nib

Premier Health Business™ Policy document

Contents

Introduction

Thank you for trusting nib to insure your health. This document explains what your policy covers and should be read with your acceptance certificate.

It is important **you** read **your** policy carefully. This will ensure **you** know what **you** are covered for, what **you** need to tell **us**, how to make a claim and any other terms and conditions of **your** policy.

We know insurance can be complex and policy documents are not always easy to read. If **you** don't understand anything, if any information is incorrect, or if **you** have any questions, just call **us** on 0800 287 642 – **we** will do everything **we** can to help **you**.

14-day free-look period

We understand the cover **you** have chosen needs to fit with **your** overall financial and health needs. To allow **you** time to review **your** policy and ensure it meets **your** needs **we** provide a 14-day free-look period. This period starts three days after **we** send **you your** policy information. During this time, should **you** decide the policy doesn't meet **your** needs, please send **your** written confirmation to **us** and **we** will cancel the policy and refund any premiums paid, providing no claims have been made.

Financial statements

You can obtain a copy of **our** financial statements for the last reported financial year by writing to **us** at nib nz limited, PO Box 91630, Victoria Street West, Auckland 1142.

Privacy

We comply with the Privacy Act 1993, including the Health Information Privacy Code 1994, and **we** will preserve the privacy of **your** and all **insured persons'** personal information. To see the full privacy policy, please go to nib.co.nz/about-us/privacy-policy.

Duty of Disclosure

You and the **insured persons** had a legal duty to disclose everything **you** or they knew (or ought to have known) which would have influenced the decision of a prudent insurer whether to accept **your** application, and if so, on what terms. For example, an **insured person** must have disclosed any medical condition or any sign, symptom, treatment or surgery of any medical condition they had at the time of applying, or have had in the past. All information given by, or on behalf of, **you** or any **insured person** must be true, correct and complete. **You** and the **insured persons** must have told **us** about any changes to the information given to **us** before the **commencement date**, **effective date** or **join date** of this policy. If **you** or any **insured person** failed to do so, or if any of the material information was not disclosed to **us** or was not true, correct and complete, **we** can cancel this policy from the **commencement date**, **effective date** or **join date** (as applicable) and not pay any claims after those dates. **We** may retain all the premiums paid, and any claims paid by **us** after those dates may be recovered from **you**.

Contract of insurance

The contract of insurance consists of:

- the **acceptance certificate** or **renewal certificate** (whichever is the later);
- this policy document (or any subsequent document that replaces this document);
- the **prosthesis schedule**; and
- any application(s) completed by the **policyowner** and all the **insured persons** covered under the policy (if any).

In descending order if there is any inconsistency.

Headings

In this policy, **we** have headings which are for **your** guidance only – these don't form part of the policy.

Words in bold

We have some words in bold, which may indicate the words have a special meaning. To find out the meaning, please refer to Definitions section on page 76.

This is an important document

Please keep this policy document, **your acceptance certificate** and **renewal certificates** in a secure place.

Help

It is important that **you** read and understand this section of **your** policy document as it contains important information about **pre-approvals**, claiming and payment.

1 How to contact us

- The my nib portal provides 24 hour access to **your** policy and claims details. This information can be found by visiting nib.co.nz/portal
- Call **us** on 0800 123 642. (**Our** opening hours are Monday to Friday 8.00am to 5.30pm, **we** are closed on public holidays.)
- Email **us** at grouphealth@nib.co.nz
- Write to **us** at:

  nib nz limited
  PO Box 91630
  Victoria Street West
  Auckland 1142.

2 Pre-approval and claim information

We strongly recommend that **you** seek **pre-approval** prior to undertaking any treatment, **consultation** or **diagnostic investigation** to understand what the **insured persons** are covered for under **your** policy.

2.1 How to seek pre-approval for a claim

Please contact **us** or visit **our** website at nib.co.nz.

Our website contains key information such as the **prosthesis schedule** and claim forms.

A **pre-approval** request can be made by **you** or a **recognised provider** on **your** behalf.

- If they have access to the nib First Choice Portal (nibfirstchoice.co.nz/portal), **you** can ask **your recognised provider** to request a **pre-approval** and submit the subsequent claim on **your** behalf.
- You can also submit **pre-approvals** and claims by visiting **our** customer portal (my nib) at nib.co.nz/portal
- Call **us** on 0800 123 642.
- Email **us** at claims@nib.co.nz

The policy number must be quoted for all claims.

If **we** give **you pre-approval** for a claim **we** will tell **you** and send **you** a **pre-approval** letter. It will take **us** up to five working days to reply, unless further information is required or insufficient information was initially supplied. If the request has been made by a **recognised provider we** will also notify them.

The **pre-approval** letter is valid for three months from the date of issue recorded on the letter.

If **we** do not accept **your** claim, **we** will also let **you** know in writing.

3. Choosing your provider

The **nib First Choice network** is a group of **recognised providers** that provide health services within **our** First Choice price range.

- If **you** choose a **recognised provider** from the **nib First Choice network** for that health service, **your** claims will be covered for 100% of eligible costs, less any **excess**.
- **You** can still choose to receive treatment from a **recognised provider** that is not part of the **First Choice network**, however **you** may not be covered for 100% of eligible costs.

- **We** may separate **First Choice network** claim costs into two components:
  - **Your approved private hospital charges** (if applicable)
  - The **surgical cost grouping**, which consists of the **registered specialist**, anaesthetist and any **prosthesis** costs.
- If either the **approved private hospital** or **registered specialist** is not a **First Choice provider** for the health service provided, then the maximum **we** will pay for claims associated with each component is the **Efficient Market Price (EMP)** determined individually for that component.
- Using a **First Choice provider** gives certainty that **you** will be covered for 100% of approved associated health service costs included in the policy up to the Benefit maximum.
- Not all health services are included in the **First Choice network**. To find out whether a health service is included or which **recognised providers** are part of the **First Choice network** visit **nibfirstchoice.co.nz/directory**.
- **We** will pay 100% of costs, up to the Benefit maximum and less any **excess**, for health services provided by **recognised providers** that are part of the **First Choice network**.
- If a **recognised provider** is not part of the **First Choice network**, and the network applies to that health service, then the maximum **we** will pay for that portion of the treatment is the **EMP**.
- Any costs above the **EMP** must be paid by the **policyowner** or the **insured person**. **We** recommend that the **policyowner** and all **insured persons** ensure they understand all the potential costs before undertaking any health services with a **recognised provider** that is not part of the **First Choice network**.

4. Efficient Market Price (EMP)

The **Efficient Market Price** is the maximum amount **we** will pay for a health service provided by a **recognised provider** that is not part of the **First Choice network**, when the network applies to that health service.

We determine the **EMP** based on:

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

The **EMP** is subject to change at **our** discretion.

- For **pre-approved** health services, the **EMP** payable will be determined as at **your pre-approval** date.
- For health services that have not been **pre-approved**, the **EMP** payable will be determined as at the treatment date.

5. Changes in network status

A **recognised provider's** inclusion in the **First Choice network** for a particular health service may change from time to time and further health services may be added to the network.

- If **you** hold a valid **pre-approval** for a **First Choice provider we** will honour the original terms of the **pre-approval**, regardless of whether that **recognised provider** is still a **First Choice provider** on the treatment date.
- If **you** hold a valid **pre-approval** for a **recognised provider** that is not a **First Choice provider**, but they are a **First Choice provider** on **your** treatment date **we** will recognise the change when assessing **your** claim, and the limit of the **Efficient Market Price** will no longer apply.

6 How to make a claim

Please pay any smaller claims such as doctor's accounts, pharmaceutical charges and dental bills directly with the **recognised provider**. Remember to always get a receipt and itemised invoice.

6.1 Contact us

You can obtain a claim form via **our** website at **nib.co.nz** or contact **us**:

- Call **us** on 0800 287 642. (**Our** opening hours are Monday to Friday 8.00am to 5.30pm, **we** are closed on public holidays.)
- Email **us** at claims@nib.co.nz
- Write to **us** at:

  nib nz limited
  PO Box 91630
  Victoria Street West
  Auckland 1142.

If **your recognised provider** has access to the nib First Choice Portal they can submit a claim on **your** behalf.

6.2 Claims conditions

Receipts should be submitted within 12 months of incurring the cost, so **we** suggest **you** submit a claim at least once a **policy year**.

Any claim must be made within 30 days of this policy ending.

The claim must relate to an **insured person**. Reimbursement cannot be made for any other person, regardless of whether an **insured person** has paid the account or bill.

You must comply with this policy in full before any claim is paid.

If any premium is outstanding on this policy at the date **we** accept a claim, **we** can:

- Deduct the outstanding premium(s) from the claim payment.
- Withhold payment of the claim until the outstanding premium(s) have been paid.

6.2.1 Provide full information

You must give **us** a full description on the claim form of:

- the **pre-approval** number for the treatment (if obtained);
- the treatment undertaken;
- the clinical reason for the treatment – if not already included on the **pre-approval** information;
- the name of the **registered specialist** who will conduct the treatment;
- the expected date of the treatment or the actual date of the treatment;
- whether the treatment was accident related; and
- the **GP** or **registered specialist** referral letter.

You must provide **us** with any other information or assistance **we** reasonably require. If not **pre-approved**, please submit supporting medical information.

You must submit original invoices and / or itemised receipts.

6.2.2 ACC treatment injury

In the event of an **injury** occurring that arises out of an **insured person's** treatment, the **insured person** must submit a claim to **ACC**. This claim may be submitted by **your registered specialist** or **your GP**. Application forms for an **ACC** claim are available on the **ACC** website.

6.2.3 Medical report or assistance

If **you** or an **insured person** need assistance to complete the claim form, or **we** request a medical report with the claim form, these will be at **your** expense. If **we** request additional information in order to assess **your** claim, this will be at **our** expense.

6.2.4 Referral by a GP or registered specialist

Where this policy requires that a service or treatment must only be performed after referral by a **GP** or **registered specialist**, the name of the referring practitioner must be shown on the account or receipt presented to **us** for payment. **You** must provide a copy of the referral letter.

6.3 Rapid refund

We will process **your** claim within five working days of receipt of the claim form, unless further information is required. Typically **we** refund the treatment provider directly. If **we** are refunding **you** by direct credit, please ensure **your** banking details on the claim form are accurate. **We** will only refund to a nominated New Zealand bank account in New Zealand dollars.

7 If you have taken out this health policy through your employer

If **you** have taken out his health policy through **your** employer, **your** employer may have negotiated additional concessions and / or Benefits to those recorded in this policy.

If this is the case, details of those concessions and / or Benefits will be recorded on **your acceptance certificate** or **renewal certificate**.

