



Southern Cross  
Health Society

# Wellbeing

Health insurance policy document

+ Skipping is good for you in so many ways. It can improve strength, speed, endurance, flexibility, balance and co-ordination.

# Welcome

## to your Wellbeing plan

Thank you for choosing us to help you take care of your health. This policy document sets out the benefits of your Wellbeing plan and it also provides information you need to make the most of your Southern Cross membership.



### The Wellbeing plan

**Wellbeing One** provides cover for surgical treatment and related expenses incurred within 4 months of surgical treatment, medical hospitalisation and other healthcare services listed in the **Coverage Tables** or the **List of Surgical Procedures**.

**Wellbeing Two** provides the same benefits as **Wellbeing One** plus cover for the consultations, diagnostic tests, and other **healthcare services** listed in the **Coverage Tables**, whether or not you undergo surgical treatment.

### Any time you need to contact us

**Member Services:** 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](http://www.southerncross.co.nz/society)

Please note that we may record and store telephone calls to and from Member Services. 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 31 of this **policy** document.

# Contents

## 5 01 Your policy

---

### 02 How to receive treatment and make a claim

- 6 How does cover work under my policy?
  - 7 What is an allowance?
  - 7 Does my policy have an excess and if so how does it work?
  - 7 Reasonable charges
  - 8 The prior approval process
  - 8 Affiliated Provider services
  - 10 The claiming process
  - 11 How does my Southern Cross policy fit with acute care?
  - 11 How does my Southern Cross policy fit with ACC?
- 

### 03 Existing medical conditions and commencement of cover

- 13 Pre-existing conditions
- 

### 04 Private healthcare services to which this policy applies

- 15 List of Surgical Procedures
- 

## 16 05 Which health service providers are covered?

---

### 06 Coverage Tables and exclusions

#### Wellbeing One

- 17 Surgical treatment
- 19 Surgical allowances
- 20 Recovery
- 20 Support
- 21 Imaging and diagnostics procedures
- 21 Tests
- 21 Consultations
- 22 Non-surgical hospitalisation
- 22 Cancer care
- 22 Psychiatric care

#### Wellbeing Two

- 23 Imaging and diagnostics procedures
  - 23 Tests
  - 23 Consultations
  - 23 Support
  - 24 Body Care Module - Preventative, allied and natural healthcare services
  - 24 Day-to-day Care Module - Day-to-day medical care
  - 25 Vision and Dental Care Module - Optical, dental and other healthcare services
  - 26 Exclusions
- 

### 07 Administrative information

- 28 Dependants
  - 29 Changing circumstances
- 

## 31 08 Your regulatory protection

---

## 34 09 Glossary of terms

# Your policy document

This policy document should be read in conjunction with your Membership Certificate, the Rules of Southern Cross, the List of Surgical Procedures and any subsequent information we send to you regarding changes to this policy document or any of these related documents.

## Terminology used in this policy document

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

Throughout this **policy** document, 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 Member Services 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 in writing (including on our website, by email or in our member magazine). The **policyholder** is responsible for

advising **dependants** of any changes to the **policy**. 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 policy document

In the remainder of this introductory section **you/your** means the **policyholder**. Benefits under this **policy** are part of your entitlement as a member of **Southern Cross**.

The **policy** comprises:

- the **Membership Certificate**,
- this **policy** document,
- the **List of Surgical Procedures**,
- the Rules of **Southern Cross**;  
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 name of your plan and level of cover or plan which applies,
- 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 **policy** document 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**, including how to make a change to it, and
- additional information relevant to your **policy**.

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

The **List of Surgical Procedures** forms part of this **policy** and is available on our website or by calling Member Services.

The **List of Surgical Procedures** 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 **List of Surgical Procedures**.

# Membership of Southern Cross

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** which are available on our website [www.southerncross.co.nz/rules](http://www.southerncross.co.nz/rules) or by calling Member Services.

Under the Rules, the **policyholder** is a member of **Southern Cross** and each of the **dependants** 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 your **dependants**) to be bound by the Rules of **Southern Cross**. On cancelling this **policy** the **policyholder's Southern Cross** membership will cease (and each of your **dependants** 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 30 of this **policy** document, then you will not become a **Southern Cross** member.

# Your policy

The Wellbeing **policy** provides you with a choice of two levels of cover (Wellbeing One or Wellbeing Two) and in respect of Wellbeing One, one additional module of cover (Body Care) and in respect of Wellbeing Two, up to three additional modules of cover (Body Care, Day-to-day Care, and Vision and Dental Care) for everyday health requirements. Your **Membership Certificate** details the level and modules that apply to you – based on what you selected on your Application Form.

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## LEVELS OF COVER

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**Wellbeing One** provides cover for surgical treatment, and related expenses incurred within 4 months of surgical treatment, medical hospitalisation and other **healthcare services** listed in the **Coverage Tables** or the **List of Surgical Procedures**.

**Wellbeing Two** provides the same benefits as Wellbeing One plus cover for the consultations, diagnostic tests, and other **healthcare services** listed in the **Coverage Tables**, whether or not you undergo surgical treatment.

**Body Care Module** provides cover for the preventative, allied and natural **healthcare services** listed in the **Coverage Tables** and can be added to either Wellbeing One or Wellbeing Two.

There are two additional modules that can be added to Wellbeing Two:

**Day-to-day Care Module** provides cover for an annual check up, **Medical Practitioner** Band I and Registered Nurse consultations, physiotherapy and prescriptions.

**Vision and Dental Care Module** provides cover for dental, optical and specified **healthcare services** listed in the **Coverage Tables**.

It is important to note that some parts of this **policy** document will not relate to you if you do not have the level or module concerned. We will make it clear throughout this **policy** document which level and modules are applicable to the section you are reading.

In return for payment of the premium, we agree to provide you with cover for **eligible healthcare services** as set out in this **policy** document. When we say “cover” throughout this **policy** document we mean cover for claims calculated in accordance with the chart on page 6.

