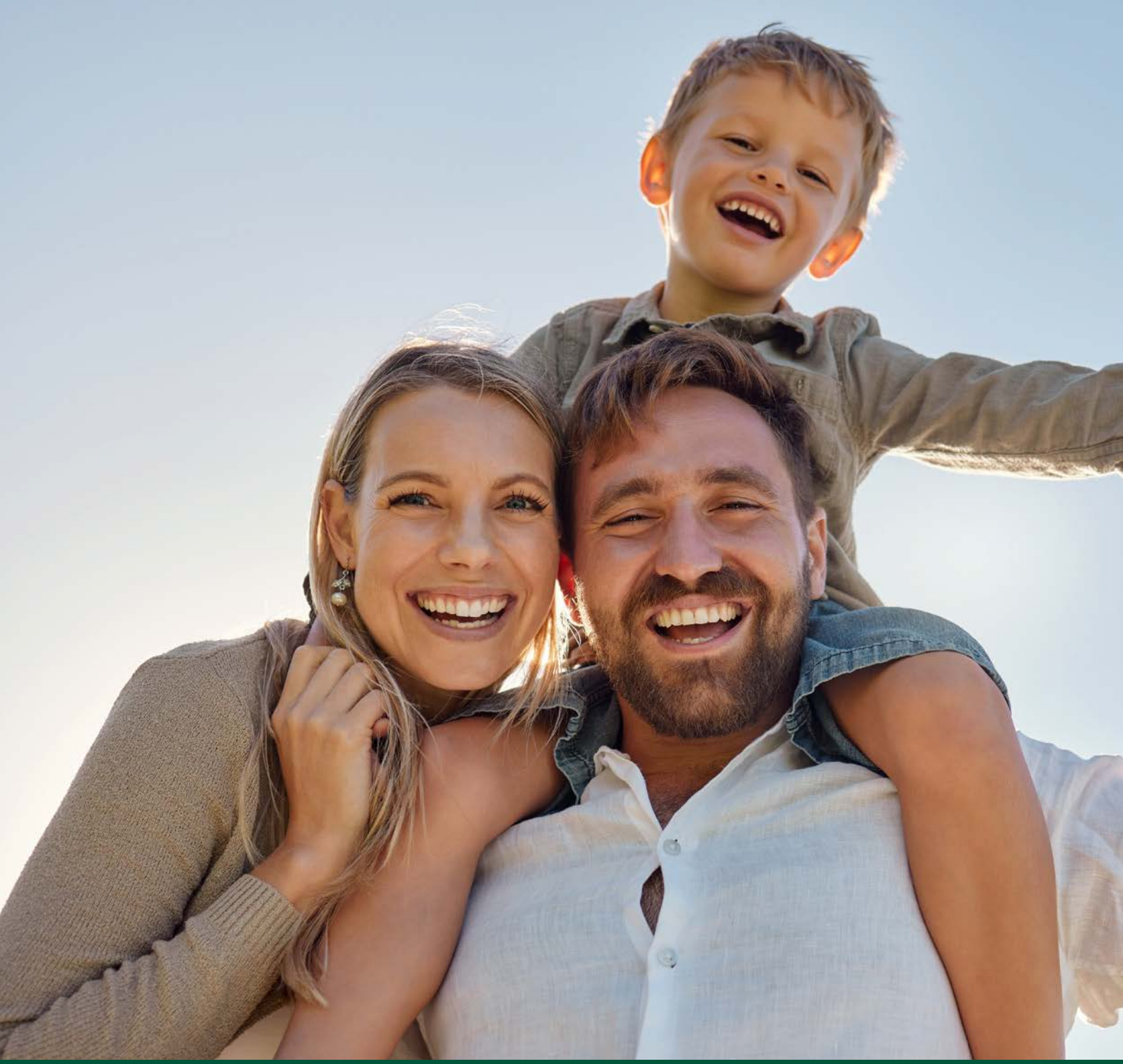

Ultimate Health Max

nib

Policy Document

Welcome to nib

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

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

Contents

01.

How this document works

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

BASE COVER

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

OPTIONS

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

Cover Overview *(continued on the next page)*

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

* This benefit may be used across multiple stages.

I'm feeling unwell and need to see a doctor, dentist, or another health professional

GP Option

- GP Benefit*
- Prescriptions Benefit
- Physiotherapy Benefit
- Nurse Practitioner Benefit

Dental, Optical, and Therapeutic Option

- Dental Benefit*
- Eye Care Benefit
- Ear Care Benefit
- Acupuncture Benefit
- Chiropractor Benefit
- Osteopath Benefit
- Foot Care Benefit
- Speech, Occupation, and Eye Therapy Benefit
- Loyalty – Orthodontic Benefit

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

Base Cover

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

Specialist Option

- Specialist Consultations Benefit
- Specialist Second Opinion Benefit
- Sports Physician Benefit
- Diagnostic Tests Benefit
- Cardiac Investigations Benefit

I need to stay in hospital for surgery or treatment

Base Cover

- Surgical Benefit
- Non-Surgical Benefit
- Cancer Treatment Benefit
- Non-PHARMAC Funded Medicines in Hospital Benefit
- Travel and Accommodation Benefit
- Parent Accommodation Benefit
- Ambulance Transfer Benefit
- Delayed Treatment Benefit
- Cover in Australia Benefit
- Overseas Treatment Benefit
- Medical Tourism Benefit
- ACC Treatment Injury Benefit
- Loyalty – Weight Loss Surgery Benefit
- Loyalty – Breast Reduction Surgery Benefit

Non-PHARMAC Plus Option

- Non-PHARMAC Plus Benefit*

Cover Overview *(continued)*

* This benefit may be used across multiple stages.

