Personal Cover - Superior Health Cover

SECTION A - GENERAL INFORMATION AND DEFINED TERMS

POLICY PURPOSE **1** **Your** Superior Health Cover plan is a major medical policy designed to assist **You** with meeting the financial costs associated with the health services covered by this plan.

POLICY **2** The terms of **Your** Superior Health Cover plan with **Us** are set out in this **Policy** and the attached **Policy Schedule**, complete with any endorsements. The **Policy Schedule** includes personal details of the people insured and may include special terms of **Your** contract. This **Policy** is a contract of insurance between **You** and **Us**. It includes the following parts:

- **Your** application for insurance; and
- this **Policy** wording; and
- the **Policy Schedule**; and
- any addendum to the **Policy Schedule**; and
- any other written notice that **We** give **You**; and
- any written notice that **You** give **Us**.

PREMIUM RATES AND TERMS OF THIS POLICY **3** We may change the premium rates, terms and conditions of this **Policy** at any time by giving **You** thirty (30) days written notice to **Your** last known postal address advising **You** of such changes.

POLICY FEE **4** **We** will charge **You** a policy fee, which forms part of **Your Total Premium.** The policy fee is used to pay the ongoing administration costs of this **Policy.** The policy fee is specified in **Your Policy Schedule. We** may change this policy fee from time to time. If this occurs any such change will be notified to **You** in writing.

The annual **Total Premium** or instalment of the **Total Premium** is payable for the entire life of the **Policy** together with any increases in **Premium** applicable where an additional benefit or amendment to the **Policy** has been effected or selected.

PRIOR APPROVAL **5** **We** strongly recommend that **You** seek prior approval for any claim to ensure that the medical treatment or procedure is covered under the terms and conditions of **Your** Superior Health Cover plan. **We** recommend **You** contact **Us** as soon as possible to start this process. **We** can be contacted on 0800 800 242. In order for a claim to be paid where **We** have provided **You** with pre-approval advice, **Your** policy must be in force on the date **You** have the medical treatment or procedure for which **We** have pre-approved.

SECOND OPINION **6** **We** reserve the right to seek a second medical opinion in certain circumstances. All costs related to a second medical opinion will be paid for by **Us**. **We** require **You** to comply with any reasonable requests **We** or **Our** medical examiner may make including attending any examinations or tests.

FREE LOOK PERIOD **7** To enable **You** to consider the **Policy** in detail **You** will have a free look period of fourteen (14) days after **You** receive **Your Policy** terms and conditions document. During this period, if **You** decide that the **Policy** does not suit **Your** needs, then **You** may return it to **Us** and receive a full refund of all **Total Premiums** paid and the **Policy** will be cancelled. **You** will be deemed to have received **Your** policy document three (3) business days after it was posted by **Us**.

CODE OF PRACTICE

8 The Superior Health Cover plan complies with the Health Funds Association of New Zealand (Inc) Code of Practice for Health Insurance Underwriters.

DEFINED TERMS

9 In this **Policy** certain words have particular meanings. These words are in **Bold** and the meanings set out below.

Interpretation
Throughout this **Policy** '**We', 'Our' 'Us'** or '**AIA New Zealand**' means AIA International Limited - New Zealand Branch, and/or any related and/or authorised companies and/or agents (including company officers acting in the scope of their authority). '**You**' or '**Your**' means the **Lives Assured**.

ACC
Means the Accident Compensation Corporation as defined by the Injury Prevention, Rehabilitation and Compensation Insurance Act 2001, or its successor under any subsequent legislation.

Allowance
Contribution toward the cost of treatment specified.

Annual Excess
The amount shown on the **Policy Schedule** which **We** do not pay. It is the amount **You** pay. (**Note:** An excess of $100 per **Life Assured** per claim automatically applies for the first two (2) years from the **Policy Commencement Date** to the Additional Specialists Visits and Diagnostics Procedures Benefit).

Annual Renewal Date
Means the annual anniversary of the **Policy Commencement Date**.

Audiologists
Means a practising member of the New Zealand Audiological Society.

Cancer Immunotherapy
Means immunotherapy for the proven treatment of cancer which stimulates or restores the ability of the immune (defense) system to fight this disease.

Cancer Immunotherapy Medicines
Means **PHARMAC** or **Non PHARMAC** medicines for the proven treatment of cancer which stimulate or restore the ability of the immune (defence) system to fight this disease.

Cancer Targeted Therapies
Means targeted therapies which interfere with specific molecular targets on cancer cells to inhibit their growth, progression and spread.

Care Provider
An employee whether indirectly or directly employed by the **Private** or **Public Hospital**.

Chemotherapy Medicines
Means **PHARMAC** and **non PHARMAC** medicines that have been registered by **Medsafe,** and are used according to **Medsafe** indications.

Child or Children
Any person under the age of twenty-one (21) who, in **Our** opinion, is financially dependent on, and may be under the legal guardianship of **You** or **Your** spouse or partner.

Chiropractor
Means a person registered as a **Chiropractor** with the Chiropractic Board of New Zealand and who holds a current Annual Practising Certificate.

Congenital
Means a condition present at birth acquired by hereditary or genetic origin, or acquired during foetal life.

Day Stay Clinic or Facility
Means a healthcare facility (usually involving an operating theatre) where a patient has been admitted for a planned clinical intervention and/or **Diagnostic Procedure** by a **Specialist**, or at **Our** discretion a **General Practitioner**, and the patient leaves the facility within twenty-four (24) hours.

Dentist
Means a person registered with the Dental Council of New Zealand and who holds a current Annual Practising Certificate.

Diagnostic Procedures
Investigative medical procedures undertaken by a **Specialist** to determine the causes of a condition.

General Practitioner
Means a person who holds a current practising certificate issued by the Medical Council of New Zealand and is practising **Primary Care** medicine but excluding a **General Practitioner** who is himself/herself the **Life Assured**, the spouse, civil union partner, de facto partner, lineal relative, or business partner/associate of **You**.

Hospice
Means a healthcare facility providing palliative care services for terminally ill patients that holds regular or associate service membership with Hospice New Zealand.

Insured Person
Means a person specified as an **Insured Person** in **Your Policy Schedule**.

