Product Comparison: AIA Real Health and AIA Private Health

This document is provided for guidance purposes only and is not designed to be relied upon as providing an exhaustive list of the differences between our AIA Real Health Cover and AIA Private Health Cover. It is your responsibility to take the appropriate steps to satisfy yourself that you understand and explain the differences between each policy and how that impacts on the individual circumstances of your client. AIA takes no responsibility for the financial advice you provide to your client in this regard.

	Benefit	Key	Key Difference
1.1	Surgical Benefit & Outpatient Treatment Support		
1.2	Cancer Care		
1.3	Public Hospital cancer treatment cash benefit		
1.4	Palliative, hospice and respite care		AIA Real = $100 per night / $2,000 Lifetime vs AIA Private Health = $1,500 per lifetime.
1.5	Dental Evaluation and Treatment Prior to Qualifying Treatments		AIA Real does not have a specific benefit covering this.
1.6	Mental Health Support		AIA Real = $5,000 per LA per policy year vs AIA Private Health = $2,500 per LA per policy year
1.7	Minor Surgery		
1.8	Medical Hospitalisation		
1.9	Congenital Conditions Surgery		
2.1	Major Diagnostic Imaging and Tests		
2.2	Home Nursing		AIA Real = $150 Day /$6,000 per policy year vs AIA Private Health = $300 Day / $5,000 policy year
2.3	Home Help		AIA Real = up to 7 days up to $500 per LA per policy year. Covers care after cancer treatment & other surgery AIA Private Health = $1,000 per LA per policy year. Only covers care after cancer treatment
2.4	Waiver of Premium on Death		
2.5	Bereavement Grant		
2.6	Parents Grieving Benefit		
2.7	Travel and Accommodation in NZ		AIA Private Health = $3,000 cap applies across both benefits vs AIA Real = $3,000 cap applies to each benefit separately
2.8	Parent Accommodation		
2.9	Ambulance Transfer		
2.10	Voluntary Treatment Overseas		Different clauses. See policy wording for detail.

	Benefit	Key	Key Difference
3.1	Translation Costs		Not available in AIA Real
3.2	Treatment Overseas where waiting period in NZ is longer than Six Months		Not available in AIA Real
3.3	Treatment Overseas Where Treatment Not Available in NZ		AIA Real – no access applies AIA Private Health – Excess applies
3.4	Public Hospital Benefits		
3.5	Sterilisation		AIA Real = two year loyalty benefit. AIA Private Health = one year loyalty benefit. Different payment amounts.
3.6	Pregnancy Complications		
3.7	Medical Misadventure		
3.8	Bariatric Surgery		
3.9	Bilateral Breast Reduction		
3.10	Specialist consultations		
4.1	Diagnostic Imaging & Tests		
4.2	Pregnancy, Maternity, Infertility		
4.3	Critical Cancer Excess Waiver		Not available in AIA Private Health
4.4	Health Screening Allowance		Optional loyalty benefit for AIA Real. AIA Private Health plus only
4.5	Specialist and Tests Excess Waiver		Not available in AIA Private Health
4.6	Non-Pharmac Subsidised Drugs		Clause covered under cancer care benefit in AIA Private Health
4.7	Intravitreal Eye Injections Benefit		Not available in AIA Private Health
4.8	Suspension of Cover		
4.9	Fertility Treatment Loyalty Benefit		Not available in AIA Private Health

Key

Not available in both | Similar with slight difference | Same or very similar cover

	BENEFIT / FEATURE		AIA REAL HEALTH	AIA PRIVATE HEALTH
A.	Eligible ages		Minimum = 0 years; Maximum = 65 years.	Minimum = 0 years; Maximum = 70 years.
B.	Eligible occupations		All	All
C.	Term of cover / Benefit Expiry		99 years.	No expiry.
D.	Excess Options		$0, $250, $500, $750, $1000, $2000, $4000 & $10,000.	$0, $250, $500, $750, $1000, $2000, $4000 & 10,000
E.	Premium Guarantee		1 year	1 year
F.	Premium Options		Community rating: 0 to 20 RFA: 21 to 70	Community rating: 0 to 20 RFA: 21 to 70 Community rating: 71+
G.	Maximum Sum Assured		• Unlimited Surgery (Non cancer) • $500,000 per category for Hospital Medical Benefit & Cancer Treatment – Surgical & Medical • $200,000 Major Diagnostic	• Unlimited Surgery (Cancer and non-cancer) • $500,000 per category for Medical Hospitalisation & Cancer Care • $200,000 Major Diagnostic

1.1	Surgical Benefit		**Coverage:** Unlimited coverage for the following:
			
			Hospital Surgical Benefit (Non Cancer)
			We will reimburse you for the usual, customary and reasonable expenses incurred for surgery in an approved facility in New Zealand, where You have been admitted upon referral by a Registered Medical Specialist or Oral Surgeon for non-cancer treatment. These costs are unlimited. An Annual Excess applies.
			
			Costs for the following is provided under this benefit:
			• Surgeon's fees
			• Anaesthetist's fees
			• Perfusionist's fees
			• Hospital fees including:
			  ○ Accommodation
			  ○ Operating theatre fees
			  ○ Intensive/coronary care unit fees
			  ○ Prostheses
			  ○ Ancillary hospital charges
			• Cardiologist's fees
			• Prescription medicines (including Non PHARMAC funded medicines (excluding chemotherapy) for the Life Assured's stay at an Approved Facility and are administered during their admission for surgery, as well as thirty (30) day's worth of take home approved medicine after their discharge from an approved facility. Conditions apply, refer to the Non-Pharmac Subsidised Drugs Benefit.
			• Diagnostic Procedures and Specialist consultations, performed six (6) months prior and post-surgery, are covered, provided they relate directly to the approved surgery, and have been recommended by a registered medical specialist.
			• Cost of the surgical removal of wisdom teeth (totally impacted and totally un-erupted, or totally impacted and partially un-erupted), performed by a Dentist or Oral or Maxillofacial Surgeon (must be referred by a Dentist). Surgery must be performed in an Approved Facility.
				Coverage: Unlimited coverage for the following:
				
				Surgery Benefit
				
				Covers the costs associated with surgery. Surgery must be performed in an approved facility by a specialist or an oral surgeon.
				The excess applies to any claims under this benefit.
				
