



Southern Cross
Health Society

RegularCare

A guide to your policy

+ Gardening is a great form of exercise – walking, bending, stretching, reaching. It helps with mobility and flexibility.

Welcome

to your RegularCare plan

Thank you for choosing us to help you take care of your health. This document is your guide to the benefits of your RegularCare plan and it also provides information you need in order to make the most of your Southern Cross Health Society membership.



The RegularCare plans

RegularCare a plan including surgical treatment, recovery, support, imaging and diagnostics, tests, consultations and non-surgical hospitalisation and day-to-day treatment where you share the costs of treatment.

RegularCare Budget a plan including the same benefits as the RegularCare plan with a \$100 excess deducted from each claim form you submit, once your refund is calculated for all of the claims on any claim form you submit.

Any time you need to contact us:

Member Services Centre: 0800 800 181. Open 8am - 6pm, Monday to Friday (except public holidays).

Fax: 0800 379 844

General correspondence: Southern Cross Medical Care Society, Private Bag 99934, Newmarket, Auckland 1149

Claims correspondence: Southern Cross Claims Centre, Private Bag 3216, Waikato Mail Centre, Hamilton 3240

Website: www.southerncross.co.nz/society

Please note that we may record and store telephone calls to and from our Member Services Centre. We do this to have a record of the information we receive and give over the telephone. This also helps us with quality assurance, continuous improvement and staff training. Your call will be handled in complete confidence, except to the extent we are authorised to discuss any aspect of your **policy**, any claim or health information relating to a claim or other information relating to your **policy** with other persons, as described in section 08 on page 29 of this **guide**.

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Your policy document

This document should be read in conjunction with your Membership Certificate, the Rules of the Southern Cross Medical Care Society, the Schedule of Surgical Maximums and any subsequent information we send to you regarding changes to the guide or any of these related documents.

Terminology used in this guide

When we have used **bold type** in this **guide**, it means that the word has a special medical or legal meaning. We define some of these terms throughout the main body of this **guide**, and the remaining terms are defined in section 09 at the end of this **guide**.

Throughout this **guide**, when we refer to *we/our/us* we mean **Southern Cross** and when we refer to *you/your* we mean the **policyholder** and any **dependant** listed on the **Membership Certificate** (unless otherwise specified).

If you do not understand any aspect of your **policy**, please contact our Member Services Centre and they will be pleased to answer your query.

Changes to your policy

We may change or update which **healthcare services** are **eligible**, the scope of cover, terms and conditions of your **policy** and premiums of this **policy** from time to time. If we make any such changes, we will notify you either in writing, or by electronic means (including website or email) or in our member magazine. The

policyholder is responsible for advising **dependants** of any changes to **policy** terms. If you are not happy with any of the changes we wish to make the **policyholder** can contact us within one month of the notification of changes to discuss alternatives or to cancel this **policy**.

Contents of this guide

In the remainder of this introductory section **you/your** means the **policyholder**. This **guide** sets out the terms and conditions of your **policy**. Benefits under this **policy** are part of your entitlement as a member of the Southern Cross Medical Care Society.

The **policy** comprises:

- the details on any Application Form relating to your **policy**, and the **Membership Certificate**,
- this **guide**,
- the **Schedule of Surgical Maximums**; and any amendment or variation made to them from time to time.

The **Membership Certificate** details:

- the key dates in respect of your **policy**,
- the people covered under your **policy**,
- the level of cover or plan applicable,
- your **Southern Cross** membership number,
- any specific **exclusions** from cover for **pre-existing conditions** known to **Southern Cross** at the time of issue of the **Membership Certificate** applicable to the people covered under your **policy**, and
- any other information specific to your **policy**.

This **guide** details:

- the terms and conditions of your **policy**, including limitations and **exclusions**,
- the process involved in making a claim,
- administration details relating to your **policy**, and
- additional information relevant to your **policy**.

Certain terms and conditions of your **policy** are set out in this **guide** as easy-to-understand questions and answers. It is important that you read all of this **guide** to ensure that you fully understand the terms and conditions of your **policy**.

The **Schedule of Surgical Maximums** forms part of this **policy** and is available on our website or by calling the Member Services Centre.

The **Schedule of Surgical Maximums** is important in determining the **healthcare services** covered by this **policy** and you should study it carefully, as there is no cover for any **healthcare service** that is not listed in the **Coverage Tables** or on the **Schedule of Surgical Maximums**.

Membership of Southern Cross Medical Care Society

Your Application Form for this **policy** also constitutes an application by the **policyholder** for membership of **Southern Cross**. Therefore, you should read your **policy** in conjunction with the Rules of the Southern Cross Medical Care Society which are available on our website www.southerncross.co.nz/society or by calling the Member Services Centre on 0800 800 181.

Under the Rules, the **policyholder** is a member of **Southern Cross** and each of the **dependants** named in the **Membership Certificate** is treated as a member of **Southern Cross** for the purposes of any benefits, claims or payments made by **Southern Cross**.

By applying for membership you agree (both for yourself and on behalf of the **dependants** named on the **Membership Certificate**) to be bound by the Rules of the Southern Cross Medical Care Society. On cancelling this **policy** the **policyholder's Southern Cross** membership will cease (and each of the **dependants** named on the **Membership Certificate** will cease to be treated as a member for the purposes of any benefits, claims or payments made by **Southern Cross**). If you are joining **Southern Cross** and cancel your **policy** during the 14 day period referred to under "How do I cancel my **policy**?" on page 28 of this **guide**, then you will not become a **Southern Cross** member.

Your policy

With the RegularCare plan you share the cost of your **healthcare services**. This guide sets out the benefits and terms and conditions of the RegularCare and RegularCare Budget plans. Your **Membership Certificate** sets out the plan type that applies to you – based on what you selected on your Application Form.

CHOICE OF PLANS

RegularCare a plan including surgical treatment, recovery, support, imaging and diagnostics, tests, consultations and non-surgical hospitalisation and day to day treatment where you share the costs of treatment.

RegularCare Budget a plan including the same benefits as the RegularCare plan with a \$100 excess deducted from each claim form you submit, once your refund is calculated for all of the claims on any claim form you submit.

The maximums set out in the **Coverage Table** and the **Schedule of Surgical Maximums** are set at a level which reflects the premium charged for the RegularCare plans. They do not provide a total refund of the costs of your **healthcare service** nor are they set at a level to ensure that you receive a particular percentage refund of the costs. Please be aware, in some cases your refund may be substantially less than your actual costs.

In return for payment of the premium, we agree to provide you with cover for **eligible healthcare services** as set out in the terms and conditions of this **policy**. When we say “cover” throughout this **guide** we mean cover for claims calculated in accordance with the chart on page 7.

To be **eligible** to claim under your **policy**, your premium payments must be up to date.

Please remember that this **policy** is designed to complement the services provided by **ACC** and the public health service. This is why we have limited cover for **healthcare services** related to an **accident** or **treatment injury** and no cover for **acute care**.

How to receive treatment and make a claim

How does my cover work under my policy?

The following chart has been included to describe how your cover for **healthcare services** works under the **policy** in an easy-to-understand format. Please note that in situations where you could claim all or part of the cost of your **healthcare service** from another insurer or other person (including the **ACC**) you will need to refer to pages 11 and 12 to fully understand how your cover works.

You should note that this calculation applies to each **eligible** component from the **Coverage Tables** and **Schedule of Surgical Maximums** so your claim may be broken down before being assessed if it encompasses more than one component.

This chart does not relate to prescription **drugs**. To understand what cover is available for prescription **drugs** refer to page 10.

Is the **healthcare service eligible** for cover?

In order to be **eligible** the **healthcare service** must be:

- listed in the applicable **Coverage Table** and/or in the **Schedule of Surgical Maximums** and comply with any applicable terms and conditions;
- **medically necessary**;
- performed by a **Medical Practitioner** with the vocational registration applicable to that **healthcare service** or by another **health services provider** with registration applicable to the **healthcare service**;
- a **healthcare service** for which costs are actually incurred or to be incurred; and
- not otherwise excluded under the terms of your **policy**.

Yes

No

Is there a fixed total dollar **allowance** payable for the **healthcare service**?

No cover available.

Yes

No

We will pay the lower of 80% of the actual cost of the **healthcare service** or the fixed total dollar **allowance** limit.

Is the cost for Surgeon/Anaesthetist or other?

Surgeon/Anaesthetist

Other

We will calculate for each **eligible healthcare service**:

- the actual cost of the **healthcare service** up to the **policy limits** stated in the **Schedule of Surgical Maximums**.

We will calculate for each **eligible healthcare service** the lower of the following:

- 80% of the actual cost of the **healthcare service**; or
- the **policy limits** applicable to that **healthcare service**.

We will pay you the amount reached under the above calculation less any excess applicable and payable by you. You will be responsible for paying the balance.

What is an allowance?

An **allowance** is a fixed amount we pay towards the actual charges for certain **eligible healthcare services**. Details of the **healthcare services** which are covered by **allowances** and the amounts of such **allowances** are set out in the **Coverage Tables** on pages 16 to 23. Some **allowances** are only available as a one-off payment as specified in the **Coverage Tables**. You should note that almost always the **allowances** will be significantly less than the actual charges for the **healthcare services** and you must pay the balances of the charges yourself. We will pay 80% of the actual charges up to the fixed total dollar **allowance** limit.

How does my excess work?