Lead Maternity Carer
All pregnant women in New Zealand are required to choose a **Lead Maternity Carer** (LMC) to coordinate the care they will receive throughout their pregnancy, labour, and birth, up to 4-6 weeks after the baby is born. **Your** LMC can be a midwife, a **General Practitioner**, a hospital-based team, or an obstetrician.

Life Assured
Means the **Life Assured** or **Lives Assured** listed in **Your Policy Schedule**.

Medical Practitioner
Means a person who holds a current practising certificate and fellowship issued by the Medical Council of New Zealand and who has qualified in an approved surgical, anaesthetic or non-surgical discipline.

Medsafe
Means the New Zealand Medicines and Medical Devices Safety Authority. **Medsafe** is responsible for the regulation of medicines and medical devices in New Zealand.

Minor Surgery
Specific surgery deemed as minor by **Us**.

Non PHARMAC
Means medicines that have been registered by **Medsafe**, and are used according to **Medsafe** indications, but are not funded by **PHARMAC** for use in a private facility.

Nurse
A registered or enrolled **Nurse** except a spouse, lineal relative or business partner/associate of **You** who holds a current Annual Practising Certificate issued by the Nursing Council of New Zealand.

Oral Surgeon
Means a person registered with the Dental Council of New Zealand and who holds an Annual Practising Certificate and is qualified to perform surgery.

Oral and Maxillofacial Surgeon
Means a person registered with the Dental Council of New Zealand and who holds an Annual Practising Certificate qualified in this surgical specialty.

Osteopath
Means a person registered as an **Osteopath** with the Osteopathic Council of New Zealand and who holds a current Annual Practising Certificate.

PHARMAC
Means the Pharmaceutical Management Agency, the New Zealand government agency that decides which pharmaceuticals to publicly fund.

Physiotherapist
Means a person registered as a **Physiotherapist** with the Physiotherapy Board of New Zealand and who holds a current Annual Practising Certificate.

Policy
Means this contract of insurance between **You** and **Us**. It includes the following parts:

- **Your** application for insurance; and
- this **Policy** wording; and
- the **Policy Schedule**; and
- any addendum to the **Policy Schedule**; and
- any other written notice that **We** give **You**; and
- any written notice that **You** give **Us**.

Policy Commencement Date
Means the **Commencement Date** of the **Policy** as specified in **Your Policy Schedule**.

Policy Schedule
Means the most recent **Policy Schedule** issued to **You** by **Us**, including any endorsements.

Policy Year
Means the twelve (12) month period which starts from the **Policy Commencement Date** and ends on the **First Anniversary Date**. Each subsequent **Policy Year** is from **Policy Anniversary Date** to **Policy Anniversary Date**.

Premium
Means the **Premium** specified in **Your Policy Schedule** or in any subsequent notice issued to **You** by **Us**.

Preventative and Routine Screening
A diagnostic investigation or procedure undertaken when the **Life Assured** has no symptoms and is undertaken as a preventative measure to screen for early detection of diseases.

Primary Care
Means day-to-day medical services provided by a **General Practitioner**.

Private Hospital
A privately owned hospital approved by **Us** which is licensed as a **Private Hospital** in accordance with the Health and Disability Services (Safety) Act 2001.

Public Hospital
A hospital service or institution licensed in accordance with the Health and Disability Services (Safety) Act 2001 directly or indirectly owned or funded by the New Zealand Government or any of its agencies.

Related Surgery
A subsequent surgery performed within 3 months of an initial surgery for the purpose of treating the same medical condition, where the **Life Assured** has had an accepted Private Hospital Surgical Benefit claim and paid any applicable **Annual Excess**. For example, if surgeries are staggered on the advice of an appropriate specialist for best medical practice.

Specialist(s)
A **Medical Practitioner** qualified in a specialist field of medical or surgical practice and who is currently vocationally registered as a specialist in that field with the New Zealand Medical Council.

Top-up
Additional coverage to supplement New Zealand Government, **ACC** or other Insurers contributions to Overseas Treatment.

Total Premium
Means the sum of the **Premium** and the policy fee together with any applicable GST as specified in **Your Policy Schedule**.

Usual, Customary and Reasonable
Charges and fees that are based on **Our** estimate of what are **Usual, Customary and Reasonable** charges and fees for services provided under similar circumstances by persons or providers with equivalent experience or qualification.

SECTION B - SUPERIOR HEALTH COVER BENEFITS FEATURES

PRIVATE HOSPITAL - SURGICAL BENEFITS

1 **We** will reimburse **You** for the **Usual, Customary and Reasonable** expenses incurred for surgery in a registered **Private Hospital** in New Zealand, where **You** have been admitted upon referral by a **Specialist**, subject to a maximum for all related costs of $200,000 per **Life Assured**, per **Policy Year**. Any applicable excess is payable by **You** to the treatment provider.

Expenses **We** will reimburse in accordance with the terms above, include:

- Surgeon and Anaesthetist's fees
- Theatre fees
- Post-operative and ancillary charges
- Perfusionist fees
- High Dependency Unit charges
- Nursing fees
- Prosthesis (subject to the schedule of maximums)
- Accommodation fees in a **Private Hospital**
- Prescription drugs including:
  - Drugs listed on the New Zealand Pharmaceutical Management Agency (**PHARMAC**) Pharmaceutical Schedule and/or
  - **Non PHARMAC** subsidised **Medsafe** indicated **Chemotherapy Medicines** for the treatment of cancer administered to **You** while **You** are in a **Private Hospital** or prescribed upon **Your** immediate discharge from a **Private Hospital** for a maximum period of one (1) month.

  The drugs must be listed on the **PHARMAC** Pharmaceutical Schedule and/or be **Medsafe** indicated as being approved for the condition being treated, taking into account any restrictions where applicable.
- **Diagnostic Procedures** and **Specialist** consultations during the twelve (12) months period prior to or after surgery provided they relate to the condition being treated and they have been recommended by a **Specialist**.

