Wellbeing One
and Wellbeing Two
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 the Wellbeing One and Wellbeing Two plans.

The Wellbeing One and Wellbeing Two plans

Wellbeing One provides cover for cancer care, surgical treatment and consultations, diagnostic imaging and tests within 6 months of related eligible surgical treatment or cancer care, as well as the other healthcare services listed in the Coverage Tables.

Wellbeing Two provides the same cover as Wellbeing One but covers consultations, diagnostic imaging and tests whether or not you undergo surgical treatment or cancer care.

Financial strength rating

Southern Cross Medical Care Society (trading as Southern Cross Health Society) has an A+ (Strong) financial strength rating given by Standard & Poor’s (Australia) Pty Limited.

The rating scale is:

<table>
<thead>
<tr>
<th>Rating</th>
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<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA (Extremely Strong)</td>
<td>AA (Very Strong)</td>
<td>A (Strong)</td>
</tr>
<tr>
<td>BBB (Good)</td>
<td>BB (Marginal)</td>
<td>B (Weak)</td>
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<tr>
<td>CCC (Very Weak)</td>
<td>CC (Extremely Weak)</td>
<td>SD or D (Selective Default or Default)</td>
</tr>
<tr>
<td>R (Regulatory Action)</td>
<td>NR (Not Rated)</td>
<td></td>
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</tbody>
</table>

Ratings from ‘AA’ to ‘CCC’ may be modified by the addition of a plus (+) or minus (−) sign to show relative standing within the major rating categories.

Full details of the rating scale are available at standardandpoors.com. Standard & Poor’s is an approved rating agency under the Insurance (Prudential Supervision) Act 2010.

Please note that we may record and store telephone calls to and from Southern Cross. 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 of this policy document.
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Your policy document

This policy document should be read in conjunction with your Membership Certificate, the List of Prostheses and Specialised Equipment 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 this 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 us and we 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 for this policy from time to time. If we make any such changes, we will notify you in writing (including on our website or by email). 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 1 month of the notification of changes to discuss alternatives or to cancel this policy. If the policyholder cancels this policy, cover will be provided until the date the policy is paid to.
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, and any document that is incorporated by reference (ie eligibility criteria),
- the List of Prostheses and Specialised Equipment, 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 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 Prostheses and Specialised Equipment forms part of this policy and is available on our website or by calling us.

The List of Prostheses and Specialised Equipment is important in determining the prostheses, specialised equipment and consumables or donor tissue preparation charges covered by this policy, as there is no cover for any prostheses, specialised equipment and consumables or donor tissue preparation charges that are not on this list.
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 the Rules of Southern Cross which are available on our website southerncross.co.nz/rules or by contacting us.

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 this policy being terminated (for whatever reason) your (and your dependants’) Southern Cross memberships will cease. Likewise, if the policyholder’s membership is terminated, this policy will be cancelled. If you join Southern Cross and cancel your policy during the 14 day period referred to under “How do I cancel my policy?” in section 07 of this policy document, then you will not become a Southern Cross member.
Your policy

You can choose either Wellbeing One or Wellbeing Two. If you choose Wellbeing One you can add the Keeping Well and/or Body Care modules.

If you choose Wellbeing Two you can add the Keeping Well, Body Care, Day-to-day and Vision and Dental modules. You can choose to add more than one module, however the Keeping Well Module cannot be held with the Day-to-day and/or Vision and Dental modules.

Your Membership Certificate details the level and modules that apply to you – based on what you selected in your application.

LEVELS OF COVER

**Wellbeing One** provides cover for cancer care, surgical treatment and consultations, diagnostic imaging and tests within 6 months of related eligible surgical treatment or cancer care, as well as other healthcare services as listed in the Coverage Table.

**Wellbeing Two** provides the same cover as Wellbeing One but covers consultations, diagnostic imaging and tests whether or not you undergo surgical treatment or cancer care.

**Keeping Well Module** provides cover for some day-to-day healthcare services, vision, dental and other healthcare services as listed in the Coverage Table.

**Body Care Module** provides cover for preventative, allied and natural healthcare services as listed in the Coverage Table.

**Day-to-day Module** provides cover for day-to-day healthcare services as listed in the Coverage Table.

**Vision and Dental Module** provides cover for vision, dental and other healthcare services as listed in the Coverage Table.

The policy limits set out in the Coverage Tables are set at a level which reflects the premium charged for the corresponding Wellbeing One and Wellbeing Two plan.

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 under “How to receive treatment and make a claim” in section 02.

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.

This policy is only for New Zealand citizens, New Zealand residents and those otherwise entitled to publicly funded healthcare for all services as determined by the Ministry of Health from time to time.
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 “The claiming process” in this section to fully understand how your cover works.

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<table>
<thead>
<tr>
<th>Is the healthcare service eligible for cover?</th>
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<tbody>
<tr>
<td>To be eligible the healthcare service must be:</td>
</tr>
<tr>
<td>• covered under or listed in the Coverage Tables and comply with any applicable terms and conditions (including any eligibility criteria we may specify from time to time)</td>
</tr>
<tr>
<td>• approved treatment</td>
</tr>
<tr>
<td>• performed in private practice by a health services provider with registration applicable to the healthcare service</td>
</tr>
<tr>
<td>• a healthcare service for which costs are actually incurred or to be incurred, and</td>
</tr>
<tr>
<td>• not otherwise excluded under the terms of your policy, including (but not limited to) the exclusions for pre-existing conditions and unapproved healthcare services.</td>
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<table>
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<tr>
<th>Is there a fixed total dollar allowance payable for the healthcare service?</th>
</tr>
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<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

| Yes |
| No |

We will pay the actual cost of the healthcare service up to the fixed dollar allowance limit.

