



Superior Health Cover Benefits Superior 3 Health Cover Benefits

Live Your Life, while we protect your future.

SUPERIOR HEALTH COVER

This is an outline of the features and benefits of Superior Health Cover and Superior 3 Health Cover which must be read in conjunction with the policy document. The policy document contains exclusions and a variety of other important conditions. The terms and conditions of the policy and the premiums charged may be changed at any time on notice. Terms in this brochure (identified with capital letters) have special meanings as defined in the policy document. Please refer to the policy document which is available from your insurance adviser.

SUPERIOR 3 HEALTH COVER

The principal difference between Superior Health and Superior 3 Health is that Superior 3 Health may cover most pre-existing medical conditions after the policy has been in force for 3 years (conditions apply).

MAJOR BENEFITS

Private Hospital - Surgical Benefits

Covers the Usual, Customary and Reasonable expenses incurred for surgery in a registered Private Hospital in New Zealand. Referral from a Specialist is required. The benefit is subject to a maximum for all related costs of \$200,000 per Life Assured, per Policy Year.

Expenses We will reimburse, in accordance with the terms of the Policy, include:

- Surgeon's 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.

OPTIONAL BENEFITS

Additional Specialist Visits and Diagnostic Procedures

This optional benefit reimburses 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
- EEG
- Mammography
- Audiology (Performed by Audiologists)
- Ultrasound
- Holter Monitoring
- Audiometric Tests
- EMG
- ECG
- Urodynamic Assessments
- Colposcopy (if carried out under a general anaesthetic)
- Gastroscopy
- Allergy Testing
- Laboratory Tests

Preventative and Routine Screening tests and costs relating to hearing aid equipment are specifically excluded. This benefit covers the Usual, Customary and Reasonable costs of up to \$3,000 per Policy Year for each Insured Person. A \$100 excess per Life Assured per claim form will apply for the first two years in all circumstances to this benefit.

Specialist consultations with a Psychiatrist are covered for an initial assessment of mental health, for the first consultation only. All forms of psychiatric treatment are specifically excluded.

Optional Waiver of Premium Benefit

This optional waiver of premium benefit waives plan premiums 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 AIG Life, 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 65 or when the adult Life Assured returns to work, whichever is sooner.

WHAT THE 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.
- Congenital ailments including but not limited to complications thereof and or sequelae.
- 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.
- Breast reduction.
- Laser surgery (for cosmetic purposes).
- Pregnancy, childbirth, abortion or caesarean sections (except where coverage is expressly stated in Section Nine of this policy document).
- Reversals of sterilisation procedures.
- Intentional self-injury or attempted suicide or suicide.

WHAT THE POLICY DOES NOT COVER (CONTINUED)

- 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 Seven (7) "Cover While in Australia" under Section C of this Policy.
- 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.
- 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 up to 18 months after the date of the last related Public or Private Hospital discharge.

What the policy does not cover - Superior 3 Health Cover

In addition to the exclusions listed prior, the following additional exclusion applies to Superior 3 Health Cover.

- If anything happens which arises from, or which is traceable, or medically related to, any pre-existing condition within the first 3 years from the commencement date of Your Policy, We will not pay the resulting claim. For the purpose of this clause the definition of a pre-existing condition is any illness, injury or medical condition:
 - of which You or the Insured Person(s) were aware; or
 - for which You or the Insured Person(s) had a direct indication that something was wrong; or
 - for which You or the Insured Person(s) sought treatment or medical advice on or before the Policy Commencement Date.

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.

DISCLAIMER: This SHOULD NOT be regarded as a full explanation of the contract. It is collateral material and is not the policy. Please refer to the terms and conditions of the policy document for full details of the contract and the limitations and exclusions that apply. All applications are subject to individual consideration. Special terms, exclusions and premium loading may apply to individual applications.

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- Prescription drugs listed on the New Zealand Pharmaceutical Management Agency (PHARMAC) Pharmaceutical Schedule and 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 month. The drugs must be listed on the PHARMAC Pharmaceutical Schedule as being approved for the condition being treated, taking into account any restrictions where applicable.
- Diagnostic Procedures and Specialist consultations during the six month period prior to or after surgery. Procedures and consultations must relate to the condition being treated and must have been recommended by a Specialist.

Private Hospital - Non-Surgical Benefits

Covers the Usual, Customary and Reasonable expenses incurred for ailments not requiring surgery, after admission to a registered Private Hospital in New Zealand. Referral from a Specialist is required. The benefit is subject to a maximum of \$100,000 per Life Assured, per Policy Year and includes:

- Private Hospital or approved Day Stay Clinic/Facility charges for chemotherapy and radiotherapy. Oral treatment for chemotherapy not requiring admission to a Private Hospital or Day Stay Clinic/Facility will also be covered. Referral from a Specialist is required. The drugs must be listed on the PHARMAC Pharmaceutical Schedule as being approved 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 listed on PHARMAC and administered while in a Private Hospital. The drugs must be listed on the PHARMAC Pharmaceutical Schedule as being approved 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 month period prior to or after admission to a Private Hospital. Recommendation from a Specialist is required.