				Cover is provided for the following costs:
				
				Inpatient treatment costs:
				• Surgeon's fees
				• Oral surgeon's fees
				• Cardiologist's fees
				• Anaesthetist's fees
				• Perfusionist's fees
				• Radiologist's fees
				• Hospital fees including:
				  ○ Accommodation
				  ○ Operating theatre fees
				  ○ Intensive/coronary care unit fees
				  ○ Ancillary hospital charges
				  ○ Disposable laparoscopic equipment
				  ○ Prostheses

	Outpatient Treatment Support Costs		**Coverage:** Unlimited coverage (within 6 months before or after surgery). **Post-operative Physiotherapy & Occupational Therapy Treatment** We will cover the costs of post-operative physiotherapy and occupational therapy treatment by a physiotherapist or registered occupational therapist for the life assured, where the treatment is required within a six (6) month period of discharge from a private	**Coverage**: Unlimited coverage (within 6 months before or after surgery). **Outpatient Treatment Support Costs** Consultations with a specialist or oral surgeon (including second opinions) and diagnostic imaging and tests referred by a specialist or oral surgeon directly relating to the

			hospital approved facility, and on referral from a registered medical specialist or registered medical practitioner. Treatment must relate to the authorised procedure or treatment. No annual excess applies.	approved surgery, performed within twelve months before or after surgery. Physiotherapy, occupational therapy and prescription costs directly relating to the approved surgery provided within six months after surgery on the recommendation of a specialist or oral surgeon.
1.2	Cancer Care		**Coverage**: Up to $500,000 per life assured per policy year. for usual, customary and reasonable expenses incurred in an approved facility where the life assured has been diagnosed with cancer by a registered medical specialist. An Annual Excess applies. Cancer treatment includes but is not limited to: • Surgery • Oncologist consultations • Diagnostic imaging and tests • Chemotherapy • Radiotherapy • Prostate brachytherapy • Breast Reconstruction approved by us and performed by a registered medical specialist in an approved facility. • Prophylactic mastectomy and/or oophorectomy surgery ('Prophylactic Surgery') where the Life Assured has: o been diagnosed with breast or ovarian cancer; and o where the Prophylactic Surgery is directly related to an acceptable breast or ovarian cancer claim under the Cancer Treatment Benefit - Surgical and Medical Treatments of this policy, or where a claim for breast or ovarian cancer would have been acceptable had the treatment not taken place in a Public Hospital; and o tested positive for the BRCA1 or BRCA2 gene mutation after the Policy Commencement Date. The Prophylactic Surgery does not need to be medically	**Coverage:** Up to $500,000 per life assured per policy year, subject to maximums for specific treatments or procedures. **Costs for the surgical treatment of cancer are covered under the above Surgical benefit, as listed under Inpatient treatment costs and/or Outpatient treatment support costs.** This benefit covers non-surgical cancer treatment costs up to the maximum cover for this benefit of the following treatments, procedures, consultations, tests, diagnostic imaging, support and care once a diagnosis of cancer has been made by a specialist. Except where stated below to the contrary, the excess applies to any claims under this benefit. **Specialist consultations** Consultations with a specialist for treatment or procedures relating to the treatment of cancer. **Diagnostic imaging and tests** Diagnostic imaging and tests and procedures in connection with the detection or treatment of cancer including: > CT, PET/CT and MRI scans > Ultrasounds > X-rays, scintigraphy > Mammography > Colonoscopy > Laboratory tests > Tumour genetic testing

			necessary, but prior approval must be obtained before the surgery takes place. Under no circumstances is a claim payable under this Benefit for Prophylactic Surgery where the Life Assured has an exclusion on this policy for either breast cancer and/or ovarian cancer, or where the Life Assured has an exclusion on this policy for any disease or disorder of the breast and/or female genital tract where this relates to a personal history and/or a family history of breast or ovarian cancer. We may approve additional treatments at our sole discretion. PHARMAC medicines and non PHARMAC chemotherapy medicines (including cancer immunotherapy medicines) are covered in New Zealand, subject to our prior approval, meeting our criteria and benefit maximums. **Coverage:** maximum of five (5) years for a claim that has been paid under this Benefit, per Life Assured per Policy Year, of up to $5000. **Post Cancer Treatment** We will cover post cancer treatments that must be medically necessary treatment and referred by a registered medical specialist. Usual, customary and reasonable costs of such treatments will be covered. This benefit does not cover routine screening.	> Gastrointestinal endoscopy > Cystoscopy > Hysteroscopy > Diagnostic laparoscopy **Chemotherapy/immunotherapy** Chemotherapy and immunotherapy treatment including targeted therapy, oral, intravenous infusion, instilled, and intraoperative chemotherapy provided by or under the direction of a specialist, whether administered in an approved facility or at home. This covers the cost of Pharmac and non-Pharmac subsidised MedSafe indicated cancer chemotherapy and immunotherapy drugs, subject to *AIA criteria*. This also includes the cost of materials, hospital accommodation and ancillary hospital charges. Prior approval must be obtained before the treatment takes place. **Radiotherapy** Radiotherapy treatment provided by a specialist in an approved facility including planning, shielding and accessories, field setup and simulation, subject to AIA criteria. Prior approval must be obtained before the treatment takes place. **Prostate brachytherapy** Implantation of radioactive seeds for the treatment of malignancies of the prostate. **Prophylactic surgery following cancer** Covers the cost of a prophylactic mastectomy and/or oophorectomy where the life assured has: • been diagnosed with breast or ovarian cancer; and • where the prophylactic surgery is directly related to an acceptable breast or ovarian cancer claim under the Surgery or Cancer Care Benefit of this policy, or where a claim for breast or ovarian cancer would have been acceptable had the treatment not taken place in a public hospital; and

				• tested positive for the BRCA1 or BRCA2 gene mutation after the risk commencement date. The surgery does not need to be medically necessary. Prior approval must be obtained before the surgery takes place. Under no circumstances is a claim payable under this benefit where the life assured has an exclusion on this policy for either breast cancer and/or ovarian cancer, or where the life assured has an exclusion on this policy for any disease or disorder of the breast and/or female genital tract where this relates to a personal history and/or family history of breast or ovarian cancer.
				Breast reconstruction following mastectomy . Breast reconstruction: • following a mastectomy for the treatment of diagnosed breast cancer; and/or • following a prophylactic mastectomy which has been covered under the Prophylactic surgery following cancer benefit of this policy; or • where a claim for prophylactic mastectomy would have been acceptable under the Prophylactic surgery following cancer benefit of this policy, had the procedure not taken place in a public hospital. Prior approval must be obtained before the procedure takes place.
				Breast Symmetry surgery following mastectomy Covers costs for procedures on the on the unaffected breast to achieve breast symmetry following a mastectomy of the affected breast. This will be available either during or following a mastectomy to treat diagnosed cancer of the affected breast, which has been covered by your AIA Private Health policy. Procedures covered under this benefit may include breast reduction surgery, but does not include prophylactic mastectomy surgery on the unaffected breast or breast reconstruction following mastectomy. The procedures to achieve breast symmetry do not need to be medically necessary. Prior approval must be obtained before the procedure takes place.