In the event there is a conflict between the concessions and / or Benefits recorded on **your acceptance certificate** or **renewal certificate** and those recorded in this policy then the **acceptance certificate** or **renewal certificate** will prevail.

The following people cannot be added to this policy unless **we** agree in writing and they are shown in the **acceptance certificate** or **renewal certificate** as a concession:

- an adult **insured person's** parents;
- an adult **insured person's** grandchildren; or
- any other adult.

8 How to change your details or your health policy

8.1 Contact us

If **you** require a change to be made to **your** policy (add or remove a **partner**, **dependent child**, **policyowner**, or change an option or the **excess**), please contact **us** on 0800 287 642 and **we** will advise **you** what is required to make the change and the **effective date** of the change.

8.1.1 Adding a newborn to your health policy

If **you** add a **dependent child** within four months of birth, **we** will cover that child for **pre-existing conditions**, other than a known **congenital** medical condition or the standard policy exclusions. Refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**.

8.1.2 Changing your excess

You can change the **excess** on any **policy anniversary date**. If **you** have made no claims **we** may, at **our** discretion, allow **you** to change the **excess** earlier. **You** must give **us** at least 30 days' prior notice in writing or by email before this change can be made. Changing **your excess** will change the premium **you** are paying.

If **you** wish to reduce the level of the **excess**, **we** will require a medical assessment of all the affected **insured persons'** current state of health to be completed and assessed before **we** agree.

8.1.3 Policyowner must be an adult

A **dependent child** under age 18 must be accompanied by at least one adult aged 18 or over as an **insured person**, or have his or her parent or legal guardian as the **policyowner**.

8.1.4 Changes in contact details

You must notify **us** of all changes in contact details of **insured persons**. Where possible, please provide an email address. **You** can advise **us** in writing or by email.

8.2 We will process the change

We may require **you** to complete a Change of Plan form. **We** will let **you** know if this is the case and **we** will send **you** the Change of Plan form within five working days. **We** will process the Change of Plan form within five working days of receiving it from **you**, unless further information is required.

8.3 New acceptance certificate

Once **we** have accepted the changes, **we** will send **you** a new **acceptance certificate** or **renewal certificate** that will show the changes.

9 Continuation of cover

Where:

- the **insured person** who is an employee resigns from his or her employment; or
- **we** or the employer ends the arrangement which this policy is part of,

this policy ends immediately. **We** may offer a replacement policy determined by **us** at **our** discretion in accordance with **our** transfer rules applying at the time the **insured person** resigns or the arrangement **we** have with the employer ends. **We** may review special benefits and concessions and the premium payable may be reviewed. **We** will write to **you** advising that this policy has been cancelled and give **you** the opportunity to continue **your** policy and cover.

Benefits

This section of this policy lists and defines the Benefits **we** insure.

It is in six parts: the Base Cover and five Options (Specialist Option, Serious Condition Lump Sum Option, **GP** Option, Dental and Optical Option and Proactive Health Option). All **insured persons** must take the Base Cover. If **you** have chosen an Option, it is shown on **your acceptance certificate** or **renewal certificate**.

All claims are subject to the Exclusions section and any limitations set out in **your acceptance certificate** or **renewal certificate**. Please refer to the Exclusions section on page 69 and **your acceptance certificate** or **renewal certificate**.

Please ensure **you** have read the Help section on page 8 for details in relation to the **nib First Choice network** which applies to the benefits under this policy.

Base Cover

1 Introduction

1.1 What we cover

The Base Cover provides the Benefits set out below during the **policy year** for each **insured person** for that **insured person's** medical condition (for medical conditions that are not covered refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**).

1.2 What we pay

We pay up to the Benefit maximum, less any **excess**.

Unless stated otherwise, the **excess** applies to each **insured person** for each treatment under each Benefit.

Where a Benefit is subject to a Benefit maximum, the Benefit maximum will apply to each **insured person** for each **policy year** in which the Benefit was provided.

However, where a medical condition results in **hospitalisation**, all Benefit payments relating to that medical condition for up to six months prior to **hospitalisation** and for up to six months after discharge, will be subject to one **excess**. For the Cancer Treatment Benefit, the **excess** will be applied per **cycle** of chemotherapy, or radiotherapy treatment unless stated otherwise in this policy.

2 Hospital – Surgical Benefit

2.1 What we cover

We cover the cost of major **surgery** requiring an anaesthetic in an **approved private hospital** in relation to a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**). This includes (for example, without limitation): general and cancer **surgery**, cardiac **surgery**, orthopaedic **surgery**, laparoscopic **surgery**, oral **surgery**, angiography, angioplasty, dilation and curettage, and lithotripsy.

We also cover the cost of associated intensive nursing care, X-rays, disposables and consumables, dressings, and drugs listed under Sections A to H of the **PHARMAC** Pharmaceutical Schedule, where they meet **PHARMAC's** funding criteria, arising from that **surgery**.

2.2 Benefit maximum

We pay up to a maximum of $300,000 per **insured person** per **policy year** for all claims under this **Hospital**-**Surgical** Benefit, less any **excess**.

This Benefit maximum also applies to the associated cover available under the following Benefits:

- Specialist **Consultations** Benefit – refer to Benefit 5.
- **Hospital** Related Diagnostics Benefit – refer to Benefit 6.
- Major Diagnostic Benefit – refer to Benefit 7.
- Follow-up Investigation for Cancer Benefit – refer to Benefit 8.
- Ambulance Transfer Benefit – refer to Benefit 9.
- Travel and Accommodation Benefit – refer to Benefit 10.
- Parent Accommodation Benefit – refer to Benefit 11.
- Physiotherapy Benefit – refer to Benefit 12.
- Therapeutic Care Benefit – refer to Benefit 13.
- Home Nursing Care Benefit – refer to Benefit 14.
- Cover in Australia Benefit – refer to Benefit 17.
- **ACC Top-up** Benefit – refer to Benefit 23.

Individual limits for these Benefits may also apply.

2.3 Other terms

- This Benefit does not cover **surgery** that is not performed by a **registered specialist**.
- This Benefit does not cover skin lesion **surgery** (except for melanoma). Cover for skin lesion **surgery** is provided under the Specialist Skin Lesion **Surgery** Benefit (refer to Benefit 20).

2.4 Prostheses costs

We cover certain **prosthesis** costs (replacement implants only) up to fixed specified maximums set by **us**. A **prosthesis schedule** specifies the **prostheses** which have a specified maximum applicable.
The **prostheses schedule** is reviewed annually and is available from **our** website or from **us** on request.
The cost of **prostheses** is included in the Benefit maximum.

2.5 Oral surgery

- **We** only cover the cost of oral **surgery** if it is performed by a registered oral or maxillo-facial surgeon.
- **We** only cover the cost of removal of unerupted and impacted teeth if a registered oral surgeon or registered dentist performs the procedure.
- A 12-month **stand-down period** from the **join date** of each **insured person** applies to the extraction of wisdom teeth.
- **We** do not cover any other dental treatments, including periodontal, orthodontic and endodontal procedures, implants and orthognathic **surgery**. Cover may be available under the Dental and Optical Option if **you** have selected that Option.

2.6 Varicose vein surgery

We will cover varicose vein **surgery** if the **surgery** is performed by a **registered specialist**, **vocational GP** or medical practitioner who is registered with the Medical Council of New Zealand and a fellow of the Australasian College of Phlebology.

3 Hospital – Medical Benefit

3.1 What we cover

We cover the cost of medical treatment (not involving **surgery**) in an **approved private hospital** in relation to a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**). This includes (for example, without limitation): heart disease, treatment of respiratory disease (for example asthma, pneumonia) and treatment for endocrine disease (for example diabetes).

We also cover the cost of associated intensive nursing care, X-rays, disposables and consumables, dressings and drugs listed under Sections A to H of the **PHARMAC** Pharmaceutical Schedule where they meet **PHARMAC's** funding criteria arising from that medical treatment.

3.2 Benefit maximum

We pay up to $200,000 per **insured person** per **policy year** for all claims under this **Hospital** – Medical Benefit, less any **excess**.

This Benefit maximum also applies to the associated cover available under the following Benefits:

- Cancer Treatment Benefit – refer to Benefit 4.
- Specialist **Consultations** Benefit – refer to Benefit 5.
- **Hospital** Related Diagnostics Benefit – refer to Benefit 6.
- Major Diagnostic Benefit – refer to Benefit 7.
- Follow-up Investigation for Cancer Benefit – refer to Benefit 8.
- Ambulance Transfer Benefit – refer to Benefit 9.
- Travel and Accommodation Benefit – refer to Benefit 10.
- Parent Accommodation Benefit – refer to Benefit 11.
- Physiotherapy Benefit – refer to Benefit 12.
- Therapeutic Care Benefit – refer to Benefit 13.
- Home Nursing Care Benefit – refer to Benefit 14.
- Cover in Australia Benefit – refer to Benefit 17.
- **ACC Top-up** Benefit – refer to Benefit 23.

Individual limits for these Benefits may also apply.

3.3 Other terms

- This Benefit does not cover medical treatment that is not managed by a **registered specialist**.
- This Benefit does not cover medical treatment where the sole or main purpose of the medical treatment is administration of an **injection**, for example without limitation, intravitreal **injections** or pain management **injections** (except where the contrary is expressly specified in this policy).

4 Cancer Treatment Benefit

4.1 What we cover

We cover the cost of the **chemotherapy agent**(s), and radiotherapy in an **approved private hospital** used in a **cycle** of treatment for cancer including the cost of a **registered specialist** or **health service provider** to administer these treatments.

Where this policy has an **excess**, it will be applied to each **cycle** of chemotherapy, or radiotherapy treatment.

4.2 Benefit maximum

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – Medical Benefit.

4.3 Other terms

- This Benefit does not cover medical treatment that is not managed by a **registered specialist**.
- Where **surgery** follows within six months of the last **cycle** of chemotherapy, or radiotherapy treatment, only one **excess** will apply to that **surgery** under the **Hospital** – **Surgical** Benefit and the chemotherapy and radiotherapy treatment during that six months. Any other **excess** paid for chemotherapy, or radiotherapy treatment during that six month period will be refunded.

To qualify for reimbursement a **cycle** of chemotherapy treatment must meet the following definition:

A specified number of sequentially administered doses of **chemotherapy agent(s)** where:

- the **chemotherapy agent** is administered at prescribed intervals within a planned time frame; and
- **PHARMAC** has approved the **chemotherapy agent** under Sections A to H of the **PHARMAC** Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and
- the **chemotherapy agent** is prescribed by a **registered specialist** and administered in New Zealand by an appropriately qualified medical professional.

