve"** means our advanced confirmation of the eligibility of an Insured Person's Claim.

"Pre-existing Condition" means any sign, symptom, treatment or

surgery of any condition that occurs on or before the:

- Commencement Date; or
- Effective Date; or
- Join Date,

whichever is applicable, and:

- which the Policyowner or any Insured Person was aware of; or
- of which the Policyowner or any Insured Person has had the first indication that something was wrong; or
- for which the Policyowner or any Insured Person sought investigation or medical advice; or
- where the condition, or the sign or symptom of a condition, existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment.

"Premium" means the amount of money the Policyowner is required to pay to nib in respect of a specified period of Cover for the Policy, and includes any applicable policy fee charged by nib.

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

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

"Prostheses" or **"Prosthesis"** means an artificial implant used for functional reasons to:

- replace a joint or body part that has been removed; or
- support a body structure

due to disease or Injury and is approved and listed by nib.

"Prosthesis Schedule" means the list of Prostheses maximum costs as published on our website at **nib.co.nz**

"Psychologist" means a Recognised Health Professional who is

- in Private Practice and holds a current annual practicing certificate; and
- a member of The New Zealand College of Clinical Psychology (or its successor).

"Public Hospital" or **"Public Hospitals"** means a Hospital owned and administered by the public funded health sector of the New Zealand Government.

"Radiotherapy" means a specified number of fractions (sequentially administered doses) of radiation where:

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

"Recognised Health Professional" means:

- a registered person who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation);

- a member of the appropriate registration body, for example Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand or the Chiropractic Board in New Zealand; and
- recognised by nib.

"Recognised Private Hospital" or **"Recognised Private Hospitals"** means a private hospital, day Surgery unit or private wing in a Public Hospital, within New Zealand that has been recognised by nib. It does not include any other type of medical facility.

"Recognised Provider" means a Recognised Health Professional, Registered Specialist, Recognised Private Hospital or other medical facility that is recognised by nib.

"Redundancy" means a situation where employment has been terminated by the employer due to the position held is no longer necessary for the employer. This will exclude the following situations:

- fixed term agreement ends; or
- voluntary redundancy; or
- seasonal work changes; or
- performance management dismissal; or
- result of extended leave which lasts longer than three months (with or without pay); or
- when the employer is a relative to the Policyowner or an Insured Person.

"Registered Nurse" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate as a registered nurse; and
- a member of the Nursing Council of New Zealand (or its successor).

"Registered Specialist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate;
- a member of an appropriately recognised specialist college and has Medical Council of New Zealand vocational registration in that speciality (or its successor); and
- recognised by nib.

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

"Renewal Certificate" means the most recent document entitled 'Renewal Certificate' forwarded to the Policyowner by nib in relation to this Policy.

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

"Serious Condition" means the medical conditions as defined under the Serious Condition Financial Support Option (see Definitions of the Serious Conditions covered on page 51).

"Skin Lesion" or **"Skin Lesions"** means an abnormal change to any one or all of the three skin layers caused by disease or Injury.

"Speech Therapy" means treatment that is provided by a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the New Zealand Speech Language Therapists Association (or its successor).

"Sports Physician Treatments" means treatment provided by a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate as a sports physician; and
- a fellow of the Australasian College of Sports Physician (or its successor).

"Sum Insured" means the total dollar value covered under the Serious Condition Financial Support Option as shown on the Acceptance Certificate or Renewal Certificate (whichever is the later) for an Insured Person.

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

"Troponin" means cardiac 'troponin' (a protein, specific to the heart muscle cells).

"Usual, Customary and Reasonable Charges" or **"UCR Charges"** means costs which are usual, customary and reasonable charges set by nib.

"Vocational GP" means a General Practitioner (GP) with a relevant, post-graduate qualification in the Health Service they are providing, as recognised by nib.

"Waiting Period" means a period of time after the Commencement Date, Effective Date or the Join Date, during which no Claim will be paid for that specific Benefit.

"Whole Person Function" means a loss of use, or derangement of any body part, organ system, or organ function, that is well established and unlikely to change substantially in the next 12 months, with or without further medical treatment.

"You" or **"Your"** means an Insured Person.

nib

Need help?

Talk to your financial adviser
Call us on **0800 123 nib** (0800 123 642)
Mon to Fri: 8am – 5.30pm
Email us at **contactus@nib.co.nz**
Go to **nib.co.nz**
PO Box 91630, Victoria Street West, Auckland 1142