Under the RegularCare plan no excess applies. However, if you have elected to have the RegularCare Budget plan an excess will be applied to each claim form submitted. In return for a \$100 excess on each claim form you submit, you pay a lower premium. After your refund is calculated for all of the claims on any claim form, \$100 is deducted from your total reimbursement.

If you follow the prior approval procedures (see pages 9 and 10) and we settle the invoice directly with the **health service provider**, then you will have to pay your excess to the **health service provider** yourself.

If you use an **Affiliated Provider** for a contracted procedure the \$100 excess will not apply.

The prior approval process

Call us on 0800 800 181 to confirm whether your surgery is **eligible** for cover and the conditions that apply. You need to provide estimated charges from the **health services provider**, we can then inform you of your level of cover (including any excess payable by you) and whether or not the estimated charges exceed the **policy limits** for your intended **healthcare service**.

In all cases, you must contact us for prior approval if the cost of your **healthcare services** is likely to be over \$1,000 or where the **healthcare services** involve any hospitalisation including day stay or in-patient surgery regardless of the cost. You should do this at least four working days prior to the **healthcare services** being provided. If you do not, when you subsequently make a claim, you may find you are not covered under your **policy** for all or part of the charges for your **healthcare services**.

If you do not contact us for prior approval before utilising the **healthcare service**, then you will have to pay the invoices yourself and then send to us a completed Claim Form and all of the original itemised receipts. We will process the claim in accordance with your **policy** coverage as set out in the chart on page 7. By not contacting us for prior approval, you will not know your level of cover and how much you may have to pay yourself. Amounts you have to pay yourself could arise from an excess which may be applicable to your claim or due to the **healthcare service** not being **eligible** for cover under your **policy**, or the actual charges exceeding the **policy limits**.

What is an Affiliated Provider and what advantages do I gain by using one?

Southern Cross has established relationships with selected **health services providers**. These providers are called **Affiliated Providers** because they have a contracted relationship with us.

By having agreed prices for certain procedures, the **Affiliated Provider** can tell you what (if anything) you will be required to pay for your **healthcare services**.

The **Affiliated Provider** will organise prior approval and submit any invoices to us. When an **Affiliated Provider** provides a **healthcare service** to you, we deem this to be a claim under your **policy**.

Affiliated Providers have internal quality monitoring and measurement processes. These processes are achieved by clinicians working with their professional bodies to develop quality indicators.

A full list of the **Affiliated Providers** and the **healthcare services** they offer can be found on our website or by calling our Member Services Centre. The **Affiliated Provider** network varies in services, and **Affiliated Providers** may not be available for all **healthcare services** listed in this **policy** in all geographic areas.

Can I use a health services provider that is not an Affiliated Provider?

Yes, you can. However the **health services provider** must be in private practice and must meet the registration requirements for their field of expertise and the **healthcare service** they are providing to you as detailed in this **guide**.

For certain **healthcare services** specified in the **Coverage Tables** or **Schedule of Surgical Maximums**, such as prostate brachytherapy, CT coronary angiogram (CTA), varicose vein leg treatment and angioplasty using drug eluting stent(s), the **healthcare service** must be provided by an **Affiliated Provider** or other **health services provider** specifically nominated by us for that **healthcare service**. You must check with our Member Services Centre before proceeding with any of these **healthcare services** as otherwise you may not have any cover.

Will my health services provider give me an estimate of the charges?

Under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 you have the right to request from a **Medical Practitioner** an outline of the treatment, risks associated with the treatment and an estimate of charges before treatment takes place. Your **health services provider** will give this information to you so that you can provide this to us and request prior approval. You should note that this is an estimate only. If the actual charges vary this may affect your level of reimbursement from us.

What if I have more than one surgery procedure at the same time?

When you have two or more surgical procedures simultaneously, sequentially or under the same anaesthetic there are special rules, (outlined in the **Schedule of Surgical Maximums**), to determine how much is reimbursed for the second and additional procedures. This is because some of the charges can be shared across all the procedures.

If you are going to have more than one surgical procedure at the same time, you should inform the Member Services Centre at the time of prior approval so that they can help you determine the extent of your cover with us.

Southern Cross will determine, in its discretion, whether, and to what extent, the **multiple procedure** rules may apply to you and therefore the extent of your cover.

What if I have more than one surgeon involved in the operation?

Your **policy** provides reimbursement for one surgeon per surgical procedure only. If you are going to have more than one surgeon involved in the surgical procedure you should inform the Member Services Centre at the time of prior approval so that they can help you determine the extent of cover with us. You may be asked to provide a medical report explaining why more than one surgeon is to be involved in the surgical procedure. **Southern Cross** will determine, in its discretion, the extent of your cover.

What if I need follow-up healthcare services after surgery?

After surgery, if you require additional surgery in connection with the initial surgery, you should contact our Member Services Centre to discuss the additional surgery and apply for further prior approval. If the additional treatment relates to a **treatment injury** refer to page 12 for information.

Do all prescription drugs qualify for cover?

Your **policy** offers different cover for prescription **drugs** depending on what type of **healthcare service** they relate to:

- **Drugs** prescribed and taken in hospital are covered as part of **ancillary hospital charges** related to surgical treatment and non-surgical hospitalisation or psychiatric care.
- **Chemotherapy drugs** taken as part of a course of chemotherapy treatment are covered as part of the cancer care benefit.
- Any other **drugs** or prescriptions are only covered under the prescription benefit.

For any **drugs** to qualify for cover, they must be listed on the **Pharmac Schedule, Pharmac approved, medically necessary**, prescribed by a **Medical Practitioner** in private practice and not otherwise excluded by your **policy** terms.

The definitions for all of these terms can be found on pages 31 to 34 of this **guide**.

You can claim from **Southern Cross** 80% of the actual amount you pay for the prescription **drug** (being the amount due after any **Pharmac** subsidy has been applied) up to your **policy limits**.

If the prescription **drug** you are prescribed requires a Special Authority from **Sector Services**, you are responsible to ensure that your **health services provider** applies for and obtains such authority from **Sector Services** to receive the maximum subsidy you qualify for, prior to submitting your claim.

The claiming process

How can I make a claim under my policy?

You can make a claim under your **policy** by submitting a completed Claim Form, using your Member card at selected **health services providers** for a **healthcare service** or visiting an **Affiliated Provider** for a **healthcare service**. When you use your Member card at a selected **health services provider** (and your claim is accepted in writing by us) or an **Affiliated Provider** provides a **healthcare service** to you, we deem this to be a claim under your **policy**. All claims are subject to the provisions of your **policy** and your Member card terms and conditions.

What do I need to provide to Southern Cross when I make a claim?

A completed Claim Form and original itemised receipts, which include the date treatment was provided, for the **healthcare services** listed on the Claim Form. We do not accept EFTPOS or credit card receipts. The Claim Form must be fully completed and signed by the **policyholder** to ensure that your claim can be processed promptly.

How long do I have to send in my receipts?

Claims must be submitted to us within 12 months of the date of provision of the **healthcare service** in order to be assessed.

Do I need to provide further information?

When you request a prior approval, we may ask you to provide us with a medical report. This will enable us to assess and advise you of the amount of your cover.

Sometimes we may not be able to assess your claim from the Claim Form, invoices and receipts and we may need to contact you or the **health services provider** to clarify some details to enable us to assess the claim correctly.

In exceptional circumstances, we may need to ask a **health services provider** chosen by us, to advise us about the medical facts or examine you in relation to the claim. We will only do this when there is uncertainty as to the level of cover under the **policy** or the nature or extent of the medical condition. This examination and advice will be at our expense. You must co-operate with the **health services provider** chosen by us, or we will not pay your claim.

I might have cover under another insurance policy, or I could claim the cost of my treatment from someone else. What should I do?

First of all make claims against the other insurer or other person who may be liable, then complete a Claim Form for the full extent of your claim and send it to us, together with details of the level of payment you have received. We will deduct that payment from the amount we will reimburse to you in accordance with this **policy**.

It is the **policyholder's** responsibility to inform us of the other insurer or other person liable to pay towards the cost of the **healthcare service** and to make every reasonable effort to obtain payment from them. We have the right to reclaim from the **policyholder** any payment made by **Southern Cross** where the cost is recoverable from another insurer or other person.

What else do I need to know about my claim?

We reimburse claims either directly to the **health services provider** if prior approval has been sought or you have used your Member card at a selected **health services provider** (and your claim has been accepted in writing by us) or to the **policyholder** (current at the time the **healthcare service** was provided not at the time the claim is submitted).

We may decline any claims that we consider to be invalid or unjustified. We may examine any claims for **healthcare services** and where appropriate investigate any aspect of the **healthcare services** provided.

If your **policy** is still in force and your premium is not paid up to date for the period in which treatment was received, then we will not pay your claim until we receive full payment of any arrears.

If the **policyholder** has been overpaid on any claims, we may seek to recover the amount incorrectly paid out.

Does Southern Cross have the right to deduct money owing from the payment of any claims I make?

If we are entitled to recover any money from you in relation to this **policy** at any time, we can deduct the amount you owe us from any claim payment or other payment we make to you.

HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACUTE CARE?

This **policy** is designed to provide cover for **eligible healthcare services** and so we will not reimburse charges for **acute care**.