5 Specialist Consultations Benefit

5.1 What we cover

We cover the cost of **registered specialist** or **vocational GP consultations** up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital** in relation to a medical condition where the **consultation** directly relates to the medical condition, after a referral from a **GP** or a **registered specialist**.

5.2 Benefit maximum

No limit per **consultation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

5.3 Other terms

We do not cover the cost of **registered specialist** or **vocational GP consultations** that do not relate to a medical condition covered under the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit or does not occur within the six months prior or six months following such a medical condition. Cover may be available under the Specialist Option if **you** have selected that Option.

6 Hospital Related Diagnostics Benefit

6.1 What we cover

We cover the cost of any **diagnostic investigation** (such as X-rays, ultrasound, mammogram, echocardiograms, visual field tests), up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital**, where those **diagnostic investigations** directly relate to a medical condition after a referral from a **GP** or a **registered specialist**.

6.2 Benefit maximum

No limit per **diagnostic investigation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

6.3 Other terms

We do not cover the costs of **diagnostic investigations** that do not relate to a medical condition covered under the **Hospital** – Surgical Benefit or **Hospital** – Medical Benefit or does not occur within the six months prior or six months following such a medical condition (except where the contrary is expressly specified in this policy).

7 Major Diagnostics Benefit

7.1 What we cover

We will cover the cost of the following **diagnostic investigations** after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised** for treatment.

- Arthroscopy.
- Capsule endoscopy.
- Colonoscopy.
- Colposcopy.
- CT Scan.
- CT Angiogram.
- Cystoscopy.
- Gastroscopy.
- MRI Scan.
- Myelogram.
- PET Scan.

7.2 Benefit maximum

No limit per **diagnostic investigation**.

Where the **insured person** is not **hospitalised**, an **excess** will apply per **diagnostic investigation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

7.3 Other terms

Where the **insured person** is **hospitalised** and undergoes a **diagnostic investigation** up to six months prior to admission to an **approved private hospital** and up to six months after being discharged from that **approved private hospital**, where those **diagnostic investigations** directly relate to the medical condition after a referral from a **GP** or a **registered specialist**, cover will be provided under the **Hospital** Related Diagnostic Benefit (refer to Benefit 6).

8 Follow-up Investigation for Cancer Benefit

8.1 What we cover

Following a **hospitalisation** approved by **us** for treatment of cancer, **we** cover one **consultation** with a **registered specialist** and one relevant **diagnostic investigation** relating to the cancer for which the initial treatment had been undertaken per **policy year**.

8.2 Benefit maximum

We pay up to a maximum of $3,000 per **insured person** per **policy year**, less any **excess**.

We pay up to five consecutive **policy years**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

9 Ambulance Transfer Benefit

9.1 What we cover

We cover the cost of a road ambulance to and from an **approved private hospital** to another **approved private hospital**, within New Zealand for the **insured person** for **hospitalisation**, if a **GP** or **registered specialist** has recommended the transfer by ambulance.

9.2 Benefit maximum

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

9.3 Other terms

The cost of ambulance society subscriptions is not covered.

10 Travel and Accommodation Benefit

10.1 Criteria

This Benefit applies where a **GP** or **registered specialist** has recommended **hospitalisation** and where that **hospitalisation** cannot be performed in the **insured person's** local **approved private hospital.**

We cover the travel and accommodation costs within New Zealand where the nearest **approved private hospital** is more than 100km one way from the **insured person's** usual residence.

Where a **GP** or **registered specialist** has recommended a support person for the **insured person's hospitalisation**, the support person must travel together with the **insured person** to and from the **approved private hospital**.

10.2 What we cover

10.2.1 Travel

We will cover the cost of travel within New Zealand. **We** will reimburse the cost of:

- return economy airfare within New Zealand; or
- cost of a return rail or bus travel; or
- mileage for road travel at the amount determined by **us**; and
- taxi fares on admission and discharge from the **approved private hospital** to / from the airport for the **insured person** and the accompanying support person, where recommended.

10.2.2 Accommodation

We cover the cost of accommodation incurred by the **insured person** and the accompanying support person, where recommended, during an **insured person's hospitalisation**.

10.3 Benefit maximum for hospitalisation / chemotherapy treatment

10.3.1 Travel

We pay up to a maximum of $2,000 per **hospitalisation** or per **cycle** of chemotherapy treatment.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

10.3.2 Accommodation

We pay up to $200 per night for the accommodation costs for the accompanying support person, where recommended during an **insured person's hospitalisation**, up to a maximum of $3,000 per **hospitalisation** or per **cycle** of chemotherapy.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

10.4 Benefit maximum for radiotherapy treatment

10.4.1 Travel and accommodation

We pay up to $200 per night for the accommodation costs for the **insured person** and the accompanying support person, where recommended, up to a maximum of $5,000 per **hospitalisation** or per **cycle** of radiotherapy for both travel and accommodation costs incurred by both the **insured person** and the accompanying support person.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

10.5 Other terms

- Any air travel cost to and from New Zealand is not covered, unless covered under the Overseas Treatment Benefit (refer to Benefit 16).
- This Benefit does not cover any travel or accommodation costs for chemotherapy or radiotherapy treatment in a public **hospital**.

11 Parent Accommodation Benefit

11.1 What we cover

We cover the cost per night of the accommodation incurred by a parent or legal guardian accompanying an **insured person** aged under 20 years (inclusive) listed in the **acceptance certificate** or **renewal certificate**, where that **insured person** is being treated in an **approved private hospital** for **hospitalisation**.

11.2 Benefit maximum

We pay up to $200 per night.

We pay up to $3,000 per **hospitalisation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

12 Physiotherapy Benefit

12.1 What we cover

We cover the cost of physiotherapy post-**hospitalisation**, up to six months after being discharged from an **approved private hospital** on referral by the treating **registered specialist**.

12.2 Benefit maximum

No limit per treatment.

We pay up to $750 per **hospitalisation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

12.3 Other terms

All accounts and receipts presented to **us** for payment must show the qualifications of the physiotherapist, dates of visits and fees charged. A **GP** or **registered specialist** letter stating the reason why physiotherapy is required and the length of time for which it is required must be submitted with the claim.

13 Therapeutic Care Benefit

13.1 What we cover

We cover the cost of osteopathic and chiropractic treatment, speech and occupational therapy and **dietician consultations** post-**hospitalisation**, up to six months after being discharged from an **approved private hospital** on referral by the treating **registered specialist.**

13.2 Benefit maximum

No limit per treatment / **consultation**.

We pay up to $250 per **hospitalisation**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

13.3 Other terms

All accounts and receipts presented to **us** for payment must show the qualifications of the osteopath, chiropractor, speech therapist, occupational therapist or the **dietician**, dates of visits and fees charged.

A **GP** or **registered specialist** letter stating the reason why the treatment / **consultation** is required and the length of time for which it is required must be submitted with the claim.

14 Home Nursing Care Benefit

14.1 What we cover

We cover the cost of home nursing care post-**hospitalisation** by a **registered nurse**, up to six months after being discharged from an **approved private hospital**, on referral by a **GP** or **registered specialist**.

14.2 Benefit maximum

We pay up to $150 per day.

We pay up to $6,000 per **insured person** per **policy year**.

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

14.3 Other terms

All accounts presented to **us** for payment must show the qualifications of the home nurse, dates of visits and fees charged. A **GP** or **registered specialist** letter stating the reason why home nursing care is required and the length of time for which it is required must be submitted with the claim.

15 Public Hospital Cash Grant

15.1 What we cover

We make a cash payment when an **insured person** is admitted to a public **hospital** in New Zealand and is in the public **hospital** for three or more consecutive nights.

15.2 Benefit maximum

We pay $300 per night for the third and each subsequent night.

We pay up to $3,000 per **insured person** per **policy year**.

15.3 Other terms

- **We** do not pay this Benefit if a fee-paying **insured person** is admitted to the private wing of a public **hospital**.
- The **excess** does not apply.
- For the Public **Hospital** Cash Grant, **you** must obtain a certificate from the **hospital** stating the reason and the date of the admission, and the date of the discharge to support **your** claim.

16 Overseas Treatment Benefit

16.1 What we cover

We cover the cost of an overseas **surgical** or medical treatment that cannot be performed at all in New Zealand, and reasonable travel cost, where an application has been submitted to the Ministry of Health for funding under the 'Medical Treatment Overseas Scheme', and the Ministry of Health has declined funding.

We cover the reasonable travel cost of the **insured person** requiring treatment plus the cost of the treatment performed overseas up to the Benefit maximum.

16.2 Benefit maximum

We pay up to $20,000 per overseas visit for treatment, per **insured person**, less any **excess**.

16.3 Other terms

- The treatment must be of a type which cannot be performed in New Zealand.
- **You** must provide a copy of the Ministry of Health's decision regarding funding to **us**.
- The treatment must be recommended by a **registered specialist** and must be recognised by **us** as a conventional form of treatment.

17 Cover in Australia Benefit

17.1 What we cover

We will reimburse the costs incurred by the **insured person** for treatment in Australia for a medical condition which arises whilst the **insured person** is in Australia for all Benefits listed under the Base Cover except for Travel and Accommodation Benefit; Overseas Treatment Benefit; **ACC Top-up** Benefit and Loyalty Benefit – Suspension of Cover.

For medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**.

We will reimburse up to 75% of the **EMP** which would be payable in New Zealand for treatment performed in New Zealand.

17.2 Benefit maximum

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies).

17.3 Other terms

- **You** must call **us** for **pre-approval**.
- **We** will not cover **you** for any treatment undertaken relating to an accident or **injury** which would normally be covered under **ACC** in New Zealand.
- All medical facilities / treatment providers must have an equivalent accreditation / registration as per New Zealand standards approved by **us.**

- **You** must provide **us** with all appropriate medical and other information **we** might reasonably require to assess **your** claim.

17.4 Payment method and currency

All reimbursements, **excesses** and Benefit maximums are in New Zealand dollars and reimbursements will be direct credit into **your** nominated New Zealand bank account.

17.5 Chemotherapy for cancer treatment

To qualify for reimbursement a **cycle** of chemotherapy treatment must meet the following definition:

A specified number of sequentially administered doses of **chemotherapy agent(s)** where:

- the **chemotherapy agent** is administered at prescribed intervals within a planned time frame; and
- **PHARMAC** has approved the **chemotherapy agent** under Sections A to H of the **PHARMAC** Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and
- the **chemotherapy agent** is prescribed by a registered specialist and administered in Australia.