I'm recovering from a stay in hospital

Base Cover

- Non-PHARMAC Funded Medicines at Home Benefit
- Cancer Treatment Accessories Support Benefit
- Cancer Treatment Counselling and Support Services Benefit
- Cardiac Counselling and Support Services Benefit
- Physiotherapy Benefit
- Therapeutic Care Benefit
- Home Care Benefit
- Follow-up Investigations for Cancer Benefit
- Breast Symmetry Post Mastectomy Benefit
- Hospital Diagnostic Tests Benefit*
- Hospital Specialist Consultations Benefit*
- Second Opinion Benefit*

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit*

I need financial support

Base Cover

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

Serious Condition Financial Support Option

Serious Condition Benefit

Paralysis Benefit

Children's Benefit

I want to be proactive about my health

Base Cover

- Loyalty – Check Up Benefit

GP Option

GP Benefit*

Loyalty – Active Wellness Benefit

Dental, Optical, and Therapeutic Option

Dental Benefit*

Proactive Health Option

Screening Benefit

Allergy Testing and Vaccinations Benefit

Dietitian or Nutritionist Consultations Benefit

Stay Active Benefit

Loyalty – Health Check Benefit

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

Your policy document tells you:

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

Your Acceptance or Renewal Certificate tells you:

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

The **prosthesis schedule** tells you the maximum amount we'll pay for prosthesis. You need to refer to the most up-to-date list, available on our website and at mynib.

If there's any inconsistency between your policy document, your **Acceptance or Renewal Certificate** and the **prosthesis schedule**, your **Acceptance or Renewal Certificate** takes priority followed by your policy document and then the **prosthesis schedule**.

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

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

Important words

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

In addition to this, where we use the words:

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

02.

Your Base Cover

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

BASE COVER

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

Diagnostic Investigations Benefit

What am I covered for?

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

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

How much am I covered for?

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

Hospital Diagnostic Tests Benefit

What am I covered for?

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

How much am I covered for?

You can have an unlimited number of **diagnostic investigations** during this time, up to your overall **benefit limit***.

What else do I need to know?

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

Hospital Specialist Consultations Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

To claim on this benefit, you'll need:

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

Second Opinion Benefit

What am I covered for?

We'll pay for you to get a second opinion from a **specialist** or **vocational GP** up to six months before and after you're **admitted** to a **private hospital**.

How much am I covered for?

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

What else do I need to know?

To claim on this benefit, you'll need to have already had a related claim paid by us under your Specialist Consultations Benefit.

Skin Lesion Surgery Benefit

What am I covered for?

We'll pay for skin lesion **surgery** by a **specialist**.

Any specialist consultations relating to the skin lesion **surgery** will be covered under the Hospital Specialist Consultations Benefit, whether or not you are admitted to a **private hospital**.

How much am I covered for?

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

What else do I need to know?

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

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

GP Surgery Benefit

What am I covered for?

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

How much am I covered for?

Up to $5,000 per **insured person** every **policy year**.

What else do I need to know?

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

Foot Surgery Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

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

Eye Injections Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

High-Risk Pregnancy Benefit

What am I covered for?

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

How much am I covered for?

Up to $4,000 for each pregnancy.

What else do I need to know?

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

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

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

Loyalty – Sterilisation Benefit

What am I covered for?

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

How much am I covered for?

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

When will I be covered?

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

What else do I need to know?

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

OPTIONS

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

Specialist Option

Specialist Consultations Benefit
Specialist Second Opinion Benefit
Sports Physician Benefit
Diagnostic Tests Benefit
Cardiac Investigations Benefit

I need to stay in hospital for surgery or treatment

BASE COVER

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

Surgical Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for **surgery**, we'll pay for your:

- surgeon's operating fees;
- anaesthetist's fees;
- intensivist's fees;
- hospital accommodation (e.g. a bed or private room, but not including suites) ;
- operating theatre fees;
- surgically implanted prosthesis
- 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.

We also cover the costs of alternative, less invasive, procedures which, in our opinion, replace **surgery** as the most appropriate treatment. This is covered under your Non-Surgical Benefit.

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

- oral **surgery**, if it's performed by a registered **oral surgeon** or **maxillo-facial surgeon**
- the removal of unerupted or impacted teeth by an **oral surgeon**, **dental practitioner**, or **maxillo-facial surgeon**. You'll be covered for this after one year of continuous cover following your **join date**.
- Specialist micrographic **surgery** (also known as Mohs)

Surgical Benefit *(continued)*

- Varicose vein treatment if it's performed by a **vocational GP**, **specialist** or a Phlebologist who is a Fellow of the Australasian College of Phlebology, in private practice, and holds a current practising certificate.

How much am I covered for?

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

What else do I need to know?

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

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

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

Non-Surgical Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for treatment that doesn't involve **surgery**, we'll pay for your:

- hospital accommodation (e.g. a bed or private room, but not including 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

How much am I covered for?

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

What else do I need to know?

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

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

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

Cancer Treatment Benefit

What am I covered for?

If you're **admitted** to a **private hospital** for chemotherapy, immunotherapy, radiotherapy, or brachytherapy, we'll pay for your:

- Chemotherapy;
- Immunotherapy;
- Radiotherapy;
- Brachytherapy;
- hospital accommodation (e.g. a bed or private room, but not including 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

How much am I covered for?

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

What else do I need to know?

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

Non-PHARMAC Funded Medicines in Hospital Benefit

What am I covered for?

We'll cover the cost of medicines you need in a **private hospital** that aren't funded by **PHARMAC** at the time of your treatment (see "What medications can I claim for?" for more information).

How much am I covered for?

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

What else do I need to know?

The medicine must be approved by **Medsafe** and the reason for use within **Medsafe** approval.

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

In addition to any personal or general exclusions that may apply, we also don't cover medicines that are administered or charged for in a public hospital or at home under this benefit.

Travel and Accommodation Benefit

What am I covered for?

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

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

What type of travel costs am I covered for?

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

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

How much am I covered for?*

Accommodation:

- up to $300 per night in total

Travel:

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

What else do I need to know?

To claim on this benefit, you'll need:

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

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

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

Parent Accommodation Benefit

What am I covered for?

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

How much am I covered for?*

- up to $300 per night
- up to a **benefit limit** maximum of $3,000 per **insured person** every **policy year**

What else do I need to know?

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

Ambulance Transfer Benefit

What am I covered for?

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

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

How much am I covered for?

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

What else do I need to know?

The transfer must be:

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

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

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

Delayed Treatment Benefit

What am I covered for?

If the **surgery** or medical treatment you need is available privately in New Zealand but can't be provided for at least six months due to a lack of medical resources, we'll pay towards having your treatment overseas.

We'll also cover return economy flights, accommodation, and transfers for you and one support person.