PRIVATE HOSPITAL - NON-SURGICAL BENEFITS

2 **We** will reimburse **You** for the **Usual, Customary and Reasonable** expenses incurred for ailments not requiring surgery, where **You** have been admitted to a **Private Hospital** in New Zealand upon referral by a **Specialist**, subject to a maximum of $100,000 per **Life Assured**, per **Policy Year** for:

- **Private Hospital** or approved **Day Stay Clinic or Facility** charges for **Chemotherapy Medicines** for the treatment of cancer, Radiotherapy, **Cancer Immunotherapy Medicines** or **Cancer Targeted Therapies.** Treatment can be administered by oral, intravenous infusion, instillation, or intraoperative means. Oral treatment for Chemotherapy, **Cancer Immunotherapy** and **Cancer Targeted Therapies** where referred by a **Specialist** that does not require admission to a **Private Hospital** or **Day Stay Clinic or Facility,** will also be covered.

Treatment is covered for prescription drugs including:

- Drugs listed on the **PHARMAC** Pharmaceutical Schedule and/or
- **Non PHARMAC** subsidised **Medsafe Chemotherapy Medicines** for the treatment of cancer.

The drugs must be listed on the **PHARMAC** Pharmaceutical Schedule as being approved for the condition being treated and/or must be

Medsafe indicated for the condition being treated, taking into account any restrictions where applicable.

- Cardiologist's fees and Angiography related charges.
- Accommodation fees in a **Private Hospital**.
- Prescription drugs including:
  - Drugs listed on the **PHARMAC** Pharmaceutical Schedule and/or
  - **Non PHARMAC** subsidised **Medsafe** indicated **Chemotherapy Medicines** for the treatment of cancer

  administered to **You** while **You** are in a **Private Hospital**. The drugs must be listed on the **PHARMAC** Pharmaceutical Schedule as being approved for the condition being treated and/or must be **Medsafe** indicated for the condition being treated, taking into account any restrictions where applicable.

- **Diagnostic Procedures** and **Specialist** consultations provided they relate to the condition being treated and that they occur within the six (6) month period prior to or after admission to a **Private Hospital** and they have been recommended by a **Specialist**.

Any applicable excess is payable by **You** to the treatment provider.

SPECIFIC DIAGNOSTICS BENEFIT

3 **We** will reimburse **You** for the cost of the following specific **Diagnostic Procedures** if they have been recommended by a **Specialist** or **General Practitioner**, even if they do not lead to treatment in a **Private Hospital**, up to $125,000 per **Life Assured** per **Policy Year** for:

- CT scan
- MRI scan
- Angiogram
- Colposcopy (if carried out under a general anaesthetic)
- Cystoscopy (if carried out under a general anaesthetic)
- Myelogram (if carried out under a general anaesthetic)
- Gastroscopy
- Colonoscopy
- Hysteroscopy
- Laparoscopy

Changes in technology in the future may see other major **Diagnostic Procedures** being introduced which involve significant expense. **We** may from time to time and at **Our** discretion, consider reimbursing the cost of such procedures. Any applicable excess is payable by **You** to the treatment provider.

ORAL SURGERY

4 **We** will cover the costs of the surgical removal of wisdom teeth carried out on **You** by an **Oral Surgeon** or **Oral and Maxillofacial Surgeon** after **You** have been referred by a **General Practitioner** or **Dentist**, up to $200,000 per **Policy Year**. The wisdom teeth must be totally impacted and totally unerupted, or totally impacted and partially unerupted. Any applicable excess is payable by **You** to the treatment provider.

We do not cover any other dental treatments including, but not limited to, periodontal surgery, orthodontal, endodontal or prosthodontal surgery, or implant prosthesis, check-ups, fillings, caps, repair of broken teeth, cost of gold, titanium or other exotic materials.

SECTION C - SUPERIOR HEALTH COVER BENEFITS

HOME NURSING

1 **We** will cover the costs of home nursing care provided by a **Nurse** within a six (6) month period after **Private Hospitalisation** and on referral from **Your** treating **Specialist** or **General Practitioner** up to $150 per day, up to $6,000 per **Life Assured**, per **Policy Year**. No excess applies.

A **Specialist's** or **General Practitioner's** Certificate must be forwarded to **Us** stating the reason why home nursing care is required and the length of time it is required. The home nursing care must relate to the condition(s) treated in the **Private Hospital**.

POST-OPERATIVE PHYSIOTHERAPY, CHIROPRACTIC OR OSTEOPATHIC TREATMENT

2 **We** will cover the costs of post-operative physiotherapy, chiropractic or osteopathic treatment by a **Physiotherapist**, **Chiropractor** or **Osteopath** required within a six (6) month period of leaving a **Private Hospital** on referral from **Your Specialist**, or **General Practitioner** up to $1,000 per **Life Assured**, per **Policy Year**. No excess applies. Treatment undertaken must relate to the condition(s) treated in the **Private Hospital**.

TRAVEL BENEFIT

3 For treatment not available in a **Private Hospital** in **Your** immediate area, which requires at least one (1) overnight stay, **We** will pay for return economy air travel, road transport or road ambulance within New Zealand to the nearest **Private Hospital** for **You** and one (1) support person, up to $3,000 per claim. No excess applies. Treatment must be recommended by a **Specialist** or **General Practitioner**.

The Travel Benefit does not apply to the cost of air travel to or from the Chatham Islands or any other New Zealand Territorial Islands.

ACCOMMODATION BENEFIT

4 For treatment not available in a **Private Hospital** in **Your** immediate area, which requires at least one (1) overnight stay, **We** will pay for accommodation for **You** and one (1) support person to accompany **You** to the maximum of $200 per night (total amount of accommodation for both **You** and **Your** support person), with a maximum of $3,000 per claim.

Accommodation costs for **You** and the support person must directly relate to the hospitalisation of the **Life Assured**. No excess applies.

OVERSEAS TREATMENT GRANT

5 Covers treatment at an overseas hospital where such treatment cannot be provided in New Zealand. This benefit provides **Top-Up** cover for reasonable return economy travel costs of the person requiring treatment plus the costs of the treatment, less the amount payable by the New Zealand Government up to a maximum of $25,000 per **Life Assured** per **Policy Year**. **You** must provide evidence of the New Zealand Government's acceptance to partially fund the treatment and the amount they are willing to pay.

Such treatment must be recommended by a **Specialist** or **General Practitioner** and be recognised by **Us** as being a conventional form of treatment. No excess applies.