				Coverage: $1,000 per life assured per policy year **Post-cancer treatment care and support** Covers support services following cancer treatment including: > Psychologist consultations, therapy and counselling, > Personal items such as wigs to cover hair loss, bras following a mastectomy, > Lymphatic massage, > Home help services including meal preparation, cleaning, showering and childcare, provided by a suitably qualified person (employed in the provision of home help services). These support services and personal items do not need to be medically necessary. No excess is payable for claims under this benefit.
1.3	Public Hospital cancer treatment cash benefit		**Coverage:** $5,000 per life assured per lifetime **Public Hospital cancer treatment cash benefit** Should the life assured have treatment for cancer in a Public Hospital that would otherwise have been covered by the Cancer Treatment Benefit in this policy, we will pay you a one off lump sum amount of $5,000 per policy lifetime per life assured. Treatment includes cancer surgery (which requires a minimum of one night's hospital stay), chemotherapy or radiotherapy. No annual excess applies.	**Coverage:** $5,000 per life assured per lifetime. **Public Hospital cancer treatment cash benefit** If a life assured has treatment for cancer in a public hospital that would otherwise have been covered by the Cancer Care Benefit in this policy, the public hospital cancer treatment cash benefit will be paid to the policy owner. Treatment includes cancer surgery requiring an overnight stay in a public hospital or a course of chemotherapy and/or radiotherapy. No excess is payable for claims under this benefit.
1.4	Palliative, hospice and respite care		**Coverage:** $100 per night up to a maximum of $2,000 **Hospice Benefit** If you are admitted to a hospice facility, you will receive $100 per night up to a maximum of $2,000. This benefit is payable once per policy per life assured. No annual excess applies.	**Coverage:** $1,500 per life assured per lifetime. **Palliative, hospice and respite care** Covers the costs of palliative, hospice and respite care at an approved facility. No excess is payable for claims under this benefit.
1.5	Dental Evaluation and Treatment Prior to Qualifying Treatments		Not available	**Coverage:** $1,500 per life assured per policy year. **Dental Evaluation and Treatment Prior to Qualifying Treatments**

				Covers dental evaluation and treatment performed by an oral surgeon or a dental practitioner, on the recommendation of the treating *specialist* as a precursor to the following treatments where those treatments are covered by your *AIA* Private Health policy: > Chemotherapy using antiresorptive drugs. > Radiotherapy treatment (head and neck). > Heart valve replacement surgery. Prior approval must be obtained before any dental evaluation or treatment takes place. No *excess* is payable for any claims under this benefit.
1.6	Mental Health		**Coverage:** Up to $5,000 per life assured per policy year. **Mental Health Support Benefit** Covers the cost of a Psychiatrist or Psychologist consultation and Counselling where the support treatments and/or consultations directly relates to a claim under the Hospital Surgical Benefit or the Cancer Treatment Benefit. After referral by the appropriate Registered Medical Specialist and where we deem the support services appropriate we will cover up to $5,000 per life assured per policy year.	**Coverage:** $2,500 per life assured per policy year. **Mental Health Support Benefit** Covers the cost of a Psychiatrist or Psychologist consultation and/or counselling where the support treatment and/or consultations directly relate to a claim under the Surgery or Cancer Care benefits. After referral from a *specialist* the support treatment and/or consultations must be received within six months of your claim being accepted. No excess is payable for any claims under this benefit.
1.7	Minor Surgery		**Coverage:** $3,000 per life assured per policy year. **Minor Surgery Benefit** We will cover the usual, customary and reasonable expenses for approved minor surgery incurred as an outpatient of up to $3,000 per life assured per policy year, where performed by a registered medical practitioner at an approved facility. No Annual Excess applies.	**Coverage:** $3,000 per life assured per policy year. **Minor Surgery Benefit** Covers the cost of minor surgery or treatment at an approved facility. The minor surgery or treatment must be carried out by a general practitioner or under the care of a general practitioner, such as a registered nurse. No excess is payable for any claims under this benefit.

1.8	Medical Hospitalisation		**Coverage:** $500,000 per life assured per policy year **Hospital Medical Benefit (Non-Surgical / Non-Cancer)** We will reimburse you the usual, customary and reasonable expenses incurred should you be admitted to an approved private hospital, upon referral by a registered medical specialist for non-surgical and/or non-cancer treatment. Cover is provided (subject to prior approval by Us) for: • Hospital accommodation fees • Registered Medical Specialist's fees • Diagnostic fees • Ancillary charges An Annual Excess applies.	**Coverage:** $500,000 per life assured per policy year **Medical Hospitalisation** Covers the following costs up to the maximum cover for this benefit of hospitalisation in an approved facility for the treatment of a condition which does not require surgery, when referred by a specialist: > Hospital accommodation fees > Specialist's fees > Diagnostic fees > Ancillary hospital charges Please note that hospitalisation and hospice care costs in relation to cancer are covered under the Cancer care benefit and not this benefit. The excess applies to any claims under this benefit.
1.9	Congenital Conditions Surgery Benefit		**Coverage:** $2,000 per life assured per lifetime of the policy This 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 registered medical specialist, an oral and maxillofacial surgeon, or a registered medical practitioner. You must seek prior approval before this benefit is payable. We will cover up to $2,000 per life assured over the lifetime of this policy. No annual excess applies.	**Coverage:** $2,000 per life assured per lifetime Covers the cost up to the maximum cover for this benefit for 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 or oral surgeon, or by a general practitioner. Prior approval must be obtained before the surgery takes place. The pre-existing conditions exclusion does not apply to the Congenital Conditions Surgery benefit. Subject to the maximum cover for this benefit, more than one claim may be made under this benefit. No excess is payable for any claims under this benefit.
2.1	Major Diagnostic Imaging and Tests		**Coverage:** $200,000 per life assured per policy year. **Major Diagnostic Tests Benefit** Covers the usual, customary and reasonable expenses incurred for specified diagnostic procedures in an approved facility following	**Coverage:** $200,000 per life assured per policy year. **Major Diagnostic Imaging and Tests** Covers the cost up to the maximum cover for this benefit of the following diagnostic tests and imaging at an approved