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

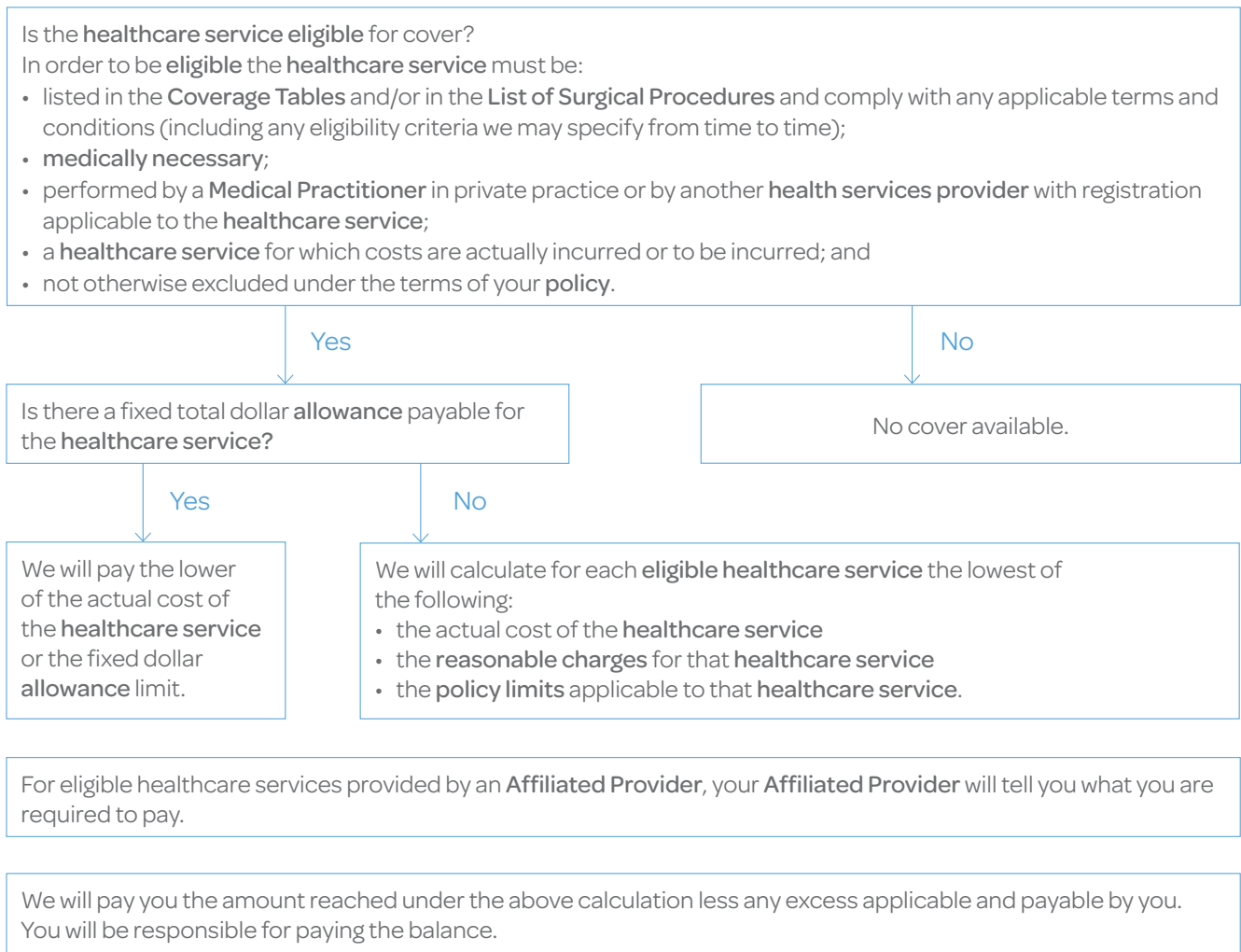
This section applies to all levels and modules

## How does 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 **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 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 9.



## 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**. 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. If the actual charges are less than the fixed total dollar **allowance** limit, we will pay the actual charges.

## Does my policy have an excess, and if so how does it work?

If you have chosen to have an excess on your **policy**, it will apply to any **eligible healthcare services** under Wellbeing One and Wellbeing Two, but will not apply to any optional modules you have chosen. We will only pay out on claims submitted in any one claims year once the total amount payable for those claims exceeds the excess.

The excess applies to each person covered under the policy for the duration of the **claims year**. When a new **claims year** starts, each person's excess will return to its full value again.

If you apply for prior approval (see pages 8 and 9) and we pay your **health services provider** directly, then you will have to pay your excess to your **health services provider** yourself.

## What does Southern Cross mean by "reasonable charges"?

**Reasonable charges** are charges for **healthcare services** determined by **Southern Cross** and are based on our ongoing review of:

- **health services provider** charges for a particular **healthcare service**;
- our claims statistics; and
- our knowledge of national and regional New Zealand health markets.

Our reviews take into account the relevant registration of the various **health services providers** in New Zealand providing that **healthcare service**, and the range of their fees for that **healthcare service**. For certain **healthcare services** and medical equipment and materials, we compare the range of fees for similar **healthcare services**, medical equipment or materials. The charges established as a result of this review process are referred to throughout this **policy** as **reasonable charges**.

## The prior approval process

Call us on 0800 800 181 to confirm whether your **healthcare service** is **eligible** for cover and the conditions that apply. You need to provide estimated charges from your **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** or the **reasonable charges** for your intended **healthcare services**.

You must contact us for prior approval if the cost of your **healthcare service** is likely to be over \$1,000 or where the **healthcare service** involves any hospitalisation (including day stay or in-patient surgery) regardless of the cost, unless you are using an **Affiliated Provider**. You should do this at least four working days prior to the **healthcare service** 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 service**.

If you do not contact us for prior approval before using the **healthcare service**, then you will have to pay the invoices yourself and then send 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 6. 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 **reasonable charges** or exceeding the **policy limits**.

## What is an Affiliated Provider and what are the benefits of using one?

Southern Cross has entered into contracts with certain **health services providers**. These providers are called **Affiliated Providers**.

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**.

A full list of **Affiliated Providers** and the **healthcare services** they offer can be found on our website, in the directory we issue or by calling Member Services. 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 (as long as the procedure is not **Affiliated Provider-only**). 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 **policy** document.

## Affiliated Provider-only procedures

For certain **healthcare services** specified in the **Coverage Tables** or **List of Surgical Procedures**, the **healthcare service** must be provided by an **Affiliated Provider** for that **healthcare service** to be covered under this **policy**. Please check with Member Services before proceeding with any of these **healthcare services**.

### 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 receive an outline of the treatment, risks associated with the treatment and an estimate of charges from your **health services provider** before treatment takes place. Please provide this to us when you apply for 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 surgical procedure at the same time?

When you have two or more surgical procedures simultaneously, sequentially or under the same anaesthetic there are special rules 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 Member Services 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, 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 Member Services 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 Member Services to discuss the additional surgery and apply for further prior approval. If the additional treatment relates to a **treatment injury** refer to page 11 for information.

### Which 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 under Wellbeing One (page 17) or related to non-surgical hospitalisation or psychiatric care under Wellbeing One (page 22).
- **Chemotherapy drugs** taken as part of chemotherapy treatment are covered as part of the cancer care benefit in Wellbeing One (page 22).
- Any other **drugs** or prescriptions are only covered under the prescription benefit in the Day-to-day Care Module (page 24).

Unless specifically stated otherwise, 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 34 to 37 of this **policy** document.

As an exception to the requirement for all drugs to be listed on the **Pharmac Schedule** and be **Pharmac approved**, we do allow you to claim non-**Pharmac approved** chemotherapy drugs but only as specifically listed under chemotherapy treatment in the **Coverage Tables**.

If the prescription **drug** you are prescribed requires a Special Authority from **Sector Services**, you are responsible for ensuring 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?