MEDICAL MISADVENTURE BENEFIT

6 If, during the course of any medical procedure or treatment in a **Public** or **Private Hospital**, **You** should die directly as a consequence of any erroneous or negligent action, omission or failure to observe reasonable and customary standards by a **Care Provider** of the said Hospital, a death benefit shall become payable, provided:

- the death occurs within thirty (30) days of such recorded and proven incident; and
- a public admission of such incident and liability is made by the said Hospital and verified and confirmed by the relevant government authority, a court of law, coroner's inquest or the Medical Council; and
- the death is independent of any other cause other than the termination of life support system after brain death has been established.

The maximum death benefit is $30,000 per **Life Assured**. No excess will apply.

COVER WHILE IN AUSTRALIA

7 **Your** cover will continue while **You** or any **Insured Persons** on the **Policy** are residing in Australia up to a maximum of twenty-four (24) months provided **Total Premiums** continue to be paid. The maximum amount payable for any claim covered under the **Policy** while in Australia will be up to 50% of the stated maximums in this **Policy**, paid in New Zealand currency.

For the purpose of this clause the definition of Resident/Residing in Australia is as follows:
"Continuously living in a fixed abode in Australia for a period of greater than four weeks (28 days) as distinguished from a visitor or transient."
We may request that **You** provide evidence satisfactory to **Us** to establish that **You** are residing in Australia.

SPECIALIST MINOR SURGERY

8 **We** will cover the costs of **Minor Surgery** performed by a **General Practitioner** not performed under a general anaesthetic. The maximum amount payable per **Life Assured**, per **Policy Year** is $1,000. No excess applies.

COMPLICATIONS OF PREGNANCY OR CHILDBIRTH

9 **We** will pay up to $2,000 per **Policy** to cover the costs of treatment recommended by the **Lead Maternity Carer** or Obstetrician resulting from diagnosis of a medical condition that is affecting or may affect the pregnancy, labour or birth. Diagnosis must be made within sixty (60) days of the expected delivery date. No coverage is available for any condition arising post birth. Caesarean Sections are specifically excluded. No excess applies.

FUNERAL BENEFIT

10 A payment of $3,500 will be paid if **You**, **Your** spouse or partner (being insured under the **Policy**) dies before turning age sixty-five (65). The payment will be paid to the **Policy** owner or survivors of them or the estate. This benefit will be void and **We** shall not be liable to pay if the **Life Assured**, whether sane or insane, dies by his or her own hand.

WAIVER OF PREMIUM

11 If **You** die before sixty-five (65) years of age **We** will continue to provide Superior Health Cover and waive the **Total Premium** for the insured surviving partner and insured **Children** on this **Policy** for up to two (2) years or until the insured surviving partner reaches the age of sixty-five (65), whichever occurs first.

PUBLIC HOSPITAL CASH BENEFIT

12 If **You** are admitted to a **Public Hospital** for three (3) or more consecutive nights, **You** will receive $200 for the fourth and each subsequent night, up to a maximum of ten (10) nights. The maximum amount payable per **Life Assured**, per **Policy Year** is $2,000. The **Public Hospital** cash benefit does not apply to any admission as a fee paying patient in a **Public Hospital**, maternity care or admission due to an accident. No excess applies.

HOSPICE COVER

13 If **You** are admitted to a **Hospice** for three (3) or more consecutive nights, **You** will receive $100 for the fourth and each subsequent night, up to a maximum of ten (10) nights. The maximum amount payable per **Life Assured**, per **Policy Year** is $2,000. No excess applies.

HEALTH FUNDING AUTHORITIES - FEE PAYING PATIENTS IN A PUBLIC HOSPITAL

14 **We** will cover treatment carried out in a **Public Hospital** up to the limits specified under **Your Policy**, provided **We** have given **Our** approval and the Private Involvement Protocols (or any replacement protocols) set by the Ministry of Health for the treatment of private patients in **Public Hospitals** have been followed.

EXCESS WAIVER BENEFIT

15 If **You** suffer one (1) or more of the Trauma conditions listed below and as a result are admitted to a **Private Hospital** or admitted as a fee paying patient to a **Public Hospital**, **We** will waive the excess selected (if any).

The Trauma conditions are:

1. Heart Attack
2. Stroke
3. Coronary Artery Bypass Surgery
4. Critical Cancer.

Diagnosis must be made in writing by a **Specialist**, to **Us** and be based upon radiological, clinical, histological or laboratory evidence acceptable to **Us**.

Trauma conditions defined as:

1 HEART ATTACK

Heart Attack means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The basis for **Diagnosis** of a heart attack will be:

- Confirmatory new electrocardiogram (ECG) changes indicative of ischaemia; and
- A diagnostic rise and fall (other than as a result of cardiac or coronary intervention) in either:
    1. Troponin I in excess on 2.0ug/L; or
    2. Troponin T in excess on 0.6ug/L.

In addition, if the above criteria are not met, **We** will pay a claim based on evidence satisfactory to **Us** that **You** have been **Diagnosed** as having suffered a myocardial infarction resulting in:

- A permanent reduction in the left ventricular ejection fraction to less than 50%, which is the result of the death of a portion of the heart muscle. For the purpose of this policy, the assessment of the ejection fraction should be made at least ninety (90) days after the event that lead to the **Diagnosis** of a heart attack.

2 STROKE

Stroke (resulting in functional loss) means any cerebrovascular accident or incident producing permanent neurological deficit causing either:

- **You** to suffer at least 25% permanent impairment of *whole person function^;* or
- **You** to be constantly and permanently unable to perform at least two (2) of the numbered activities of daily living without the physical assistance of someone else (if **You** can perform the activity on **Your** own by using special equipment, **We** will not treat **You** as unable to perform that activity).

This requires clear evidence on a CT, MRI or similar scan that a stroke has occurred and evidence of:

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

Cerebral symptoms due to transient ischaemic attacks, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye or optic nerve or vestibular functions are excluded.

^as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th Edition.

3 CORONARY ARTERY BYPASS SURGERY

Coronary Artery Bypass Surgery means the actual undergoing of surgery to correct the narrowing or blockage of one (1) or more coronary arteries with bypass grafts for the first time, due to disease of those arteries. The operation must be considered necessary by a Specialist Cardiologist. Non-surgical techniques such as **Angioplasty**, catheter based techniques, laser or other intra-arterial procedures are excluded.