How much am I covered for?

The maximum amount we'll pay is the **usual, customary and reasonable charges** that would've been payable in New Zealand for the same **surgery** or treatment, up to your overall **benefit limit***.

What else do I need to know?

- any related **diagnostic investigations** and histology must be done before your departure
- all details regarding your destination, travel, accommodation, and support person need to be approved by us before your departure
- all medical facilities, providers, and health professionals that you use must have accreditation and/or registration that would be acceptable for New Zealand standards

Payments:

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

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

- **surgery** or treatment that isn't available in New Zealand
- **surgery** or treatment that isn't performed in an overseas **private hospital**
- any **surgery** or treatment that can be claimed under the Overseas Treatment Benefit

Cover in Australia Benefit

What am I covered for?

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

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

How much am I covered for?

The maximum amount we'll pay is the **usual, customary and reasonable charges** that would've been payable in New Zealand for the same **surgery** or treatment, up to your overall **benefit limit***.

What else do I need to know?

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

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

Payments:

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

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

- **surgery** or treatment that relates to an injury which would be covered under **ACC** if it had happened in New Zealand
- any ambulance costs
- a claim for the same **surgery** or treatment under the Overseas Treatment Benefit – we'll pay under the benefit with the higher cover amount

Overseas Treatment Benefit

What am I covered for?

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

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

How much am I covered for?

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

What else do I need to know?

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

Overseas Treatment Benefit *(continued)*

Payments:

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

The treatment must meet all of the following criteria:

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

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

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

Medical Tourism Benefit

What am I covered for?

We'll cover the cost of overseas **surgery** or treatment under the following benefits, if the treatment can be provided in New Zealand within six months:

- Surgical Benefit
- Non-Surgical Benefit
- Cancer Treatment in Hospital Benefit
- Non-PHARMAC Funded Medicines in Hospital Benefit
- Non-PHARMAC Funded Medicines at Home Benefit

How much am I covered for?*

The maximum amount we'll pay is 75% of the **usual, customary and reasonable charges** that would have been payable in New Zealand for the same surgery or treatment, up to your overall **benefit limit***.

What else do I need to know?

- you need to get pre-approval to use this benefit
- all medical facilities, providers and health professionals that you use must have accreditation and/or registration that would be acceptable for New Zealand standards
- the treatment must be a type that can be performed in New Zealand and must be recommended by the specialist who treated you in New Zealand
- medications are only covered if they would've been covered in New Zealand
- you can choose the country you want to be treated in, but receipts and medical reports must be provided in English at your own cost

Payments:

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

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

- any complications or ongoing treatment related to the initial treatment
- a claim for the same surgery or treatment under the Cover in Australia Benefit

ACC Treatment Injury Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

Loyalty – Weight Loss Surgery Benefit

What am I covered for?

We'll cover the cost of sleeve gastrectomy, gastric banding or bypass **surgery** if you meet all of the following criteria:

- physical growth is complete;
- previous attempts at weight loss haven't been successful long-term;
- 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:
    - coronary heart disease;
    - type 2 diabetes mellitus;
    - clinically significant obstructive sleep apnoea (which is proven by sleep studies);
    - moderate or severe osteoarthritis of weight bearing joints, for example hips and knees (radiological evidence required); or
    - blood pressure greater than 140/90 despite 6 months or more of antihypertensive medications, proven to be ineffective at maximum doses

We'll also cover your related **consultations** and **diagnostic investigations**.

How much am I covered for?

$10,000 per **insured person** over the life of this policy deducted from your Surgical Benefit **benefit limit***.

When will I be covered?

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

What else do I need to know?

- we only pay for the weight loss **surgeries** that are specified above, and don't cover any other treatment, for example banded gastroplasty (stomach stapling)
- to claim on this benefit, you'll need to send us a report from your **specialist** before your **surgery** showing that you meet the criteria above
- if you suspend your cover, the suspension period doesn't count towards the three years
- in addition to any personal or general exclusions that may apply, we also don't cover any complications or follow-up treatment relating to your **surgery** under this benefit

Loyalty – Breast Reduction Surgery Benefit

What am I covered for?

We'll cover the cost of bilateral breast reduction **surgery** if you meet all of the following criteria:

- 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
- 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**
- 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)
  - pain, discomfort or ulceration from bra straps cutting into shoulders (not just imprints of straps)
  - associated skin disorders that have not responded to conservative medical treatment

We'll also cover your related **consultations** and **diagnostic investigations**.

How much am I covered for?

$10,000 per **insured person** over the life of this policy deducted from your Surgical Benefit **benefit limit***.

When will I be covered?

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

What else do I need to know?

- to claim on this benefit, you'll need to send us a report from your **specialist** before your **surgery** showing that you meet the criteria above
- if you suspend your cover, the suspension period doesn't count towards the three years
- in addition to any personal or general exclusions that may apply, we also don't cover any tumescent liposuction or any follow-up treatment relating to your **surgery** under this benefit

OPTIONS

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

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit

I'm recovering from a stay in hospital

BASE COVER

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

Non-PHARMAC Funded Medicines at Home Benefit

What am I covered for?

We'll cover the cost of medicines used at home for up to six months after you're **admitted** to a **private hospital** for treatment. The medicine must be:

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

How much am I covered for?

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

What else do I need to know?

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

Cancer Treatment Accessories Support Benefit

What am I covered for?

If you've had cancer **surgery** or treatment paid for by us under this policy, we'll contribute towards the costs of any of the following related to your **surgery** or treatment:

- wigs
- hats
- scarves
- mastectomy bras

How much am I covered for?

Scarf / hat:

- up to $50 for each cancer condition, deducted from your overall **benefit limit***

Wig / mastectomy bra:

- up to $500 for each cancer condition, deducted from your overall **benefit limit***

What else do I need to know?

To claim on this benefit, you'll need:

- to provide us with your receipts
- a related claim already paid by us under your Surgical or Non-Surgical Benefit

You must buy the accessory within six months of being **admitted** to a **private hospital** for your **surgery** or treatment.

In addition to any personal or general exclusions that may apply, we also don't cover any accessories that aren't related to your cancer under this benefit.

Cancer Treatment Counselling and Support Services Benefit

What am I covered for?