We will pay the actual cost of the healthcare service up to the policy limits applicable to that healthcare service (subject to reasonable charges). This includes in the case of prostheses the limit set out in the List of Prostheses and Specialised Equipment.

For eligible healthcare services provided by an Affiliated Provider, unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged up to policy limits.

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

An allowance is a fixed amount we pay towards the actual charges for certain eligible healthcare services. Details of the healthcare services which are covered by allowances and the amounts of such allowances are set out in the Coverage Tables in section 06. 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 some eligible healthcare services under Wellbeing One and Wellbeing Two as specified in the Coverage Tables. We will reimburse claims submitted in any 1 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 (as described in this section) and we pay your health services provider directly, then you will have to pay your excess to your health services provider.

What does Southern Cross mean by “reasonable charges”?

Reasonable charges are charges for healthcare services that are determined as reasonable by us (acting reasonably) based on our review of our data.

The charges established as a result of this review process are referred to throughout this policy as reasonable charges.

Which health service providers are covered?

In order for a healthcare service to be eligible, it must be performed by a Specialist, General Practitioner, Nurse or by another health services provider practising in private practice 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 us.
The prior approval process

You can confirm whether your healthcare service is eligible for cover and the conditions that apply by requesting approval in My Southern Cross or via the mobile app. 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 5 working days prior to the healthcare service being provided.

If you do not contact us for prior approval before using the healthcare service, you will have to pay for the healthcare service yourself and then submit a claim. We will process the claim in accordance with your policy. By not contacting us for prior approval, you will not know what you are entitled to receive under this policy and what you are responsible to pay yourself. Amounts you are responsible for could arise due to an excess applying or due to the healthcare service not being eligible for cover under your policy, or the actual charges exceeding reasonable charges or 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. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged up to policy limits.

The Affiliated Provider will organise prior approval and claim directly from us for the healthcare service. 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 at healthcarefinder.co.nz. The Affiliated Provider network varies in services, and Affiliated Providers may not be available for all healthcare services covered by this policy or 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).

Affiliated Provider-only procedures

Healthcare services specified in the Coverage Tables must be provided by an Affiliated Provider for that healthcare service to be covered under this policy.
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 two or more surgical procedures at the same time?

When you have two or more surgical procedures simultaneously, sequentially or under the same anaesthetic the following will apply:

For eligible healthcare services provided by an Affiliated Provider, unless you are advised otherwise by us or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider for each of the procedures up to the policy limits. For multiple surgical procedures provided by a Specialist who is not an Affiliated Provider, we will pay the actual cost of each procedure up to the policy limits.

If you are going to have two or more surgical procedures at the same time, you should inform us at the time of prior approval so that we can help you determine the extent of your cover with us.

What if I have more than one surgeon, an assistant surgeon or a registered nurse first surgical assistant involved in the operation?

Your policy provides reimbursement for one surgeon per operation only. If you are going to have more than one surgeon, an assistant surgeon or a registered nurse first surgical assistant involved in the operation you should inform us at the time of prior approval so that we can help you determine the extent of 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 us to discuss the additional surgery and apply for further prior approval. If the additional treatment relates to a treatment injury refer to the chart under “How does my Southern Cross policy fit with ACC?” in this section for information.

Which prescription drugs qualify for cover?

Your policy provides different cover for drugs depending on what type of healthcare service they relate to.

- Drugs prescribed and taken in hospital during surgical treatment, non-surgical treatment or psychiatric care are covered as part of ancillary hospital charges.
- Chemotherapy drugs taken as part of chemotherapy treatment are covered as part of the chemotherapy treatment benefit.
- Any other drugs or prescriptions are only covered under the prescription benefit in the Keeping Well and Day-to-day modules.

Unless specifically stated otherwise, for any drugs to qualify for cover, they must be Pharmac approved, prescribed by a Medical Practitioner in private practice and not otherwise excluded by your policy terms.

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

As an exception to the requirement for all drugs to 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 any drug you are prescribed would require a special authority from Pharmac if it was being administered in a public facility, you are only entitled to reimbursement of that drug under this policy once you have met that same special authority criteria.

The definitions for all the terms can be found in section 09 of this policy document.
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 (online at My Southern Cross, via the My Southern Cross app, or by post), claiming electronically using Easy-claim for a healthcare service or visiting an Affiliated Provider for a healthcare service. When you claim electronically via Easy-claim for eligible healthcare services (and your claim is accepted 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.

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

Unless you are visiting an Affiliated Provider or claiming electronically using Easy-claim, you need to submit a completed claim form and 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 to ensure that your claim can be processed promptly. If the claim form is being posted to us, please ensure the form is signed by you and that the original copies of the itemised receipts are included.

What rules apply when claiming electronically via Easy-claim?

When a selected health services provider claims electronically via Easy-claim on your behalf for an eligible healthcare service provided to you, we deem this to be a claim under your policy and you authorise us to pay the health services provider directly.