4 CRITICAL CANCER

Critical Cancer means the presence of one (1) or more malignant tumours, characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue, provided the **Diagnosis** is unequivocal as confirmed by histopathology.

This includes leukaemia, lymphomas, Hodgkin's disease, malignant bone marrow disorders but excludes the following:

- Malignant Melanoma less than 1.5 mm maximum thickness as determined by histological examination based on Breslow thickness and Malignant Melanoma less than Clark Level 3.
- A growth histologically described as Carcinoma-in-Situ.
- All hyperkeratosis or basal cell carcinomas of the skin.
- All squamous cell carcinomas of the skin unless there has been spread to other organs.
- Kaposis Sarcoma and other cancers which are directly attributed to AIDS and HIV infections.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least a clinical TNM classification T2N0M0 as defined by AJCC 6th Edition 2002.
- Tumours treated by endoscopic procedures alone.
- **We** will allow cover for carcinoma-in-situ of the breast where it results in the entire removal of the breast specifically to arrest the spread of malignancy. This procedure must be the appropriate and necessary treatment.

EXCESS WAIVER LOYALTY BENEFIT **16** This benefit is included with the optional Specialists Visits and Diagnostics Procedures benefit. The $100 excess per **Life Assured** per claim form submitted will no longer apply after **You** have had continuous cover in place for two (2) years from the **Policy Commencement Date.**

STERILISATION LOYALTY BENEFIT **17** This benefit is included with the optional Specialists Visits and Diagnostics Procedures benefit. The Sterilisation Loyalty Benefit applies after **You** have had continuous cover in place for two (2) years from the **Policy Commencement Date**. It specifically covers vasectomies and tubal ligation procedures, excluding reversals. Vasectomies carried out by a **General Practitioner** will be covered. Prior approval must be obtained in writing from **Us** prior to incurring any costs.

BILATERAL BREAST REDUCTION / BARIATRIC SURGERY ALLOWANCE **18** **We** will provide a combined **Allowance** of up to $7,500 per **Life Assured** over the lifetime of the **Policy** after three (3) years of continuous cover towards the costs of:

- Bilateral Breast Reduction Surgery
  Bilateral breast reduction surgery including the costs of the related consultations, tests and diagnostic imaging for the **Life Assured**.

  Excludes any surgery to correct any traumatic or post-surgical asymmetry, or to remove breast implants.

- Bariatric Surgery
  Medically necessary sleeve gastrectomy, gastric banding or bypass surgery including the costs of related consultations, tests and diagnostic imaging, where surgery is recommended by a specialist because the **Life Assured** has all of the following:
  - a BMI of:
    a. 40 or more, or
    b. 35 or higher and at least one of the following obesity-related diseases that is expected to be improved:
       - coronary heart disease;
       - type 2 diabetes;
       - obstructive sleep apnoea;
       - osteoarthritis in a weight bearing joint (radiological evidence required); or
       - blood pressure greater than 140/90 that cannot be effectively controlled via medication; and
  - completed physical growth; and
  - previously failed attempts to lose weight.

  Excludes any other type of bariatric surgery, such as banded gastroplasty (stomach stapling).

You must seek prior approval before this **Allowance** is payable.
The maximum amount payable under this **Allowance** is $7,500 per **Life Assured** over the lifetime of the **Policy** across both bilateral breast reduction surgery and bariatric surgery combined. Once this amount has been exhausted no further **Allowance** is payable.

An **Annual Excess** applies.

CONGENITAL CONDITIONS BENEFIT

19 This Congenital Conditions Benefit covers the costs of surgery for any of the following **Congenital** conditions:

- umbilical hernia
- inguinal hernia
- undescended testes
- hydrocele
- tongue tie
- phimosis
- squint

The surgery must be performed in an **Approved Facility** by a **Specialist**, an **Oral and Maxillofacial Surgeon**, or a **Medical Practitioner**.

You must seek prior approval before this Congenital Conditions Benefit is payable.

We will cover up to $2,000 per **Life Assured** over the lifetime of the **Policy**.

No **Annual Excess** applies

SECTION D - OPTIONAL BENEFITS

ADDITIONAL SPECIALIST VISITS AND DIAGNOSTIC PROCEDURES

1 If **Your Policy Schedule** shows that **You** have selected this optional benefit, **We** will reimburse the costs of **Specialist** consultations and **Diagnostic Procedures** if they do not relate to a claim for treatment in a **Private Hospital**. To qualify for reimbursement the procedure or consultation must be recommended by a **Specialist** or **General Practitioner**.

Diagnostic tests covered include, but are not limited to:

- X-rays
- Mammography
- Ultrasound
- Audiology (Performed by **Audiologists**)
- Urodynamic Assessments
- Audiometric Tests
- Laboratory Tests
- Colposcopy (not performed under general anaesthetic)
- Allergy Testing
- Holter Monitoring
- ECG
- EEG
- EMG

But do not include **Preventative and Routine Screening** tests. **We** specifically exclude the payment of costs relating to Hearing Aid equipment.

Specialist consultations with a **Psychiatrist** are covered for an initial assessment of mental health, for the first consultation only. This assessment should include one (1) or more of a review of previous records, a clinical assessment, or a production of a written summary and recommendations. All forms of psychiatric treatment are specifically excluded as set out in Section G “Exclusions”.

We will reimburse **You** for the **Usual, Customary and Reasonable** costs of up to $3,000 per **Policy Year** on each person insured on the **Policy Schedule**.

A $100 excess per **Life Assured** per claim form submitted will apply in all circumstances for the first two (2) years from the **Policy Commencement Date** to the Additional Specialists Visits and Diagnostic Procedures benefit.

OPTIONAL WAIVER OF PREMIUM BENEFIT

2 If **Your Policy Schedule** shows that **You** have selected this Optional Waiver of Premium Benefit, **Total Premiums** will be waived in the event that an adult **Life Assured** meets the definition of disablement as set out below:

The adult **Life Assured** continues, having provided supporting medical evidence acceptable to **Us**, to be totally disabled as a result of bodily injury or illness which commenced during the period of insurance which directly and independently of any other cause, wholly prevents the **Life Assured** from engaging in his/her normal or usual business, occupation or work from which he/she derives remuneration or income, or in any business, occupation or work for which he/she is suited by way of education, training or experience.