You need to provide 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 obtained 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?

Yes, 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.

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## HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACUTE CARE?

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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.

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## HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACC?

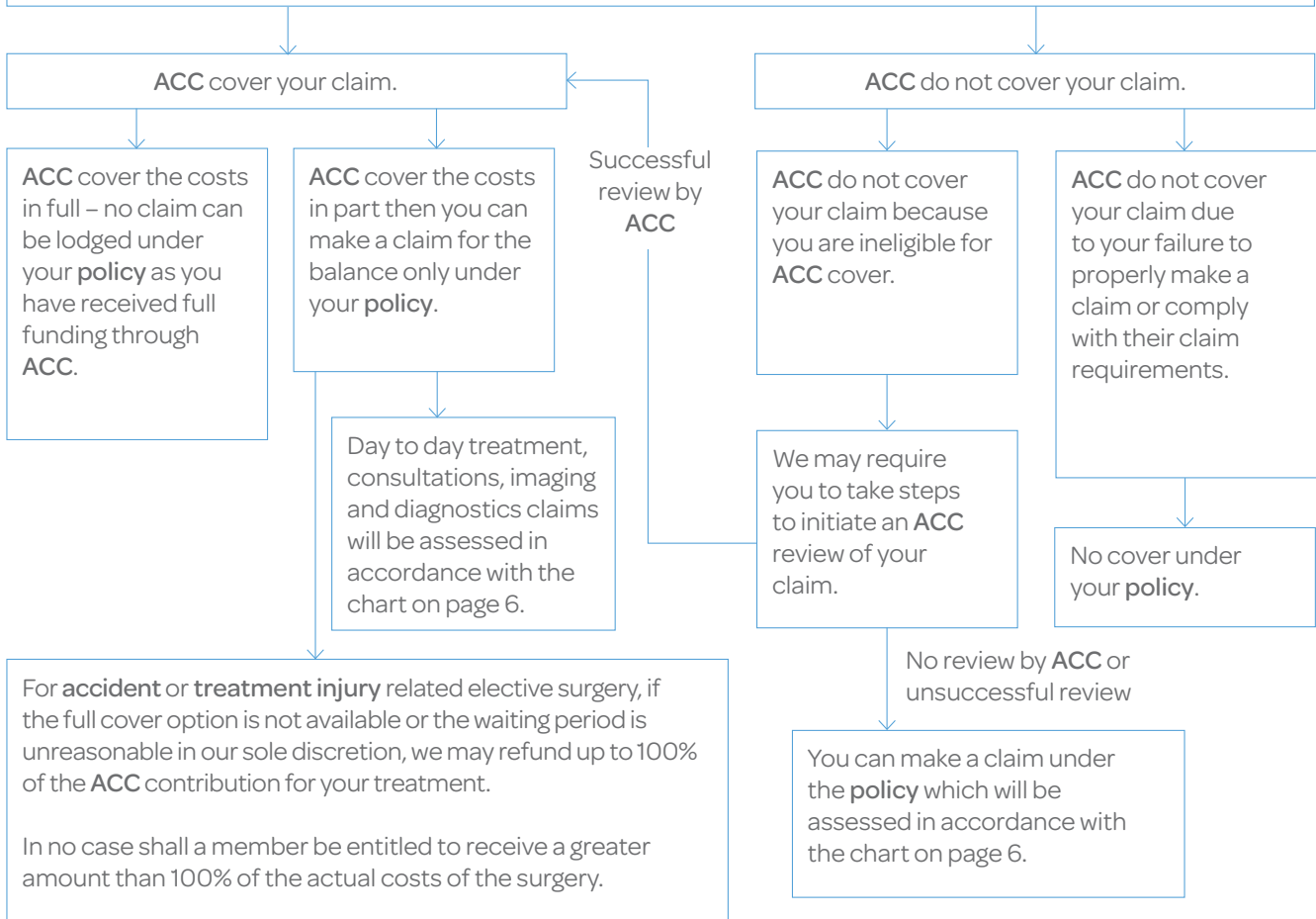
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Your Wellbeing plan will not provide cover for **accident** or **treatment injury** expenses that **ACC** is legally responsible for. In some cases **ACC** will not pay the full amount charged for your treatment. In these cases you may be able to make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

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.

Where you require a **healthcare service** related to an **accident** or **treatment injury** you must first make every reasonable effort to obtain **ACC** approval for payment of the cost of your **healthcare service**. This includes signing all documents and performing all acts necessary to permit **Southern Cross** to fully protect and realise any entitlement either on your behalf or in its own right.



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.

# Existing medical conditions and commencement of cover

This section applies to all levels and modules.

## 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.

When the **policyholder** completed the Application Form for this **policy** the **policyholder** declared the conditions, signs and symptoms for which the **policyholder** or any **dependant** had received treatment, or which the **policyholder** or any **dependant** knew about at 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**. You will not have cover for that **pre-existing condition** for the duration of your **policy**, except where we review excluded **pre-existing conditions** in accordance with the review procedure set out following, and agree to cover a **pre-existing condition**.

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 **policy** document.

## Review of pre-existing conditions

For some **pre-existing conditions** which have been excluded from cover, you can request a review of that **exclusion** after the person affected by that **pre-existing condition** has had **continuous cover** under the **policy** for a specified period of time. If the review procedure applies to you, your **Membership Certificate** will state the review period which applies to that excluded **pre-existing condition**. The review period commences from the date the **exclusion** was applied. If we do not offer cover for the excluded **pre-existing condition** after the first review you can request further reviews after time intervals equivalent to the review period.

A review is initiated when either the **policyholder** or the **dependant** affected by the excluded **pre-existing condition** asks us to conduct the review (following the expiry of the relevant review period). The person requesting the review must supply us with appropriate medical and other documentation. The decision as to whether the excluded **pre-existing condition** will be removed as an exclusion will be made in **Southern Cross'** sole discretion.

## Declaration of pre-existing conditions

If the **policyholder** did not declare an existing medical condition, signs or symptoms of such condition which the **policyholder** or any **dependant** knew about, or ought reasonably to have known about, on the Application Form, and the relevant person subsequently requires treatment for that 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.

## When does cover under the policy commence?

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

There is 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 for newborn **dependent** children added within 3 months of birth, who are covered from the date of their addition).

Also, there is no cover for any **healthcare services** covered by any Module added to the **policy** for 3 months following the date of such addition (except if the Day-to-day Care Module is added, under which cover starts immediately).

# Private healthcare services to which this policy applies

The **Coverage Tables** set out on pages 17 to 25 give details of **healthcare services** which are covered under each level and module, together with details of **policy limits** and other terms and conditions of cover.

The following terms and conditions of cover apply to all of the levels and modules.

## List of Surgical Procedures

We publish a **List of Surgical Procedures** for which we provide cover. This list is referred to throughout this **policy** as the **List of Surgical Procedures**. If a **healthcare service** is not listed in the **Coverage Tables** or on the **List of Surgical Procedures**, 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 **List of Surgical Procedures**, you should discuss this with Member Services before you proceed with the **healthcare service**.