18 Intravitreal Eye Injections Benefit

18.1 What we cover

We cover the cost for intravitreal **injections** administered by a **registered specialist**, on referral from a **GP** or **registered specialist**. The cost of drugs administered is covered if it is listed under Section A to H of the **PHARMAC** Pharmaceutical Schedule.

18.2 Benefit maximum

We pay up to $3,000 per **insured person** per **policy year**, less any **excess**.

18.3 Other terms

This Benefit does not cover any drugs not funded by **PHARMAC** under Sections A to H of the **PHARMAC** Pharmaceutical Schedule.

19 GP Minor Surgery Benefit

19.1 What we cover

We cover the cost of treatment for minor **surgery**, performed by a **GP**.

19.2 Benefit maximum

We pay up to $750 per **insured person** per **policy year**, less any **excess**.

19.3 Other terms

We recommend **pre-approval** as some **GP** minor **surgery** is deemed cosmetic **surgery** and is not covered.

This Benefit does not include any **GP consultation** costs.

20 Specialist Skin Lesion Surgery Benefit

20.1 What we cover

We cover the cost of treatment for skin lesion **surgery** performed by a **registered specialist**, on referral from a **GP**.

20.2 Benefit maximum

We pay up to $6,000 per **insured person** per **policy year**, less any **excess**.

20.3 Other terms

- **We** recommend **pre-approval** as some **surgery** is deemed cosmetic **surgery** and is not covered.
- This Benefit includes cover for one pre-**surgery registered specialist consultation** for skin lesions.
- This Benefit does not cover cryotherapy, pulse light therapy and photodynamic therapy.

21 Podiatric Surgery Benefit

21.1 What we cover

We cover the cost of **surgery** performed by a **podiatric surgeon** under local anaesthetic, including up to one pre and one post **surgery** consultation and related x-rays.

21.2 Benefit Maximum

We pay up to $6,000 for each **insured person** every **policy year**. This Benefit maximum includes the cost of surgically implanted **prosthesis** (see **prosthesis schedule**).

21.3 Other terms

- Costs relating to **diagnostic investigations** other than x-ray are covered under the Major Diagnostics Benefit (Refer to Benefit 7).
- Benefits are not payable for removal of corns and callouses.

22 Obstetrics Benefit

22.1 What we cover

We cover the cost of treatment by an obstetrician when the diagnosis is made of a medical condition that is affecting or may affect the pregnancy, after a referral by the **GP** or **registered specialist**, but excluding caesarean sections and ectopic pregnancies.

22.2 Benefit maximum

We pay up to $2,000 per **insured person** per pregnancy, less any **excess**.

22.3 Other terms

- Any conditions arising post birth are not covered.
- **We** do not pay this Benefit if a fee-paying **insured person** is admitted to a public **hospital**.
- **We** do not pay this Benefit in relation to a pregnancy conceived prior to the **join date**.

23 ACC Top-up Benefit

23.1 What we cover

We cover any shortfall between what **ACC** pays for a physical **injury** and the actual costs incurred for the **surgical** and / or medical treatment in an **approved private hospital**, less any **excess**. This is limited to the applicable Benefit maximum, less any **excess**. A copy of **ACC's** decision must be supplied to **us** prior to treatment being undertaken.

23.2 Benefit maximum

All costs paid under this Benefit are included within the Benefit maximum for the **Hospital** – **Surgical** Benefit or **Hospital** – Medical Benefit (whichever applies)

23.3 Other terms

- An **insured person** must obtain **ACC's** acceptance of their claim prior to the treatment being performed, and provide **us** with evidence of **ACC's** acceptance of their claim and the amount payable by **ACC** in respect of that treatment.
- **We** may require an **insured person** to apply for a review of **ACC's** decision. **You** must reimburse **us** for any cost subsequently covered by **ACC** as a result of the review. **We** may request **your** permission to seek legal advice at **our** cost to address the review of **ACC's** decision.

24 Waiver of Premium Benefit

24.1 What we cover

We cover the premiums due on this policy for all surviving **insured persons** if a **policyowner** dies before the age of 65 from any cause.

24.2 Benefit maximum

We pay the premiums:

- for two years; or
- until anyone of the surviving **insured persons** turns 65 years of age,

whichever occurs first.

24.3 Other terms

- No **excess** will be deducted from the Waiver of Premium Benefit.
- The Benefit starts from the next premium payment date following the death of the **policyowner**.
- When the Benefit ends, the premiums will recommence and be payable in respect of all surviving **insured persons**.
- When claiming for a Waiver of Premium Benefit, please provide the original death certificate or a certified copy of the similar documentation acceptable to **us**.

25 Funeral Support Grant

25.1 What we cover

We make a cash payment when an **insured person** dies between the age of 16 and 64 (inclusive). This grant is payable to the **policyowner** or the **policyowner's** estate.

25.2 Benefit maximum

We pay $3,000 in respect of that **insured person.**

25.3 Other terms

- No **excess** will be deducted from the Funeral Support Grant.
- When claiming for a Funeral Support Grant, please provide the original death certificate or a certified copy of the similar documentation acceptable to **us**.

26 Loyalty Benefit – Sterilisation

26.1 What we cover

After two years' continuous cover under this policy, an **insured person** is covered for the cost of male or female sterilisation as a means of contraception, performed by a **GP** or **registered specialist**.

26.2 Benefit maximum

We pay up to $1,000 per procedure.

26.3 Other terms

No **excess** will be deducted from the Loyalty Benefit – Sterilisation Benefit.

27 Loyalty Benefit – Suspension of Cover

27.1 What we cover

After 12 months' continuous cover under this policy, the cover (including the premium payments) can be suspended as follows:

- **Overseas travel / residence**
  If the **insured person** lives or travels outside New Zealand for longer than three consecutive months the cover for the **insured person** can be suspended for between three and 24 months. To suspend cover **you** must tell **us** in writing before the **insured person** travels overseas, and provide any evidence of travel **we** require.
- **Unemployment**
  If **you** are registered as unemployed, cover can be suspended for between three and six months. To suspend cover **you** must tell **us** in writing within 30 days of **you** registering as unemployed and provide evidence of registration.

27.2 Other terms

- **You** and the **insured person** cannot suspend cover for more than 24 months in any 10 year period.
- While cover is suspended for an **insured person** no premium is payable and no cover is provided for that **insured person** affected.

- **We** will reinstate cover without enquiring into the **insured person's** health so long as cover is reinstated before the suspension of cover period ends.
- If cover is not reinstated at the end of the suspension of cover period, **we** will write to **you** at **your** last known address and give **you** 90 days within which to pay any arrears of premium. If **you** do not pay the arrears by the end of 90 days where this policy is suspended, this policy will end and where an **insured person's** cover is suspended, the cover on that **insured person** will end.
- If **you** have suspended an **insured person's** cover for overseas travel / residence and at the end of the suspension of cover period **you** do not wish to reinstate the cover on the **insured person** affected, this policy will end and **we** will issue a new policy to any remaining **insured persons**.

28 Loyalty Benefit – Wellness

28.1 What we cover

After an **insured person** aged 21 or over has been continuously covered under the Base Cover for 36 months, **we** cover the cost of a medical examination of that **insured person** by a **GP** including, for example, the cost of laboratory tests, ECG, blood pressure checks, breast examinations, mole map, cervical smears and prostate examinations.

28.2 Benefit maximum

We pay up to $100 per **insured person** aged 21 or over, after each 36 months of continuous cover.

28.3 Other terms

- **We** will advise **you** when an **insured person** is eligible to take up this Benefit.
- This Benefit is not available to **dependent children**.

- Once a **dependent child** reaches age 21, this Benefit is available to him or her and the period of 36 months of continuous cover begins on the **policy anniversary date**, on or immediately after that **insured person** reaches age 21, if that **insured person** remains on this policy, or from the **commencement date** of that **insured person's** own policy.
- This Benefit must be taken in the **policy year** after entitlement and cannot be accumulated over subsequent years.
- If cover is suspended, the suspended period is included in calculating the 36 months of continuous cover.
- Where an **insured person** is added to this policy, each period runs from that **insured person**'s **join date**.
- The **excess** does not apply to this Benefit.

Specialist Option

1 Introduction

1.1 What we cover

The Specialist Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Specialist Option.

The Specialist Option provides the Benefits set out below during the **policy year** for each **insured person** for that **insured person's** medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**).

Benefits under the Specialist Option apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**, unless stated otherwise in this policy.

It is highly recommended that **you** obtain **pre-approval** before an **insured person** visits a **registered specialist** or undergoes any **diagnostic investigations**.

1.2 What we pay

We will refund **you** up to the applicable Benefit maximums for each Benefit. The Base Cover **excess** does not apply to the Specialist Option.

2 Specialist Consultations Benefit

2.1 What we cover

We cover the cost of **registered specialist** or **vocational GP consultations**, after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised**.

If **consultations** result in **hospitalisation** in an **approved private hospital** within six months of the **consultation**, the cost of the **consultation** will be covered under the Base Cover and is included within the applicable Benefit maximum.

2.2 Benefit maximum

No limit per **consultation.**

No limit per **insured person** per **policy year**.

3 General Diagnostics Benefit

3.1 What we cover

We cover the cost of **diagnostic investigations** after referral by a **GP** or **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised** for treatment. This includes (for example, without limitation) X-rays, arteriogram, ultrasound, scintigraphy, mammogram, visual field tests.

3.2 Benefit maximum

We pay up to $3,000 per **insured person** per **policy year**.

3.3 Other terms

If any of the **diagnostic investigations** result in **hospitalisation** to an **approved private hospital** within six months of the **diagnostic investigation**, the cost of the **diagnostic investigation** will be covered under the Base Cover and is included within the applicable Benefit maximum.

4 Cardiac Investigations Benefit

4.1 What we cover

We cover the cost of cardiac investigations after referral from a **GP** or a **registered specialist**, even when the **insured person** has not been, or will not be, **hospitalised**. Investigations such as treadmills, holter monitoring, ambulatory blood pressure monitoring, cardiovascular ultrasound, echocardiography, myocardial perfusion scans and cardioversion are included.

4.2 Benefit maximum

We pay up to $60,000 per **insured person** per **policy year**.

4.3 Other terms

If these cardiac investigations result in **hospitalisation** to an **approved private hospital** within six months of the investigation, the cost of the cardiac investigation will be covered under the Base Cover and is included within the applicable Benefit maximum.

5 New application

If **you** wish to add the Specialist Option to **your** policy after the **commencement date**, **you** must complete a new application form. The terms of **our** acceptance depend on the information **you** provide **us**.

Serious Condition Lump Sum Option

1 Introduction

1.1 What we cover

The Serious Condition Lump Sum Option can be added to the Premier Health Business Base Cover for an additional premium.