			recommendation by a registered medical specialist, irrespective of whether surgery or hospitalisation occurs (subject to prior approval by us). An Annual Excess applies. Diagnostic Procedures covered include: • Angiogram • Arthroscopy • Capsule endoscopy • Colonoscopy • CT scan • Cystoscopy • Gastroscopy • Hysteroscopy • Laparoscopy • MRI scan • Myelogram • Myocardial perfusion imaging • PET • Scintigraphy Changes in technology in the future may see other major Diagnostic Procedures being introduced. We may at Our sole discretion, consider reimbursing the cost of such procedures. Routine Health Screening is excluded.	facility when referred by a specialist irrespective of whether surgery occurs: > Angiogram > Arthroscopy > Capsule endoscopy > Colonoscopy > CT scans > Cystoscopy > Gastroscopy > Hysteroscopy > Laparoscopy > MRI scans > Myelogram > Myocardial perfusion imaging > PET/CT > Scintigraphy The *excess* applies to any claims under this benefit.
2.2	Home Nursing		**Coverage:** $150 per day with a maximum benefit payable of $6,000 per policy year. **Home Nursing Benefit Following Cancer Treatment or Surgery** Upon authorisation by us, we will cover the costs of home nursing care provided by a registered nurse up to six (6) months after an authorised medical or surgical procedure. The life assured must have stayed for a minimum of one (1) night in an approved facility. A referral for this service must be made by the treating registered medical specialist or registered medical practitioner. No annual excess applies.	**Coverage:** $300 per day, up to $5,000 per life assured per policy year. **Home Nursing** Covers the cost of home nursing care up to the maximum cover for this benefit where the care is provided by a registered nurse following a surgical or medical procedure covered by this policy, and such care is recommended by a specialist or registered medical practitioner. No excess is payable for any claims under this benefit.
2.3	Home Help		**Coverage:** Up to seven (7) days following discharge from an Approved Facility up to $500 per life assured per policy year.	**Coverage:** $1,000 per life assured per policy year. ***Post-cancer treatment care and support*** …..

			Home Help Allowance Following Cancer Treatment or Surgery Benefit if a claim for cancer treatment or surgery has been accepted by us, which requires at least one (1) night's stay in an approved facility, we will cover the reasonable costs of home help services including meal preparation, cleaning, showering and child care provided by a suitably qualified person (employed in the provision of home help services). Receipts specifying the services provided, dates and fees charged by a suitably qualified provider must be submitted with your claim. This benefit does not apply to any accident related surgery or maternity. No annual excess applies.	> Home help services including meal preparation, cleaning, showering and child care, provided by a suitably qualified person (employed in the provision of home help services). These support services and personal items do not need to be medically necessary. No excess is payable for claims under this benefit.
2.4	Waiver of Premium on Death		**Waiver of Premium** If the policy owner dies, (where the death is not caused by something excluded under this policy), we will waive premiums and continue to provide cover for all surviving lives assureds covered by this policy for a period of up to two (2) years. No annual excess applies.	**Waiver of Premium on Death** Upon the death of a policy owner (where the death is not caused by something excluded under this policy), AIA will provide cover under this policy for the surviving lives assured covered by the policy at the time of death, free of charge for a period of two years. No excess is payable for any claims under this benefit.
2.5	Bereavement Grant		**Coverage:** $3,500 per life assured. **Funeral Benefit** We will pay a funeral benefit if an adult life assured dies before turning age seventy (70), provided the death is not caused by something excluded under this policy. The benefit will be paid to the policy owner/s or to the policy owner/s estate. This benefit is payable once per adult life assured. No annual excess applies.	**Coverage:** $3,500 per life assured per lifetime. **Bereavement Grant** If a life assured dies between the ages of 21 and 70 (inclusive), the bereavement grant will be paid to the policy owner or to the policy owner's estate. No excess is payable for any claims under this benefit.
2.6	Parents Grieving Benefit		**Coverage:** $2,000 per child **Parents Grieving Benefit** If, during the term of this Policy, a life assured's child dies, then we will pay a parents grieving benefit immediately upon receiving written notification of the death of the child subject to the following: • We will only pay one (1) Parents Grieving Benefit per child under this policy irrespective of how many lives assured are under this policy, or any other policy containing the Parents Grieving Benefit. • This Parents Grieving Benefit ceases when the child reaches age twenty one (21).	**Coverage:** $2,000 per child **Parents Grieving Benefit** If a child of a life assured dies before the age of 21, the Parents Grieving Benefit will be paid to the policy owner. AIA will pay a maximum of one claim per child under the Parents Grieving Benefit across all AIA policies for the life assured(s) irrespective of how many lives assured are covered under this policy. No excess is payable for any claims under this benefit.

2.7	Treatment Away From Home in New Zealand		**Coverage:** $300 per day, up to $3,000 per claim per life assured per policy year. **Travel and Accommodation in New Zealand Benefit** Should treatment for an approved benefit not be available within your immediate residential region (which is further than 100km away from your home or usual place of residence). We will cover the costs of accommodation, transport for you and one (1) support person. Treatment must be recommended by a registered medical specialist or registered medical practitioner. The Travel and Accommodation in New Zealand Benefit does not apply to the cost of air travel to or from the Chatham Islands or any other New Zealand Territorial Islands. No annual excess applies.	**Coverage:** The combined maximum cover for the Treatment Away from Home in New Zealand benefit and the Parent Accommodation benefit is a total of $3,000 per life assured per policy year, with a daily sub-limit of $300 for accommodation costs across both benefits. **Treatment Away From Home in New Zealand** If a treatment covered by one of the other benefits of this policy is not available within 100km of your home or usual place of residence, AIA will pay up to the maximum cover for this benefit of transport and accommodation for the life assured and/or a support person to accompany them. No excess is payable for any claims under this benefit.
2.8	Parent Accommodation		**Coverage:** $200 per night, up to $3,000 per policy year. **Parent Accommodation Benefit** We will cover the cost for accommodation expenses incurred by a parent accompanying a child who is listed on the policy schedule. The child must be undergoing medical treatment in an Approved Facility in New Zealand. No annual excess applies.	**Coverage:** The combined maximum cover for the Treatment Away from Home in New Zealand benefit and the Parent Accommodation benefit is a total of $3,000 per life assured per policy year, with a daily sub-limit of $300 for accommodation costs across both benefits. **Parent Accommodation Benefit** Covers the cost for accommodation expenses incurred by a parent accompanying a child who is listed on the schedule. The child must be undergoing medical treatment in an approved facility in New Zealand. No excess is payable for any claims under this benefit.
2.9	Ambulance Transfer		**Coverage:** $200 per life assured per policy year. **Ambulance Transfer Benefit** We will cover the costs of ambulance transfer expenses incurred by the life assured for emergency transportation to or from hospital within New Zealand. This benefit is not payable in respect of any ambulance transfers provided for either personal or social reasons, or where the associated costs would be covered by ACC or any other benefit provision under this policy. No annual excess applies.	**Coverage:** $200 per life assured per policy year. **Ambulance Transfer Benefit** Covers the costs of ambulance transfer expenses incurred by the life assured for emergency transportation to or from hospital within New Zealand. This Benefit is not payable in respect of any ambulance transfers provided for either personal or social reasons, or where the associated costs would be covered by ACC or any other benefit provision under this policy. No excess is payable for any claims under this benefit.