Please be aware that for electronic claiming at a pharmacy, the first time you claim electronically for an eligible drug for you, you are electing to electronically claim for that and any subsequent eligible drug that you may wish to acquire from that pharmacy and any subsequent transaction/s will be automatically processed as an electronic claim on your policy, unless you advise us or the pharmacy otherwise.

How long do I have to send in my receipts?

To assist in processing please submit claims within 12 months of the date of provision of the healthcare service.

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 your 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 recover from the policyholder any payment made by Southern Cross for a healthcare service where the cost is recoverable from another insurer or other person.

If you have two or more policies with Southern Cross, you are not entitled to claim for, or be reimbursed for, an amount higher than the actual cost of the healthcare service provided.
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 visited an Affiliated Provider or claimed electronically via Easy-claim at a selected health services provider (and your claim has been accepted 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 claim that we reasonably 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 (by you and/or your employer) 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.

If any claim or other payment we are due to make to you by cheque or otherwise remains unclaimed for 2 years or more, such payment may be applied for the benefit of Southern Cross.

Does Southern Cross not reimburse any health services providers?

We have set out elsewhere in the policy how we reimburse eligible healthcare services and any terms that may apply to such reimbursement. However, there may also be rare occasions where we will not reimburse particular health services providers for any healthcare services, for example in the case of fraud. In the rare circumstances that we do not recognise a health services provider for reimbursement we will first advise you that there would be no cover for any healthcare service if it is carried out by that health services provider. If the healthcare service itself is eligible for reimbursement we will of course be able to approve the healthcare service with another health services provider.
**HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACUTE CARE?**

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

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

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

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

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.

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**ACC cover your claim.**

ACC cover the costs in full – no claim can be lodged under your policy as you have received full funding through ACC.

**ACC do not cover your claim.**

ACC do not cover your claim because you are ineligible for ACC cover.

We require you to initiate an ACC review of your claim.*

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**Successful review by ACC.**

Day-to-day treatment, consultations, imaging and diagnostics claims will be assessed in accordance with the chart under “How to receive treatment and make a claim” in section 02.

ACC cover the costs in part then you can make a claim for the balance only under your policy.

**ACC do not cover your claim due to your failure to properly make a claim or comply with their claim requirements.**

No cover under your policy.

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Special conditions apply to accident and treatment injury related surgery. Under the ACC legislation, you can choose between full cover (where your health services provider is fully contracted by ACC to provide your procedure at no cost to you) or partial cover (where your health services 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.

For accident or treatment injury related elective surgery, if the full cover option is not available or the waiting period is unreasonable, we may refund up to 100% of the remaining balance of the eligible healthcare service, after the ACC contribution has been deducted.

In no case shall a member be entitled to receive a greater amount than 100% of the actual costs of the surgery.

You must first send us a copy of the decline letter from ACC. You will need to pay your health services provider for any treatment that you receive. We will then reimburse you the amount you are entitled to under this policy.

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*If you withdraw from a review without consulting us we may seek reimbursement of any payment we have already made to you.
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 agree in writing to offer cover for pre-existing conditions.

When the policyholder completed the Application Form for this policy the policyholder declared the conditions, signs, symptoms and events for which the policyholder or any dependant knew about at the date of application. We assess the conditions, signs, symptoms and events 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 by Southern Cross, acting reasonably.

Declaration of pre-existing conditions

If the policyholder did not declare a pre-existing condition relating to the policyholder or any dependant on the Application Form, and the relevant person subsequently requires treatment, then we may decline cover for that pre-existing condition. In these circumstances, at the time we become aware of the pre-existing condition we will also add it to your Membership Certificate so that we have a record of the pre-existing condition.

When does cover under the policy commence?

The policyholder’s cover commences from the policy start date. Dependant’s cover commences from the date they are added to the policy. Newborn dependants added to the policy within 3 months following their date of birth are covered from the date of their addition.
Private healthcare services to which this policy applies

The Coverage Tables set out in section 06 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 Prostheses and Specialised Equipment

We publish on our website a List of Prostheses and Specialised Equipment which outlines the prostheses, specialised equipment and consumables or donor tissue preparation charges covered by this policy. If a prosthesis is not listed in the List of Prostheses and Specialised Equipment, we will not provide cover unless we advise otherwise.

We may change the List of Prostheses and Specialised Equipment 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 in this policy document.

Treatment in a public facility

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

Quality of healthcare services

We are not liable to you for the quality, standard or 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 new eligibility criteria in place or update the existing eligibility criteria.

Treatment overseas

There is an allowance for approved treatment not available in the public or private sector within New Zealand. This allowance is only to contribute towards the medical expenses you incur and does not pay towards accommodation or travel costs. The treatment must be recommended by a Specialist in private practice. Southern Cross must 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.
**Understanding your cover for cancer**

Cancer related healthcare services are covered under a range of benefits included in the **Coverage Tables**. The list below helps you identify cover for cancer included in your policy and where to find the applicable maximums and terms and conditions.