Your acceptance certificate or **renewal certificate** shows whether **you** have chosen the Serious Condition Lump Sum Option. Where it does, the **insured person** covered and the **sum insured** will be shown in **your acceptance certificate** or **renewal certificate**.

If the **insured person** suffers one of the **Trauma Conditions** (summarised in section 2 and defined in section 3 in this Option) for the first time on or after the **effective date** and before or on the end date of the Serious Condition Lump Sum Option (refer to section 6 of this Option), **we** will pay **you** the **sum insured** that applies at that time.

The **insured person's** medical condition must come exactly within the **Trauma Condition** definition in section 3 in this Option.

1.2 Stand-down period

If any of the highlighted Trauma Conditions summarised in section 2 below occur, or symptoms leading to any of those **Trauma Conditions** occur, within the first 90 days after:

- the **effective date** of the Serious Condition Lump Sum Option; or
- the **effective date** of the Serious Condition Lump Sum Option being reinstated; or
- **you** increasing the **sum insured**,

we will not pay the **sum insured** or the amount by which the **sum insured** increased (whichever is applicable), and there is no cover under this Option for any subsequent reoccurrence of that same **Trauma Condition** at any time.

1.3 What we pay

The Serious Condition Lump Sum Option pays the **sum insured** shown in the **acceptance certificate** or **renewal certificate** as a lump sum.

Only one **sum insured** is paid for each **insured person** covered by the Serious Condition Lump Sum Option.

We pay the **sum insured** that applied at the date that the **insured person** first suffered the **Trauma Condition**.

The **sum insured** will be reduced proportionally if the **insured person** covered is older than the age stated in the application form.

2 Trauma Conditions

The Trauma Conditions are summarised as follows:

a. Heart and circulation

- Aortic **Surgery**.
- Coronary Artery Bypass Grafting **Surgery**.
- Major Heart Attack (Myocardial Infarction).
- Heart Valve **Surgery**.

b. Cancer

- Cancer – Life Threatening.

c. Functional Loss / Neurological

- Benign Tumour of the Brain or Spinal Cord.
- Paralysis (including):
  - Hemiplegia.
  - Diplegia.
  - Paraplegia.
  - Quadriplegia.
  - Tetraplegia.
- Stroke.

d. Organs

- Chronic Liver Failure.
- Chronic Lung Failure.
- Chronic Renal Failure.
- Major Organ Transplant.
- Pneumonectomy.

If the **Trauma Condition** is a **surgical** procedure, then that **surgical** procedure must be the usual treatment in respect of the **Trauma Condition**.

3 Definitions of the Trauma Conditions

3.1 Aortic Surgery

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

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

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

3.2 Benign Tumour of the Brain or Spinal Cord

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

- medically necessary **surgery** to remove the tumour; or
- neurological deficit causing:
  - at least 25% impairment of **whole person functions** that is permanent; or
  - the **insured person** to be constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

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

3.3 Cancer – Life Threatening

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

The following are not included:

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

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

3.4 Chronic Liver Failure

End stage liver failure with permanent jaundice, ascites or encephalopathy. This does not include liver disease related to alcohol use or drug abuse.

3.5 Chronic Lung Failure

End stage respiratory failure requiring extensive, continuous and permanent oxygen therapy and

- FEV 1 test results of consistently less than one litre; or
- the **insured person** is constantly and permanently unable to perform at least one of the **activities of daily living** without the physical assistance of another person.

3.6 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.

3.7 Coronary Artery Bypass Grafting Surgery

The undergoing of medically necessary Coronary Artery Bypass Grafting **Surgery** to correct or treat coronary artery disease.

3.8 Heart Valve Surgery

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

3.9 Major Heart Attack (Myocardial Infarction)

Means the **insured person** has had a Myocardial Infarction (other than as a direct result of cardiac or coronary intervention) with the following criteria being satisfied:

- a diagnostic rise and fall in either **Troponin** I in excess of 2.0ug/L, **Troponin** T in excess of 0.6ug/L or cardiac enzyme **CK-MB**; and
- development on an ECG of either new pathological Q waves or new changes indicative of ischaemia.

If the above criteria are not met then **we** will pay a claim based on satisfactory evidence that the **insured person** has suffered a Myocardial Infarction which has resulted in a permanent reduction in the Left Ventricular Ejection Fraction to less than 50%.

3.10 Major Organ Transplant

Means either:

- the undergoing of; or

- upon the advice of a **registered specialist** being on a waiting list of a Transplantation Society of Australia or New Zealand recognised transplant unit for at least four weeks for

the medically necessary human to human transplant from a donor to the **insured person** of one or more of the following complete organs: kidney, liver, heart, lung, pancreas, small bowel or the transplantation of bone marrow.

3.11 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. For this trauma condition only, limb is defined as the complete arm or the complete leg.

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

3.12 Pneumonectomy

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

3.13 Stroke

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

This requires clear evidence on a Computerised Tomography Scan (CT) or Magnetic Resonance Imaging Scan (MRI) or similar appropriate scan that a stroke has occurred and evidence of:

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

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

4 How to make a claim

4.1 Diagnosis

When claiming under the Serious Condition Lump Sum Option, the **insured person** covered must first:

- receive a definite diagnosis of the **Trauma Condition.** The diagnosis must be by a **registered specialist** based on conventional medical testing acceptable to **us**; and
- co-operate with any requests **we** make to confirm diagnosis of that **insured person's Trauma Condition**. For example, undergoing a medical examination by a **registered specialist** of **our** choice at **our** expense.

4.2 Information to be provided

You must:

- advise **us** as soon as possible but no later than 90 days after that **insured person** is diagnosed with a **Trauma Condition**; and
- give **us** an original or certified copy of that **insured person's** birth certificate, driver's licence or passport; and
- complete and return **our** claim form. **you** can call **us** on 0800 287 642 to request a claim form; and
- at **your** own expense, supply medical certificates and any other information that **we** may require from time to time.

4.3 Seek treatment

You must obtain, as soon as possible after the **insured person** first become aware that he or she might be suffering from a **Trauma Condition**, advice and medical treatment from an appropriate **registered specialist** (or other **registered specialist** approved by **us**) and to follow that advice and medical treatment.

4.4 Medical examination

If requested by **us**, the **insured person** must undergo medical examinations and other tests by a **registered specialist** of **our** choice to enable **us** to confirm that the **insured person** is suffering from one of the **Trauma Conditions**. This will be at **our** expense.

5 When we will not pay

5.1 Exclusions

We will not pay anything under the Serious Condition Lump Sum Option if what happens to the **insured person** is in connection with:

- intentional self-inflicted **injury** (whether sane or insane) by the **insured person**; or
- the **insured person** engaging in conduct which gives rise to any criminal offence for which the **insured person** is convicted; or
- the **Trauma Condition** suffered by the **insured person** covered is in connection in any way with a **pre-existing condition**; or
- the **Trauma Condition** has not been suffered for the first time after the **commencement date**, **effective date** or after the **join date** (whichever is applicable); or
- the **insured person** not following the advice and treatment recommended by a **registered specialist**; or
- if the **insured person** dies within the 14-day period immediately following the date of diagnosis of the **Trauma Condition**.

6 When the Serious Condition Lump Sum Option ends

6.1 End date

The Serious Condition Lump Sum Option ends in relation to an **insured person** at the earliest of the following:

- at the **policy anniversary date** immediately after that **insured person's** 70th birthday; or
- when the **sum insured** for the Serious Condition Lump Sum Option is paid in respect of that **insured person**; or
- when that **insured person** dies.

7 New application or alteration to the sum insured

7.1 Additions or alterations

If **you** wish to add the Serious Condition Lump Sum Option to **your** policy or alter the **sum insured** (to a level agreed by **us**) after the **commencement date**, **effective date** or **join date**, where an **insured person** is added to this policy, **you** must complete a new application form.

8 Upgrading an existing policy with Trauma Cover and / or Serious Condition Lump Sum Option to the enhanced Serious Condition Lump Sum Option

8.1 Upgrade

Where this Option is an upgrade from an existing Trauma Cover and / or Serious Condition Lump Sum cover held by **you**, to this enhanced Serious Condition Lump Sum Option, and where there are new **Trauma Conditions** covered, there is no cover for any new **Trauma Conditions** that are in connection in anyway with any **pre-existing conditions** the **insured person** had prior to the **effective date** of the upgrade.

GP Option

1 Introduction

1.1 What we cover

The **GP** Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the **GP** Option.

This Option provides the Benefits set out below during the **policy year** for each **insured person** for that **insured person's** medical conditions (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**).

1.2 Stand-down period

The **GP** Option has a 90-day **stand-down period** before Benefits can be claimed, unless **we** have agreed otherwise. The medical condition and resulting treatment must first occur after the **stand-down period**.

1.3 What we pay

We will refund **you** 80% or 100% of the applicable Benefit maximums for each Benefit (if **you** have selected the **GP** Option, refer to **your acceptance certificate** or **renewal certificate** for details). The Base Cover **excess** does not apply to the **GP** Option.

2 General Practitioners Benefit

2.1 What we cover

We cover the cost of **GP** visits, including home visits, ECG, cervical smears and minor **surgery** under local anaesthetic.

2.2 Benefit maximum

We pay up to $55 per **GP** clinic visit, including after hours.

We pay up to $80 per home visit.

We pay up to $25 per visit for **ACC Top-up**. **You** cannot use the $55 / $80 per clinic / home visit Benefit to add to this.

We pay up to 12 **GP** visits per **insured person** per **policy year**. Minor **surgical** procedures are not counted in the 12 visits.

We pay up to $200 per minor **surgical** procedure. **You** cannot use the $55 / $80 per clinic / home visit Benefit to add to this.

3 Prescription Benefit

3.1 What we cover

We cover the cost of medicines and drugs listed under Sections A to H of the Ministry of Health **PHARMAC** Pharmaceutical Schedule prescribed by a **GP** or **registered specialist** that meet the eligibility criteria for funding.

3.2 Benefit maximum

We pay up to $15 per item.

We pay up to $300 per **insured person** per **policy year**.

3.3 Other terms

- This excludes after hours fees.
- **You** must submit pharmacist receipts stating the name of the patient, prescription number, the name of the medication prescribed and the cost of each item. The reason for the medication must be stated on the claim form.
- Any claim for reimbursement of prescription costs must relate to the **insured person**, regardless of whether the **insured person** paid the account or bill.
- **We** will only reimburse the cost of the prescription. **We** will not reimburse administration costs (for example faxing costs incurred between the prescribing **GP**, **registered specialist** or pharmacy).