2.10	Voluntary Treatment Overseas		**Global Surgical Benefit** You can elect to have a medically necessary surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care at Your choice of overseas approved facility, provided that: • The surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care has been recommended by a New Zealand registered medical specialist; and • The surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care is available in New Zealand; and • You seek prior-approval for your claim from Us (subject to AIA New Zealand's criteria); and • The surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care would have otherwise been covered by Us in New Zealand under the applicable Benefit. We will reimburse up to a maximum of 85% of the usual, customary and reasonable costs, which would have been incurred for the surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care (as outlined in the applicable benefit) if it had been undertaken in New Zealand per Life Assured per policy year. An annual excess applies. Should the costs of the surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care be less than the 85% maximum detailed above, then AIA New Zealand will also reimburse the following costs up until the 85% maximum is reached: • accommodation costs for the life assured as deemed medically necessary and one (1) support person of up to NZ $500 per day for a maximum of ten (10) days; and • ordinary public transport costs to and from the destination for the Life Assured and one (1) support person (including economy airfare, taxi, bus, ferry and train). We will not accept responsibility for the costs associated with any complications that might arise as a direct or indirect result of the treatment undertaken at Your choice of overseas Approved Facility, unless the treatment costs for these complications (including medical emergency evacuation costs) and the other costs listed above remain below the 85% limit detailed above and occurs within six (6) months of the treatment. After six (6) months of the treatment referred above occurring, We will not accept responsibility for on-going treatment costs directly or indirectly associated with the surgical treatment undertaken at Your choice of overseas Approved Facility.	**Voluntary Treatment Overseas** All payments made under this benefit will be in New Zealand dollars will be credited directly to the bank account nominated by the policy owner. We will not accept responsibility for costs associated with any complications during or following any treatment or procedure covered under this benefit that arise as a direct or indirect result of the treatment, procedure, consultation, test, diagnostic imaging, support or care covered under this benefit. Prior approval must be obtained before the treatment, procedure, consultation, test, diagnostic imaging, support or care takes place. The excess applies to any claims under this benefit. **Treatment in Australia** This benefit covers the costs for the approved treatment, procedure, consultation, test, diagnostic imaging, support or care recommended by a New Zealand Specialist. **Treatment outside Australia** This benefit covers the costs for the approved treatment, procedure, consultation, test, diagnostic imaging, support or care recommended by a New Zealand specialist. Cover is also provided for the cost of a single return economy class airfare for the life assured and one support person. The total amount payable under this benefit is 85% of the reasonable charges, subject to the maximum cover under this policy for the applicable benefit in New Zealand dollars, at a health service facility approved by AIA. **Treatment in and outside Australia** Following the treatment, procedure, consultation, test, diagnostic imaging, support or care, a receipt in English needs to be provided to AIA, together with any other information reasonably required by AIA from the health service provider. Where applicable, any translation services must be provided by an appropriate registered translator in New Zealand acceptable to AIA.

			No Medical Misadventure Benefit is payable should You claim under the Global Surgical Benefit. **Treatment In Australia** This benefit covers the costs for any medically necessary approved surgery, treatment, procedure, consultation, test, diagnostic imaging, support or care. The maximum amount payable for any claim is 100% of New Zealand usual, customary and reasonable charges for the medically necessary treatment that would have been covered by this policy in New Zealand, at an approved facility up to the stated maximums in this policy, paid in New Zealand currency. Prior approval must be obtained from us prior to any treatment taking place. Premiums must be up to date. An annual excess applies.	
3.1	**Translation Costs**		Not available	**Coverage:** $500 per life assured, per policy year This benefit covers the cost of any translation services provided by an appropriate registered translator in New Zealand acceptable to AIA, where translation of any receipt or information into English is required by AIA to support a claim under the Voluntary Treatment Overseas Benefit.
3.2	Treatment Overseas where waiting period for treatment in an approved facility in New Zealand is greater than six months		Not available	**Coverage:** Benefit maximum for the applicable benefit applies. When a medically necessary treatment or procedure covered by one of the other benefits of this policy is available in New Zealand but is unable to be carried out within six months in an approved facility, and so is carried out in an overseas facility approved by AIA, this benefit covers that treatment, procedure, consultation, test, diagnostic imaging, support or care up to the maximum cover stated for the applicable benefit in New Zealand dollars. Cover is also provided for the cost of two return economy class airfares for the life assured and a support person. Prior approval must be obtained prior to the treatment or procedure taking place. The excess applies to any claims under this benefit.
3.3	Treatment Overseas Where The Treatment Is Not Available in NZ		**Coverage:** Up to a maximum of $30,000 per life assured per policy year. **Overseas Treatment Benefit** Covers treatment at an overseas approved facility where the treatment cannot be provided in New Zealand. This benefit provides	**Coverage:** $30,000 per life assured per policy year. **Treatment Overseas Where Treatment Not Available in NZ** When a medically necessary treatment or procedure is unable to be undertaken in New Zealand, this benefit covers the cost of that treatment or procedure up to the maximum