The Waiver of Premium Benefit will cease at age sixty-five (65) or when the adult **Life Assured** returns to work, whichever is sooner.

SECTION E - OTHER IMPORTANT INFORMATION GOVERNING THIS POLICY

INJURY PREVENTION, REHABILITATION AND COMPENSATION ACT 2001 (KNOWN AS 'ACC')

1

- Where the **ACC** provides cover for an injury, illness or condition, **You** must obtain approval of the **ACC** for the provision of treatment in a **Private Hospital**; or
- Where the **ACC** approves the claim but declines to pay the costs of surgical treatment. **We** may meet the cost of that treatment when **You** provide **Us**, prior to **Your** treatment, with a copy of the **ACC**'s decision; or
- Where the **ACC** accepts **Your** claim, **We** will provide **Top-Up** payments for the difference between **ACC** reimbursements and **Our Usual, Customary and Reasonable** charges applicable for surgical and medical costs.
- Where the **ACC** declines **Your** claim outright, **We** may require **You** to appeal the **ACC** decision through the documented **ACC** Review Process (www.acc.co.nz/claimscare/resolve-issues/ask-for-a-review) or any subsequent appeal process. All appeals must be made within the **ACC** timeframes of three (3) months post original decision.

SUSPENSION OF COVER

2 **You** can suspend the cover and **Total Premium** payments under this Superior Health **Policy** for a period of between three (3) and twenty-four (24) consecutive months if **You** reside outside of New Zealand for longer than three (3) consecutive months or **You** have been subject to involuntary redundancy provided the **Policy** has been in force for at least twelve (12) consecutive months. **You** must advise **Us** in writing before going overseas and when made redundant. **We** must have confirmed in writing that cover is suspended. The Superior Health **Policy** may not be suspended for less than three (3) consecutive months.

We will resume cover without requiring evidence of health for any **insured person** at the end of the requested period of suspension. Once cover is reinstated, **Total Premiums** must recommence.

We will not pay any benefits under this Superior Health **Policy** in respect of any event, symptom or condition that **You** became aware of, or sought treatment or advice for (whether diagnosed or not) that occurred while cover is suspended.

The total period of time that **Total Premiums** may be suspended under this Superior Health **Policy** is for a period of twenty-four (24) months. If cover for all adult **Lives Assured** has been suspended, cover for any **Children** covered by the Superior Health **Policy** must also be suspended.

ADDITIONAL INSURED PERSONS

3 **You** may extend cover under this **Policy** at any time to include:

- **Your** spouse or partner - subject to health evidence and acceptance by **Us**.
- any **Child** under the age of twenty-one (21) who, in **Our** opinion, is financially dependent on, and under the legal guardianship of **You** or **Your** spouse or partner subject to health evidence and acceptance by **Us**.

If the category of cover specified in the **Policy Schedule** is either 'single parent' or 'family', additional **Children** (as defined above) can be insured under the **Policy** without any increase in **Premiums**. Otherwise, additional **Premiums** may be required.

You may remove any person insured under the **Policy** at a **Premium** due date by written request to **Us** at least thirty (30) days before that date.

Children receive automatic coverage for the first six (6) months after being born, subject to the exclusions specified in the Section G "Exclusions". If **You** require **Your** Child to be covered after this six (6) month period, **You** must advise **Us** of the **Child's** name, sex and date of birth before this free coverage period expires. However all **Children** are subject to an exclusion for Congenital (i.e. present at birth) disorders as specified in the Section G "Exclusions".

After the six (6) month period **Children** will be medically underwritten and the relevant **Premium** will then be charged. However, **Children** will not be covered under **Your Policy** after the age of twenty-one (21).

TRANSFER TO OTHER POLICIES

4 A person who is:

- over the age of twenty-one (21); or
- no longer financially dependent on, or under the legal guardianship of **You** or **Your** spouse or partner, may transfer to their own **Policy** if they make a written application to **Us** within three (3) months of their twenty-first (21st) birthday or the date (as determined by **Us**) that they ceased to be dependent. No health evidence will be required for a person transferring from an existing **Policy** to his or her own **Policy** as long as the person has applied to **Us** and the new **Policy** has been issued within the three (3) month period outlined above. Medical underwriting will be required where the new **Policy** contains additional benefits to that of the original **Policy**.
- **Your** spouse or partner may also transfer to their own **Policy** if they make a written application to **Us** within three (3) months of the date they were removed from the **Policy**. No health evidence will be required for a person transferring from an existing **Policy** to his/her own **Policy** as long as the person has applied to **Us** and the new **Policy** has been issued within the three (3) month period outlined above. Medical underwriting will be required where the new **Policy** contains additional benefits to that of the original **Policy**.

ADDING OPTIONAL BENEFITS

5 Additional Specialist Visits and Diagnostic Procedures.
This optional benefit can be added to **Your Policy** subject to the following:

- A full health statement must be completed and forwarded to **Us**.
- Any increase in **Premium** for the additional benefit will start from the **Policy Commencement Date** of the new benefit.
- **We** do not have to agree to any optional benefit addition unless **We** are satisfied that the **Life Assured** is in good health.

You may remove the optional benefit by giving **Us** thirty (30) days notice in writing.

ANNUAL EXCESS

6 If the **Policy Schedule** shows that **Your Policy** has an **Annual Excess**, **We** will deduct the amount of this excess from any claim that **We** admit under this **Policy** in respect of expense that **You** have undergone during the **Policy Year**, unless:

- the claim is submitted under the optional additional **Specialists** Visits and **Diagnostics Procedures** benefit or specific benefits listed under Section C "What Your Policy Covers - Superior Health Cover Benefits" of this **Policy**.
- **We** have already deducted the **Annual Excess** amount from another claim in respect of treatment undergone during the same **Policy Year** in respect of a person insured under this **Policy**.

- It relates to a **Related Surgery**, in which case it will be waived

You are responsible for paying any **Annual Excess** to treatment providers.