4 Physiotherapy Benefit

4.1 What we cover

We cover the cost of physiotherapy treatment after referral by a **GP** or **registered specialist**.

4.2 Benefit maximum

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit Benefit to add to this.

We pay up to $400 per **insured person** per **policy year**.

5 Independent Nurse and Nurse Practitioner Benefit

5.1 What we cover

We cover the cost of visits to / by an **independent nurse** or **nurse practitioner**.

5.2 Benefit maximum

We pay up to $30 per visit.

We pay up to six visits per **insured person** per **policy year**.

6 Loyalty Benefit – Active Wellness

6.1 What we cover

After 24 months' continuous cover under the **GP** Option, and at the end of every 24 months thereafter, providing claims for events that occurred within the preceding 24 month period under the **GP** Option are less than $150, each **insured person** aged 21 or over will receive a reimbursement towards the cost of either:

- membership to a recognised gym or sports club; or
- sports / fitness equipment purchased from a recognised sporting retailer.

If **you** submit a claim for events which occurred within the preceding 24-month period after this Benefit has been paid, **we** will deduct the amount paid to **you** for this Active Wellness Benefit from the claim.

6.2 Benefit maximum

We pay up to $150 per **insured person**, aged 21 or over, after each 24 months of continuous cover under the **GP** Option.

6.3 Other terms

- Receipts or evidence of membership should be submitted at time of claim.
- The Benefit must be taken in the **policy year** after entitlement and cannot be accumulated over subsequent years.
- This Benefit does not apply to **dependent children**.
- Once a **dependent child** reaches age 21, this Benefit is available to him or her and the period of 24 months of continuous cover begins on the **policy anniversary date**, on or immediately after that **insured person** reaches age 21 if that **insured person** remains on this policy, or from the **commencement date** of that **insured person's** own policy.
- If cover is suspended, the suspended period is included when calculating the 24 months' continuous cover.
- Where an **insured person** is added to this policy, each period runs from that **insured person's join date**.

7 New application

If **you** wish to add the **GP** Option to **your** policy after the **commencement date**, **you** must complete a new application form. The terms of **our** acceptance depend on the information **you** provide **us**.

Dental and Optical Option

1 Introduction

1.1 What we cover

The Dental and Optical Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Dental and Optical Option.

This Option provides the Benefits set out below during the policy period for a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in **your acceptance certificate** or **renewal certificate**).

The Dental and Optical Option and the Benefit maximums apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**, unless stated otherwise in this policy.

1.2 Stand-down period

This Option has a six-month **stand-down period** before Benefits can be claimed, unless **we** have agreed otherwise. The medical condition and resulting treatment must first occur after the **stand-down period**.

1.3 What we pay

We will refund **you** 80% or 100% of the applicable Benefit maximums for each Benefit (if **you** have selected this Option, refer to **your acceptance certificate** or **renewal certificate** for details).The Base Cover **excess** does not apply to the Dental and Optical Option.

2 Dental Care Benefit

2.1 What we cover

We cover the cost of dental treatment by a registered dental practitioner or oral surgeon, including examination, cleaning and scaling, fillings, associated X-rays and removal of teeth.

2.2 Benefit maximum

We pay up to $500 per **insured person** per **policy year**.

2.3 Other terms

- This Benefit excludes treatment for **dependent children** covered under the school dental service or general dental benefit scheme.
- The Benefit excludes the additional cost of gold or other exotic materials.

3 Eye Care Benefit

3.1 What we cover

We cover the cost of optometrist, orthoptist and optician examination fees and the cost of glasses and contact lenses when these are required as a result of a vision change.

3.2 Benefit maximum

We pay up to $55 per **consultation** / examination.

We pay up to $275 per **insured person** per **policy year** for **consultations** / examinations.

We pay up to $330 per **insured person** per **policy year** for each **insured person** for glasses and contact lenses.

3.3 Other terms

- **We** do not cover the cost of changing glasses and contact lenses for fashion reasons.
- **We** only cover the cost of treatment by an orthoptist on referral by an optometrist, **GP** or **registered specialist**.

- **We** require written confirmation from the **insured person's** optometrist that the **consultation**, examination, glasses or contact lenses are required as a result of a vision change.

4 Ear Care Benefit

4.1 What we cover

We cover the cost of audiometric tests and audiology treatment after referral from a **registered specialist**.

4.2 Benefit maximum

We pay up to $250 per **insured person** per **policy year** for audiology.

We pay up to $250 per **insured person** per **policy year** for audiometric tests.

5 Acupuncture Care Benefit

5.1 What we cover

We cover the cost of acupuncture treatment by a **GP** or by a registered physiotherapist, after referral from a **GP** or **registered specialist**.

5.2 Benefit maximum

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit Benefit to add to this.

We pay up to $250 per **insured person** per **policy year**.

6 Spinal Care Benefit

6.1 What we cover

We cover the cost of chiropractic treatment and related X-rays after referral from a **GP** or **registered specialist**.

6.2 Benefit maximum

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit Benefit to add to this.

We pay up to $250 per **insured person** per **policy year** for visits.

We pay up to $80 per **insured person** per **policy year** for X-rays.

7 Joint Care Benefit

7.1 What we cover

We cover the cost of osteopathy treatment and related X-rays after referral from a **GP** or **registered specialist**.

7.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $15 per visit for **ACC Top-up**. **You** cannot use the $40 per visit Benefit to add to this.

We pay up to $250 per **insured person** per **policy year** for visits.

We pay up to $80 per **insured person** per **policy year** for X-rays.

8 Foot Care Benefit

8.1 What we cover

We cover the cost of podiatry treatment after referral from a **GP** or **registered specialist**.

8.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $250 per **insured person** per **policy year**.

9 Therapeutic Care Benefit – Speech, Occupational and Eye

9.1 What we cover

We cover the cost of speech, occupational and eye therapy after referral from a **GP** or **registered specialist**.

9.2 Benefit maximums

We pay up to $40 per visit.

We pay up to $300 per **insured person** per **policy year** under this Therapeutic Care Benefit.

10 Loyalty Benefit – Orthodontic Treatment

10.1 What we cover

After an **insured person** has been continuously covered under the Dental and Optical Option for 24 months, the Dental Care Benefit will be extended to include orthodontic treatment up to the same Benefit maximums.

10.2 Benefit maximum

All costs paid under this Benefit are included within the Benefit maximum for the Dental Care Benefit of up to $500 per **insured person** per **policy year**.

11 New application

If **you** wish to add the Dental and Optical Option to **your** policy after the **commencement date**, **you** must complete a new application form. The terms of **our** acceptance depend on the information **you** provide **us**.

Proactive Health Option

1 Introduction

1.1 What we cover

The Proactive Health Option can be added to the Base Cover for an additional premium. **Your acceptance certificate** or **renewal certificate** shows whether **you** have chosen the Proactive Health Option.

Benefits under the Proactive Health Option apply to each **insured person** shown on **your acceptance certificate** or **renewal certificate**.

This Option provides the Benefits set out below during the **policy year**. The **pre-existing conditions** exclusion does not apply to this Option. Refer to the Exclusions section on page 69.

1.2 Stand-down period

This Option has a six-month **stand-down period** before Benefits can be claimed, unless **we** have agreed otherwise.

1.3 What we pay

We will refund **you** 80% of the eligible cost under the Benefit up to the Benefit maximums. The Base Cover **excess** does not apply to the Proactive Health Option.

2 Health Screening Benefit

We cover the cost of the following health screening tests;

- Bone **screening**
- Bowel **screening**
- Breast **screening**
- Cervical **screening**
- Heart **screening**
- Prostate **screening**

- Eye test and / or visual fields tests
- Hearing test
- Mole mapping

2.1 Benefit maximum

We pay up to $750 per **insured person** per **policy year**.

2.2 Other terms

If the **screening** test results in hospitalisation within six months of the test, the cost of the **screening** test will be covered under the Base Cover and is included within the applicable Benefit maximum.

3 Allergy Testing and Vaccination Benefit

We cover the cost of allergy testing and vaccination administered by a **registered specialist**, **GP** or **nurse practitioner**.

3.1 Benefit maximum

We pay up to $100 per **insured person** per **policy year**.

3.2 Other terms

This Benefit does not cover any medication not listed under Section A to H of the **PHARMAC** pharmaceutical schedule.

4 Dieticians and Nutritionist Consultations Benefit

We cover the cost of **dieticians** and / or **nutritionist consultations**.

4.1 Benefit maximum

We pay up to $300 per **insured person** per **policy year**.

4.2 Other terms

- This Benefit does not cover any food items, supplements, vitamins, videos, books or DVDs.
- If **consultations** occur within six months after a **hospitalisation**, and an eligible claim has been submitted under the **Hospital-Surgical** Benefit or **Hospital**-Medical Benefit, they will be covered under the Base Cover and are included within the applicable Benefit maximum.

5 Stay Active Benefit

We cover the cost of gym memberships, weight loss management programs and quit smoking programs to assist the **insured person** to stay active.

5.1 Benefit maximum

We pay up to $100 per **insured person** per **policy year**.

5.2 Other terms

- This Benefit does not cover any food items, supplements, vitamins, videos, books or DVDs.
- This Benefit does not cover activity related garments, footwear or equipment of any type.
- This Benefit will only be reimbursed after the cost has incurred.

6 Loyalty Benefit – Health Check

After 24 months' continuous cover under this Option, and at the end of every 24 months thereafter, **we** cover the cost of a medical examination by a **GP**, including, for example, a full health check.

6.1 Benefit maximum

We pay up to $150 per **insured person**, after each 24 months of continuous cover.

6.2 Other terms

This Benefit must be taken in the same **policy year** after entitlement and cannot be accumulated over subsequent years.

While cover is suspended for an **insured person** no cover is provided for that **insured person** affected.

Where an **insured person** is added to this policy or the **policyowner** selects this Proactive Health Option, each period runs from that **insured person's join date** or **effective date** of this option.

General Conditions

1 Period of cover

1.1 Cover for the Base Cover and any Options shown on the **acceptance certificate** or **renewal certificate** start on the **commencement date**, **effective date** or the **join date** where an **insured person** is added to this policy, subject to any applicable **stand-down period**.

1.2 Cover ends when any of the following happen:

- **you** ask **us** to cancel it. **you** must give **us** not less than 30 days' notice in writing or by email; or
- **you** fail to pay the premium or any premium instalment within 90 days after the due date for payment; or
- where an **insured person** holds a work permit at the **join date**, when that work permit ends or is no longer valid; or
- **you** or any **insured person** breach the terms of this policy; or
- when the last **insured person** covered by this policy dies.