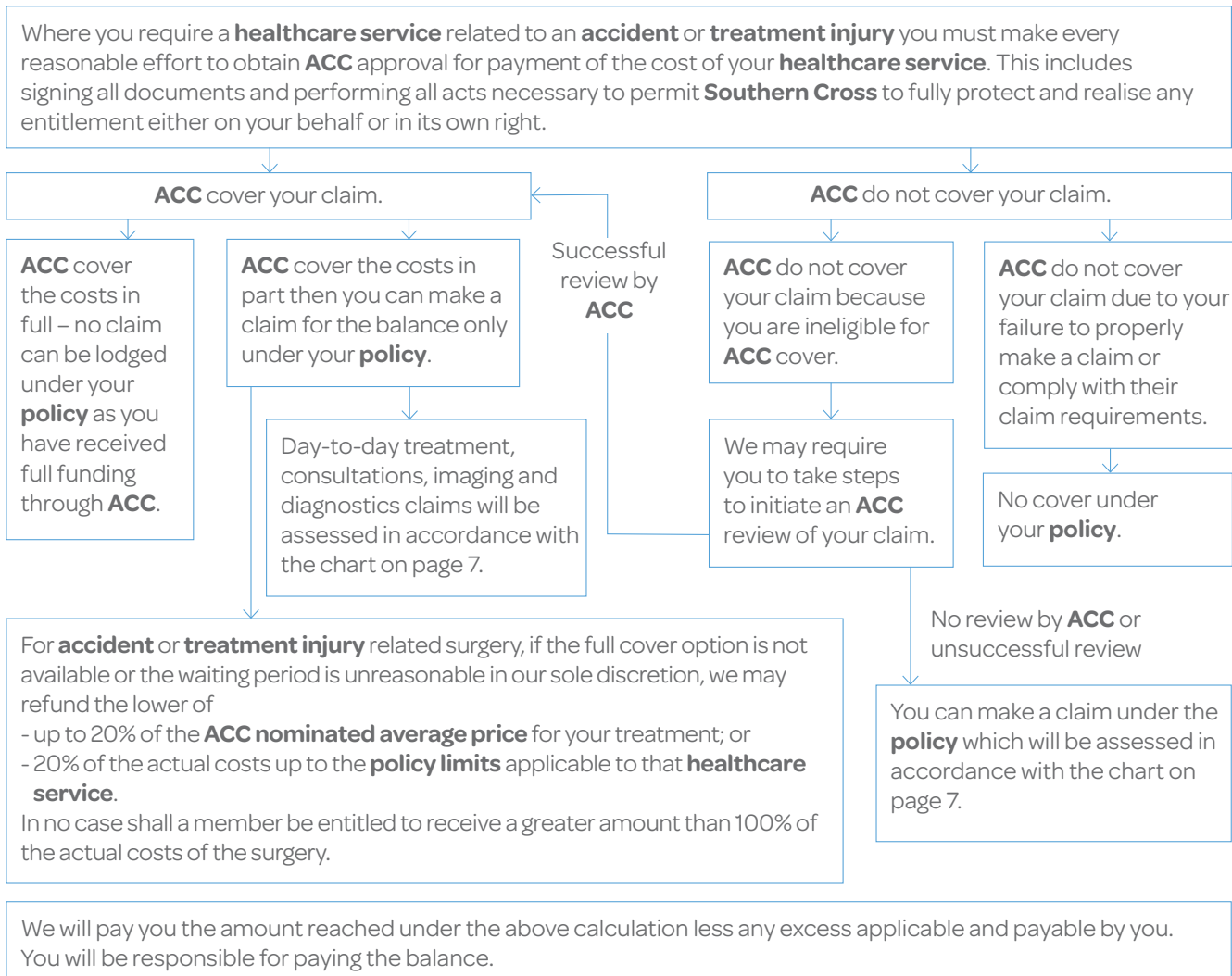
If you need **acute care** you should go directly to your nearest Accident and Emergency unit in a public hospital.

HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACC?

Your RegularCare plan will not provide cover for **accident** treatment or **treatment injury** expenses that **ACC** is legally responsible for. In some cases **ACC** will not pay the full amount charged for your treatment. In these cases you may be able to make a claim under against your RegularCare plan.

Special conditions apply to **accident** and **treatment injury** related surgery. Under the **ACC** legislation, you can choose between full cover (where your provider is fully contracted by **ACC** to provide your procedure at no cost to you) or partial cover (where your provider is partially contracted by **ACC** to provide your procedure and you will be required to contribute towards the surgery costs). The full cover option should be your first choice as you may not have to make any contribution to your surgery costs. By comparison, under the partial cover option you will have to make a contribution towards the costs of the **healthcare service**.

The following chart has been included to describe how your cover for **healthcare services** related to an **accident** or **treatment injury** works under your **policy** in an easy-to-understand format.



Existing medical conditions and commencement of cover

Are pre-existing conditions covered?

Health insurance is primarily meant to provide cover for the treatment of health conditions, signs and symptoms that arise after the **policy** has been taken out. There is no cover for **pre-existing conditions** under the **policy** unless we decide to offer cover for those conditions. However after three years continuous cover a **healthcare service** relating to any **pre-existing condition** may be covered under your **policy** provided that the **healthcare service** is **eligible** for cover.

When the **policyholder** completed the Application Form for this **policy** the **policyholder** declared the conditions, signs and symptoms for which you had received treatment, or which you knew about before the date of the application. We assess the conditions, signs and symptoms disclosed in the application and make a decision whether to offer cover for any **pre-existing conditions** or not. **Pre-existing conditions** which we know of at the time of issuing the **Membership Certificate** and which we decline to cover will be set out on your **Membership Certificate**.

The **exclusions** for **pre-existing conditions** (including any specific conditions listed on the **Membership Certificate**) are in addition to the standard **exclusions** noted in this **guide**.

Declaration of pre-existing conditions

If you do not declare an existing medical condition, signs or symptoms of such condition which you know about, or ought reasonably to have known about, on your Application Form, and subsequently require treatment for the condition, signs or those symptoms, then we may decline cover as the condition is considered to be a **pre-existing condition**. In these circumstances at the time we become aware of the condition we will also add it to your **Membership Certificate** so that we have a record of the excluded condition.

Please note that regardless of whether the **policyholder** declares any conditions, signs or symptoms of any **pre-existing conditions** you may have on the Application Form, and whether you know, or ought reasonably to have known, about any condition, signs or symptoms you may have prior to the **policy start date** (or prior to the date a person was added to the **policy** in respect of any **dependant** added to the **policy** after the **policy start date**) such conditions, signs or symptoms will be **pre-existing conditions** and will not be covered by the **policy** unless specifically disclosed and accepted by us.

When does cover under the policy commence?

Cover under this **policy** does not commence until 3 months after the **policy start date**.

There is also no cover under this **policy** for any **healthcare services** provided to any **dependant** added to this **policy** after the **policy start date** for a period of 3 months after the date that **dependant** was added to the **policy** (except newborn **dependant** children who are added within 3 months of birth who are covered from the date of addition).

Private healthcare services to which this policy applies

The **Coverage Tables** set out on pages 16 to 23 give details of **healthcare services** included under the RegularCare plans, together with details of **policy limits** and other terms and conditions of cover.

Schedule of Surgical Maximums

We publish a Schedule of Surgical Maximums for which we provide cover. This schedule is referred to throughout this **policy** as the **Schedule of Surgical Maximums**. If a **healthcare service** is not listed in the **Coverage Tables** or on the **Schedule of Surgical Maximums**, we will not provide cover unless otherwise advised by **Southern Cross** at our sole discretion. If you are unsure as to whether any particular **healthcare service** is listed in the **Coverage Tables** or in the **Schedule of Surgical Maximums**, you should discuss this with our Member Services Centre before you proceed with the **healthcare service**.

We may change the **Schedule of Surgical Maximums** from time to time and these changes will be notified to you in the same way as any other changes to the **policy**, as set out on page 2 of this **guide**.

When new procedures or technologies become available we assess them and determine whether to offer cover or not.

If we decide to offer cover for the procedure or technology, we will add it to the **policy** and certain conditions may apply.

Treatment in a public facility

Southern Cross does not pay for any **healthcare service** undertaken in a public hospital or facility controlled directly or indirectly by a **DHB** unless specifically accepted in writing by and at the sole discretion of **Southern Cross** prior to treatment.

New Zealand residency

Cover is only available under this **policy** for **New Zealand Residents**.

Quality of healthcare services

Under the Rules of the Southern Cross Medical Care Society, we are not liable to you for either the quality, standard and effectiveness of any **healthcare service** provided to you by, or any other actions of, any **health services provider** or any of their employees or agents.

Which health service providers are covered?

Treatment in New Zealand

All **Medical Practitioners** must have the relevant registration with the Medical Council of New Zealand and be practising in private practice.

Medical Practitioners in Band I must have full general registration or full vocational registration with the

Medical Council of New Zealand. **Medical Practitioners** in Bands II, III and IV must have full vocational registration with the Medical Council of New Zealand.

Southern Cross has established four bands to group **Medical Practitioners** according to their vocational registration. This enables us to confirm the level of cover available under your **policy**.

The allocation of specialities by Bands is as follows:

Medical Practitioners:

Band I

General Practice
Accident and medical practice
Emergency medicine
Family planning and reproductive health

Band II

Breast medicine
Musculoskeletal medicine
Palliative medicine
Rehabilitation medicine
Sexual health medicine (venereology)
Sports medicine

Band III

Dermatology
Internal medicine (including cardiology, endocrinology, gastroenterology, general medicine, haematology, neurology, respiratory medicine and rheumatology)
Occupational medicine
Paediatrics

Band IV

Anaesthesia
Cardiothoracic surgery
General surgery
Neurosurgery
Obstetrics and gynaecology
Ophthalmology
Orthopaedic surgery
Otolaryngology and head and neck surgery
Paediatric surgery
Plastic and reconstructive surgery
Urology
Vascular surgery

Registered nurses

who provide services must be:

Band I

Registered Nurse as recognised by the Nursing Council of New Zealand

Band II

Registered Nurse Practitioner as recognised by the Nursing Council of New Zealand

In order for a **healthcare service** to be **eligible**, it must be performed by a **Medical Practitioner** with the vocational registration applicable to that **healthcare service**, or by another **health services provider** with registration applicable to the **healthcare service**. If you are unsure whether any **health services provider** you are intending to use has appropriate registration or is a member of an appropriate organisation, please contact our Member Services Centre.