If you've had cancer **surgery** or treatment paid for by us under this policy, we'll pay towards the following **counselling** and support services related to your **surgery** or treatment:

- Any of these **counselling** services:
  - grief **counselling**
  - illness crisis **counselling**
  - anxiety **counselling**
  - depression **counselling**
  - anger management
- Any of these support services provided by an expert in their field:
  - stop smoking
  - drug addiction
  - alcohol addiction
  - gambling addiction
  - relationship guidance
  - budgeting advice
  - career advice
  - small business advice

How much am I covered for?

Counselling services:

- up to $400 for each cancer condition, deducted from your overall **benefit limit***

Support services:

- up to $300 for each cancer condition, deducted from your overall **benefit limit***

Cancer Treatment Counselling and Support Services Benefit *(continued)*

What else do I need to know?

- the service(s) must occur within six months of being **admitted** to a **private hospital** for your **surgery** or treatment
- the services must relate to your cancer treatment which was paid for by us
- the services must be approved by us in advance and will be paid after you provide receipts
- to claim on this benefit, you'll need:
  - a referral from the **GP** or **specialist** who treated your cancer condition
  - a related claim already paid by us under your Surgical or Non-Surgical Benefit
- in addition to any personal or general exclusions that may apply, we also don't cover services provided by family members, friends, associates or anyone who doesn't meet our criteria under this benefit

Cardiac Counselling and Support Services Benefit

What am I covered for?

If you've had heart **surgery** paid for by us under this policy, we'll pay towards the following **counselling** and support services related to your **surgery**:

- Any of these **counselling** services:
  - grief **counselling**
  - illness crisis **counselling**
  - anxiety **counselling**
  - depression **counselling**
  - anger management
- Any of these support services provided by an expert in their field:
  - stop smoking
  - drug addiction
  - alcohol addiction
  - gambling addiction
  - relationship guidance
  - budgeting advice
  - career advice
  - small business advice

How much am I covered for?

Counselling services:

- up to $400 for each heart **surgery**, deducted from your overall **benefit limit***

Support services:

- up to $300 for each heart **surgery**, deducted from your overall **benefit limit***

What else do I need to know?

- the service(s) must occur within six months of being **admitted** to a **private hospital** for your **surgery** or treatment
- the services must relate to your heart **surgery** which was paid for by us
- the services must be approved by us in advance and will be paid after you provide receipts
- to claim on this benefit, you need:
  - a referral from the **GP** or **specialist** who treated your cardiac condition
  - a related claim already paid by us under your Surgical or Non-Surgical Benefit
- in addition to any personal or general exclusions that may apply, we also don't cover services provided by family members, friends, associates or anyone who doesn't meet our criteria under this benefit

Physiotherapy Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

To claim on this benefit, you'll need:

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

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

Therapeutic Care Benefit

What am I covered for?

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

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

How much am I covered for?

Up to $1,000 per **insured person** every **policy year**, deducted from your overall **benefit limit***.

What else do I need to know?

To claim on this benefit, you'll need:

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

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

Home Care Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

The care must meet all of the following criteria:

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

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

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

Follow-up Investigations for Cancer Benefit

What am I covered for?

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

You're covered for both:

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

How much am I covered for?

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

What else do I need to know?

This benefit starts once your cancer treatment has ended.

Breast Symmetry Post Mastectomy Benefit

What am I covered for?

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

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

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

How much am I covered for?

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

What else do I need to know?

- you don't need to pay an excess on this benefit.
- you'll need to provide us with a medical report from your **specialist** before any **surgery**

ADDITIONAL COVER

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

Base Cover

Hospital Diagnostic Tests Benefit
Hospital Specialist Consultations Benefit
Second Opinion Benefit

Non-PHARMAC Plus Option

Non-PHARMAC Plus Benefit

I need financial support

BASE COVER

Public Hospital Payment

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

- you don't need to pay an excess under this benefit
- you can claim on this benefit once you've been in a public hospital for three or more nights in a row
- to claim on this benefit, you'll need to provide us with the discharge summary from the public hospital – it needs to include the reason for your stay and the dates you arrived and left the public hospital
- we'll only pay this benefit if you would have been able to claim under the Surgical Benefit, Non-Surgical Benefit, or Cancer Treatment Benefit in a **private hospital**
- in addition to any personal or general exclusions that may apply, we also don't cover any stays in the private wing of a public hospital under this benefit

Hospice Benefit

What am I covered for?

If you're **admitted** to a **hospice**, we'll make a payment to you from the third night of your stay onwards.

How much am I covered for?

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

What else do I need to know?

- you'll need to have been in **hospice** for three or more nights in a row to be able to claim
- to claim under this benefit, we'll need a summary from the **hospice** which includes the reason and length of your stay

Funeral Support Benefit

What am I covered for?

If you die between the ages of 16 and 64 (inclusive), we'll pay this benefit.

How much am I covered for?

$10,000 for each deceased **insured person**.

What else do I need to know?

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

Medical Misadventure Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

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

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

ACC Top-Up Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

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

Waiver of Premium Benefit

What am I covered for?

We won't charge any premiums if a **policyowner** dies before the age of 70, or at the end of the Terminal Illness Waiver of Premium Benefit.

How long will my premiums be waived for?

We won't charge any premiums from the next billing date after the death of the **policyowner** or the end of the Terminal Illness Waiver of Premium Benefit, until the first of these happens:

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

After this, your premium payments will resume.

What else do I need to know?

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

Terminal Illness Waiver of Premium Benefit

What am I covered for?

We won't charge any premiums if a **policyowner** is diagnosed with a terminal illness before the age of 70.

How long will my premiums be waived for?

We won't charge any premiums from the next billing date after your claim is submitted to us, until the first of these happens:

- six months have passed
- the **policyowner** dies

After this your premium payments will resume, unless the Waiver of Premium Benefit is initiated.

What else do I need to know?

- you don't need to pay an excess on this benefit
- you need to provide a letter from your **specialist** confirming your terminally ill diagnosis
- this benefit must be used while the **policyowner** is terminally ill, it can't be used after they have died
- premiums won't be waived for any new **insured person(s)** or Option(s) added to your policy after we started waiving the premiums
- if the **policyowner** dies during this six-month period, the Waiver of Premium Benefit will start when this benefit ends

Loyalty – Suspending your Cover Benefit

What am I covered for?