We may change the **List of Surgical Procedures** 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 **policy** document.

We assess new or additional procedures or technologies 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 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 **Southern Cross**, 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.

## Eligibility criteria

We may from time to time put eligibility criteria in place to specify any additional terms and conditions that may apply to a particular benefit. These eligibility criteria are available on request.

# Which health service providers are covered?

This section applies to all levels and modules.

## 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 under Wellbeing One, Wellbeing Two and the Day-to-day Care Module 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 Member Services.

## 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 Wellbeing One, Wellbeing Two and modules for Body Care, Day-to-day Care and Vision and Dental Care. 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 6 for how your refund will be calculated, and to the explanation of **Medical Practitioners** and the Bands in which they practice on page 16 of this **policy** document. All figures include GST charged by the providers.

## Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>SURGICAL TREATMENT</b>		
Surgical procedures	\$100,000 per operation	Performed by a <b>Medical Practitioner</b> Band II, III or IV, an <b>Oral surgeon</b> or a <b>Medical Practitioner</b> vocationally registered in diagnostic and interventional radiology in private practice and in an <b>approved facility</b> .
Surgeon's operating fee		
Anaesthetist's fee		
Intensivist's fee		
Laparoscopic disposables		
Operating theatre fee		
Hospital accommodation		
Intensive post operative care and special in-hospital nursing		
In-hospital x-ray examination and ECG		
In-hospital post-operative physiotherapy		
<b>Ancillary hospital charges</b>		Refer to the <b>List of Surgical Procedures</b>
Surgically implanted prostheses	Policy limits will apply	
<b>Angiography</b>	\$100,000 per operation	Performed by a <b>Medical Practitioner</b> Band III or IV or a <b>Medical Practitioner</b> vocationally registered in diagnostic and interventional radiology in private practice and in an <b>approved facility</b> .
Stent for peripheral vascular angioplasty	Refer to the Prosthesis section of the <b>List of Surgical Procedures</b>	
CT coronary angiogram	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for CT coronary angiogram unless procedure performed by an <b>Affiliated Provider</b> . In order to receive cover the treatment must be <b>medically necessary</b> , as determined by the eligibility criteria. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
Cardiac surgery	\$100,000 per operation	Performed by a <b>Medical Practitioner</b> Band IV in private practice and in an <b>approved facility</b> .
Surgeon's operating fee		
Anaesthetist's fee		
Intensivist's fee		
Perfusionist's charge		
Operating theatre fee		
Hospital accommodation		
<b>Ancillary hospital charges</b>		
In-hospital x-ray examination and ECG		
In-hospital post-operative physiotherapy		
Intensive post-operative care and special in-hospital nursing		
Surgically implanted prostheses	Policy limits will apply	Refer to the Prosthesis section of the <b>List of Surgical Procedures</b> .

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>SURGICAL TREATMENT (continued)</b>		
Coronary angioplasty	\$100,000 per operation	Performed by a <b>Medical Practitioner</b> Band III in private practice and in an <b>approved facility</b> .  No cover for angioplasty using Drug Eluting Stent(s) unless performed by an <b>Affiliated Provider</b> .
Renal lithotripsy	\$100,000 per claims year	Performed by a registered urologist in private practice and in an <b>approved facility</b> .
Cardioversion	\$1,470 per procedure	Performed by a <b>Medical Practitioner</b> Band III in private practice and in an <b>approved facility</b> and includes any charges by a <b>Medical Practitioner</b> Band IV vocationally registered in anaesthesia.
Minor skin surgery	\$7,500 per claims year	Performed by a <b>Medical Practitioner</b> Band III or IV in private practice under a local anaesthetic. Excludes Mohs surgery - refer to the benefit on page 19.
Minor surgery	\$450 per operation	Performed by a <b>Medical Practitioner</b> Band I in private practice, including removal of cysts, skin lesions and ingrown toenails.
Other procedures	\$350 per procedure	Performed by a <b>Medical Practitioner</b> Band I in private practice, includes hormone implants and plaster casts.
Varicose vein (legs)	2 varicose vein procedures per leg per lifetime.  Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for varicose veins unless the treatment is provided by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> 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 <b>medically necessary</b> , as determined by the eligibility criteria, and not for <b>cosmetic treatment</b> . 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 receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for a colonoscopy unless the procedure is carried out by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas. In order to receive cover the colonoscopy must be <b>medically necessary</b> , as determined by the eligibility criteria and not for <b>health screening</b> .
Gastroscopy	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for a gastroscopy unless the procedure is carried out by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas. In order to receive cover the gastroscopy must be <b>medically necessary</b> , as determined by the eligibility criteria and not for <b>health screening</b> .
Cataract surgery	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for cataract surgery unless carried out by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> 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 <b>eligible</b> cataract surgery.
Intravitreal injections	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for Intravitreal injections unless carried out by an <b>Affiliated Provider</b> , if there is an <b>Affiliated Provider</b> within 100km of your home. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>SURGICAL TREATMENT (continued)</b>		
Mohs surgery	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for Mohs surgery unless carried out by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas. In order to receive cover the treatment must be <b>medically necessary</b> and not for <b>cosmetic treatment</b> , as determined by the eligibility criteria. This benefit includes cover for excision and closure, and follow-up consultations within 6 weeks of <b>eligible</b> Mohs surgery.
Prostate treatment	Policy limits will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	No cover for Laparoscopic Prostatectomy, Prostate Brachytherapy, External Beam Radiotherapy and Prostate Cryotherapy, Radical Retropubic Prostatectomy, Perineal Prostatectomy, Transurethral Resection of Prostate (TURP) and Laser Prostatectomy procedures unless the treatment is provided by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
<b>SURGICAL ALLOWANCES</b>		
Sterilisation allowance	\$5,000 one-off payment	After one year of <b>continuous cover</b> in this plan. (Does not include reversals).
Gastric banding/bypass allowance	\$7,500 one-off payment	After three years of <b>continuous cover</b> in this plan. Payable at the discretion of <b>Southern Cross</b> on receipt of a medical report prior to surgery performed by a <b>Medical Practitioner</b> Band IV (this benefit also includes any subsequent treatment that may be required).
Bilateral breast reduction allowance	\$5,000 one-off payment	After three years of <b>continuous cover</b> in this plan. Payable at the discretion of <b>Southern Cross</b> on receipt of a medical report prior to surgery performed by a <b>Medical Practitioner</b> Band IV (this benefit also includes any subsequent treatment that may be required).
Post mastectomy allowance to achieve breast symmetry	\$2,500 one-off payment per <b>lifetime</b>	Payable at the discretion of <b>Southern Cross</b> on receipt of a medical report prior to surgery performed by a <b>Medical Practitioner</b> Band IV. Surgery must be completed within 2 years of initial reconstruction following <b>eligible</b> mastectomy.
Overseas treatment allowance	\$10,000 per claims year	Reimbursement of medical expenses for <b>medically necessary</b> treatment not available in the public or private sector within New Zealand. The treatment must be recommended by a <b>Medical Practitioner</b> Band III or IV in private practice. <b>Southern Cross</b> must approve the treatment based on a medical report you provide before treatment takes place. Ordinary <b>policy exclusions</b> apply. No reimbursement for accommodation or travel.