			top-up cover for the treatment and reasonable return economy travel costs of the person requiring treatment and one (1) support person, less any amount payable by the New Zealand government. The treatment must be recommended by a registered medical specialist and be recognised by us as being a conventional form of treatment. No experimental or trialled procedures will be covered. No annual excess applies.	cover stated for this benefit in New Zealand dollars. The treatment must be at an overseas facility acceptable to AIA and is only provided for those treatments, procedure, consultation, test, diagnostic imaging, support or care that a specialist has recommended. Cover is also provided for the cost of two return economy class airfares for the life assured and a support person. Cover for airfares is included within the maximum cover stated for this benefit. Prior approval must be obtained prior to the treatment or procedure taking place. The excess applies to any claims under this benefit.
3.4	Public Hospital Benefits		**Public Hospital Credit** When you have a publicly funded treatment or procedure in a public hospital that would otherwise have been covered by a benefit in this policy and that treatment or procedure includes overnight admission of two (2) or more nights stay, we will waive the life assured's premium for this policy for twelve (12) months. A copy of the hospital discharge summary must accompany the claim form. Excludes hospital admissions for treatment of accidents or injuries or maternity admissions. No annual excess is payable for any claims under this Benefit. --- **Coverage**: $300 per day, maximum amount payable per life assured per policy year $3,000 **Public Hospital Cash Benefit** If the Life Assured is admitted to a Public Hospital for three (3) or more consecutive nights, $300 will be paid from the fourth and each subsequent night, up to a maximum of ten (10) nights. The Public Hospital Cash Benefit does not apply to any admission as a fee paying patient in a Public Hospital or for maternity care. This Benefit will not be paid in addition to the Public Hospital Cancer Treatment Cash Benefit. No annual excess applies. **Fee Paying Patients in a Public Hospital Benefit** We will cover the fees charged for treatment carried out in a public hospital up to the limits specified on this policy once prior approval has been obtained by us, 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. This benefit does not apply to any person who does not qualify for publicly funded health services in New Zealand. No annual excess applies.	**Public Hospital Credit** Where a life assured has a publicly funded treatment or procedure in a public hospital that would otherwise have been covered by a benefit in this policy and that treatment or procedure includes overnight admission of two or more nights' stay, AIA will credit the amount of the life assured's premium to this policy for 12 months in line with the premium due date. A copy of the hospital discharge summary must accompany the claim form. Excludes hospital admissions for treatment of accidents or injuries or maternity admissions. No excess is payable for any claims under this benefit. --- **Coverage:** $300 per day up to $3,000 per life assured per policy year **Public Hospital Cash Grant** Provides a lump sum payment up to the maximum cover for this benefit for any life assured who has an overnight admission of three or more nights in a public hospital and where the hospitalisation is publicly funded. This benefit is payable from the third night of admission. A copy of the hospital discharge summary must accompany the claim form. Excludes maternity admissions. No excess is payable for any claims under this benefit.

3.5	Sterilisation		NOTE: For AIA Real this is just covered under the Optional Specialist and Tests Benefit. Available after two years of continuous cover **Coverage:** Usual, customary and reasonable charges. **Specialists and Tests Loyalty Sterilisation Benefit** If the policy schedule shows you have selected the Specialists and Tests Benefit we will cover the usual, customary and reasonable charges of a vasectomy or tubal ligation procedure performed by a registered medical specialist after two (2) years of continuous cover. Reversals of previous sterilisation procedures are excluded. Vasectomies carried out by a registered medical practitioner will be covered. No annual excess applies.	**Coverage:** Up to $5,000 per life assured per life of the policy. Available after one year of continuous cover **Sterilisation** Covers the cost up to the *maximum cover* for this benefit of sterilisation procedures including vasectomy, tubal ligation and hysteroscopic sterilisation. Prior approval must be obtained prior to the treatment or procedure taking place. This benefit is available to a life assured after one year of continuous cover under this policy. The *excess* applies to any claims under this benefit.
3.6	Pregnancy Complications		**Coverage:** up to $2,000 per life assured per policy year. **Complications of Pregnancy or Child Birth Benefit** We will cover the cost of obstetric care after a referral by a registered medical practitioner or registered lead maternity carer (Midwife) for assessment and monitoring of a recognised risk factor(s). Benefits are not paid if the life assured is admitted to a public hospital, or if related to a pregnancy that is conceived prior to the policy commencement date. Conditions arising post birth are not covered. Caesarean Sections are specifically excluded. No annual excess applies.	**Coverage:** up to $2,000 per life assured per policy year. **Obstetric Care Allowance** Covers the cost up to the maximum cover for this benefit of medically necessary obstetric care referred by the life assured's registered medical practitioner, specialist or registered lead maternity carer (Midwife) for assessment and monitoring of a recognised risk factor(s) in respect of complications during pregnancy. This benefit includes cover for reasonable accommodation costs incurred by the life assured for related stays in an approved facility. Cover under this benefit is not provided if: • the life assured is admitted to a public hospital; • related to a pregnancy that is conceived prior to the risk commencement date; • related to conditions arising post birth. Caesarean Sections are specifically excluded. No *excess* is payable for claims under this benefit.
3.7	Medical Misadventure		**Coverage:** $30,000 per life assured**.** **Medical Misadventure Benefit** If, during the course of any medical procedure or treatment in an Approved Facility, a Life Assured should die as a direct consequence of any erroneous or negligent action, omission or failure to observe reasonable and customary standards by a care provider of the said approved facility, a death benefit shall become payable, provided: • the death occurs within thirty (30) days of such recorded and proven incident; and	**Coverage:** $30,000 per life assured per lifetime. **Medical Misadventure** If, during the course of any medical procedure or treatment in an approved facility, a life assured 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 in that approved facility, the maximum cover of this benefit will be paid, provided: • the death occurs within 30 days of such a recorded and proven incident

			• the incident is verified and confirmed by the relevant government authority, a court of law, coroner's inquest or the Medical Council of New Zealand; and • the death is independent of any other cause other than the termination of life support system after brain death has been established. No Medical Misadventure Benefit is payable if the death is as a direct or indirect result of the life assured claiming under the Global Surgical Benefit. The maximum benefit is $30,000 per life assured. No annual excess applies.	• the incident is verified and confirmed by the relevant Government authority, a court of law, coroner's inquest or the Medical Council of New Zealand • the death is independent of any other cause other than the termination of the life support system after brain death has been established. Caesarean Sections are specifically excluded. No *excess* is payable for claims under this benefit.
3.8	Bariatric Surgery		Coverage: $7,500 per life assured per lifetime 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: Bariatric Surgery Medically necessary sleeve gastrectomy, gastric banding or bypass surgery including the costs of related consultation, 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 joing (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 wight. 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 the 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.	**Coverage:** $7,500 per life assured, per lifetime for the Bariatric Surgery and Bilateral Breast Reduction benefits combined. **Bariatric Surgery** • Provides a contribution towards the cost, up to the maximum cover for this benefit, of medically necessary sleeve gastrectomy, gastric banding or bypass surgery including the costs of the related consultations, tests and diagnostic imaging fr the life assured, where surgery is recommended by a specialist because the life assured has all of the following: a. a BMI of: • 40 or more, or • 35 or high 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 weigh bearing joint (radiological evidence required); or - blood pressure greater than 140/90 that cannot be effectively controlled via medication; and a. completed physical growth; and b. previously failed attempts to lose weight. • Excludes any other type of bariatric surgery, such as banded gastroplasty (stomach stapling).