WHEN CAN THIS POLICY END

7 This **Policy** will end when any of the following happens:

- **You** ask **Us** in writing to cancel it.
- **You** fail to pay the **Total Premium** or any **Total Premium** instalment within thirty (30) days after the due date for payment.
- If **We** void **Your** policy from inception as outlined in Clause 8 "Responsibility for Truthfulness" below.

RESPONSIBILITY FOR TRUTHFULNESS

8 When **You** apply for insurance with **AIA New Zealand**, **You** have a legal duty of disclosure to **AIA New Zealand**. This means that:

1. All the statements that **You** make to **AIA New Zealand** (both written and oral) including the answers in:
    a. the application;
    b. any claim made by **You**;
    c. any other communication by **You** with **AIA New Zealand**;

must be true and correct; and

2. **You** must disclose everything that **You** know, or could reasonably be expected to know, that is relevant to **AIA New Zealand** decision whether:
    a. to accept **Your** application for insurance; and
    b. if **AIA New Zealand** accepts **Your** application then on what terms **AIA New Zealand** will accept it and how much it will cost; or
    c. to accept **Your** claim on the insurance policy.
3. This duty of disclosure continues from the time **You** complete the application until either:
    a. the **Policy Commencement Date** or the date **AIA New Zealand** accepts **Your** application for insurance, whichever is later;
    b. **AIA New Zealand** declines or defers **Your** application for insurance.
4. **You** also have the same duty of disclosure to **AIA New Zealand** at the time that **You** extend, vary or reinstate **Your** insurance, and at any time when **You** make a claim on the **Policy** of insurance or otherwise communicate with **AIA New Zealand**.

IMPORTANT

If **You** do not comply with **Your** duty of disclosure, and **AIA New Zealand** would not have accepted **Your** application for insurance on the same terms or at the same premium if **You** had made full disclosure, then **AIA New Zealand** may:

- decline any claim that **You** make; and/or
- alter at any time the terms of any benefits under this **Policy**; and/or
- remove at any time any benefits under this **Policy**; and/or
- void **Your** insurance from inception; and/or
- retain all **Premiums**, policy fees and recover any benefits paid.

If You are not sure whether You are to disclose a particular fact, please ask Us or Your Insurance Adviser.

GST

9 The benefit maximums stated in the **Policy** terms and conditions include Goods and Services Tax (GST) charged by the supplier of the goods or provider of the services.

JURISDICTION AND CURRENCY

10 The laws of New Zealand apply to this **Policy**. The New Zealand courts have exclusive jurisdiction. All monetary amounts referred to in this policy are expressed and payable in New Zealand dollars and include GST.

NOTICES

11 Should **You** write to **Us** about this policy, **You** must send the letter to **Our** head office in New Zealand.

The postal address of **AIA New Zealand's** head office is:
AIA New Zealand
Private Bag 92499
Victoria Street West
Auckland 1142

The street address of **AIA New Zealand**'s head office is:
AIA New Zealand
AIA House
74 Taharoto Road
Takapuna
AUCKLAND 0622

NO SURRENDER VALUE

12 This policy does not participate in the profits of **AIA New Zealand**. **Your Policy** has no surrender value or cash value if it is cancelled.

COMPLAINTS

13 **You** may at any time write to **Us** or to **Your** Insurance Adviser for further information about **Your** policy. **We** have a complaints procedure that is intended to resolve any problem quickly and fairly. If **You** have any questions or complaints about this **Policy** please phone **Us** on **Our** freephone 0800 800 242 or write to **Us** at the above address.

If **You** have been through **Our** internal complaints procedure and the situation has reached a 'deadlock' then **We** will advise **You** of how to contact the Insurance and Savings Ombudsman for further assistance.

SECTION F - PRIOR APPROVAL AND MAKING A CLAIM

PRIOR APPROVAL

1 To have **Your** claim pre-approved:

- Call **Us** on 0800 800 242 for a claim application form or log on to **Our** website **www.aia.co.nz**
- On acceptance of **Your** claim, **We** will send **You** a pre-approval advice. **You** can then forward the Hospital's, Surgeon's or Anaesthetist's account to **Us** and **We** will settle the claim with the service provider directly. Any shortfall in payment, such as any stated excess, is **Your** responsibility. In order for a claim to be paid where **We** have provided **You** with pre-approval advice, **Your Policy** must be in force on the date **You** have the medical treatment or procedure.
- Pre-approval requires five (5) working days to be processed provided all requested information is submitted. Please be aware it may be necessary to request further information before completing assessment of **Your** claim.

CLAIMING AFTER SURGERY OR HOSPITALISATION OR AFTER A DIAGNOSTIC PROCEDURE

2 To claim:

- Call **Us** on 0800 800 242 for a claim form or log on to our website **www.aia.co.nz**
- Once **You** have completed the claim form, return it to **Us** along with the original receipts and invoices (photocopies or duplicates are not acceptable).
- The claim form must be received by **Us** within twelve (12) months of the date of the insured event(s).

Any costs involved in completing the claim form and where appropriate providing an attached medical report (or any additional information **We** may request) will be at **Your** expense. Additional information may be requested by **Us** in order to assess and pay **Your** claim. Please refer to the checklist contained within the claim form to ensure **You** have supplied all of the requirements to **Us**.

If **You** become aware, in respect of any health or medical procedure for which **You** have cover under this **Policy** that there has been a "medical misadventure" (as defined in the Injury Prevention, Rehabilitation and Compensation Act of 2001 or any replacement legislation) then:

You must notify **Us** of that event together with all material details which are known to **You**. Those details must include:

1. the cause of the medical misadventure
2. the names and addresses of the health service providers(s) at fault
3. the level of increased fees caused by the medical misadventure
4. whether **You** have notified **ACC** and, if so, whether **ACC** has accepted cover.

To this extent and where practical **You** must not:

1. pay the fees of any of the negligent health service provider(s)
2. pay the extra fees of the other health service provider(s) without **Our** written consent. If **You** are sued by the health service provider(s) **We** will conduct the defense at **Our** sole cost, but **You** must co-operate fully with **Us** throughout the proceedings.