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>RECOVERY</b>		
		Must be within 4 months after surgery. The preceding surgery must have been eligible for cover under your policy.
Home nursing	\$125 per day up to \$2,000 per claims year	Post-operative nursing commencing within 14 days of related surgery and performed by a Registered Nurse Band I or II in private practice and on referral of a registered <b>Medical Practitioner</b> in private practice.
Speech and language therapy	\$70 per visit up to \$350 per claims year	Post-operative treatment by a qualified speech and language therapist who is a member of the NZSTA and on the referral of a registered <b>Medical Practitioner</b> .
Post-operative physiotherapy	\$60 per visit up to \$300 per claims year	Post-operative treatment by a physiotherapist registered with the Physiotherapy Board of New Zealand and in private practice.
<b>SUPPORT</b>		
Ambulance allowance	\$180 per claims year	Only for a public facility or an <b>Affiliated Provider</b> in-patient admission.
Parent accommodation	\$100 per night up to \$500 per claims year	For hospital accommodation expenses incurred by a parent when accompanying a <b>dependant child</b> . Both parent and child must be listed on the <b>Membership Certificate</b> .  Accommodation must be in an <b>approved facility</b> .
Travel and accommodation allowance	\$500 per claims year	When private treatment is not available in your home town or city and you have to travel more than 100km from home to receive an <b>eligible healthcare service</b> . Allowance payable to cover the person covered by this <b>policy</b> receiving the <b>eligible healthcare service</b> and a support person. Allowance payable for public transport costs and hotel/motel rooms within New Zealand only.
Hospital cash allowance	<b>Child:</b> \$25 per night up to \$250 per admission up to \$1,200 per claims year  <b>Adult:</b> \$50 per night up to \$500 per admission up to \$2,400 per claims year	For overnight admissions of two nights or more in a public facility for surgery. A copy of the hospital discharge summary must accompany the claim form. Excludes maternity, <b>accident</b> and <b>treatment injury</b> admissions.
Waiver of premium	2 years free cover	Upon the death of the <b>policyholder</b> from a cause other than an <b>accident</b> , before age 60 years, the surviving <b>dependants</b> will continue to qualify for cover provided by the existing <b>policy</b> free of charge for 24 months from the date of the <b>policyholder's</b> death.
Funeral allowance	\$2,400 one off payment	On the death of any current member before age 65 years, from a causes other than an <b>accident</b> . This <b>allowance</b> is payable to the estate or guardian.

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>IMAGING AND DIAGNOSTIC PROCEDURES</b>		Diagnostic imaging performed by a registered radiologist in private practice. Must be within 4 months before or after surgery. (Not available where Wellbeing Two purchased).
Computed Axial Tomography (CT/CAT Scan)	\$1,500 per claims year	Excludes calcium scoring.
Magnetic Resonance Imaging (MRI)	\$2,000 per claims year	On referral by a <b>Medical Practitioner</b> Band II, III or IV and in private practice.
Myocardial perfusion scan	\$1,500 per test	On referral by a <b>Medical Practitioner</b> Band III or IV.
X-rays	\$500 per claims year	Excluding x-rays performed by a dentist, chiropractor or an <b>Oral surgeon</b> .
Ultrasounds	\$500 per claims year	Excluding obstetrics and varicose vein (legs) treatment.
Mammography	\$500 per claims year	
Nuclear scanning (scintigraphy)	\$700 per claims year	
Positron Emission Tomography / Computed Tomography (PET/CT)	\$2,500 per claims year	No cover for PET/CT unless the service is provided by an <b>Affiliated Provider</b> . Cover is limited to cancer indications only and eligibility criteria will apply.  On referral by a <b>Medical Practitioner</b> Band III or IV in private practice, performed by a <b>Medical Practitioner</b> vocationally registered in diagnostic and interventional radiology in private practice. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
<b>TESTS</b>		On referral by a <b>Medical Practitioner</b> Band III or IV and in an approved facility. Must be within 4 months before or after surgery. (Not available under Wellbeing Two).
Cardiac tests	\$5,000 per claims year	Limited to the procedures listed in section 14 of the <b>List of Surgical Procedures</b> .
Diagnostic tests	\$3,000 per claims year	Limited to the procedures listed in section 14 of the <b>List of Surgical Procedures</b> .  Optical Coherence Tomography is only available following a referral by a <b>Medical Practitioner</b> Band IV and must be performed by an <b>Affiliated Provider</b> , if there is an <b>Affiliated Provider</b> within 100km of your home. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
<b>CONSULTATIONS</b>		Must be within 4 months before or after surgery.
<b>Medical Practitioner Band II</b> Initial consultation Follow-up consultation	\$150 per consultation \$115 per consultation	
<b>Medical Practitioner Band III</b> Initial consultation Follow-up consultation	\$300 per consultation \$125 per consultation	Includes allergy tests when performed by a <b>Medical Practitioner</b> Band III.
<b>Medical Practitioner Band IV</b> Initial consultation Follow-up consultation	\$175 per consultation \$125 per consultation	Including consultations by a <b>Medical Practitioner</b> Band IV vocationally registered in anaesthesia for chronic pain or pre-operative clinic consultations only.
<b>Oral surgeon</b> Initial consultation Follow-up consultation	\$175 per consultation \$125 per consultation	Consultations (including x-rays) by an <b>Oral surgeon</b> in private practice.