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

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

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

How long can I put my cover on hold?

- unemployment/redundancy: for up to six months
- overseas travel/residence: for at least 90 days, up to a maximum of 24 months
- parental leave: for at least 90 days, up to a maximum of 12 months

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

When can I use this benefit?

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

What else do I need to know?

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

OPTIONS

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

Serious Condition Financial Support Option

Serious Condition Benefit

Paralysis Benefit

Children's Benefit

I want to be proactive about my health

BASE COVER

Loyalty – Check Up Benefit

What am I covered for?

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

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

How much am I covered for?

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

When will I be covered?

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

What else do I need to know?

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

OPTIONS

You may also have cover under the following Options if you have added them to your policy:

GP Option

GP Benefit

Loyalty – Active Wellness Benefit

Dental, Optical, and Therapeutic Option

Dental Benefit

Proactive Health Option

Screening Benefit

Allergy Testing and Vaccinations Benefit

Dietitian or Nutritionist Consultations Benefit

Stay Active Benefit

Loyalty – Health Check Benefit

03.

Options

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

- Specialist Option
- GP Option
- Dental, Optical, and Therapeutic Option
- Non-PHARMAC Plus Option
- Proactive Health Option
- Serious Condition Financial Support Option

Specialist Option

This section outlines the benefits that are covered under the Specialist Option.

If you add your **dependent child** to this Option within four months of birth, we'll cover their **pre-existing conditions** under this Option, except for any **congenital conditions**.

When will I be covered?

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

What else do I need to know?

- to claim on these benefits, you'll need a referral from a **GP** or **specialist**
- we pay 100% of eligible costs under each benefit up to your available **benefit limit**
- you don't need to pay an excess on this Option
- we don't pay for any hospital services under this Option

OPTIONS

Specialist Consultations Benefit

What am I covered for?

We'll pay for **consultations** you need with a **specialist** or **vocational GP**.

How much am I covered for?

You can have an unlimited number of **consultations**.

Specialist Second Opinion Benefit

What am I covered for?

We'll pay for you to get a second opinion from another **specialist** or **vocational GP**.

How much am I covered for?

You can have an unlimited number of second opinions.

Sports Physician Benefit

What am I covered for?

We'll pay for any **sports physician treatments** that you need.

How much am I covered for?*

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

Diagnostic Tests Benefit

What am I covered for?

We'll pay for any **diagnostic investigations** that you need. For example, this could include x-rays, ultrasounds, and mammograms.

How much am I covered for?

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

Cardiac Investigations Benefit

What am I covered for?

We'll pay for any cardiac **diagnostic investigations** that you need, including:

- Treadmills
- Holter monitoring
- Ambulatory blood pressure monitoring
- Cardiovascular ultrasound
- Echocardiography
- Myocardial perfusion scans

How much am I covered for?

Up to $60,000 per **insured person** every **policy year**.

GP Option

This section outlines the benefits that are covered under the GP Option.

If you add your **dependent child** to this Option within four months of birth, we'll cover their **pre-existing conditions** under this Option, except for any **congenital conditions**.

When will I be covered?

Unless otherwise specified under a benefit, you're covered by these benefits 90 days after your **join date** on this Option.

What else do I need to know?

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

OPTIONS

GP Benefit

What am I covered for?

We'll pay for:

- **GP** or **nurse practitioner consultations**; and
- **GP surgery** performed in a **GP** room under local anaesthetic

This includes home **consultations**, ECG, and cervical smears.

How much am I covered for?

You can have up to twelve **GP** and/or **nurse practitioner consultations** per **insured person** every **policy year**.

For **consultations** we'll pay:

- up to $55 per **consultation**, including after hours
- up to $80 per home **consultation**
- up to $25 per **ACC** top-up **consultation**

For **GP surgery** we'll pay:

- up to $200 for each procedure

What else do I need to know?

The amounts we'll pay for **consultations** and **GP surgery** can't be combined with each other.

Prescriptions Benefit

What am I covered for?

We'll pay for your pharmaceutical prescriptions.

How much am I covered for?

Up to $15 per item, to a total maximum of $300 per **insured person** for all items every **policy year**.

What else do I need to know?

You'll need to provide us with your pharmacy receipts that show the patient's name, prescription number, name of the prescribed drug(s) and the cost of each item.

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

- after-hours fees
- administration costs
- medicines that aren't prescribed by a **GP**, **specialist**, or **nurse practitioner**

Physiotherapy Benefit

What am I covered for?

We'll pay for **physiotherapy** treatment that you need.

How much am I covered for?

- up to $40 per treatment/visit
- up to $15 per **ACC** treatment
- to a total maximum of $400 per **insured person** every **policy year**

What else do I need to know?

- to claim on this benefit, you'll need a referral from a **GP** or **specialist**
- the amounts we'll pay for treatments can't be combined with each other

Nurse Practitioner Benefit

What am I covered for?

We'll pay for the cost of visits with a **nurse practitioner**.

How much am I covered for?

Up to $30 per visit, to a total maximum of six visits per **insured person** every **policy year**.

Loyalty – Active Wellness Benefit

What am I covered for?

We'll reimburse an **insured person** who was 21 or older at the last **policy anniversary date** for costs paid towards the following:

- a gym membership
- sports club membership
- fitness equipment bought at a sporting retailer

recognised by us

How much am I covered for?

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

When will I be covered?

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

What else do I need to know?

- you need to provide us with receipts
- you can claim on this benefit if, in the two years prior to you becoming eligible for this benefit, you've claimed less than $150 in total on this Option
- you must use this benefit in the year that you're entitled to it; it can't be accumulated
- if you suspend your cover, the suspension period doesn't count towards the two years

Dental, Optical, and Therapeutic Option

This section outlines the benefits that are covered under the Dental, Optical, and Therapeutic Option.

If you add your **dependent child** to this Option within four months of birth, we'll cover their **pre-existing conditions** under this Option, except for any **congenital conditions**.

When will I be covered?

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

What else do I need to know?

- we pay 80% of eligible costs on each benefit up to your available **benefit limit**
- you don't need to pay an excess under this Option
- we don't pay for any hospital services under this Option

OPTIONS

Dental Benefit

What am I covered for?