Treatment overseas

There is an **allowance** for **medically necessary** treatment not available in the public or private sector within New Zealand. This **allowance** is to contribute towards the medical expenses and does not pay towards accommodation or travel charges. The treatment must be recommended by a **Medical Practitioner** Band III or IV in private practice. It is imperative that **Southern Cross** approve the treatment based on a medical report you provide before treatment takes place. Without this prior approval, the claim cannot be paid. Ordinary **policy exclusions** apply.

Coverage Tables

The following **Coverage Tables** set out the **healthcare services** included under RegularCare plans. The **Coverage Tables** give **policy limits** applicable to the listed **healthcare services** and also specify additional terms and conditions applicable to the cover.

When reading the **Coverage Tables** you must refer to the chart on page 7 for how your refund will be calculated, and to the explanation of **Medical Practitioners** and the Bands in which they practice on page 15 of this **guide**. All figures include GST charged by the providers.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL TREATMENT	Does not include cover for any costs relating to the extraction or implantation of teeth. No benefit is payable either for any oral surgery or implant cost relating to titanium implants.	
Surgeon's operating fees	Refer to Schedule	Performed by a Medical Practitioner Band II, III or IV, an Oral Surgeon or a Medical Practitioner vocationally registered in diagnostic and interventional radiology in private practice and in an approved facility . We reimburse surgeon's and anaesthetist's fees, which are not otherwise listed separately in the Coverage Table , up to the maximum stated in the Schedule of Surgical Maximums for the specific procedure.
Anaesthetist's fees	Refer to Schedule	
Surgically implanted prosthesis	Refer to Schedule	
Intensivist's fee	\$970 per operation	
Laparoscopic disposables	\$4,000 per operation	
Hospital accommodation	\$450 per night or per day stay up to \$7,200 per operation	
Operating theatre fee	\$4,000 per operation	
Intensive care and special in-hospital nursing	\$960 per operation	
In-hospital x-ray examination and ECG	\$480 per operation	
Ancillary hospital charges	\$4,000 per operation	
In-hospital post-operative physiotherapy	\$320 per operation	Treatment performed by a registered physiotherapist in private practice.
Angiography		Performed by a Medical Practitioner Band III or IV or a Medical Practitioner vocationally registered in diagnostic and interventional radiology, in private practice and in an approved facility . e.g. leg (femoral) and neck (carotid) Peripheral vascular angiogram and angioplasty in an approved facility , including hospitalisation, specialist and ancillary hospital charges and stents for angioplasty.
Peripheral vascular angiogram	\$2,560 per operation	
Peripheral vascular angioplasty	\$3,280 per operation	
CT angiogram	\$1,280 per operation	
MR angiogram	\$1,200 per operation	
Lithotripsy		Performed by a registered urologist in private practice and in an approved facility .
Lithotripter fee	\$3,200 per claims year	
Urologist fee	Refer to Schedule	
Anaesthetist fee	Refer to Schedule	
Hospital fee	\$450 per claims year	
Minor Surgery	\$240 per operation	Performed by a Medical Practitioner Band I in private practice, including removal of cysts, moles and toenails.
Other Procedures	\$240 per procedure	Performed by a Medical Practitioner Band I in private practice, includes hormone implants and plaster casts.

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL TREATMENT (continued)		
Cardiac surgery		Coronary artery bypass and heart valve replacement surgery in an approved facility by a Medical Practitioner Band IV in private practice.
Surgeon's fee	Refer to Schedule	
Anaesthetist's fee	Refer to Schedule	
Surgically implanted prosthesis	Refer to Schedule	
Hospital fees	\$28,500 per operation	
Perfusionist's charges	\$2,800 per operation	Including bypass machine supplies and octopus system.
Intensivist's fee	\$970 per operation	
Coronary angiogram	\$2,560 per operation	Performed by a Medical Practitioner Band III in private practice and in an approved facility . Includes hospitalisation, specialist and ancillary hospital charges . No cover for CT coronary angiogram (CTA) unless procedure performed by an Affiliated Provider .
Cardioversion	\$1,045 per procedure	Includes any charges by a Medical Practitioner Band IV vocationally registered in anaesthesia.
Coronary angioplasty		Coronary angioplasty in an approved facility including hospitalisation, specialist, stent(s) and ancillary fees performed by a Medical Practitioner Band III in private practice.
Procedure by Affiliated Provider <u>with or without</u> Drug Eluting Stent(s).	Policy limits will apply. Prior to receiving treatment your Affiliated Provider will advise the balance payable by you.	No cover for Drug Eluting Stent(s) unless angioplasty procedure performed by an Affiliated Provider .
Procedure by other provider <u>with or without</u> Drug Eluting Stent(s).	\$8,800 per operation	No cover for Drug Eluting Stent(s)

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL TREATMENT (continued)		
Coronary angiogram and angioplasty on the same day		Coronary angioplasty and angiogram performed on the same day in an approved facility including hospitalisation, specialist, stent(s) and ancillary fees performed by a Medical Practitioner Band III in private practice.
Procedure by Affiliated Provider <u>with or without</u> Drug Eluting Stent(s).	Policy limits will apply. Prior to receiving treatment your Affiliated Provider will advise the balance payable by you.	No cover for Drug Eluting Stent(s) unless angioplasty procedure performed by an Affiliated Provider .
Procedure by other provider <u>with or without</u> Drug Eluting Stent(s).	\$8,800 per operation	No cover for Drug Eluting Stent(s).
Varicose vein (legs)	2 Varicose vein procedures per leg, per lifetime Policy limits will apply. Prior to receiving treatment your Affiliated Provider will advise the balance payable by you.	No cover for varicose veins unless the treatment is provided by an Affiliated Provider . Please be aware that not all procedures are available from all Affiliated Providers or in all areas, and that a limited range of procedures for leg varicose veins are funded. In order to receive cover the treatment must be medically necessary treatment, as determined by the agreed clinical guidelines, and not for cosmetic treatment . This benefit is inclusive of any consultations, treatment, and/or follow up assessment or treatment that may be required.
Colonoscopy	Policy limits will apply. Prior to treatment your Affiliated Provider will advise the balance payable by you.	No cover for a colonoscopy unless the procedure is carried out by an Affiliated Provider . Please be aware that not all procedures are available from all Affiliated Providers or in all areas. In order to receive cover the colonoscopy must be medically necessary , as determined by the agreed clinical guidelines and not for health screening .
Gastroscopy	Policy limits will apply. Prior to treatment your Affiliated Provider will advise the balance payable by you.	No cover for a gastroscopy unless the procedure is carried out by an Affiliated Provider . Please be aware that not all procedures are available from all Affiliated Providers or in all areas. In order to receive cover the gastroscopy must be medically necessary , as determined by the agreed clinical guidelines and not for health screening .
Cataract surgery	Policy limits will apply. Prior to treatment your Affiliated Provider will advise the balance payable by you.	No cover for cataract surgery unless carried out by an Affiliated Provider . Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Cover is limited to the surgical insertion of a monofocal intraocular lens only (there is no cover for the cost of any other type of surgically implanted intraocular lens). This benefit includes cover for follow up consultations within 6 weeks of eligible cataract surgery.

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL ALLOWANCES		
Sterilisation allowance Vasectomy	\$408 per operation	After one year of continuous cover in this plan. For surgery by a Medical Practitioner Band I in private practice in an approved facility . This benefit includes all qualifying associated costs, but does not include reversals.
Vasectomy Surgeon's fee Anaesthetist's fee Hospital fees	Refer to Schedule Refer to Schedule Refunded under Surgical Treatment	After one year of continuous cover in this plan. For surgery by a Medical Practitioner Band IV in private practice in an approved facility . This benefit does not include reversals.
Tubal ligation Surgeon's fee Anaesthetist's fee Hospital fees	Refer to Schedule Refer to Schedule Refunded under Surgical Treatment	
Gastric banding/ bypass allowance	\$5,000 one-off payment	After three years of continuous cover in this plan. Payable at the discretion of Southern Cross on receipt of a medical report prior to surgery by a Medical Practitioner Band IV (this benefit also includes any subsequent treatment that may be required).
Bilateral breast reduction allowance	\$3,200 one-off payment	After three years of continuous cover in this plan. Payable at the discretion of Southern Cross on receipt of a medical report prior to surgery by a Medical Practitioner Band IV (this benefit also includes any subsequent treatment that may be required).
Overseas treatment allowance	\$5,000 per claims year	Reimbursement of medical expenses for medically necessary treatment not available in the public or private sector within New Zealand. The treatment must be recommended by a Medical Practitioner Band III or IV in private practice. Southern Cross must approve the treatment based on a medical report you provide before treatment takes place. Ordinary policy exclusions apply. No reimbursement for accommodation or travel.