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing One - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>NON SURGICAL HOSPITALISATION</b>		
Medical hospitalisation		On referral by a <b>Medical Practitioner</b> Band II, III or IV for treatment or observation in an <b>approved facility</b> , other than when following surgery, and under the control of a <b>Medical Practitioner</b> Band II, III or IV. Excludes hospice, geriatric, oncology and psychiatric hospital care.
Hospital accommodation	\$700 per night or per day stay up to \$25,000 per <b>claims year</b> .	Single room basis, excludes suites.
Ancillary hospital charges	\$200 per <b>claims year</b>	
<b>CANCER CARE</b>		
Oncologist consultations Initial consultation Follow-up consultation	\$300 per consultation \$125 per consultation	Consultations by a registered oncologist in private practice.
Chemotherapy treatment	up to \$60,000 per <b>claims year</b>	For treatment provided by a <b>Medical Practitioner</b> Band III or IV vocationally registered in oncology in private practice. Includes cost of materials and <b>chemotherapy drugs</b> , hospital accommodation in a single room and <b>ancillary hospital charges</b> .  Maximum also includes payment of 50% of the cost (up to a maximum of \$10,000 per <b>claims year</b> ) for non- <b>Pharmac approved MedSafe</b> indicated chemotherapy drugs.
Radiotherapy treatment	<b>Policy limits</b> will apply. Prior to receiving treatment your <b>Affiliated Provider</b> will advise the balance payable by you.	Cover for radiotherapy treatment is only available when the procedure is provided by an <b>Affiliated Provider</b> . Please be aware that not all procedures are available from all <b>Affiliated Providers</b> 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, <b>drugs</b> , hospital accommodation, other <b>healthcare service(s)</b> , or follow-up CT scans).
Palliative care and treatment allowance	\$2,000 per <b>claims year</b>	Payable at the discretion of <b>Southern Cross</b> following three years of <b>continuous cover</b> in this plan.
<b>PSYCHIATRIC CARE</b>		
Psychiatric consultations	\$750 per <b>claims year</b>	Performed by a <b>Medical Practitioner</b> vocationally registered in psychiatry and in private practice.
Psychiatric hospitalisation Hospital accommodation	\$700 per night or per day stay up to \$3,500 per <b>claims year</b>	Referred by and under the care of a <b>Medical Practitioner</b> vocationally registered in psychiatry and in private practice, for treatment, convalescence or observation in an <b>approved facility</b> .
Ancillary hospital charges	\$200 per <b>claims year</b>	
<b>BEING ACTIVE</b>		
Being Active	up to \$50 every second <b>claims year</b>	After three years of <b>continuous cover</b> in this plan.  Payable on receipt of proof of completion of a <b>sports event</b> and payment of the related entry fees.

\*See the chart on page 6 for how your refund will be calculated.

# Wellbeing Two - Coverage Tables

Includes all cover from Wellbeing One (except for Imaging and Diagnostic Procedures and Tests) plus the following cover

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
<b>IMAGING AND DIAGNOSTIC PROCEDURES</b>		
		Diagnostic imaging performed by a registered radiologist in private practice.
Computed Axial Tomography (CT/CAT Scan)	\$1,500 per claims year	Excludes calcium scoring.
Magnetic Resonance Imaging (MRI)	\$2,000 per claims year	On referral by a <b>Medical Practitioner</b> Band II, III or IV and in private practice.
Myocardial perfusion scan	\$1,500 per test	On referral by a <b>Medical Practitioner</b> Band III or IV.
X-rays	\$500 per claims year	Excluding x-rays performed by a dentist, chiropractor or an <b>Oral surgeon</b> .
Ultrasounds	\$500 per claims year	Excluding obstetrics and varicose vein (legs) treatment.
Mammography	\$500 per claims year	
Nuclear scanning (scintigraphy)	\$700 per claims year	
Positron Emission Tomography / Computed Tomography (PET/CT)	\$2,500 per claims year	No cover for PET/CT unless the service is provided by an <b>Affiliated Provider</b> . Cover is limited to cancer indications only and eligibility criteria will apply.  On referral by a <b>Medical Practitioner</b> Band III or IV in private practice, performed by a <b>Medical Practitioner</b> vocationally registered in diagnostic and interventional radiology in private practice. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
<b>TESTS</b>		
		On referral by a <b>Medical Practitioner</b> Band III or IV and in an approved facility.
Cardiac tests	\$5,000 per claims year	Limited to the procedures listed in section 14 of the <b>List of Surgical Procedures</b> .
Diagnostic tests	\$3,000 per claims year	Limited to the procedures listed in section 14 of the <b>List of Surgical Procedures</b> .  Optical Coherence Tomography is only available following a referral by a <b>Medical Practitioner</b> Band IV and must be performed by an <b>Affiliated Provider</b> , if there is an <b>Affiliated Provider</b> within 100km of your home. Please be aware that not all procedures are available from all <b>Affiliated Providers</b> or in all areas.
Laboratory tests	\$70 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.
<b>CONSULTATIONS</b>		
<b>Medical Practitioner Band II</b>		
Initial consultation	\$150 per consultation	
Follow-up consultation	\$115 per consultation	
<b>Medical Practitioner Band III</b>		
Initial consultation	\$300 per consultation	Includes allergy tests when performed by a <b>Medical Practitioner</b> Band III.
Follow-up consultation	\$125 per consultation	
<b>Medical Practitioner Band IV</b>		
Initial consultation	\$175 per consultation	Including consultations by a <b>Medical Practitioner</b> Band IV vocationally registered in anaesthesia for chronic pain or pre-operative clinic consultations only.
Follow-up consultation	\$125 per consultation	
<b>Oral surgeon</b>		
Initial consultation	\$175 per consultation	Consultations (including x-rays) by an <b>Oral surgeon</b> in private practice.
Follow-up consultation	\$125 per consultation	
<b>SUPPORT</b>		
Obstetrics allowance	\$1,250 per claims year	After three years of <b>continuous cover</b> in this plan. Reimbursement of expenses from a <b>Medical Practitioner</b> vocationally registered in obstetrics and gynaecology or anaesthesia, and/or for accommodation in an <b>approved facility</b> .

\*See the chart on page 6 for how your refund will be calculated.

## OPTIONAL MODULES

### Body Care Module – Preventative, allied and natural healthcare services

Can be added to either Wellbeing One or Wellbeing Two plans

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
Health management: dietitian/nutritionist consultations	\$45 per visit up to \$225 per <b>claims year</b>	Performed by a dietitian registered with the NZ Dietitian Board or a nutritionist registered with the Nutrition Society of New Zealand and in private practice. Excludes the cost of food and food substitutes.
Podiatry consultations	\$40 per visit up to \$200 per <b>claims year</b>	Performed by a podiatrist registered with the Podiatrists Board of New Zealand and in a private practice.
Podiatry surgery	\$180 per <b>claims year</b>	Performed by a podiatrist or podiatric surgeon registered with the Podiatrists Board of New Zealand and in a private practice.
Cover for the four <b>healthcare services</b> following is limited to \$500 per <b>claims year</b> in total:		
Acupuncture	\$400 per <b>claims year</b>	Performed by an acupuncturist registered with the New Zealand Register of Acupuncturists (NZRA), the NZ Acupuncture Standards Authority (NZASA) or the NZ Chinese Medicine and Acupuncture Society (NZCMAS) and in private practice.
Osteopathy or Chiropractic	\$400 per <b>claims year</b>	Performed by a chiropractor registered with the New Zealand Chiropractic Board or by an osteopath registered with the Osteopathic Council of New Zealand and in private practice. Includes the cost of x-rays. Excludes the cost of medication.
Homeopathy or naturopathy consultations	\$400 per <b>claims year</b>	Performed by a homeopath registered with the New Zealand Council of Homeopaths or by a naturopath registered with the New Zealand Society of Naturopaths and in private practice. Excludes the cost of medication.
Remedial massage therapy	\$400 per <b>claims year</b>	Performed by an Remedial Massage Therapist registered with Massage New Zealand and in private practice.