1.3 All information given by, or on behalf of, **you** or any **insured person** when arranging this policy or making any changes to it must be true, correct and complete. If it is not, **we** may at **our** discretion, cancel this policy from the **commencement date**. If **we** cancel this policy, any premiums **you** have paid may be retained by **us**. If **we** have already made any payments, **we** can recover these from **you**.

2 Insured person

2.1 An **insured person** must be eligible to receive health services funded under the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation) at all times.

2.2 **We** may request to see originals or certified copies of the **insured person's** visa or work permit in the **insured person's** passport, birth certificate or driver's licence.

3 Dependent children

3.1 Cover for a **dependent child** ends on the **policy anniversary date** after they reach age 21.

3.2 **We** will automatically continue cover for that person on this policy as an adult **insured person** and deduct the additional premium based on their age and gender for the cover from the same payment source and at the same frequency as this policy.

3.3 Alternatively, within 30 days following the **policy anniversary date** after the **dependent child** has reached 21 years of age, that person can opt to arrange a separate policy with **us** with similar terms without having to provide any further evidence of health.

4 Important information about premiums and benefits

4.1 **You** must pay **us** the premium at one of the frequencies provided by **us**. These are payable in advance. The premium is calculated according to the rates applying from time to time for the policy **you** selected.

4.2 Premiums are based on age and gender.

4.3 The premiums may automatically increase when an **insured person** attains a specified age. Any changes to the premium rates and age related steps apply across all **insured persons** with this policy. No changes will be made to **your** individual policy alone, based upon the individual claims experience of **your** policy.

4.4 The premiums and the Benefits for this policy are not guaranteed. **We** may alter the schedule of premium rates (including the ages at which premiums increase) and / or the Benefits and / or the terms of cover (including Exclusions and Definitions) during the life of the policy, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

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

4.5 **We** will give the **policyowner** 30 days' prior written notice of any alteration. The **policyowner** retains the right to cancel this policy at any time.

4.6 **We** want to ensure **your** valuable cover continues if a deduction advice is returned to **us** 'gone / no address'.

4.7 **We** will continue to make deductions in accordance with **our** premium rates until **we** are advised otherwise and **you** authorise **us** to do this.

Exclusions

1 What we will not pay for

1.1 We will not provide any cover under any of the Benefits in respect of:

a) A medical condition in connection with the misuse of alcohol, prescription drugs or non-prescription drugs.

b) A mental condition which includes but is not limited to a psychiatric, behavioural, psychological or developmental condition or eating disorders and subsequent treatment.

c) A dental medical condition (except where the contrary is expressly specified in this policy).

d) Senile **illness** or dementia (except where the contrary is expressly specified in this policy).

e) Acquired immune deficiency syndrome (AIDS) or associated medical conditions including human immunodeficiency virus (HIV) and related medical conditions (except where the contrary is expressly specified in this policy).

f) Any sexually transmitted disease and any related medical conditions or resulting complication.

g) Any:

- **congenital** medical condition; or
- developmental medical condition relating to a **congenital** deformity,

(except where the contrary is expressly specified in this policy).

h) Any medical condition as a consequence of war, invasion, act of foreign enemy, hostilities or warlike operations (whether war is declared or not), civil war, civil commotion, mutiny, rebellion, revolution, insurrection, act of terrorism, act of bio terrorism, peace keeping duties, or military or usurped power.

i) Any medical condition not registered with the Ministry of Health as a disease entity.

j) Any **pre-existing condition** as determined by **us**, this exclusion does not apply:
   - To any medical condition declared on the application form and accepted by **us**.
   - Where it is noted on the **acceptance certificate** or **renewal certificate** that **pre-existing conditions** are covered, but subject to the other exclusions in this policy and any special terms on the **acceptance certificate** or **renewal certificate**.
   - To the Benefits covered under the Proactive Health Option.

k) Any **acute medical condition**.

l) A medical condition arising from a criminal offence under the Crimes Act by an **insured person**.

m) Infertility, normal pregnancy and childbirth, caesarean sections, termination of pregnancy, erectile dysfunction, reversal of sterilisation, sterilisation, contraception or contraceptive procedures, hormone replacement therapy and slow replacement hormone therapy (except where the contrary is expressly specified in this policy).

n) Any medical condition or medical treatment requiring an admission to a private **hospital** for care that does not involve **surgical** or medical treatment as covered under the **Hospital-Surgical** Benefit or **Hospital**-Medical Benefit.

1.2 The following tests, diagnostic procedures, treatments or health services:

a) Geriatric care, including geriatric **hospitalisation**, rehabilitation (except where the contrary is expressly specified in this policy), **long-term care**, convalescence, respite, palliative and **disability support services** costs.

b) Breast reduction, mastopexy or gynaecomastia, gender reassignment for any reason, whether or not the undertaking is functional, physical, medical, psychological, emotional or social and complications thereof.

c) **Obesity** and any consequences of **obesity** for which assessment or treatment may be required or deemed necessary; this includes, but is not limited to bariatric **surgery** and complications thereof.

d) Any treatment (including dentistry) that improves, alters or enhances **your** appearance whether or not undertaken for medical, physical, functional, psychology, social or emotional reasons including complications thereof.

e) All forms of **prophylactic (preventative) treatment** (except where the contrary is expressly specified in this policy).

f) Any **surveillance testing or screening** (except where the contrary is expressly specified in this policy).

g) Sleep disorder assessment or treatment, this includes, but is not limited to sleep disturbances, snoring, sleep apnoea or lung function tests.

h) Treatment of self-inflicted **injuries** or treatment of **injuries** arising from attempted suicide.

i) Any services or treatment not normally conducted by a **GP** or **registered specialist**, and / or not recognised by the Medical Council of New Zealand or Ministry of Health (except where the contrary is expressly specified in this policy).

j) Any specialised tertiary treatments such as any organ and / or tissue transplants or organ donation (except where the contrary is expressly specified in this policy).

k) Renal dialysis or specialised transfusions of blood, blood products and derivatives.

l) Any treatment for the correction of myopia (short sightedness) or hypermetropia (long sightedness), or presbyopia (blurred vision) or any related complications except where provided for under the Dental and Optical Option.

m) Radial keratotomy or photo-refractive keratectomy (such as laser or Lasik treatment) or any related complications.

n) Any costs incurred as a result of cancellation of treatment under one of the eligible Benefits, except where that cancellation is on medical advice.

o) Costs incurred outside New Zealand (except where the contrary is expressly specified in this policy).

p) Costs of periodontal, orthodontic and endodontal procedures, implants and orthognathic surgery, except where provided for under the Dental and Optical Option.

q) Costs of after hours treatment and other administration costs (for example faxing charges incurred between the prescribing doctor, specialist or pharmacy) associated with prescriptions.

r) Costs of changing glasses and contact lenses for fashion reasons where there has been no change in vision.

s) Costs associated with additional treatment performed that has not been approved by **us** which is performed along with a treatment approved by **us**.

t) Any investigation, diagnoses, provision of medical advice, assessment and management and treatment of an **insured person** in relation to inherited genetic, chromosomal disorders and any familial predispositions (unless specifically accepted by **our chief medical officer**) (except where the contrary is expressly specified in this policy).

u) Costs incurred in relation to immunology therapy (including but not limited to allergy testing and desensitisation).

v) Gene therapy or genetic testing.

1.3 We will not pay for the following mechanical tools, aids or appliances:

a) Mechanical tools as determined by **us**; for example (without limitation): glucometers, blood glucose and ketone meters, insulin pumps, oxygen machines, C-PAP equipment, dialysis equipment, respiratory machines.

b) Aids as determined by **us**; for example (without limitation): hearing aids, battery operated aids, cochlear implants, pacemakers, defibrillators, personal alarms.

c) Appliances to assist with mobility as determined by **us**; for example (without limitation): crutches, moonboots, wheelchairs and artificial limbs.

This exclusion does not apply to any **surgically** implanted **prostheses** listed on **our prosthesis schedule**.

1.4 We do not pay for the following:

a) Any **injury** covered under **ACC** (except to the extent the **ACC Top-up** cover applies).

b) Medicines or pharmaceuticals that are not funded by **PHARMAC** under Sections A to H of **PHARMAC's** Pharmaceutical Schedule.

c) A medical condition that arose during a **stand-down period** unless stated otherwise in the **acceptance certificate** or **renewal certificate**, **stand-down periods** do not apply to newborn **dependent children** added to this policy within four months of birth.

d) Ambulance society subscriptions.

e) Any incidental costs which are not medically necessary (except where the contrary is expressly specified in this policy).

f) Anything that is recoverable from a non-insurer third party or under any other contract of insurance except to the extent that the other contract of insurance is exhausted.

g) **GP** and prescription charges (except where the contrary is expressly specified in this policy).

1.5 We will not pay for any medical or surgical treatments, procedures, diagnostics or technologies that:

a) Are experimental or unorthodox.

b) Are not widely accepted professionally as effective, appropriate or essential based on recognised standards of healthcare in New Zealand specifically for the condition being treated.

c) Use alternative or complementary medicines or therapies where these products and practices are not part of standard care and conventional medicine.

d) Are any kind of drug trials or experimental drug treatments in connection with a treatment.

Feedback and complaints

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

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

Alternatively, **you** can write to the nib Complaints Committee:

nib nz limited
PO Box 91630
Victoria Street West
Auckland 1142

Email complaints@nib.co.nz

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

The Insurance & Financial Services Ombudsman
PO Box 10-845
Wellington 6143

Phone 0800 888 202

Email info@ifso.nz

Website www.ifso.nz

Definitions

We realise that insurance language can sometimes be difficult to understand, so we have provided the following section to explain the special meanings of words in the context of this policy. This helps simplify your policy document and makes it easier to read and understand. The words in bold in this policy (and any derivatives) have the following meanings:

Definition	Meaning
ACC	The Accident Compensation Corporation as defined in the Accident Compensation Act 2001 (or its successor under any subsequent legislation).
acceptance certificate	The most recent document entitled 'acceptance certificate' forwarded to **you** by **us** as part of this policy.
ACC Top-up	The difference between what **ACC** pays for services and what the **recognised provider** charges for treatment.

Definition	Meaning
activities of daily living	Activities of daily living are: ■ bathing and showering; ■ dressing and undressing (including grooming and fitting artificial limbs); ■ eating and drinking; ■ using a toilet to maintain personal hygiene; and ■ moving to or from place to place by walking, wheelchair or walking aid.
acute medical condition	A medical condition in response to a sign, symptom, condition or disease that requires immediate, or within 48 hours, **hospital** admission for treatment or monitoring.
approved private hospital	A private **hospital**, day **surgery** unit, or private wing in a public **hospital** within New Zealand that has been approved by **us**. However, it does not include a hospice, nursing home or outpatient clinic, even if it is connected in anyway with a private **hospital**, day **surgery** unit, or private wing in a public **hospital**.
carcinoma in situ	Carcinoma in situ characterised by a focal autonomous new growth of carcinomatous cells, which has not yet resulted in the invasion of normal tissues. “Invasion” means an infiltration and / or active destruction of normal tissue beyond the basement membrane. The diagnosis of carcinoma in situ must be based on histological examination of tissue. A clinical or radiological diagnosis will not be sufficient.