### CANCER SCREENING AND PREVENTION

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
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<tbody>
<tr>
<td>Prophylactic treatment to address a highly increased risk of developing cancer</td>
<td>covered under prophylactic treatment allowance</td>
</tr>
<tr>
<td>Screening mammograms</td>
<td>covered under diagnostic imaging</td>
</tr>
<tr>
<td>Screening colonoscopies (when confirmed to have a 'moderately high risk' or 'high risk' for colorectal cancer because of family history as defined in the eligibility criteria)</td>
<td>covered under surgical procedures</td>
</tr>
</tbody>
</table>

### CANCER DIAGNOSIS

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic imaging for cancer</td>
<td>covered under diagnostic imaging</td>
</tr>
<tr>
<td>Tests for cancer</td>
<td>covered under diagnostic tests</td>
</tr>
<tr>
<td>Consultations for cancer</td>
<td>covered under specialist consultations and skin surgery</td>
</tr>
</tbody>
</table>

### CANCER TREATMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer surgery</td>
<td>covered under surgical procedures and skin surgery</td>
</tr>
<tr>
<td>Chemotherapy treatment in an approved facility or at home</td>
<td>covered under chemotherapy treatment</td>
</tr>
<tr>
<td>Pharmac approved chemotherapy drugs</td>
<td>covered under chemotherapy treatment</td>
</tr>
<tr>
<td>Non-Pharmac approved MedSafe indicated chemotherapy drugs</td>
<td>covered under chemotherapy treatment</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>covered under radiotherapy treatment</td>
</tr>
<tr>
<td>Breast symmetry surgery post mastectomy</td>
<td>covered under the post mastectomy allowance to achieve breast symmetry</td>
</tr>
<tr>
<td>Overseas cancer treatment</td>
<td>covered under the overseas treatment allowance</td>
</tr>
<tr>
<td>Recovery from cancer</td>
<td>covered under post-operative home nursing, post-operative speech and language therapy and post-operative physiotherapy</td>
</tr>
<tr>
<td>Support for cancer</td>
<td>covered under the travel and accommodation allowance and parent accommodation allowance</td>
</tr>
</tbody>
</table>

### CANCER PALLIATIVE CARE

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care for cancer</td>
<td>covered under the palliative care and treatment allowance</td>
</tr>
</tbody>
</table>

**Optional Cover: Cancer Assist**

Supplement the benefits already included in this policy by adding Cancer Assist.

Cancer Assist provides you with a one-off payment if you are diagnosed with a qualifying cancer. You can use this payment for whatever you need, for example additional non-Pharmac approved drugs, alternative treatment not covered by this policy, mortgage payments or travel.

Your one-off payment options are:
- $20,000
- $50,000
- $100,000
- $200,000
- $300,000

For more details please see the Cancer Assist benefit summary after the Coverage Tables. For a copy of the Cancer Assist policy document, including full terms and conditions please go to southerncross.co.nz/plans or contact us.
The following Coverage Tables set out the healthcare services included under Wellbeing One, Wellbeing Two, and for the Keeping Well, Body Care, Day-to-day and Vision and Dental modules. The Coverage Tables specify the policy limits and terms and conditions applicable to the listed healthcare services. The Coverage Tables should be read together with the List of Prostheses and Specialised Equipment, which is available at southerncross.co.nz/plans, or by calling us.

Eligibility criteria may apply to some procedures, please refer to southerncross.co.nz/eligibilitycriteria.

When reading the Coverage Tables you can refer to the chart under “How to receive treatment and make a claim” in section 02 to understand how your cover will be calculated, and to the glossary of terms in section 09 for the explanation of all bolded terms. All figures include GST.

Also included is a benefit summary for Cancer Assist.

---

### Wellbeing One and Wellbeing Two - Coverage Tables

<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical procedures (includes cardiac and cancer surgery)</td>
<td>Unlimited</td>
<td>Performed by a Specialist or Affiliated Provider contracted for that healthcare service in an approved facility. Some surgical procedures must be performed by an Affiliated Provider to be eligible for cover under this policy – see “Surgical procedures that must be performed by an Affiliated Provider” for details.</td>
</tr>
<tr>
<td>Surgeon’s operating fee/s Anaesthetist’s fee/s Intensivist’s fee Perfusionist’s charges</td>
<td></td>
<td>Including bypass machine supplies and off-bypass cardiac stabilisation consumables.</td>
</tr>
<tr>
<td>Hospital fees</td>
<td></td>
<td>Refer to the List of Prostheses and Specialised Equipment.</td>
</tr>
<tr>
<td>Surgically implanted prostheses and specialised equipment</td>
<td>Maximums apply</td>
<td></td>
</tr>
<tr>
<td>Skin surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin lesion removal under general anaesthetic or sedation, and Mohs surgery</td>
<td>Refunded under surgical procedures</td>
<td>For excision, biopsy, cryotherapy, curettage and diathermy of skin lesions when performed under general anaesthetic or sedation and Mohs surgery (including excision and closure). Must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td>Skin lesion services under local anaesthetic or with no anaesthetic</td>
<td>$5,000 per claims year (includes $1,000 per claims year when performed by a General Practitioner)</td>
<td>For excision, biopsy, cryotherapy, curettage and diathermy of skin lesions when performed without anaesthetic or under local anaesthetic. Must be performed by an Affiliated Provider or General Practitioner. Includes all consultations related to skin lesions.</td>
</tr>
<tr>
<td>GP minor surgery</td>
<td>$1,000 per claims year</td>
<td>Performed by a General Practitioner. Excludes consultations and skin lesion services.</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
**SURGICAL PROCEDURES THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER**

The following surgical procedures must be performed by an Affiliated Provider to be eligible for cover under your policy. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged up to policy limits. To receive cover the surgical procedure must meet applicable eligibility criteria. Please be aware that not all surgical procedures are available from all Affiliated Providers or in all areas. Excess applies to this section.