We'll pay for treatments by a **dental practitioner** including examination, cleaning, scaling, fillings, x-rays, removal of teeth, and crowns.

How much am I covered for?

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

What else do I need to know?

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

- treatments covered under the school dental service or government dental scheme
- gold or other exotic materials
- orthodontic treatment, until you are eligible for the Loyalty – Orthodontic Benefit on this Option

Eye Care Benefit

What am I covered for?

We'll pay for:

- **consultations** and examinations by:
  - Optometrists
  - Orthoptists
  - Opticians
- **eyewear** when you've had a change in vision

How much am I covered for?

For **consultations** and examinations:

- up to $55 per visit, to a total maximum of $275 per **insured person** for all visits every **policy year**

For **eyewear:**

- up to $330 per **insured person** every **policy year**

What else do I need to know?

In addition to any personal or general exclusions that may apply, we also don't cover **eyewear** for fashion reasons, or tinting and transition lenses under this benefit.

Ear Care Benefit

What am I covered for?

We'll pay for audiometric tests and **audiology treatment** that you need.

How much am I covered for?

For audiometric tests:

- up to $250 per **insured person** every **policy year**

For **audiology treatments**:

- up to $250 per **insured person** every **policy year**

What else do I need to know?

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

Acupuncture Benefit

What am I covered for?

We'll pay for acupuncture treatment you need.

How much am I covered for?

- up to $40 per visit
- up to $15 per **ACC** visit
- to a total maximum of $250 per **insured person** for all visits every **policy year**.

What else do I need to know?

- to claim on this benefit, you'll need a referral from a **GP** or **specialist**
- the amounts we pay for treatments can't be combined with each other

Chiropractor Benefit

What am I covered for?

We'll pay for **chiropractic treatment** and related x-rays.

How much am I covered for?

For **chiropractic treatment**:

- up to $40 per visit
- up to $15 per **ACC** visit
- to a total maximum of $250 per **insured person** for all visits every **policy year**

For x-rays:

- up to $80 per **insured person** every **policy year**

What else do I need to know?

- to claim on this benefit, you'll need a referral from a **GP** or **specialist**
- the amounts we pay for treatments can't be combined with each other

Osteopath Benefit

What am I covered for?

We'll pay for **osteopathic treatment** and related x-rays.

How much am I covered for?

For **osteopathic treatment**:

- up to $40 per visit
- up to $15 per **ACC** visit
- to a total maximum of $250 per **insured person** for all visits every **policy year**

For x-rays:

- up to $80 per **insured person** every **policy year**

What else do I need to know?

- to claim on this benefit, you'll need a referral from a **GP** or **specialist**
- the amounts we pay for treatments can't be combined with each other

Foot Care Benefit

What am I covered for?

We'll pay for **podiatry treatment**.

How much am I covered for?

Up to $40 per visit, to a total maximum of $250 per **insured person** for all visits every **policy year**.

What else do I need to know?

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

Speech, Occupation, and Eye Therapy Benefit

What am I covered for?

We'll pay for any of the following:

- **speech therapy**
- **occupational therapy**
- eye therapy

How much am I covered for?

Up to $40 per visit, to a total maximum of $300 per **insured person** for all visits every **policy year**.

What else do I need to know?

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

Loyalty – Orthodontic Benefit

What am I covered for?

After you've had this Option for two continuous years, the Dental Benefit will be extended to cover Orthodontic treatment.

How much am I covered for?

Claims under this benefit are paid from the Dental Benefit. You're covered up to the **benefit limit** remaining on that benefit in the same **policy year**.

When will I be covered?

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

What else do I need to know?

If you suspend your cover, the suspended period doesn't count towards the two years.

Non-PHARMAC Plus Option

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

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

When will I be covered?

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

What else do I need to know?

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

OPTION

Non-PHARMAC Plus Benefit

What am I covered for?

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

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

The medicines must be either:

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

We also cover any costs to administer the medicines.

How much am I covered for?

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

What else do I need to know?

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

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

Proactive Health Option

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

When will I be covered?

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

What else do I need to know?

- we'll pay 80% of eligible costs under each benefit up to your available **benefit limit**
- you don't need to pay an excess on this Option
- we don't pay for any hospital services under this Option

OPTIONS

Screening Benefit

What am I covered for?

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

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

How much am I covered for?

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

Allergy Testing and Vaccinations Benefit

What am I covered for?

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

How much am I covered for?

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

Dietitian or Nutritionist Consultations Benefit

What am I covered for?

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

How much am I covered for?

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

What else do I need to know?

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

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

Stay Active Benefit

What am I covered for?

We'll pay for one of the following:

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

How much am I covered for?

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

What else do I need to know?

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

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

Loyalty – Health Check Benefit

What am I covered for?

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

How much am I covered for?

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

When will I be covered?

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

What else do I need to know?

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

Serious Condition Financial Support Option

This section outlines the cover that is provided under the Serious Condition Financial Support Option.

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

OPTIONS

Serious Condition Benefit

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

We only pay the sum insured once per **insured person** covered under this Option, except under the Paralysis Benefit and Children's Benefit.

In addition to any personal or general exclusions that may apply, we also don't pay if you or your **dependent child** dies within 14 days of being diagnosed with a listed serious **condition**.

When will I be covered?

You will be covered for the following serious **conditions** 90 days after your **join date** on this Option. If any of these serious **conditions** occur, or you have any signs or symptoms of that serious **condition** in this 90 day period, you won't have cover for that serious **condition** under this Option:

- Aortic **surgery**
- Benign tumour of the brain or spinal cord
- Cancer – life-threatening
- 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

Serious Condition Benefit *(continued)*

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

The waiting period also applies to your **dependent child** covered under the Children's Benefit.

When does this Option end for you?

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

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

How do I claim?

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

You need to provide us with all of the following:

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

Serious Condition Definitions

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.

Aortic surgery

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

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

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

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.

Benign tumour of the brain or spinal cord

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

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

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

Serious Condition Definitions *(continued)*

Cancer – life threatening

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

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

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

Cardiac arrest – out of hospital

Cardiac arrest which has occurred outside of hospital and is not caused by or associated with any medical procedure.

This must be documented by an electrocardiogram and be due to:

- ventricular fibrillation; or
- cardiac asystole.