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
RECOVERY		
The preceding surgery must have been eligible for cover under your policy .		
Home nursing	\$120 per day up to \$720 per claims year	After one year of continuous cover in this plan. Post-operative nursing commencing within 14 days of related surgery and performed by a Registered Nurse Band I or II in private practice on the referral of a registered Medical Practitioner .
Speech and language therapy	\$56 per visit up to \$280 per claims year	Post-operative treatment completed within 6 months of related surgery and performed by a qualified speech and language therapist who is a member of the NZSTA on the referral of a registered Medical Practitioner .
SUPPORT		
Ambulance allowance	\$144 per claims year	Only for a public facility or an Affiliated Provider in-patient admission.
Travel and accommodation allowance	\$400 per claims year	When private treatment is not available in your hometown or city and you have to travel more than 100km from home for treatment. Allowance payable to cover the person covered by this policy requiring the healthcare service and a support person. Allowance payable for public transport costs and hotel/motel rooms within New Zealand only.
Parent accommodation	\$80 per night up to \$400 per operation	For hospital accommodation expenses incurred by a parent when accompanying a dependant child . Both parent and child must be listed on the Membership Certificate . Accommodation must be in an approved facility .
Hospital cash allowance	Child benefit: \$12 per night up to \$300 per admission up to \$1,050 per claims year Adult benefit: \$24 per night up to \$600 per admission up to \$2,100 per claims year	For overnight admissions of two nights or more in a public facility for surgery. A copy of hospital discharge summary must accompany the claim form. Excludes maternity, accident and treatment injury admissions. The \$100 excess under RegularCare Budget does not apply to this benefit.
Obstetrics allowance	\$315 per claims year	After three years of continuous cover in this plan. Carried out by a Medical Practitioner vocationally registered in obstetrics and gynaecology or anaesthesia, and/or for accommodation in an approved facility .
Funeral allowance	\$600 one-off payment	On the death of any current member before the age of 65 years, from causes other than accidental. This benefit is payable to the estate or guardian. The \$100 excess under RegularCare Budget does not apply to this benefit.

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
IMAGING AND DIAGNOSTICS		
Diagnostic imaging performed by a registered radiologist in private practice.		
X-rays and image intensifiers	\$400 per claims year	Excluding X-rays performed by a dentist, chiropractor or an Oral Surgeon .
Mammography	\$400 per claims year	
Ultrasound	\$400 per claims year	Excluding obstetrics and varicose vein (legs) treatment.
Nuclear scanning (scintigraphy)	\$560 per claims year	
Computer Axial Tomography (CT/CAT Scan)	\$650 per CT Scan up to \$1,300 claims year	Excludes calcium scoring.
Magnetic Resonance Imaging (MRI)	\$1,200 per claims year	On referral from a Medical Practitioner Band II, III or IV, in private practice.
Myocardial perfusion scan	\$1,110 per test	On referral by a Medical Practitioner Band III or IV.
TESTS		
On referral by a Medical Practitioner Band III or IV and in an approved facility .		
Cardiac tests	\$1,000 per test up to \$3,000 per claims year	Limited to the procedures listed in section 14 of the Schedule of Surgical Maximums .
Diagnostic tests	\$400 per test up to \$2,000 per claims year	Limited to the procedures listed in section 14 of the Schedule of Surgical Maximums .
CONSULTATIONS		
Medical Practitioner Band II		
Initial consultation	\$125 per consultation	
Follow up consultation	\$75 per consultation	
Medical Practitioner Band III		
Initial consultation	\$240 per consultation	Includes allergy tests when performed by a Medical Practitioner Band III.
Follow up consultation	\$100 per consultation	
Cardiologist's consultations		
Initial consultation	\$240 per consultation	Consultations with a registered cardiologist in private practice.
Follow up consultation	\$100 per consultation	
Medical Practitioner Band IV		
Initial consultation	\$140 per consultation	Including consultations by a Medical Practitioner Band IV vocationally registered in anaesthesia for chronic pain or pre-operative clinic consultations only.
Follow up consultation	\$100 per consultation	
Oral Surgeon consultations		
Initial consultation	\$140 per consultation	Consultations (including x-rays) by an Oral Surgeon in private practice. Does not include cover for any costs related to the extraction or implantation of teeth.
Follow up consultation	\$100 per consultation	

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
NON SURGICAL HOSPITALISATION		
Medical hospitalisation		On referral by a Medical Practitioner Band II, III or IV for treatment or observation in an approved facility , other than when following surgery, and under the control of a Medical Practitioner Band II, III or IV. Excludes hospice, geriatric, oncology and psychiatric hospital care.
Hospital accommodation	\$450 per night or per day stay up to \$10,000 per claims year	Single room basis, excludes suites.
Ancillary hospital charges	\$160 per claims year	
CANCER CARE		
Oncologist consultations Initial consultation Follow up consultation	\$240 per consultation \$100 per consultation	Consultations by a registered oncologist in private practice.
Chemotherapy treatment	\$20,000 per course of treatment up to \$48,000 per claims year	Under the care of a registered oncologist in private practice. Includes costs of materials and chemotherapy drugs , hospital accommodation and ancillary hospital charges .
Radiotherapy treatment	Policy limits will apply. Prior to receiving treatment your Affiliated Provider will advise the balance payable by you.	Cover for radiotherapy treatment is only available when the procedure is provided by an Affiliated Provider . Please be aware that not all procedures are available from all Affiliated Providers or in all areas, and that a limited range of radiotherapy treatments are funded. This benefit is inclusive of any radiotherapy planning and radiation treatment (does not include cover for initial or follow-up oncologist consultations, drugs , hospital accommodation, other healthcare services , or follow-up CT scans).
PSYCHIATRIC CARE		
Psychiatrist consultations	up to \$600 per claims year	Performed by a Medical Practitioner vocationally registered in psychiatry and in private practice.
Psychiatric hospitalisation		In an approved facility , on admission and under the care of a Medical Practitioner vocationally registered in psychiatry and in private practice.
Hospital accommodation	\$450 per night or per day stay up to \$2,250 per claims year	
Ancillary hospital charges	\$160 per claims year	

*See the chart on page 7 for how your refund will be calculated.

RegularCare - Coverage Table

Your refund for any **eligible healthcare service** will be the lower of 80% of the actual cost or the **policy limit** (less any excess).*

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
DAY-TO-DAY TREATMENT		
Medical Practitioner Band I Clinical consultation Home or after hours consultation	\$36 per consultation \$45 per consultation	Treatment and consultations (including dressings, acupuncture and ECG) by a Registered Medical Practitioner .
Registered Nurse Practitioner	\$20 per consultation	Only applicable where no Medical Practitioner Band I fee applies. Performed by a Band I Registered Nurse or Band II Registered Nurse Practitioner.
Prescriptions	\$240 per claims year	Charges for prescription drugs (on the Pharmac Schedule) prescribed by a Medical Practitioner (all Bands) or Registered Nurse Band II.
Laboratory tests	\$56 per claims year	Performed for diagnostic purposes but not funded by a government agency. Performed by an accredited hospital, community based or regional referral laboratory approved by International Accreditation New Zealand.
Physiotherapy consultations and treatment	\$30 per visit \$180 per claims year	Treatment by a physiotherapist registered with the Physiotherapy Board of New Zealand, and in private practice, including acupuncture and manipulations.
Audiology consultations Hearing tests	\$40 per consultation \$128 per claims year \$128 per claims year	Consultations and Audiology testing fees by an audiologist in private practice who is a full member of the New Zealand Audiological Society. Including puretone, audiometry, impedance, tympanometry and brain stem evoked responses.
Orthoptist	\$128 per claims year	Treatment by a registered Orthoptist in private practice.
Chiropractor	\$35 per visit \$105 per claims year	After one year of continuous cover in this plan. Consultations, x-rays or treatment by a chiropractor registered with the New Zealand Chiropractic Board and in private practice.

*See the chart on page 7 for how your refund will be calculated.

Exclusions

No reimbursement shall be made for the costs of, or payment made for, any **healthcare service** which is not specifically listed in the **Coverage Tables**, or in the **Schedule of Surgical Maximums**. No reimbursement shall be made for the costs of, or payment made for, any **healthcare services**, equipment, appliances, prescription **drug** or devices which are for or relate to any investigations or treatments related to, or any conditions which have as the underlying cause or are associated with, or are otherwise incurred in relation to, or as a consequence of, any of the following:

- **Pre-existing conditions** including but not limited to those conditions specifically set out in your **Membership Certificate**;
- Abdominoplasty and/or repair of rectus divarication;
- **Acute care**;
- Breast reduction, except as specifically provided by the bilateral breast reduction **allowance** in the **Coverage Tables**;
- Cardiac pacemakers, implantable defibrillators, nerve appliances, hearing aids and cochlear implants and any other appliances (surgical, medical or dental) other than surgically implanted **prostheses** included in the **prostheses** section of the **Schedule of Surgical Maximums**;
- **Chronic conditions**;
- **Congenital conditions**;
- Contraception or intrauterine devices (but not including Mirena when used for medical reasons and approved by **Southern Cross** prior to treatment);
- Correction of refractive visual errors or astigmatism by surgery, surgically implanted intraocular lens(es), or laser treatment;
- **Cosmetic treatment**;
- Dementia;
- Dental titanium implants and / or related surgery;
- Developmental or congenital deformities or abnormalities of the facial skeleton and associated structures;
- Equipment, including but not limited to braces, crutches, mouthguards and orthotics, except as otherwise specifically provided by your plan;
- Extraction of teeth;
- Gender reassignment;
- Geriatric in-patient care and **disability support services**;
- Gynaecomastia;
- **Health screening**;
- **Healthcare services** at a public facility directly or indirectly controlled by a **DHB** unless specifically accepted in writing by **Southern Cross** prior to treatment;
- **Healthcare services** provided by a person who is not a **Medical Practitioner** as defined on page 15, except as specifically provided in the **Coverage Tables**;
- **Healthcare services** provided in relation to, or as a consequence of, any **accident** or **treatment injury** except as specifically provided in section 02 page 12 of this **guide**;
- **Healthcare services** provided outside New Zealand, except as specifically provided by the overseas treatment **allowance** in the **Coverage Tables**;
- HIV, HIV disorders including AIDS, and any medical condition that arises in any way from HIV infection;
- Hospital charges of a personal convenience nature;
- Hospitalisation which is not **medically necessary**, including but without limitation, convalescence, respite care and similar types of care;
- Infertility or assisted reproduction;
- Injuries or disability directly or indirectly related to playing professional sport;
- Injury, illness, condition or disability arising from, or caused or contributed to by, substance abuse, intoxication or drug taking whether prescribed or recreational;