Definition	Meaning
chemotherapy agent	A chemotherapy drug orally or intravenously administered for the treatment of cancer that is approved, listed on the **PHARMAC** Pharmaceutical Schedule under Sections A to H and meets the **PHARMAC** funding criteria.
chief medical officer	**Our** chief medical officer.
CK-MB	An enzyme that is specific to heart muscle and increases following a heart attack.
commencement date	The 'Original policy commencement date' shown on the **acceptance certificate** or **renewal certificate**.
congenital	A health anomaly or defect which is recognised at birth, or diagnosed within four months of birth, whether it is inherited or due to external or environmental factors such as drugs or alcohol.
consultation	A necessary meeting with a **registered specialist**, **GP**, **dietician** for discussion or the seeking of advice, or conferring to evaluate the medical case and any treatment. A consultation does not include the treatment itself. This does not include virtual consultation.

Definition	Meaning
cycle	For chemotherapy treatment: A specified number of sequentially administered doses of **chemotherapy agent(s)** where: ■ the **chemotherapy agent** is administered at prescribed intervals within a planned time frame; and ■ **PHARMAC** has approved the **chemotherapy agent** under Sections A to H of the **PHARMAC** Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and ■ the **chemotherapy agent**: ■ meets the **PHARMAC** funding criteria; and ■ is prescribed by a **registered specialist** and administered in New Zealand. For radiotherapy treatment: A specified number of sequentially administered doses of radiation where: ■ the radiation is administered at prescribed intervals within a planned time frame; and ■ the radiation is prescribed by a **registered specialist** and administered in a licensed facility in New Zealand.
dependent child	The **policyowner's** child under the age of 21 years, who usually lives with the **policyowner** or who is a tertiary student. 'Dependent children' has the same meaning.

Definition	Meaning
diagnostic investigation	A diagnostic procedure undertaken to determine the causes of a medical condition.
dietician	Any person who holds a current practising certificate issued by the Dieticians' Board in New Zealand (or its successor under any subsequent legislation).
disability support services	Support services provided where a condition or disability or **illness** has been, or is likely to be, present for six months or more, but does not include **surgical** or medical treatment.
effective date	The date shown on the **acceptance certificate** or **renewal certificate** in relation to a particular cover.
Efficient Market Price/EMP	The maximum amount (as may change from time to time) **we** will pay for a health service provided by a **recognised provider** that is not part of the **nib First Choice network**.
excess	The 'Base Cover excess amount' shown on the **acceptance certificate** or **renewal certificate** which **we** do not pay. It is the amount **you** pay.
First Choice network/nib First Choice network	The group of **recognised providers** that are pre-determined by **us** to charge a fair and reasonable amount for a particular health service (as may change from time to time).
First Choice provider/nib First Choice provider	A **recognised provider** that is part of the **nib First Choice network** for a particular health service (as may change from time to time).

Definition	Meaning
GP	A doctor registered in terms of the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) and recognised by the Medical Council of New Zealand to practice as a General Practitioner.
health service provider	Any registered person who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) and is a member of the appropriate registration body, for example Medical Council of New Zealand, Dental Council of New Zealand, the Nursing Council of New Zealand or the Chiropractic Board in New Zealand.
hospital	Premises that come within part (a) of the definition of 'hospital care' in the Health and Disability (Safety) Act 2001 (or its successor under any subsequent legislation).
hospitalisation / hospitalised	Admission in New Zealand to an **approved private hospital** for the purposes of ■ undergoing a **surgical** procedure; or ■ receiving medical treatment or a **cycle** of chemotherapy or radiotherapy treatment, approved by **us**.
illness	Any illness, sickness or disease suffered by the **insured person**.

Definition	Meaning
independent nurse	Any person who holds a current practising certificate issued by the Nursing Council of New Zealand as a **registered nurse** and who operates in private practice.
injection(s)	The act of forcing a liquid or pharmaceutical into any part of the body using a needle, cannula or other introducer.
injury / injuries	External or internal bodily injury caused solely and directly by violent, external or visible means.
insured person	A person named as an 'insured person' in **your acceptance certificate** or **renewal certificate**.
join date	Date when cover for an **insured person** is added to this policy.
long-term care	Those public and private **hospital**-based services provided on an ongoing regular basis where a medical condition has been or is likely to be present for more than 14 nights.
Medsafe	New Zealand Medicines and Medical Devices Safety Authority, a business unit of the Ministry of Health established by the New Zealand Medicines Act 1981 and the New Zealand Medicines Regulations 1984 (or its successor under any subsequent legislation).
nurse practitioner	Any person who is registered with the Nursing Council of New Zealand (or its successor under any subsequent legislation) as a nurse practitioner and who operates in private practice.

Definition	Meaning
Nutritionist	Any person who holds a current practicing certificate issued by the Nutrition Society New Zealand Inc (or its successor under any subsequent legislation)
obesity	A medical condition in which excess body fat has accumulated to a body mass index (BMI) of 30.00 or more on more than three recordings over a three year time frame. Metric: BMI = kilograms/metre^2. In the absence of BMI measures being available the **chief medical officer** reserves the right of decision to accept or decline a claim.
partner	The **insured person's** spouse or a person who cohabits with the **insured person** in the nature of a marriage.
PHARMAC	The Pharmaceutical Management Agency, being a Crown entity established by the New Zealand Public Health and Disability Act 2000 (or its successor under any subsequent legislation).
podiatric surgeon	A **health service provider** who is: ■ in private practice and holds a current annual practising certificate; and ■ a member of the Podiatrists Board of New Zealand (or its successor); and ■ vocationally registered and recognised as a podiatric surgeon
policy anniversary date	The date 12 months after the **commencement date** and every 12-month anniversary of that date.

Definition	Meaning
policyowner	The person(s) who is / are named in the **acceptance certificate** or **renewal certificate** as 'Policyowner(s)'.
policy year	The 12-month period that commences on the **commencement date** and ends at midnight on the **policy anniversary date**, and each successive 12-month period from **policy anniversary date** to **policy anniversary date**.
pre-approval / pre-approved	Approval of a claim by **us** prior to an **insured person** undergoing treatment, **surgery** or a **diagnostic investigation**.

Definition	Meaning
pre-existing condition	Any sign, symptom, treatment or surgery of a medical condition or any medical condition that occurs on or before the: ■ **commencement date**; or ■ **effective date**; or ■ **join date,** whichever is applicable, and a) which **you** or any **insured person** was aware of; or b) of which **you** or any **insured person** had the first indication that something was wrong; or c) for which **you** or the **insured person** sought investigation or medical advice; or d) where the medical condition, or the sign or symptom of a medical condition, existed that would cause a reasonable person in the circumstances to seek diagnosis, care or treatment.
prophylactic (preventative) treatment	Any treatment in the absence of signs or symptoms of an **illness**, disease or medical condition that seeks to reduce or prevent the risk of an **illness**, disease or medical condition developing in the future.
prosthesis / prostheses	A **surgically** implanted artificial replacement of a joint or body part used to restore functionality, (but does not include spectacles or corrective lenses, appliances) or an aid of any kind unless stated otherwise in this policy.

Definition	Meaning
prosthesis schedule	The prosthesis schedule is a list, as approved by **us** of metal ware, and / or artificial devices that replace or augment (support) missing or impaired body parts.
recognised provider	A **health service provider**, **registered specialist**, **approved private hospital** or other medical facility that is recognised by **us**.
registered nurse	Any person who holds a current practising certificate issued by the Nursing Council of New Zealand.
registered specialist	A medical practitioner who has trained and specialised in a specific branch of medicine. Any specialist who is a member of an appropriately recognised specialist college and has Medical Council of New Zealand vocational registration in that speciality. For the purposes of this definition it will not include those holding vocational registration for accident and medical practice, emergency medicine, family planning and reproductive health, general practice, medical administration, public health medicine or sports medicine.
renewal certificate	The most recent document entitled 'Renewal Certificate' forwarded to **you** by **us** in relation to this policy.
stand-down period	Period of time after the **commencement date**, **effective date** or the **join date** where an **insured person** is added to this policy, for which no claim will be paid for anything that happens during this period.

Definition	Meaning
sum insured	The total dollar value covered under the Serious Condition Lump Sum Option, as shown on the **acceptance certificate** or **renewal certificate** for an **insured person** covered by the lump sum benefit, and determined by **us**.
surgery, surgical or surgeries	An operation performed under an anaesthetic (general, intravenous sedation, local or spinal) requiring a surgical incision to remove or repair damaged or diseased tissue. This does not include **injections** of any type.
surgical cost grouping	The overall cost for **registered specialist**, anaesthetist and any **prosthesis** (if applicable) for a health service.
surveillance testing or screening	A **diagnostic investigation** or procedure that is undertaken where there are no signs or symptoms that a medical condition is present.
troponin	Protein specific to the heart muscle cell.
usual occupation	The occupation in which the **insured person** was engaged and from which he or she was deriving income at the time of diagnosis of the **Trauma Condition**.
vocational GP	A **GP** with a relevant, post-graduate qualification in the health service they are providing, as recognised by **us**.
we, our and us	nib nz limited.

Definition	Meaning
whole person functions	A criteria based on the current edition of the American Medical Association publication entitled 'Guides to the Evaluation of Permanent Impairment' until similar means of measurement have been established by the New Zealand or Australian medical associations that are acceptable to **us**.
you and your	The **policyowner**.

The dates shown in your acceptance certificate or renewal certificate have the following definitions applied.

Definition	Meaning
group anniversary date	The date the premiums for the group are reviewed. The first group anniversary date will be 12 months after the start date of the group scheme and at each 12-month period thereafter.
review date	The review date is each 12-month period from the date shown in the **acceptance certificate** or **renewal certificate**. The review date is also the date on which Benefits and premiums would normally be reviewed and where necessary changed by **us**. Reviews would generally occur at each 12-month period after this date.

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Premier Health Business™ Policy document

Need help?

Talk to your financial adviser
Call us on **0800 287 642**
Mon to Fri: 8.00am - 5.30pm
Go to **nib.co.nz**
Email us at grouphealth@nib.co.nz
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