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.

Chronic liver failure

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

Chronic lung failure

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

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

Chronic renal failure

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

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 **specialist**.

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.

Coronary artery bypass grafting surgery

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

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.

Serious Condition Definitions *(continued)*

Encephalitis resulting in functional loss

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

- documented functional loss that is deemed permanent; or
- you being constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Heart valve surgery

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

Intensive care

Means that a **condition** has resulted in you 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 **specialist**.

Loss of independent existence

As a result of a **condition** where you are 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 you requiring permanent and constant supervision.

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.

Loss of speech

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

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
- you being constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

Myocardial infarction (heart attack) – major

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

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

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

Major organ transplant

Means either:

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

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

Serious Condition Definitions *(continued)*

Medically acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where in nib's opinion the infection arose from you having one of the following **medically necessary** events:

- transfusion with blood products; or
- organ transplant to you; or
- assisted reproductive techniques; or
- a medical procedure or operation performed by a **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.

Motor neurone disease

The unequivocal diagnosis of motor neurone disease.

Multiple sclerosis resulting in functional loss

Multiple sclerosis with significant persistent neurological deficit resulting in one of the following:

- documented functional loss that is deemed permanent; or
- you being constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person; or
- a restriction of at least 7.5 as measured by the Expanded Disability Status Score (EDSS).

Muscular dystrophy

The unequivocal diagnosis of muscular dystrophy.

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 seroconversion 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 you, 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.

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.

Serious Condition Definitions *(continued)*

- Tetraplegia:
    - the permanent and total loss of function of both arms and both legs and loss of head movement as a result of injury to, or disease of, the spinal cord or brain.

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

Parkinson's disease

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

- tremor/shaking; or
- bradykinesia; or
- rigidity; or
- postural instability.

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

Pneumonectomy

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

Primary pulmonary hypertension

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

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.

Stroke

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

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

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

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.

Paralysis Benefit

What am I covered for?

If you meet the criteria of Paralysis under this Option, we'll pay you double your selected sum insured amount for this Option.

How much am I covered for?

The sum insured you've selected is specified on your **Acceptance or Renewal Certificate**. We'll pay double this selected amount.

What else do I need to know?

- you can only claim on this benefit once
- this payment replaces any claim made for Paralysis under the Serious Condition Benefit

Children's Benefit

What am I covered for?

If your **dependent child** aged between two and 20 is diagnosed with or suffers from one of the **conditions** defined in this Option, we'll make a payment of half your selected sum insured.

How much am I covered for?

The sum insured you've selected is specified on your **Acceptance or Renewal Certificate**. We'll pay half of this amount.

This payment won't reduce your sum insured.

What else do I need to know?

We'll only pay once per **dependent child** under all nib policies.

04.

What we don’t cover

WHAT WE DON'T COVER

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

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

Cosmetic

- anything cosmetic or reconstructive that is not **medically necessary**
- Abdominoplasty, Hyperhidrosis, Rectus divarication repair

Weight Loss

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

Breast

- breast implants
- breast reductions
- Gynaecomastia
- revision of breast reconstruction

Reproductive Health

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

Sexual Health

- contraception
- erectile dysfunction
- sterilisation or reversal of sterilisation

Gender

- gender dysphoria
- gender reassignment

Mental Health

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

Congenital, Genetic, or Hereditary

- **congenital** or chromosomal disorders (for example: a birth defect)
- **congenital** kyphosis, **congenital** scoliosis, cystic fibrosis, or pectus excavatum
- Marfan's syndrome
- gene therapy
- genetic testing
- hereditary or genetic **conditions**, in the absence of signs or symptoms that a **condition** exists at your **join date**.

Emergency and Injury

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

Rehabilitation and Mobility

- aids that assist with rehabilitation and mobility (for example: crutches, toilet frames, artificial limbs)

Continuous care and mechanical tools

- continuous care (for example: geriatric, palliative, rehabilitation, long-term care, convalescence and disability, support services costs, senile condition and dementia)
- mechanical tools, aids or appliances of any type as determined by nib (for example: insulin pumps, CPAP machines and equipment, pacemakers)

Transfusions or Transplants

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

Dental

- dentures
- dental implants
- orthognathic **surgery**
- periodontics, orthodontics, and endodontic procedures
- tooth exposure

Vision

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

Crime or Conflict

- any treatment for a **condition** relating to a crime committed by you where you are charged under the Crimes Act
- **health services** relating to or consequences of wars, riots, or terrorism

Immune System Disease

- HIV or AIDS

Allergies

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

Not funded or registered

- medicines that aren't funded by **PHARMAC** under the latest **PHARMAC** Pharmaceutical Schedule
- medicines that aren't approved by **Medsafe** and/or haven't met the therapeutic indications of **Medsafe**
- **conditions** not registered with the Ministry of Health as a disease

Pre-existing

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

Risk management

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

Sleep

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

Care that isn't standard practice

- alternative or complementary medicine or therapy (for example: homoeopathy and natural therapy)
- experimental, unproven, or unconventional treatments, procedures or technologies that haven't been pre-approved by nib
- providers who don't meet our criteria
- services provided by a family member or relative (for example: **health services**, travel costs, or accommodation)
- services provided by someone who is not recognised by the Medical Council of New Zealand (except where expressly specified in your policy)
- treatment or procedures that we haven't approved that we consider novel or experimental or that are more expensive than an available alternative treatment or procedure which will provide the same or a similarly acceptable medical outcome

Costs outside the terms of your policy

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

Other general exclusions

- any medical treatment, investigations or admissions that isn't **medically necessary**
- anything that isn't **medically necessary** (for example: alcohol, toiletries, car parking, visitor meals, or administration costs)
- **GP** and out-of-hospital prescription charges
- Services provided outside of New Zealand (except where expressly specified in your policy)
- goods that were received or purchased outside of New Zealand (for example: goods bought online from another country) (except where expressly specified in your policy)
- false or inaccurate information provided for a policy application or claim request
- substance misuse (for example: misuse of alcohol or drugs)

05.

Using your cover

Who can I see for treatment?

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

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

Do I have to see a particular recognised provider?

You can see any **recognised provider**.