<table>
<thead>
<tr>
<th>Category</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac</strong></td>
<td>Coronary artery bypass graft surgery (CABG), valve replacement, valvuloplasty, Bentall’s procedure, coronary angiogram and/or angioplasty, electrophysiology studies, ablation of cardiac arrhythmias, percutaneous patent foramen ovale (PFO) closure, percutaneous atrial septal defect (ASD) closure, transcatheter aortic valve implantation/replacement (TAVI/TAVR), left atrial appendage occlusion.</td>
</tr>
<tr>
<td><strong>Gastroenterology</strong></td>
<td>Gastroscopy, colonoscopy, balloon enteroscopy, wireless pH capsule and wireless capsule endoscopy, endoscopic ultrasound, contrain biofeedback and electrostimulation for faecal incontinence, sacral nerve stimulation for faecal incontinence (no reimbursement will be made towards the cost of the stimulation device used to treat faecal incontinence).</td>
</tr>
<tr>
<td><strong>General surgery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cholecystectomy</strong></td>
<td>Open and laparoscopic cholecystectomy.</td>
</tr>
<tr>
<td><strong>Hernia</strong></td>
<td>Femoral, hiatus, inguinal and umbilical hernia repair.</td>
</tr>
<tr>
<td><strong>Skin lesion removal</strong></td>
<td>See skin surgery benefit.</td>
</tr>
<tr>
<td><strong>Interventional radiology</strong></td>
<td>Percutaneous medial branch thermal radiofrequency neurotomy (cover is limited to 2 procedures per lifetime).</td>
</tr>
<tr>
<td><strong>Lung and chest</strong></td>
<td>Microwave ablation of lung tumours, endoscopic ultrasound.</td>
</tr>
<tr>
<td><strong>Neurosurgery</strong></td>
<td>Endoscopic third ventriculostomy.</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>Posterior vitrectomy, entropion and ectropion repair, upper eyelid blepharoplasty, correction of ptosis, removal of tarsal cyst, probing/syringing of lacrimal passage, bleb needling, minor eyelid surgery, cataract surgery (cover is limited to the surgical insertion of a standard monofocal intraocular lens only, there is no cover for the additional cost of any other type of surgically implanted intraocular lens or associated costs), excision of pterygium, excision of pinguecula, YAG laser capsulotomy, laser iridotomY, laser iridoplastY, laser trabecuoplastY, cyclodeide laser cyclophotocoagulation, photocoagulation of the retina, pan retinal laser, macular laser, corneal crosslinking, intravitreal injections (cover for drug costs is limited to $100 per injection regardless of the type of drug used).</td>
</tr>
<tr>
<td><strong>Oral and maxillofacial</strong></td>
<td>Extraction of unerupted or impacted teeth (cover is available after 1 year of continuous cover on this plan).</td>
</tr>
<tr>
<td><strong>Orthopaedic</strong></td>
<td>Primary total knee joint replacement, primary partial (hemi) knee joint replacement, primary total hip joint replacement, carpal tunnel release, radiofrequency ablation of benign bone lesions, synthetic ligament repair and reconstruction.</td>
</tr>
<tr>
<td><strong>Otolaryngology</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ear</strong></td>
<td>Insertion and/or removal of grommets in theatre, KTP laser mastoidectomy, KTP laser revision mastoidectomy, KTP laser tympanoplasty, KTP laser second look tympanoplastY, KTP laser middle ear adhesiolysis, KTP laser stapedectomy, KTP laser medial canalplasty, and KTP laser myringotomy.</td>
</tr>
<tr>
<td><strong>Nose</strong></td>
<td>Balloon sinusplasty, endoscopic modified Lothrop, functional endoscopic sinus surgery (FESS), septoplastY, nasal cautery.</td>
</tr>
<tr>
<td><strong>Throat</strong></td>
<td>Adenoidectomy, tonsillectomy, laser treatment for pharyngeal, laryngeal and oesophageal conditions, transoral robotic surgery.</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td>Resection of bladder tumour, ureteroscopy, laparoscopic renal cryotherapy, circumcision, nephrectomy, robotic partial nephrectomy.</td>
</tr>
<tr>
<td><strong>Prostate</strong></td>
<td>Laparoscopic prostatectomy, prostate brachytherapy, external beam radiotherapy, prostate cryotherapy, radical retropubic prostatectomy, perineal prostatectomy, transurethral resection of prostate (TURP), open enucleation of prostate, laser resection of prostate, robotic assisted laparoscopic prostatectomy, prostate biopsy.</td>
</tr>
<tr>
<td><strong>Vascular</strong></td>
<td>Peripheral angiogram and/or angioplastY, varicose vein (legs) treatment via endovenous laser treatment, ultrasound guided sclerotherapy, varicose vein surgery, endovenous radiofrequency (RF) ablation, duplex vein mapping. (cover is limited to 2 varicose vein procedures per leg per lifetime), superficial vascular malformation sclerotherapy and embolisation – simple (cover is limited to 2 procedures per vascular malformation per lifetime).</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGICAL ALLOWANCES</td>
<td>Excess applies to this section. Eligibility criteria may apply.</td>
<td></td>
</tr>
<tr>
<td>Gastric banding/bypass allowance</td>
<td>$7,500 per lifetime</td>
<td>After 3 years of continuous cover on this plan. Payable on receipt of a medical report by a Specialist prior to surgery. This allowance includes 1 surgical procedure and any subsequent treatment that may be required. Specialist consultations and diagnostic imaging must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td>Bilateral breast reduction allowance</td>
<td>$5,000 per lifetime</td>
<td>After 3 years of continuous cover on this plan. Payable on receipt of a medical report by a Specialist prior to surgery. This allowance includes 1 surgical procedure and any subsequent treatment that may be required. Specialist consultations and diagnostic imaging must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td>Post mastectomy allowance to achieve breast symmetry</td>
<td>$6,500 per lifetime</td>
<td>Payable on receipt of a medical report by a Specialist prior to surgery. Cover is for symmetry procedures performed on the unaffected breast. This allowance includes 1 surgical procedure and any subsequent treatment that may be required. Specialist consultations and diagnostic imaging must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td>Prophylactic treatment allowance</td>
<td>$40,000 per lifetime</td>
<td>After 3 years of continuous cover on this plan. Covers prophylactic treatment to address a highly increased risk of developing a disease. Approval must be granted prior to treatment. This allowance is the total amount available for both the prophylactic treatment and all subsequent associated costs. Specialist consultations and diagnostic imaging must be performed by an Affiliated Provider. Cover is not available where the high risk status was present prior to the original date of joining.</td>
</tr>
<tr>
<td>Overseas treatment allowance</td>
<td>$30,000 per claims year</td>
<td>Reimbursement of medical expenses for approved treatment not available in the public or private sector within New Zealand. The treatment must be recommended by a Specialist. Southern Cross must approve the treatment based on a medical report you provide before treatment takes place. Ordinary policy exclusions apply. No reimbursement for accommodation or travel.</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.*
CANCER CARE
Cancer related healthcare services are also covered under the following benefits listed in the Coverage Tables: surgical procedures, skin surgery, post mastectomy allowance to achieve breast symmetry, prophylactic treatment allowance, overseas treatment allowance, post-operative home nursing, post-operative speech and language therapy, post-operative physiotherapy, travel and accommodation allowance, parent accommodation allowance, palliative care and treatment allowance, diagnostic imaging, diagnostic tests and specialist consultations. Excess applies to this section. Eligibility criteria may apply.