- Injury or disability suffered as a result of war or any act of war, declared or undeclared, or of active duty in the military, naval or air forces of any country or international authority, or as a direct or indirect result of terrorism;
- Maintenance examinations or medical check ups;
- Management and treatment of snoring;
- Mental health **healthcare services** for which the public health system is responsible;
- **Mole mapping** or dermatological surveillance;
- Obesity except as specifically provided by the gastric banding/ bypass **allowance** in the **Coverage Tables**;
- Organ transplant or any related expenses for both donors and recipients;
- Physical examinations for life insurance, travel insurance, driving license or any other examination or check up as required for a third party, including preparation of reports;
- Pregnancy and childbirth, except for as specifically provided by the obstetrics **allowance** in the **Coverage Tables**;
- **Prophylactic Healthcare Services** unless approved by **Southern Cross** prior to treatment;
- Renal dialysis;
- Services performed by a dentist, periodontist, endodontist or orthodontist;
- Sterilisation (except as specifically provided by the sterilisation **allowance** in the **Coverage Tables**) or its reversal;
- Self-inflicted illness or injury;
- Surgery designed to assist or allow the implementation of orthodontic **healthcare services**;
- Surgically implanted lens(es) other than monofocal lens(es);
- Termination of pregnancy;
- Treatment of any condition not **detrimental to health** or any **healthcare service** not **medically necessary**;
- **Unapproved healthcare services**;
- Vaccinations.

Administrative information

In this section, when we say **you/your** we refer to the **policyholder**.

The **policy** is renewable annually on the anniversary of the **policy start date**, and this date is referred to as the **policy anniversary date**. The **policy anniversary date** is the same for all persons listed on the **Membership Certificate** as covered by the **policy** regardless of the **original date of joining**. If you change in any way the frequency or the manner in which you pay your premiums under the **policy**, then the **policy year** will be reset to start on the date of such change and the **policy anniversary date** will be the anniversary of the date of the change.

If your cover is through a work scheme or association scheme, your **policy anniversary date**, however, is aligned to that of your scheme. This could mean that your first **policy anniversary date** may take place less than 12 months after the **policy start date**. However, from this time, the **policy anniversary date** will fall every 12 months unless changes are made to the scheme or you leave the scheme.

Where will Southern Cross send any communications in relation to my policy?

Unless otherwise advised, every notice or other communication required to be sent by **Southern Cross** relating to you, this **policy**, or any **dependant** covered by the **policy** will be sent to the **policyholder** at his or her last known address and shall be considered to have been delivered 3 days after having been posted.

The **policyholder** must immediately notify **Southern Cross** of any change of postal or residential address.

When can I add dependants on to my policy?

You can add **dependants** on to the **policy** at any time, excluding **children** aged 21 years or older. You will need to complete an Application Form for the **dependant** being added with details of their medical history. We will then assess their medical history to determine whether we will cover any **pre-existing conditions** disclosed on the Application Form. They will not be able to make any claims for expenses incurred for any **healthcare services** received within the first 3 months from the date they were added to the **policy**.

If you wish to add a newborn **child**, the application should be completed within 3 months of birth. This means that the **child** will have cover for **pre-existing conditions** as long as they are not excluded under the general terms of this **policy** or are not **congenital conditions** or **chronic conditions** excluded under the **exclusions** section on page 24 of this **guide**. You will also be able to claim for **eligible healthcare services** received by that **child** during the first 3 months of cover as cover will commence on the date the **child** was added to your **policy**.

If you don't add a newborn **child** before he or she is 3 months old, you will have to complete a medical history declaration for the **child** and we will determine whether we will cover any **pre-existing conditions** disclosed on the Application Form. You will not be able to claim for **healthcare services** for the **child** for the first 3 months from the date the **child** is added to the **policy**.

Premiums for **dependants** added will be charged from the date of the addition of the **dependant** as part of your normal billing cycle. You are responsible for payment of premiums in respect of any **dependant** added to the **policy**.

How long can my adult children stay on my policy?

Your children are charged at the **child's** rate until they reach 21 years of age. On reaching 21 the premiums payable in respect of your children will be based on their age but they can remain on your **policy**. **Adult** children will automatically remain on your **policy** unless you, your work scheme or association scheme specifically request us to remove them.

If you wish to remove them from your **policy**, and they would like to continue cover with **Southern Cross**, they should apply for their own **Southern Cross** membership.

If they apply for the same level of cover as they had under your **policy** and they apply within one month of being removed from your **policy** they will not need to complete a new medical declaration.

How do I remove dependants from my policy?

The removal of a **dependant** can take place at any time – you should inform us of the request to remove the **dependant** in writing or by calling the Member Services Centre. It is the responsibility of the **policyholder** to remove **dependants** from the **policy** where the circumstances change so that the **policyholder** no longer requires the **dependant** to be covered by the **policy** (for example, following a marital separation or a death).

You should note that if a **dependant** is removed from the **policy** and subsequently added back on, you will have to complete a new Application Form with details of their medical history. They will not have cover for **pre-existing conditions** existing prior to the date of the new Application Form and no cover for **healthcare services** provided to them during the period of 3 months after being added back on to the **policy**.

When can I change my cover? Can I upgrade or downgrade?

Upgrading or downgrading your cover can affect coverage for **pre-existing conditions**, **annual limits**, excesses, waiting periods and premiums and it is therefore important you discuss your proposed changes with our Member Services Centre to fully understand the implications of upgrading or downgrading your **policy**.

Changes to your **policy** will not be backdated. In particular you should note:

- to upgrade your **policy** you will be required to complete a new medical declaration in relation to yourself and all **dependants** covered by the **policy**;
- if you upgrade, cover for non-cardiac **pre-existing conditions** will continue at the same level as under the **policy** prior to the upgrade, until you have been on the new plan for a continuous period of three years;
- if you upgrade with a qualifying cardiac **pre-existing condition** and your new plan you have upgraded to covers the treatment / condition, your level of cover for that condition on your new plan will never be higher than the **Pre-existing Cardiac Schedule** level even after you have been on the new plan for a continuous period of three years;

- if you upgrade or downgrade your **policy** any **pre-existing condition** exclusions affecting you or any **dependant** covered by the **policy** will remain.
- if you upgrade or downgrade your **policy** the **claims year** for you and each **dependant** covered by the **policy** each start over again from the date of the upgrade or downgrade as the case may be.

What is a claims year and how do annual limits work?

You and all of your **dependants** covered by the **policy** have the same **claims year** regardless of when a particular person was added to the **policy**. **Annual limits** applicable to RegularCare plans last for the duration of a **claims year** and revert to their maximum levels at the start of each **claims year**. If any **dependant** is added to the **policy** part way through a **claims year** that **dependant** will have the same **annual limits** as the people covered under the **policy** from the start of the **claims year**.

Annual limits cannot be carried over from one **claims year** to the next, nor can they be transferred to other people covered under the **policy**.

A claim is allocated against the **annual limit** based on the date when the **healthcare services** are provided, and not the date of the invoice or the date a claim is submitted.

You should note that in relation to some **healthcare services**, in addition to an **annual limit** there are other **policy limits**. These limits are all set out in the **Coverage Tables** and **Schedule of Surgical Maximums**.

How does Southern Cross calculate 'continuous cover' for some of the elements of cover?

'Continuous cover' means that the person covered by the **policy** must have had no break in cover for the particular **healthcare service** in this plan to which the **continuous cover** qualification relates to for the specified minimum period. Periods when the **policy** is suspended in relation to that person while that person is travelling overseas count as part of continuous cover. However, if that person is a **dependant** who is taken off the **policy** for any period and then added back on, then that will break the period of continuous cover.

I am going to travel overseas for a while, can I suspend my policy until I return?

It is possible to suspend cover under the **policy** in respect of you or any of your **dependants** covered by the **policy**, for a period of 2 to 12 calendar months if you, or that **dependant**, are going to be overseas. There are certain conditions that apply as set out below. Each of these conditions relates personally to the **policyholder** or each individual who is travelling, and wishing to suspend their cover:

- you or your **dependant** must request suspension in writing before leaving New Zealand;
- you or your **dependant** must have been covered by the **policy** for at least 12 continuous months up to the date the suspension is to take effect;
- the period of suspension must be between 2 and 12 calendar months;
- you or your **dependant** can each suspend cover up to 3 times per **lifetime** only;
- you or your **dependant** must provide proof of departure and re-entry (e.g. passport stamps, airline tickets, or other evidence) to **Southern Cross** within 30 days of return to New Zealand. You or your **dependant** must return to New Zealand within 12 months of the date the suspension started;
- you or your **dependant** must be continuously covered under the **policy** for a period of 12 months between the end of the last suspension and the commencement date of the next suspension.