				• Prior approval must be obtained prior to the treatment or procedure taking place. • Cover under this benefit is only available to a life assured after three years of continuous cover under this policy. • The excess applies to any claims under this benefit.
3.9	Bilateral Breast Reduction		**Coverage:** $7,500 per life assured per lifetime for the Bariatric Surgery and Bilateral Breast Reduction benefits combined. 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 including the costs of the related consultations, tests and diagnostic imaging for the life assured. You must seek prior approval before this allowance is payable. The maximum amount payable under the 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.	**Coverage:** $7,500 per life assured, per lifetime for the Bariatric Surgery and Bilateral Breast Reduction benefits combined. **Bilateral Breast Reduction** Provides a contribution towards the cost, up to the maximum cover this this benefit, of a 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. Prior approval must be obtained prior to the treatment or procedure taking place. Cover under this benefit is only available to a life assured after three years of continuous cover under this policy. The excess applies to any claims under this benefit.
3.10	Specialist consultations		Covered within the Optional Specialists and Test Benefit below. If the Policy Schedule shows you have selected the Specialists and Tests Benefit, we will cover the usual, customary and reasonable fees charged for registered medical specialist consultations up to $10,000 per policy year per life assured and diagnostic procedures which have been referred by a registered medical practitioner or registered medical specialist, if they do not relate to a claim for treatment in a Private Hospital or medical facility.	**Coverage:** $10,000 per life assured, per policy year **Specialist Consultations – Private Health Plus only** Cover for the cost up to the maximum cover for this benefit of consultations (including second opinions) with a specialist where the consultation is referred by a registered medical practitioner. The excess applies to any claims under this benefit.
4.1	Diagnostic Imaging & Tests		**Coverage:** up to $100,000 per policy year per life assured. **Optional Specialists & Tests Benefit** Diagnostic Procedures covered include but are not limited to: • Allergy testing • Audiology tests • CT scans • Capsule endoscopy • Colonoscopy • Colposcopy	**Coverage:** $100,000 per life assured per policy year. **Diagnostic Imaging & Tests – Private Health Plus only** Covers the cost up to the maximum cover for this benefit of the following diagnostic imaging and tests at an approved facility when referred by a registered medical practitioner or a specialist: • Allergy testing • Audiology tests • CT scans

			• Cystoscopy • Electroencephalography (EEG) • Electromyography (EMG) • Exercise/Stress (ECG) • Gastroscopy • Holter monitoring/24 Hour Ambulatory monitoring • Laboratory tests • Mammogram • MRI scans • Myelogram • Myocardial perfusion imaging • PET/CT scans • Scintigraphy • Sleep studies • Ultrasound • Urodynamic assessments • X-rays Preventative and Routine Screening tests, and hearing aids are excluded. Psychiatrist consultations for an initial assessment of mental health are covered for the first consultation only. All forms of Psychiatric treatment are excluded as set out in Section E "Exclusions". An Annual Excess of nil or $250 will apply as stated on the policy schedule per life assured per policy year.	• Capsule endoscopy • Colonoscopy • Colposcopy • Cystoscopy • Electroencephalography (EEG) • Electromyography (EMG) • Exercise/Stress ECG • Gastroscopy • Holter monitoring/24 Hour Ambulatory monitoring • Laboratory tests • Mammography • MRI scans • Myelogram • Myocardial perfusion imaging • PET/CT scans • Scintigraphy • Sleep studies • Ultrasound • Urodynamic assessments • X-rays Cover is available for the cost of other diagnostic imaging and tests, subject to AIA's prior approval. The excess applies to any claims under this benefit.
4.2	Pregnancy, Maternity, Infertility		**Coverage:** up to $1,500 per life assured after two (2) years of continuous cover. **Optional Specialists & Tests Loyalty Family Allowance** If the policy schedule shows you have selected the Specialists and Tests Benefit, we will cover pregnancy scans, fertility treatment and birth care accommodation post-delivery at an approved facility. This benefit does not apply to any person who does not qualify for publicly funded health services in New Zealand. No annual excess applies.	**Coverage:** $1,500 per pregnancy, per life assured, per policy year, after two years continuous cover. **Pregnancy, Maternity and Infertility Allowance – Private Health Plus only** Covers the cost up to the maximum cover for this benefit of obstetric care (including scans), infertility diagnosis and treatment carried out by a registered medical practitioner or a specialist at an approved facility. This benefit includes cover for reasonable accommodation costs incurred by a life assured for maternity, pregnancy or infertility related stays in an approved facility. Pregnancy and maternity care is available to a pregnant life assured only. Cover under this benefit is only available to a life assured who has had two years of continuous cover under AIA Private Health Plus. No excess is payable for any claims under this benefit.