Any claim costs will be compared to our **usual, customary and reasonable charges**. This is to help us manage the cost of claims. If we find your provider's costs are significantly higher than other providers, we will negotiate with the provider concerned directly. This process, and our success or failure in it, will not affect what we pay under this policy.

What medications can I claim for?

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

- are registered and approved by **Medsafe**
- are prescribed and administered within **Medsafe** guidelines and associated criteria
- are prescribed by the treating **specialist** or **GP**

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

If the cost of your medication isn't fully funded by **PHARMAC** at the time of your treatment, you'll need to provide us with a recommendation from your **specialist** explaining the reason(s) for the medication.

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

- charged in a public hospital
- pending review by **Medsafe**

Am I covered for prostheses?

Yes, if you need a prosthesis as part of your **surgery**, we'll pay up to the amount stated in our **prosthesis schedule**. This is reviewed annually and is available on mynib.

When will nib pay for health services?

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

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

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

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

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

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

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

When can I start claiming?

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

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

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

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

If you move on to Ultimate Health Max from a policy which we consider comparable, we will recognise any waiting period that you've already served on that policy.

How much do I pay towards health services?

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

If an excess applies to your claim, you'll need to pay your excess directly to your **recognised provider**, along with any costs that aren't covered by us.

What happens if ACC won't cover me?

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

This might include:

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

06.

Making changes to your policy

Who can view and change my policy?

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

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

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

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

Who can I add to my policy?

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

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

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

How do I remove someone from my policy?

To remove an **insured person** from your policy we'll need a request from either:

- the **policyowner(s)**; or
- the **insured person** who wants to be removed. If they're under 16, the **policyowner** will need to request this

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

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

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

Can I change my excess amount?

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

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

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

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

How do I cancel my policy?

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

Can nib cancel my policy?

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

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

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

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

How do I change my smoking or vaping status?

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

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

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

07.

Conditions of your policy

Who can be a policyowner?

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

Our responsibilities

We will:

- treat you as a valued nib customer
- answer questions promptly and accurately at the first point of contact (whenever possible)
- provide detailed health policy information and help you understand what you are covered for
- deal with feedback and complaints in a timely and responsible manner
- make every possible effort to resolve complaints to your satisfaction (whenever possible)
- provide timely and accurate **pre-approval** (whenever possible)
- keep you informed regarding the process of your claim (whenever possible)
- treat personal information with respect and in total accordance with the Privacy Act 2020, including the Health Information Privacy Code 2020

Your responsibilities

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

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

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

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

08.

About your premiums and benefits

Managing your payments

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

If we send you communications about your premiums and they're returned to us, we'll keep making deductions until you tell us to stop.

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

Changes to your premiums or benefits

Guaranteed Benefits and Future Upgrades

The benefits, terms, important words and exclusions for this policy are guaranteed. We can only make changes to these if:

- a law that applies to your policy has changed (including tax changes); or
- information provided by you, or on your behalf is not true, correct and complete; or
- we want to increase the level of cover under a benefit, or add a new benefit to this product

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.

Premiums

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

Premium increases apply to all **insured person(s)** on your policy. We won't make changes to your premiums because of any individual claims that have been made under your policy.

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

When can nib change my premiums?

We increase your premiums as you get older.

We may also make changes to your premiums for any the following reasons:

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

Premiums for children

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

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

09.

Important Words

IMPORTANT WORDS

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

ACC

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

Acceptance or Renewal Certificate

The most recent version of your Acceptance or Renewal Certificate.

Activities of daily living

Any of the following:

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

Acute

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

Admitted

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

This doesn't include treatment in the emergency room.

Audiology treatment

Treatment by an audiologist who:

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

Benefit limit(s)

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

Chiropractic treatment

Treatment by a chiropractor who:

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

Condition(s)

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

Congenital

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

Consultation(s)

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

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

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

Counselling

A provision of professional assistance and guidance in resolving personal or psychological conditions provided by a **GP**, clinical psychologist, psychiatrist or psychologist.

Dental practitioner

A **health professional** who:

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

Dependent child

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

Diagnostic Investigation

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

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

Dietitian

A **health professional** who:

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

Eyewear

Glasses or contact lenses to correct vision which are approved by us and prescribed by an **optometrist**, **optician** or ophthalmologist.

GP

A **health professional** who:

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

Health professional

A registered person who:

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

Health service(s)

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

Healthcare assistant

A healthcare or care support worker who:

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

Hospice

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 replacement)

Insured person(s)

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

Join date

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

Maxillo-facial surgeon

A **health professional** who:

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

Medically necessary

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

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

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

Medsafe

The New Zealand Medicines and Medical Devices Safety Authority, a business unit of the Ministry of Health established by the Medicines Act 1981 and the Medicines Regulations 1984 (or its replacement).

Nurse practitioner

A **health professional** who:

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

Nutritionist

A **health professional** who:

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

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

Obstetrician

A **health professional** who:

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

Occupational Therapy

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

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

Optician(s) or Optometrist(s)

A **health professional** who:

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

Oral surgeon

A **health professional** who:

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

Orthoptist(s)

A **health professional** who is:

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

Osteopathic treatment

Treatment provided by an osteopath who:

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

PHARMAC

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

Physiotherapy

Treatment by a physiotherapist who:

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

Podiatric surgeon

A **health professional** who:

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

Podiatry treatment

Treatment that is done by a podiatrist who:

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

Policy anniversary date

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

Policy year

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

Policyowner(s)

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

This means all policyowners if there is more than one.

Pre-approval

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

Pre-existing condition(s)

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

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

Private hospital

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

Prosthesis schedule

The document which lists the prosthesis that we cover and the maximum amount we will pay towards them. This is published on our website.

Recognised provider

Any:

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

that is recognised by us.

Registered nurse

A **health professional** who:

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

Screening

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

Specialist

A **health professional** who:

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

This doesn't include those holding vocational registration in:

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

Speech Therapy

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

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

Sports Physician Treatment

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

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

Start date

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

Surgery / surgical / surgeries

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

This doesn't include injections.

us, our, we, nib

nib nz limited.

usual, customary and reasonable charges

The costs that are charged for a **health service** which we determine are usual, reasonable and customary according to our data.

Vocational GP

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

Whole person functions

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, your, yourself

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

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

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

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