### Day-to-day Care Module – Day-to-day medical care

Can be added to Wellbeing Two plan only

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
Annual health check	\$90 per <b>claims year</b>	Performed by a <b>Medical Practitioner</b> .
Flu vaccination	One vaccination per <b>claims year</b>	
<b>Medical Practitioner</b> Band I Clinical consultation	\$55 per consultation	
Home or After Hours consultation	\$65 per consultation	
Registered Nurse Bands I and II consultations	\$30 per consultation	Only applicable where no <b>Medical Practitioner</b> Band I fee applies.
Prescriptions	\$400 per <b>claims year</b>	Charges for prescription <b>drugs</b> prescribed by a <b>Medical Practitioner</b> (all Bands) or Band II Registered Nurse Practitioner
Physiotherapy consultations and treatment	\$60 per consultation/ treatment up to \$300 per <b>claims year</b>	On referral by a <b>Medical Practitioner</b> Band I and provided by a physiotherapist registered with the Physiotherapy Board of New Zealand and in private practice.

\*See the chart on page 6 for how your refund will be calculated.

## Vision and Dental Care Module – Optical, dental and other benefits

Can be added to Wellbeing Two plan only

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS OF COVER
Spectacles / lenses	75% of expenses incurred up to \$400 per claims year	Provision of prescription spectacles and contact lenses, including repair or replacement for loss or breakage, prescribed by a registered ophthalmologist, a registered optometrist, or a registered optician in private practice. Please note: Benefit is inclusive of frames and lenses. New lenses required as a result of change of vision are claimable. Prescription lenses and frames must be purchased at the same time for the frames to qualify for cover.
Optometrist consultation	\$50 per claims year	Must be an optometrist registered with the New Zealand Opticians Board and in private practice.
Orthoptist consultations	\$200 per claims year	Performed by a registered orthoptist in private practice.
Dental consultations and treatment	75% of expenses up to \$500 per claims year	Performed by a Dental Practitioner registered with the Dental Council of New Zealand, endodontist, periodontist or orthodontist in private practice.
Hygienist consultations and treatment	75% of expenses up to \$100 per claims year	Performed by a hygienist registered with the Dental Council of New Zealand and in private practice.
Audiology consultations and hearing tests	\$200 per claims year	Performed by an audiologist registered with the New Zealand Audiological Society and in private practice.
Brain stem evoked response tests	\$210 per claims year	

\*See the chart on page 6 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 **List of Surgical Procedures**. 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 Prosthesis section of the **List of Surgical Procedures**;
- **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 in this **policy** document;
- 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 16, 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 11 of this **policy** document;
- **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 unless specifically provided under the Day-to-day Care Module;
- 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** or the health management benefit under the Body Care Module;
- 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;
- Pre-existing cardiac conditions, unless otherwise specified on your **Membership Certificate**;
- Pregnancy and childbirth except 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, except as specifically provided under dental benefit in the Vision and Dental Care Module;
- Sterilisation (except as specifically provided by the sterilisation benefit 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**, except as specifically provided under the Body Care and Day-to-day Care Modules;
- **Unapproved healthcare services**;
- Vaccinations except as specifically provided under the Day-to-day Care Module.

## Administrative information

This section applies to all levels and modules. In this section, when we say **you/your** we refer to the **policyholder**.

This **policy** commences on the **policy start date**. The **policy anniversary date** is the anniversary of the **policy start 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** may be reset to start on the date of such change. The new **policy anniversary date** will be the anniversary of the date of the change.

If your **policy** is provided 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 communications about my policy?

Unless otherwise advised, or unless you have chosen to receive communications electronically, we will send every notice or other communication required to be sent by **Southern Cross** relating to you, this **policy**, or any **dependant**, to the **policyholder** at his or her last known address and such notice 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, residential or email 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 a medical declaration for the **dependant** being added. We will determine whether we will cover any **pre-existing conditions** disclosed on the medical declaration. 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 26 of this **policy** document. 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 declaration for the **child** and we will determine whether we will cover any **pre-existing conditions** disclosed on the medical declaration. 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 request to remove the **dependant** in writing or by calling Member Services. 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 medical declaration for them. They will not have cover for **pre-existing conditions** existing prior to the date they are added back on to your **policy** 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 my policy?

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

Changing your level of cover on your **policy** is not allowed during the first 3 months of cover.

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**;
- if you upgrade at any time other than on a **policy anniversary date**, any health conditions affecting you or any **dependant** that have developed since you first took out the Wellbeing **policy**, will be treated as **pre-existing conditions** and will be excluded;
- if you upgrade at the **policy anniversary date**, cover for such conditions will continue at the same level as under the **policy** prior to the upgrade;

- if you upgrade or downgrade your **policy** any **pre-existing condition exclusions** affecting you or any **dependant** will remain;
- if you upgrade or downgrade your **policy** the **claims year** and excess for you and each **dependant** 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** have the same **claims year** regardless of when a particular person was added to the **policy**. **Annual limits** applicable to levels and modules 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**.

## 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 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**, 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 **dependant** 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 Member Services 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** 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 **pre-existing 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 this **policy** document and your **Membership Certificate**, 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 Member Services.

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** 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

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## PRIVACY

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Privacy of information relating to you and your **dependants** 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**;
- to process and investigate claims made under your **policy**; and
- for statistical purposes (although for this purpose neither you nor any of your **dependants** 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. 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 **health services providers**, medical authorities or the third party authorised by you or any other party as required by law, 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, suppliers 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** 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 **dependants'** 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** 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 Member Services.

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 **policy** document.

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**).

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 Member Services.

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## FINANCIAL ADVICE

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**Southern Cross** is a Qualifying Financial Entity (QFE). We take responsibility for any financial advice our staff and advisers provide on the **Southern Cross** range of health insurance products. We are licensed and regulated by the Financial Markets Authority for that financial advice. For more information and a copy of our disclosure statement please visit [www.southerncross.co.nz/disclosure-statement](http://www.southerncross.co.nz/disclosure-statement).

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## FINANCIAL STRENGTH RATING

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**Southern Cross** has elected to be rated by Standard & Poor's. This rating 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, our website [www.southerncross.co.nz/society](http://www.southerncross.co.nz/society), or in the latest health insurance sales brochure.

You can also obtain background information from Standard and Poor's website [www.spglobal.com](http://www.spglobal.com).