If **We** have paid any amounts to **You** in respect of health service provider fees for a health or medical procedure which has given rise to

a medical misadventure, then **We** are to be subrogated to all the rights which **You** have to claim against the health service provider(s) for recovery of those fees. **We** will pay all legal costs and related expenses in such recovery proceeding, but **You** must provide all reasonable assistance and co-operation and agree to **Our** use of **Your** name in those proceedings.

Please note for claims while residing in Australia, call collect on +64 9 488 8800.
Please refer to the Claims Form checklist to ensure all relevant information is supplied to Us.

SECTION G - EXCLUSIONS (WHAT YOUR POLICY DOES NOT COVER)

- Ailments wholly or partially attributable to the misuse of alcohol and/or prescription drugs.
- Ailments wholly or partially attributable to the use of non-prescription drugs.
- Any illness, injury or condition caused by or traceable to any medical condition of which **You** were aware or the **Insured Person** was aware, or displayed symptoms of, or for which treatment or medical advice had been sought prior to the **Policy Commencement Date**, which should have been disclosed to **Us** in the application form or by additional correspondence up to the date the **Policy** was issued (as per **Your** Duty of Disclosure outlined in **Our** application form and in this **Policy** document). Any ailment declared on **Your** application form which was not excluded by **Us** on **Your Policy Schedule** will be covered on this plan.
- Acquired immune deficiencies (AIDS) or associated ailments including HIV and related ailments EXCEPT where the virus can be proved, to **Our** satisfaction, to have been acquired by accidental means in the course of the **Life Assured's** normal occupation, or via blood transfusion. Seroconversion to the HIV infection must be demonstrated by testing within six (6) months of the accident. (Any incident giving rise to a potential claim must be reported to **Us** within thirty (30) days of the event causing the claim and supported by a negative HIV antibody test taken from the **Insured Person** after the incident. **We** can independently test the blood samples used and can require additional samples to be taken and tested. Ailments arising from HIV transmission via any form of sexual activity and/or non-prescribed intravenous drug use are excluded.)
- Appliances and or devices, including but not limited to, surgical, medical or dental appliances.
- Bariatric surgery for any condition including but not limited to obesity, diabetes and sleep apnoea, except where coverage is expressly stated in this **Policy**.
- **Congenital** ailments including, but not limited to, complications thereof and or sequelae except where coverage is expressly stated in this **Policy**
- Any form of psychiatric treatment and or psychological treatment including, but not limited to: medical psychotherapy; any form of therapy or counselling; in-patient care in a **Private Hospital** or clinic; prescription or non-prescription drugs.
- Any mental disorder as defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992 (or any subsequent Acts).
- Any geriatric or senile condition or geriatric hospitalisation, and disability support services.
- Any injury or disability as a consequence of war, warlike hostilities, civil war or civil commotion.
- Cosmetic treatment including complications thereof.

- Elective treatment (such as treatment of or for an ailment not materially detrimental to health) including complications thereof.
- Treatment and investigations deemed not medically necessary by **Us**.
- Dental surgery, including, but not limited to periodontal surgery or prosthodontal surgery for implant prosthesis, or check-ups, fillings, caps, repair of broken teeth or orthodontics, except where cover is expressly provided by this **Policy.**
- Infertility, or treatment for it, impotency or treatment for it, sterilisation and contraceptive procedures (except where coverage is expressly stated in Clause 17 under Section C of this **Policy**).
- Breast reduction except where coverage is expressly stated in this **Policy**.
- Laser surgery (for cosmetic purposes).
- Pregnancy, childbirth, abortion or caesarean sections (except where coverage is expressly stated in Clause 9 under Section C of this **Policy**).
- Reversals of sterilisation procedures.
- Intentional self-injury or attempted suicide or suicide.
- Preventative Treatment, mole mapping, **Preventative and Routine Screening** or health surveillance testing (investigative procedure where there is no medical condition/symptoms) unless a medical condition is diagnosed as a result of the investigations and the **Preventative and Routine Screening** is directly related to any **Private Hospital** admission by **Us**.
- Expenses recovered or recoverable from a third party or under any other contract of indemnity or insurance.
- Treatment, expenses incurred outside New Zealand except where coverage is set out under Clause 7 “Cover While in Australia” under Section C of this **Policy**.
- Radial Keratotomy or Photo-refractive Keratectomy or any related complications.
- Spectacles, corrective lenses or surgery for visual errors.
- **General Practitioner** costs.
- Optometrist costs.
- Prescription drugs or charges, excluding medications prescribed upon discharge from a **Private Hospital**.
- Expenses covered by the Injury Prevention, Rehabilitation and Compensation Act 2001 (or any subsequent legislation).
- Where the Ministry of Health has declined the insured free access of the full Public Health Services, **We** will not cover the insured under this **Policy**, as **Our Policy** is designed to complement Ministry of Health and Disability services provided in the Public Sector.
- Any investigation and/or treatment for sleep disturbances, snoring or obstructive sleep apnoea.
- Any services or treatment other than services or treatment relating to a medical ailment treated by a health service provider, and recognised by the Medical Council of New Zealand or the New Zealand Department of Health or equivalent in Australia.
- New medical technologies, treatments or procedures that have not been approved of in writing by **Us**.
- No amount will be paid for charges relating to naturopaths, homeopaths, acupuncturists, podiatrists, herbalists, nutritionists, dieticians or alternative treatment therapists.
- Any treatment for obesity or weight reduction except where coverage is expressly stated in this **Policy**.
- Ancillary **Public or Private Hospital** charges of personal convenience nature.
- Treatment for renal failure.

- Medical certificates for immigration purposes or other purposes.
- Treatment for sclerotherapy (for cosmetic purposes).
- Where the Government (or the local District Health Board) has withdrawn funding for any particular treatment or diagnostic test, **We** will not provide coverage for the costs of the treatment or diagnostic test, or any associated additional administration fees incurred by **You** as a result of the withdrawal of that funding.
- Any other exclusion or endorsement placed upon this **Policy** at time of underwriting or **Policy** issue including any complication related to that exclusion or endorsement.

No reimbursement for expenses will be made where accounts are received after twelve (12) months form the date of the insured event(s).

We reserve the right to claim expenses from any other source, including other insurers, wherever You may have additional coverage in respect to any claim made under this plan.

(INSIGHT 27.0.0 December 2015)

(Updated April 2022)