<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy treatment</td>
<td>$60,000 per claims year</td>
<td>Must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td></td>
<td>Maximum also includes reimbursement of the actual cost up to $10,000 per claims year for non-Pharmac approved MedSafe indicated chemotherapy drugs.</td>
<td>Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year maximum. Please note that not all procedures are available from all Affiliated Providers or in all areas. Includes cost of materials and chemotherapy drugs, hospital accommodation in a single room and ancillary hospital charges. Excludes consultations.</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>Unlimited</td>
<td>Must be performed by an Affiliated Provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider we will pay 100% of the amount charged by your Affiliated Provider. Please note not all procedures are available from all Affiliated Providers or in all areas, and that a limited range of radiotherapy treatments are funded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This benefit is inclusive of any radiotherapy planning and radiation treatment (does not include cover for initial or follow-up Specialist consultations, drugs, other healthcare services, or follow up imaging).</td>
</tr>
<tr>
<td>RECOVERY</td>
<td>Excess applies to this section. Must be performed within 6 months of related eligible surgical treatment or cancer care.</td>
<td></td>
</tr>
<tr>
<td>Post-operative home nursing</td>
<td>$175 per day up to $2,800 per claims year</td>
<td>Post-operative home nursing commencing within 14 days of related eligible surgical treatment or cancer care and performed by a Nurse on the referral of a Specialist in private practice.</td>
</tr>
<tr>
<td>Post-operative speech and language therapy</td>
<td>$70 per visit up to $350 per claims year</td>
<td>Treatment by a speech and language therapist registered with the New Zealand Speech-language Therapists’ Association, on the referral of a Specialist in private practice.</td>
</tr>
<tr>
<td>Post-operative physiotherapy</td>
<td>$60 per visit up to $300 per claims year</td>
<td>Treatment by a physiotherapist registered with the Physiotherapy Board of New Zealand. Includes cover for treatment by a hand therapist registered with Hand Therapy New Zealand.</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPPORT</td>
<td>Excess does not apply to this section (except for the obstetrics allowance).</td>
<td></td>
</tr>
<tr>
<td>Ambulance allowance</td>
<td>$180 per claims year</td>
<td>For emergency transportation to a public facility.</td>
</tr>
<tr>
<td>Travel and accommodation allowance</td>
<td>$500 per claims year</td>
<td>For 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 eligible healthcare service. Allowance payable to cover the person covered by the policy receiving the eligible healthcare service and a support person. Allowance payable for public transport costs (includes buses, trains, taxis, shuttles, planes and ferries) and hotel/motel rooms (or hospital rooming fees for the support person) within New Zealand only. No cover for car hire, mileage or petrol costs.</td>
</tr>
<tr>
<td>Parent accommodation allowance</td>
<td>$100 per night up to $500 per operation</td>
<td>For hospital accommodation expenses incurred by a parent when accompanying a dependant child. Both parent and child must be listed on the Membership Certificate. Accommodation must be in an approved facility.</td>
</tr>
<tr>
<td>Obstetrics allowance</td>
<td></td>
<td>After 1 year of continuous cover on this plan. For obstetric care and services carried out by a Specialist vocationally registered in obstetrics and gynaecology or anaesthesia and/or for accommodation in an approved facility and 2D and Doppler ultrasounds. Excesses apply.</td>
</tr>
<tr>
<td>Wellbeing One</td>
<td>No cover</td>
<td></td>
</tr>
<tr>
<td>Wellbeing Two</td>
<td>$750 per claims year</td>
<td></td>
</tr>
<tr>
<td>Palliative care and treatment allowance</td>
<td>$2,400 per claims year</td>
<td>After 3 years of continuous cover on this plan. Cover for palliative care and treatment when diagnosed with a progressive terminal illness.</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
### DIAGNOSTIC IMAGING – MUST BE PERFORMED BY AN AFFILIATED PROVIDER