If you or your **dependant** are leaving New Zealand for a period greater than 12 months, call our Member Services Centre to discuss options available to you.

What happens to my policy if I give Southern Cross incomplete, false or misleading information?

Southern Cross may cancel this **policy** or reduce cover immediately where it appears to **Southern Cross** that a **policyholder**, or any **dependant** covered by the **policy** has provided false, misleading or incomplete information. If this false, misleading or incomplete information relates to a claim, then we may decline your claim and recover any amount paid.

If at any time we become aware of a condition you have failed to disclose we will add it to your **Membership Certificate** so that we have a record of the excluded condition.

In certain circumstances where fraudulent behaviour is evidenced, **Southern Cross** may take legal action against you and/or your **dependant** involved.

How do I cancel my policy?

If you are joining **Southern Cross** for the first time and are not satisfied with the **policy** during the first 14 days after the date you have received all the documents comprising the **policy** (as listed on page 3 of this **guide**), you can cancel the **policy** and we will provide a full refund of all premiums paid. You can only do this if you have not made a claim under the **policy** during this period. If you wish to cancel the **policy** within the 14 day period please contact our Member Services Centre.

You can cancel your **policy** at any other time but if you do so you will not be entitled to a refund of any premium already paid to us and you will remain liable for premium due up to the date the cancellation takes effect.

Nothing in this **policy** limits or affects any rights you or any **dependant** covered by the **policy** may have under the Consumer Guarantees Act 1993.

What if I forget to pay my premium?

If you don't pay premiums for 3 months or more, we will cancel your **policy**.

Your regulatory protection

PRIVACY

Privacy of information relating to you and your **dependants** covered under this **policy** is governed by the Privacy Act, and in relation to health information, by the Health Information Privacy Code. The information we collect and hold about you and your **dependants** will be used:

- to consider your eligibility and the eligibility of your **dependants** for cover under this **policy**;
- to consider the specific terms applying to your **policy** (including the exclusion of any **pre-existing conditions**);
- for administration purposes, such as billing and claims management;
- to consider whether any **healthcare service** is **eligible** for cover under this **policy**;
- to contact you from time to time with information about products and services relating to **Southern Cross**;
- for market research and targeted promotions by **Southern Cross**;
- to process and investigate claims made under your **policy**; and
- for statistical purposes (although for this purpose neither you nor any of your **dependants** covered by this **policy** will be identified).

We collect information about you and your **dependants** directly from you (for example, from the Application Form).

We may also collect information about you and each of your **dependants** from your husband/wife or partner (provided they are covered by the **policy**), **health services providers** and medical authorities (including **ACC** and Ministry of Health), **Southern Cross**' agents, contractors, suppliers and other business partners and any third party authorised by you, and you and each of your **dependants** authorises this collection and the disclosure of such information to such parties for any of the above purposes.

We may need to disclose information about you or any of your **dependants** to your husband/wife or partner (provided they are covered by the **policy**), the relevant **healthcare services** providers, medical authorities or the third party authorised by you in relation to any of the above purposes (and you and each of your **dependants** authorises us to disclose this information).

We may also disclose information about you or your **dependants** to **Southern Cross**' agents, contractors, supplier's and other business partners in relation to any of the above purposes, and you and each of your **dependants** authorises us to disclose this information.

If you are a member of a work scheme or association scheme, we may also collect information about you and each of your **dependants** (other than health information) from your scheme administrator, and disclose information (other than health information) to your scheme administrator, for administrative purposes. Your scheme administrator may also disclose information about you and each of your **dependants** to us (other than health information) for administrative purposes.

You and each of your **dependants**, authorises such collection and disclosure.

All communications from us relating to you or any of your **dependants** will be sent to you. This means that information about each of your **dependants** covered by the **policy** will be disclosed to you (and each of your **dependants** authorises his disclosure).

We may also contact you and or your **dependants** within a reasonable time of you or your **dependants** ceasing to be covered by the **policy** with information about products and services relating to **Southern Cross**.

Southern Cross will endeavour to ensure that you and your **dependant's** personal (and health) information that we collect, store, use or disclose is accurate, complete and up to date. Prompt notification of any changes to personal contact details will help us do this. We also endeavour to protect your personal and health information from misuse or loss and from unauthorised access, modification or disclosure in accordance with the Privacy Act and the Health Information Privacy Code.

Under the Privacy Act and the Health Information Privacy Code, you and each of your **dependants** covered by the **policy** are entitled to have access to, and request correction of, any personal information (including any health information) held by us. If you or any of your **dependants** have any queries about privacy of information or wish to access any personal information held by us, please contact our Member Services Centre.

If any of the information requested on the Application or Claim Form (or as part of the application or claims process) is not provided, it may delay the processing of the Application Form or your claim, or may result in us not providing you and any of your **dependants** with cover. If any false or misleading information (including incomplete information) is provided to us at any time, the consequences are set out on page 28 of this **guide**.

You may advise us at any time that you do not wish **Southern Cross** to collect and or disclose information to your husband/wife or partner (covered by the **policy**).

Electronic Communications - from time to time **Southern Cross** may send you marketing and other information electronically such as by email or text message. If you have provided your email address or mobile phone number we take this as your implied consent to us doing this. If you wish to withdraw your consent at any time please contact our Member Services Centre.

FINANCIAL STRENGTH RATING

Southern Cross Medical Care Society has elected to be rated by Standard & Poor's. This provides reassurance on our ability to meet claims in the future. Full details of the current rating given to **Southern Cross** together with information on the rating scale can be obtained from our offices or our website www.southerncross.co.nz/society, and is also in the latest RegularCare sales brochure.

You can also obtain background information from Standard and Poor's website www.spglobal.com.

INDUSTRY ORGANISATIONS

Southern Cross Medical Care Society is registered as a Friendly Society and is a member of the Health Funds Association of New Zealand, the Insurance and Savings Ombudsman scheme and the International Federation of Health Plans. We are bound by the Code of Practice as laid down by the Health Funds Association of New Zealand.

MEMBER SERVICE

We aim to provide you with efficient and courteous service. In the event that you are unhappy with our service or our treatment of your **policy** or claim, you should write, in the first instance to:

The Member Relations Manager
Southern Cross Medical Care Society
Private Bag 99934
Newmarket
Auckland 1149

We will investigate and reply to your specific complaint as soon as practically possible.

If you are unhappy with the response from the Member Relations Manager, then write to our Chief Operating Officer at the same address detailing the reasons you remain unhappy. The Chief Operating Officer will respond to you as soon as practically possible.

After you have followed the **Southern Cross** internal process outlined above, if your complaint relates to a claim and deadlock has been reached, you can write to the Insurance and Savings Ombudsman within two months of being notified by us in writing that a deadlock has been reached or, if we do not notify you that a deadlock has been reached, within 3 months of the date of your original complaint. You can obtain more information on the Ombudsman from the website www.iombudsman.org.nz.

The Ombudsman's address is:
Insurance and Savings Ombudsman
PO Box 10 845
Wellington 6143

You may also like to consult the Rules of the Southern Cross Medical Care Society which set out our formal disputes processes in relation to:

- disputes in relation to your membership of Southern Cross Medical Care Society;
- disputes relating to this **policy**.

You can obtain a copy of the Rules by calling our Member Services Centre or from our website.

Glossary of terms

(where not explained in earlier sections of this guide)

For explanations of medical terminology please look at the Medical Terms Glossary on our website www.southerncross.co.nz/society or contact our Member Services Centre.

Some terms used in this **guide** have been explained as they arose. Other terms are defined below:

ACC means the Accident Compensation Corporation referred to in the Injury Prevention, Rehabilitation and Compensation Insurance Act 2001 (or its successor).

ACC nominated average price means the price **ACC** deems appropriate for a particular **healthcare service** from time to time.

Accident means an accident as defined in the Injury Prevention, Rehabilitation and Compensation Insurance Act 2001 (or its successor), which includes a specific event, or a series of events, that involves the application of a force (including gravity) or resistance external to the human body, or involves the sudden movement of the body to avoid such a force or resistance external to the human body, and is not a gradual process.

Acute Care means care provided in response to a sign, symptom, condition or disease that warrants immediate or same day hospital admission for treatment or monitoring.

Adult means a person 21 years of age and over.

Affiliated Provider means a **health services provider** who **Southern Cross** has established a contractual relationship with for selected **healthcare services**.

Allowance means the fixed amount that we will contribute towards the cost of certain **eligible healthcare services** as specified in the **Coverage Tables**.

Ancillary hospital charges means anaesthetic supplies, dressings, pathology tests, **drugs** (which are prescribed and taken in hospital), intravenous fluids, and irrigating solutions, used whilst the member is hospitalised for an **eligible healthcare service**.

Angiography means MRI angiograms, CT angiograms, cardiac catheterisation and all coronary, renal and peripheral angiograms, and peripheral vascular angioplasty.

Annual limit(s) means, the maximum amount in respect of any one person that can be reimbursed in any one claims year.

Approved facility means, a **registered private hospital** or other healthcare facility approved by **Southern Cross**.

Chemotherapy drugs means prescription medicines for the treatment of cancer or neoplastic disease, prescribed or recommended by a registered oncologist in private practice, listed in the **Pharmac Schedule**, **Pharmac approved**, and not otherwise excluded by the terms of your **policy**.

Child means a person under 21 years of age.