Specific Diagnostics Benefit

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

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

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.

ANCILLARY BENEFITS

Home Nursing

Covers the costs of home nursing care provided by a Nurse within a six month period after Private Hospitalisation. Referral from the treating Specialist or General Practitioner is required. This benefit provides up to \$150 per day, maximum \$6,000 per Life Assured, per Policy Year. No excess applies.

A Specialist's or General Practitioner's Certificate must be forwarded to AIG Life 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, Osteopathic or Chiropractic Treatment

Covers the costs of post-operative physiotherapy, osteopathic or chiropractic treatment by a Physiotherapist, Osteopath or Chiropractor required within a six month period of leaving a Private Hospital. Referral from a Specialist or General Practitioner is required. This benefit provides 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

Where treatment is not available in a Private Hospital in the immediate area, We will pay for return economy air travel, road transport or road ambulance within New Zealand to the nearest Private Hospital. This benefit covers the Life Assured and one support person. This benefit is limited to \$3,000 per claim. No excess applies. Treatment must be recommended by a Specialist or General Practitioner.

Accommodation Benefit

Where treatment is not available in a Private Hospital in the immediate area, We will pay for accommodation for the Life Assured and one support person. Treatment must require at least one overnight stay. The maximum benefit is \$200 per night (maximum total benefit for both the Life Assured and the support person), with an overall maximum of \$3,000 per claim.

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

Overseas Treatment Grant

Covers treatment at an overseas hospital where such treatment can not be provided in New Zealand. This benefit provides Top-Up cover for the 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. This benefit pays up to a maximum of \$25,000 per Life Assured, per Policy Year. Evidence must be provided of the New Zealand Government's acceptance to partially fund the treatment and the amount they are willing to pay.

The treatment must be recommended by a Specialist or General Practitioner and be recognised by AIG Life as being a conventional form of treatment. No excess applies.

Medical Misadventure Benefit

We will pay a death benefit if, during the course of any medical procedure or treatment in a Public or Private Hospital, the Life Assured should die directly as a consequence of any erroneous or negligent action, or as a consequence of any omission or failure to observe reasonable and customary standards by a Care Provider of the hospital. The payment is made subject to the following:

- The death occurs within 30 days of such recorded and proven incident.
- A public admission of such incident and liability is made by the hospital. This must be verified and confirmed by the relevant government authority, a court of law, coroner's inquest or the Medical Council.
- 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

Your cover will continue while You or any Insured Persons on the Policy are residing in Australia up to a maximum of 24 months provided 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

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 and Childbirth

Pays up to \$2,000 per Policy to cover the costs of treatment resulting from diagnosis of a medical condition that is affecting or may affect the pregnancy, labour or birth. Treatment must be recommended by the Lead Maternity Carer or Obstetrician. Diagnosis must be made within 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

A payment of \$3,500 will be paid if the Life Assured dies before turning age 65. The payment will be paid to the Policy Owner or survivors of them (or the estate). This benefit will then become void. We shall not be liable to pay if the Life Assured, whether sane or insane, dies by his or her own hand within thirteen (13) months after the Policy Commencement Date or the date of last reinstatement of the Policy (if any).

Public Hospital Cash Benefit

On admission to a Public Hospital for three or more consecutive nights, this benefit pays \$200 for the fourth and each subsequent night, up to a maximum of ten 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.

Health Funding Authorities - Fee paying patients in a public hospital

We will cover treatment carried out in a Public Hospital up to the limits specified under the 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.

Hospice Cover

On admission to a Hospice for three or more consecutive nights, we will pay \$100 for the fourth and each subsequent night, up to a maximum of ten nights. The maximum We will pay is \$2,000 per Policy Year.

Waiver of Premium

If the Life Assured dies before 65 years of age We will continue to provide cover and waive the premium for the insured surviving partner and insured Children (if any) on the Policy. This cover will continue for up to two years or until the insured surviving partner reaches the age of 65, whichever occurs first.

Excess Options

Annual excess options available: Nil; \$250; \$500; \$1000; \$2000. We will deduct the selected excess for any claim that we admit under this Policy in respect of expense You have undergone during the Policy Year, unless:

- The claim is submitted under the optional additional Specialist Visits and Diagnostic Procedures Benefit (where a separate excess applies) or specific benefits listed under the Ancillary Benefits section of this Policy (where no excess applies)
- We have already deducted the annual excess amount from another claim in respect of treatment undergone in the same Policy Year in respect of a person assured under this Policy.

Excess Waiver Benefit

If the Life Assured suffers one or more of the trauma conditions listed below and as a result is admitted to a Private Hospital (or as a fee paying patient to a Public Hospital) We will waive the excess selected (if any). The Trauma conditions are:

- Heart Attack
- Stroke
- Coronary Artery Surgery
- Critical Cancer

Diagnosis by a Specialist based upon radiological, clinical, histological or laboratory evidence (acceptable to Us) is required and must be submitted to Us in writing.

Loyalty Benefits

Excess Waiver Loyalty Benefit

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 years from Policy Commencement.

Sterilisation Loyalty Benefit

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 years from Policy Commencement. 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 by Us prior to any costs are incurred.