All Diagnostic imaging must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year (in total) listed below. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Excess does not apply to this section.

<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td>$60,000 per claims year (in total)</td>
<td>Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One.</td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td>Excludes x-rays performed by a dentist or chiropractor.</td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td>Excludes obstetrics and varicose veins (legs) treatment.</td>
</tr>
<tr>
<td>Digital breast tomosynthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear scanning (scintigraphy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial perfusion scan</td>
<td></td>
<td>Must be referred by a Specialist in private practice.</td>
</tr>
<tr>
<td>CT angiogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT coronary angiogram</td>
<td></td>
<td>Must be referred by a Specialist in private practice.</td>
</tr>
<tr>
<td>MR angiogram</td>
<td></td>
<td>Must be referred by a Specialist in private practice.</td>
</tr>
<tr>
<td>Computed Axial Tomography (CT scan)</td>
<td></td>
<td>Cone Beam Computed Tomography (CBCT) must be referred by a Specialist in private practice.</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI scan)</td>
<td></td>
<td>Must be referred by a Specialist in private practice.</td>
</tr>
<tr>
<td>Positron Emission Tomography / Computed Tomography (PET/CT)</td>
<td></td>
<td>Must be referred by a Specialist in private practice. Cover is limited to specific diagnosed cancers and cardiac conditions.</td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
HEALTHCARE SERVICE | MAXIMUM* | OTHER TERMS AND CONDITIONS OF COVER
--- | --- | ---
TESTS | Excess does not apply to this section. Eligibility criteria may apply. | 
Cardiac tests | $5,000 per claims year (in total) | On referral by a Specialist in private practice. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. 

ALL CARDIAC TESTS MUST BE PERFORMED BY AN AFFILIATED PROVIDER
All cardiac tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $5,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas.

The following cardiac tests are covered under this benefit:
- Advanced electrocardiogram (A-ECG)
- Resting ECG
- Exercise ECG
- Holter monitoring
- Echocardiogram
- Stress echocardiogram
- Dobutamine stress echocardiogram
- Transoesophageal echocardiogram (TOE)

Diagnostic tests | $3,000 per claims year (in total) | On referral by a Specialist in private practice and in an approved facility. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One.

For a list of all diagnostic tests covered under this benefit please see the definition of diagnostic tests in section 09.

DIAGNOSTIC TESTS THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER
The following diagnostic tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $3,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas.

- Ambulatory blood pressure monitoring
- Breath nitric oxide test
- Corneal topography
- Fundus fluorescein angiography
- Fundus photography
- GDx Retinal scanning
- Heidelberg Retinal Tomography (HRT)
- Intraocular pressure test (IOP)
- Matrix screen
- Optical Coherence Tomography (OCT)
- Optic disc photos
- Visual fields
- Retinal photography

Laboratory tests
- Wellbeing One | No cover | 
- Wellbeing Two | $70 per claims year | 

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONSULTATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist consultations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Wellbeing One          | 5 visits per claims year up to $5,000 per claims year (in total)         | Must be performed by an **Affiliated Provider**.  
|                        |                                                                          | Excludes psychiatrist and all skin lesion consultations.  
|                        |                                                                          | Must be performed within 6 months of related **eligible surgical** treatment or cancer care to be entitled to cover.  
|                        |                                                                          | 5 visit limit and 6 month rule do not apply to oncologist and radiation oncologist consultations.  
| Wellbeing Two          | $5,000 per claims year (in total)                                       | Must be performed by an **Affiliated Provider**.  
|                        |                                                                          | Excludes psychiatrist and all skin lesion consultations.  
| Psychiatrist consultations | $750 per claims year                                                   | Must be performed by an **Affiliated Provider** vocationally registered in psychiatry.  
| Dietitian consultations | $100 per consultation up to $500 per claims year                       | Consultations with a dietitian registered with the New Zealand Dietitian Board. On referral by a **Specialist** in private practice.  
|                        |                                                                          | Must be performed within 6 months of related **eligible surgical** treatment or cancer care to be entitled to cover under Wellbeing One.  
| **NON-SURGICAL TREATMENT** | Excess applies to this section (except for allergy services benefit).  
|                        |                                                                          | Eligibility criteria may apply.  
| Non-surgical hospitalisation | $60,000 per claims year (in total) for the following:                   | For non-surgical treatment in a hospital performed by or on referral of a **Specialist** or **Affiliated Provider** in private practice and in an **approved facility** (does not include cover for consultations, imaging and tests).  
|                        |                                                                          | Excludes **long term care**, accommodation following surgery, rehabilitation, geriatric care, hospice, respite and convalescent care, psychiatric hospitalisation and the cost of non-Pharmac approved drugs.  
| Hospital accommodation  | $700 per night or per day stay                                          | Single room, excludes suites.  
| Ancillary hospital charges | $200 per claims year                                                   |                                      |
| Psychiatric hospitalisation | $3,500 per claims year (in total) for the following:                   | For admission and care by a **Specialist** vocationally registered in psychiatry in an **approved facility**.  
| Hospital accommodation  | $700 per night or day stay                                              |                                      |
| Ancillary hospital charges | $200 per claims year                                                   |                                      |
| Allergy services        | $750 per claims year                                                    | Must be provided by or under the care of an **Affiliated Provider** or a **General Practitioner** who has an Easy-claim agreement with us. Covers allergy related services including allergy testing and desensitisation.  
|                        |                                                                          | Excludes consultations and the cost of non-Pharmac approved drugs.  
| **BEING ACTIVE**        | Excess does not apply to this section                                   |                                      |
| Being active            | $50 per claims year                                                     | After 3 years of continuous cover on this plan.  
|                        |                                                                          | Payable on receipt of proof of completion of a sports event and payment of the related entry fees.  