Chronic conditions means cystic fibrosis, polycystic kidney, marfans syndrome, spina bifida, scoliosis, kyphosis, pectus excavatum and pectus carinatum.

Claims anniversary date means the date 12 months following the date the **policyholder** started on current plan and the anniversary each 12 months thereafter as specified on the current **Membership Certificate**.

Claims year means the first 12 months following the **policy start date** and each successive 12 month period from your **claims anniversary date**.

Congenital condition(s) means congenital anomalies or defects which are present at birth and for which the **policyholder** or **dependant** had either:

- (a) signs or symptoms of the condition prior to joining **Southern Cross**, or
- (b) signs or symptoms of the condition within 3 months of birth, as determined by **Souther Cross**.

Continuous cover means that the person covered by the **policy** must have had no break in cover for the particular **healthcare service** in this plan to which the **continuous cover** qualification relates to for the specified minimum period.

Cosmetic treatment means any surgery, procedure or treatment that improves, alters or enhances appearance, whether or not undertaken for medical, physical, functional, psychological or emotional reasons.

Course of treatment means the total chemotherapy treatment plan for each episode of cancer.

Coverage Table(s) means the table(s) set out on pages 16 to 23 of this **guide**, and any subsequent changes we make to those **Coverage Tables**.

Dependant means the husband/ wife or partner (including any former husband/wife or partner) of the **policyholder** and any **child** (including any stepchildren or adopted children) of the **policyholder**.

Detrimental to health means a medical condition that is causing significant problems for the physical health of an individual.

DHB means a District Health Board established under the New Zealand Public Health and Disability Act 2000, or its successor.

Disability support service(s) means support service(s) provided where a condition, disability or illness has been, or is likely to be, present for six months or more excluding surgical or medical treatment.

Drug(s) means subsidised prescription medicines, (and non-subsidised diabetic test strips and needles only), listed in the **Pharmac Schedule, Pharmac approved**, and not otherwise excluded by the terms of your **policy**.

Eligible means those private **healthcare services** which are:

- (a) listed in the applicable **Coverage Table** and/or in the **Schedule of Surgical Maximums** and comply with any applicable terms and conditions; and
- (b) are **medically necessary**; and
- (c) performed by a **Medical Practitioner** with vocational registration applicable to that **healthcare service** or by another **health services provider** with registration applicable to the **healthcare service**; and
- (d) a **healthcare service** for which costs are actually incurred or to be incurred; and
- (e) are not otherwise excluded under the terms of your **policy**.

Exclusion(s) means conditions, treatments or situations that are not covered by this **policy**, as expressed in this **guide** and the **Membership Certificate**.

Guide means this document which forms part of the **policy**.

Health screening means diagnostic test(s), investigation(s) or consultation(s) in the absence of any sign or symptom suggesting the presence of the illness disease or medical condition the screening is designed to detect.

Health services provider means a **Medical Practitioner** or registered practising member of certain professions allied to medicine who we approve for the provision of **healthcare services** under this **policy**.

Healthcare service(s) means any private surgery or other procedure, treatment, investigations, diagnostic test, consultation or other private **healthcare service** including hospitalisation provided by a **health services provider** or an **approved facility**.

Hospital fees means hospital costs for accommodation, parent accommodation with a **child** in hospital, operating theatre fees, anaesthetic supplies, intensive care and special in-hospital nursing, in-hospital x-rays, **ancillary hospital charges** and in-hospital post operative physiotherapy fees from a registered physiotherapist in private practice.

Lifetime means the duration of a **policyholder** or **dependant's** relationship with **Southern Cross** whether or not continuous.

Medical Practitioner must have the relevant registration with the Medical Council of New Zealand and be practising in private practice.

Medically necessary means **healthcare services** that in the opinion of **Southern Cross** are necessary for treatment of the health condition involved, are not experimental or unorthodox, and are widely accepted professionally as effective, appropriate and essential based upon recognised standards of the healthcare speciality involved.

Membership Certificate is the document we issue to the **policyholder** from time to time which details the key dates in respect of the **policy**, the people

covered and the level of cover and plans applicable, the **policyholder's Southern Cross** membership number, any specific **exclusions** from cover for **pre-existing conditions** applicable to the people covered under the **policy** known to **Southern Cross** at the date of issue of the certificate, and any other information specific to the **policy**.

Mole mapping is the process which uses technology such as digital computer images to aid in the monitoring and diagnosis of skin cancers and other skin lesions.

Multiple procedures means two or more surgical procedures performed simultaneously, sequentially or under the same anaesthetic.

New Zealand Resident means a person who is entitled to free public healthcare for all services as determined by the Ministry of Health from time to time, (including a New Zealand citizen, a holder of a resident visa, or a holder of a work visa valid for a minimum of two years).

Operation means all surgical procedures performed under one anaesthetic.

Oral Surgeon means an oral surgeon, oral medicine specialist or oral and maxillofacial surgeon registered with the Dental Council of New Zealand or a **Medical Practitioner** vocationally registered in Oral and Maxillofacial surgery.

Original date of joining means the most recent date of joining **Southern Cross** for each person covered by the **policy** as shown on your **Membership Certificate**.

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

Pharmac approved means any drug that would be routinely funded within the public system, taking into account all of the relevant clinical circumstances, criteria, prescribing guidelines, rules, conditions and/or restrictions published by **Pharmac** which must be met for a prescription medicine or related product to qualify for public subsidy.

Pharmac Schedule means the New Zealand Pharmaceutical Schedule managed by **Pharmac**, which lists prescription medicines and related products

subsidised by the Government, via the Ministry of Health.

Policy means the details on the Application Form and the **Membership Certificate**, this **guide**, the **Schedule of Surgical Maximums** and any amendment or variation made to them from time to time.

Policy anniversary date means:

- (a) in relation to a **policy** which is not part of a work scheme or association scheme, each anniversary of the **policy start date**, and is the date from which your **policy** will be renewed for the following year; and
- (b) in relation to a **policy** which is part of a work scheme or association scheme, the anniversary of the commencement date of the scheme under which your **policy** is provided and the date from which your **policy** will be renewed for the following year.

Policyholder means the person in whose name the **policy** is issued and who is responsible for the payment of premiums and to whom claims relating to the **policyholder** and any **dependants** covered by the **policy** are paid.

Policy limits means in relation to any **eligible healthcare services** the maximum amounts payable per procedure, per **operation**, per item, per day, per **course of treatment**, per **lifetime**, or as an **annual limit** as specified in the **Coverage Tables** or **Schedule of Surgical Maximums**, or as specified in our contract with an **Affiliated Provider**.

Policy start date is the date your **policy** commences as shown on your **Membership Certificate**.

Policy year means in relation to the first year of the **policy** the period from the **policy start date** to the first **policy anniversary date** and thereafter means the period from one **policy anniversary date** to the next.

Pre-existing Cardiac Schedule means a schedule of cardiac maximums applicable to members who have pre-existing cardiac conditions.

Pre-existing condition means any health condition occurring or existing, or any health condition which relates to a sign, symptom or event occurring or existing:

- (a) in relation to the **policyholder** and each **dependant** named in the Application Form, before the **policy start date**; and
- (b) in relation to any **dependant** added to the **policy** after the **policy start date**, before the date the relevant **dependant** was added to the **policy**; and
- (c) in relation to any upgrade after the **original date of joining**, before the date of upgrading; where the **policyholder** or the **dependant** was aware, or ought reasonably to have been aware, of the health condition, sign, symptom or event.

Prophylactic healthcare services means **healthcare service(s)** provided in the absence of any sign or symptom suggesting the presence of an illness, disease or medical condition, that seek to reduce or prevent the risk of an illness, disease or medical condition developing in the future.

Prostheses means surgically implanted parts of the body, such as artificial replacement hips or knees.

Registered private hospital means a certified facility registered as a private surgical or medical hospital, and licensed as such by the Ministry of Health.

Schedule or **Schedule of Surgical Maximums** sets out the **healthcare service** and level of cover for surgeon, anaesthetist and surgically implanted **prosthesis** costs for procedures specifically listed in the **Coverage Tables**. The **Schedule of Surgical Maximums** is available on our website www.southerncross.co.nz/society or by calling our Member Services Centre.

Sector Services means the Ministry of Health agency responsible for prescription authorisations and payment of **Pharmac** benefits.

Southern Cross means Southern Cross Medical Care Society.

Treatment injury means treatment injury as defined in the Injury Prevention, Rehabilitation and Compensation Insurance Act 2001 (or its successor) and includes personal injury that is suffered by a person seeking treatment from, or at the direction of, a registered health professional, that is caused by the treatment and that is not a necessary part or ordinary consequence of the treatment.

Unapproved healthcare services means any prescription **drugs**, devices, techniques, tests and/or other **healthcare services** that, at the sole discretion of **Southern Cross** prior to treatment, have either:

- (a) not been approved by us; or
- (b) which we determine are not widely used or practiced in New Zealand.

Varicose vein procedures means a procedure as defined in our contract with an **Affiliated Provider**.

We/us/our means Southern Cross Medical Care Society, having its registered office at Level 1, Ernst & Young Building, 2 Takutai Square, Auckland 1010.

You/your means the **policyholder** and any **dependant** named on the **Membership Certificate** (unless otherwise specified).

Visit our website

www.southerncross.co.nz/society

or call us on

0800 800 181

Southern Cross Medical Care Society

Level 1, Ernst & Young Building

2 Takutai Square, Auckland 1010

Private Bag 99934, Newmarket, Auckland 1149