4.3	Critical Cancer Excess Waiver		If a life assured suffers a critical cancer condition as defined below and is admitted to a Private Hospital, or as a fee paying patient to a Public Hospital, we will waive the annual excess that you have selected, for a maximum of three (3) years per life assured. Diagnosis must be made in writing by a registered medical specialist and be based upon medical evidence acceptable to Us. 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 with less than 1.5 mm maximum thickness as determined by histological examination based on Breslow thickness, and Malignant Melanoma with a Clark Level less than 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. • All tumours of the prostate unless histologically classified as having a Gleason score greater than six (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 appropriate and necessary treatment.	Not available
4.4	Health Screening Allowance		**Coverage:** up to $500 per life assured after every three (3) years of continuous cover or up to $750 if the life assured is a member of AIA vitality **Optional Specialists and Tests Loyalty Health Screening Benefit** If the Policy Schedule shows you have selected the specialists and tests benefit, we will cover up to $500 per, or up to $750 per Life Assured if that life assured is a member of AIA Vitality after every three (3) years of continuous cover, for tests or procedures for the following: • Prostate screening • Cervical screening • Mammogram • Blood glucose screening • Bowel screening	**Coverage:** $500 per life assured after three years of continuous cover for each three year period or $750 if the life assured is a member of AIA Vitality. **Health Screening Allowance - Private Health Plus only** Covers the cost up to the maximum cover for this benefit of the following procedures performed at an approved facility: > bone screening (osteoporosis) > bowel screening > breast screening > cervical screening > heart screening > prostate screening > eye tests and / or visual field tests > hearing tests

			• Bone screening (osteoporosis) • Heart screening • Eye tests and/or visual field tests • Hearing tests • Skin checks • Aortic aneurysm screening Health screening tests do not have to be medically necessary, but must be performed by a registered medical practitioner or registered medical specialist in an approved facility. No annual excess applies.	> skin checks > aortic aneurysm screening Cover under this AIA Private Health Plus benefit is only available to a life assured after three years of continuous cover, or after two years or continuous cover if the life assured is a member of AIA Vitality. The health screening test does not need to be medically necessary but the procedure must be performed by or referred by a registered medical practitioner. The pre-existing conditions exclusion and the congenital conditions exclusion do not apply to the Health Screening Allowance benefit. If as a result of a health screening test, a diagnosis is made for a condition requiring treatment or care that is covered under another benefit in this policy, the costs incurred for the screening will be covered under that benefit and the maximum cover for this benefit will be reinstated. No excess is payable for any claims under this benefit.
4.5	Specialists and Tests Excess Waiver		**Optional Specialists and Tests Loyalty Excess Waiver Benefit** If the policy schedule shows you have selected the Specialists and Tests Benefit, after two (2) years of continuous cover, any applicable annual excess on the Specialists and Tests Benefit will be waived per life assured.	Not available.
4.6	Non-Pharmac Subsidised Drugs		**Non-Pharmac Subsidised Drugs Benefit** Covers the usual, customary and reasonable expenses incurred for accessing the most effective treatment available, irrespective of whether that treatment qualifies for PHARMAC funding. We will reimburse the costs of all medicines registered by Medsafe, provided they are used according to Medsafe indications for use in New Zealand (subject to our prior approval) and meeting our criteria where: • The treatment has been recommended by a registered medical specialist as the appropriate medical treatment for the condition; and • The cost of the medicine is covered under the Hospital Surgical Benefit (Non Cancer); and • The medicine is being prescribed within the guidelines set by Medsafe.	*Please note non-Pharmac cancer chemotherapy drugs are covered within AIA Private Health's Cancer Care Benefit. Refer to 1.2 Chemotherapy.*

			All costs under this Non-PHARMAC Subsidised Drugs Benefit are included within the benefit maximums that apply to the Hospital Surgical Benefit (Non Cancer).	
4.7	Intravitreal Eye Injections Benefit		**Intravitreal Eye Injections Benefit** We will cover the cost of intravitreal eye injections administered by a registered medical specialist in an approved facility, on referral by a registered medical practitioner or registered medical specialist up to a maximum of $3,000 per life assured per policy year. No Annual Excess applies.	Not available
4.8	Suspension of Cover		After twelve (12) months of continuous cover, You can apply to suspend the cover and Total Premium payments under this Policy: • for up to twenty-four (24) consecutive months, if You reside outside of New Zealand for longer than two (2) months; or • for up to twelve (12) months if You: a. become redundant; or unemployed; b. go on Leave Without Pay for any reason; c. experience at least a 20% reduction in pay (comparing the most recent payslip against a previous payslip from the same year); or d. If self-employed, experience a 30% reduction in revenue (by comparing one month's revenue against the same month for the previous year) You must apply for the Suspension of Cover Benefit in writing and, if accepted, You will receive confirmation from Us in writing confirming the request has been approved. We will resume cover without requiring evidence of health for any Lives Assured 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 Policy in respect of any claim event that first meets the criteria for an eligible claim while cover is suspended. If cover for all adult Lives Assured has been suspended, cover for any Children on this Policy will also be suspended. No Annual Excess applies.	You may request a suspension of cover for a life assured under this policy: • For up to 24 months if they travel overseas for a period of up to twenty-four months, or; • For up to 12 months if the policy owner: ○ Becomes unemployed or redundant; ○ Goes on leave without pay for any reason; ○ Experiences at least a 20% reduction in pay (comparing the most recent payslip against previous payslip from the same year); or ○ If self-employed, experiences a 30% reduction in revenue (by comparing one month's revenue against the same month for the previous year), Provided that: • you notify AIA within three months of one of the above listed suspension events occurring and provide evidence to AIA of the suspension event; and • AIA acknowledges in writing receipt of that notification. Where cover is suspended in one of the circumstances described above, no premium for the particular life assured, or for all lives assured, is payable during the period of suspension and no cover will be provided for any claim event for that life assured or lives assured during the period of suspension. Cover for that life assured or the lives assured under this policy will be reinstated provided the premium is paid when the nominated period of suspension ends or within the maximum time periods described, whichever comes first.

4.9	Fertility Treatment Loyalty Benefit (after exhausting public options)		**Fertility Treatment Loyalty Benefit (after exhausting public options)** We will cover up to $25,000 per policy after two (2) years of continuous cover for fertility treatment at an approved facility. To be eligible for the Fertility Treatment Loyalty Benefit the criteria for publicly funded fertility treatment in New Zealand must have been met and all publicly funded fertility treatment must have been exhausted before this benefit is payable. You must seek prior approval before this benefit is payable. As a part of the pre-approval process we will require proof of the publicly funded treatment being exhausted. The Fertility Treatment Loyalty Benefit is available for fertility treatment and associated treatment costs. The maximum amount payable per Policy is $25,000 over the lifetime of the policy. Once this amount has been exhausted no further benefit is payable. No annual excess applies. Maximum age to be eligible to claim the Fertility Treatment Loyalty Benefit is forty three (43) years.	Not available

Please Note:

This comparison is a product summary only.
Please refer to the Policy Wordings for AIA's full requirements and eligibility criteria.
The content is not a personalised financial adviser service under the Financial Advisers Act 2008.
This comparison is based on information current as at April 2025 and is subject to change.