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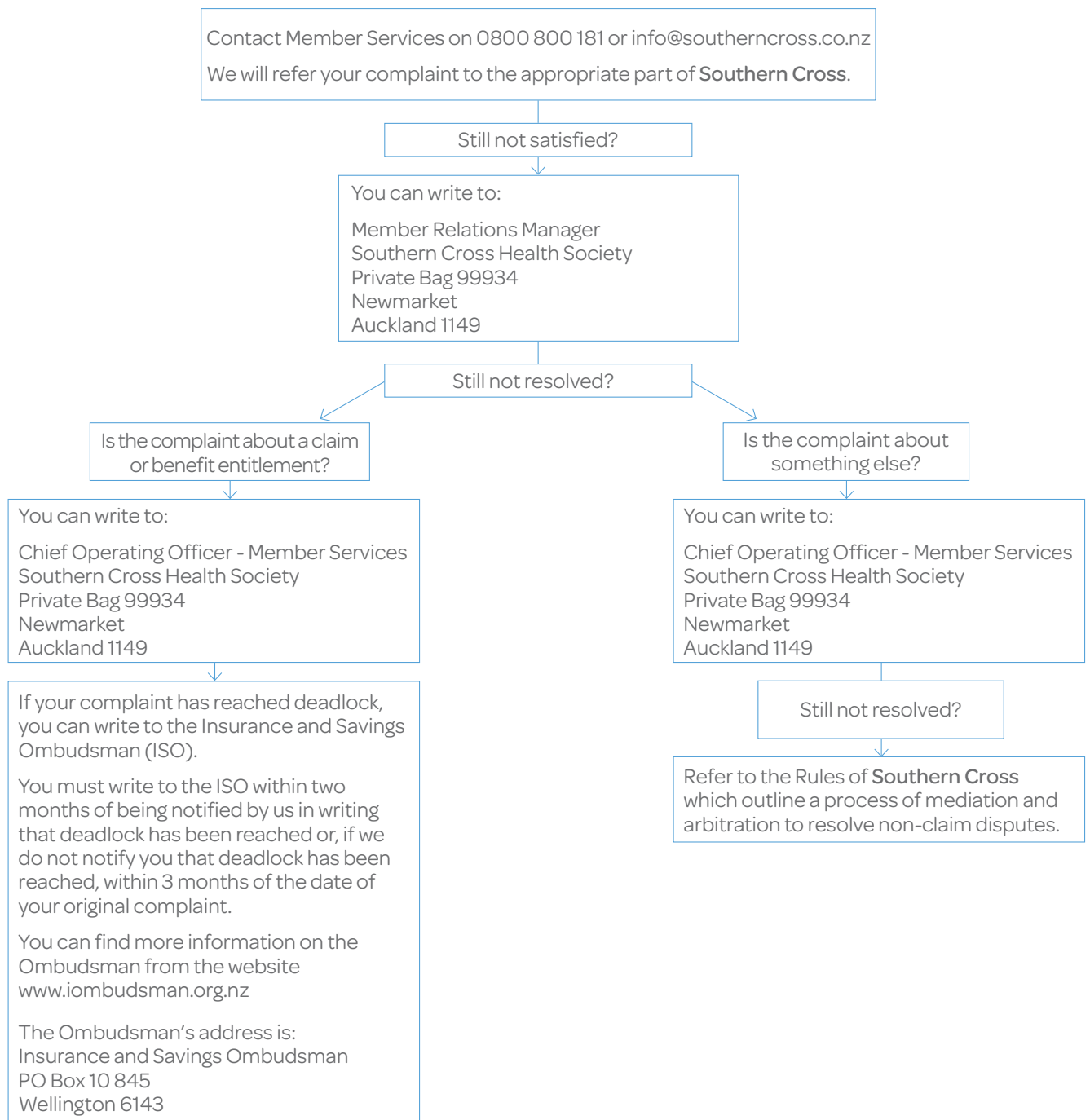
## INDUSTRY ORGANISATIONS

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**Southern Cross** 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 any industry code issued by the Health Funds Association of New Zealand.

## COMPLAINTS PROCEDURE

If you are unhappy with our service or our treatment of your policy or claim you can follow the process outlined below.



You can get a copy of the Rules from our website [www.southerncross.co.nz/rules](http://www.southerncross.co.nz/rules) or by calling Member Services.

# Glossary of terms

For explanations of medical terminology please look at the Medical Terms Glossary at our website [www.southerncross.co.nz/society](http://www.southerncross.co.nz/society) or contact Member Services.

Some terms used in this **policy** document 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).

**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 has entered into a contract with **Southern Cross** to provide certain **healthcare services** at agreed prices.

**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 **certified private facility** or other healthcare facility approved by **Southern Cross**.

**Certified private facility** means a private surgical or medical facility certified as such by the Ministry of Health.

**Chemotherapy drugs** means prescription medicines for the treatment of cancer or neoplastic disease, prescribed or recommended by a registered oncologist in private practice, listed on 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 **Southern 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 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.

**Coverage Table(s)** means the table(s) set out on pages 17 to 25 of this **policy** document, 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** (or the **policyholder's** husband/wife or partner) who are listed on the **Membership Certificate**.

**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 on 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 Tables**; and/or in the **List of Schedule Procedures** and comply with any applicable terms and conditions (including any eligibility criteria we may specify from time to time);
- (b) **medically necessary**; and

- (c) performed by a **Medical Practitioner** in private practice 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 listed in this **policy** document and /or the **Membership Certificate**.

**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**.

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

**List of Surgical Procedures** means the document published by **Southern Cross** from time to time which details the medical and surgical procedures and **prostheses** which are covered under this **policy**, the latest copy of which is available on the **Southern Cross** website or by calling Member Services.

**Medical Practitioner** means a medical practitioner who has the vocational registration applicable to the relevant **healthcare service** and the relevant registration with the Medical Council of New Zealand and who is 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.

**MedSafe** means the New Zealand Medicines and Medical Devices Safety Authority, a division of the Ministry of Health, responsible for the regulation of therapeutic products in New Zealand.

**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 publicly funded 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 **Membership Certificate**, this **policy** document, the **List of Surgical Procedures**, the Rules of **Southern Cross** 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** are paid.

**Policy limits** means in relation to any **eligible healthcare services** the maximum amounts payable by **Southern Cross** per procedure, per **operation**, per item, per day, per **lifetime**, or as an **annual limit** as specified in the **Coverage Tables** or **List of Surgical Procedures**, 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 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 items and specialised equipment as set out in the Prosthesis section of the **List of Surgical Procedure**.

**Reasonable charges** are charges for **healthcare services** determined by **Southern Cross** and are based on our ongoing review of **health services provider** charges for a particular **healthcare service**, our claims statistics, and our knowledge of national and regional New Zealand health markets.

**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 trading as Southern Cross Health Society, having its registered office at Level 1, Ernst & Young Building, 2 Takutai Square, Auckland 1010.

**Sports event** means involvement in an organised and competitive sporting event or tournament that requires human activity capable of achieving a result requiring physical exertion and/or physical skill which, by its nature and organisation, is competitive and is generally accepted as being a sport.

**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 have not been approved by **Southern Cross** in its sole discretion, prior to treatment.

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

**We/us/our** means **Southern Cross**.

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





Visit our website  
[www.southerncross.co.nz/society](http://www.southerncross.co.nz/society)  
or call us on  
**0800 800 181**

Southern Cross Medical Care Society  
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