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
### Optional Modules

Excess does not apply to these optional modules.

### Keeping Well Module - GP, vision, dental and other benefits

Can be added to Wellbeing One or Wellbeing Two plans.

Please note: The Keeping Well Module cannot be held with Day-to-day and/or Vision and Dental modules.

<table>
<thead>
<tr>
<th>Healthcare Service</th>
<th>Maximum*</th>
<th>Other Terms and Conditions of Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu vaccination</td>
<td>One vaccination per claims year</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$100 per claims year</td>
<td>Charges for prescription drugs prescribed by a General Practitioner, Specialist or Nurse. Excludes the cost of non-Pharmac approved drugs.</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>$100 per claims year</td>
<td>Performed by a psychologist registered as a clinical psychologist with the New Zealand Psychologists Board.</td>
</tr>
</tbody>
</table>

Cover for the following healthcare services is limited to $200 per claims year in total:

- **General Practitioner**
- **Nurse**
- **Optometrist**
- **Audiologist and hearing tests**
- **Dental**

### Body Care Module - preventative, allied and natural healthcare services

Can be added to Wellbeing One or Wellbeing Two plans.

<table>
<thead>
<tr>
<th>Healthcare Service</th>
<th>Maximum*</th>
<th>Other Terms and Conditions of Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitian or nutritionist</td>
<td>$250 per claims year</td>
<td>Performed by a dietitian registered with the New Zealand Dietitian Board or a nutritionist registered with the Nutrition Society of New Zealand or Clinical Nutrition Association. Excludes the cost of food and food substitutes.</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>$250 per claims year</td>
<td>Performed by a podiatrist registered with the Podiatrists Board of New Zealand.</td>
</tr>
</tbody>
</table>

Cover for the following alternative healthcare services is limited to $500 per claims year in total:

- **Acupuncturist**
- **Chiropractor or osteopath**
- **Homeopath or naturopath**
- **Registered massage therapist**

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.
### Day-to-day Module - day-to-day medical care
Can be added to Wellbeing Two plan only.

<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual health check</td>
<td>$90 per claims year</td>
<td>Performed by a General Practitioner or Specialist.</td>
</tr>
<tr>
<td>Flu vaccination</td>
<td>One vaccination per claims year</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>$65 per consultation</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>$30 per consultation</td>
<td>Only applicable where no General Practitioner fee applies.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$600 per claims year</td>
<td>Charges for prescription drugs prescribed by a General Practitioner, Specialist or Nurse. Excludes the cost of non-Pharmac approved drugs.</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>$300 per claims year</td>
<td>Performed by a physiotherapist registered with the Physiotherapy Board of New Zealand. Includes acupuncture and manipulations.</td>
</tr>
</tbody>
</table>

### Vision and Dental Module - vision, dental and other benefits
Can be added to Wellbeing Two plan only.

<table>
<thead>
<tr>
<th>HEALTHCARE SERVICE</th>
<th>MAXIMUM*</th>
<th>OTHER TERMS AND CONDITIONS OF COVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription glasses, sunglasses and contact lenses</td>
<td>75% of expenses incurred up to $500 per claims year</td>
<td>Prescription glasses/sunglasses (frames and lenses) and contact lenses for change of vision, replacement for loss or breakage when prescribed by a registered ophthalmologist, optometrist, or optician.</td>
</tr>
<tr>
<td>Optometrist</td>
<td>$50 per claims year</td>
<td>Consultations with an optometrist registered with the New Zealand Optometrists and Dispensing Opticians Board.</td>
</tr>
<tr>
<td>Orthoptist</td>
<td>$200 per claims year</td>
<td>Treatment by a registered orthoptist.</td>
</tr>
<tr>
<td>Dental</td>
<td>75% of expenses incurred up to $750 per claims year</td>
<td>Performed by an oral health practitioner including a dental hygienist registered with the Dental Council of New Zealand or Specialist vocationally registered in oral &amp; maxillofacial surgery.</td>
</tr>
<tr>
<td>Audiologist and hearing tests</td>
<td>$200 per claims year</td>
<td>Performed by an audiologist who is a member of the New Zealand Audiological Society.</td>
</tr>
<tr>
<td>Brain stem evoked response tests</td>
<td>$210 per claims year</td>
<td></td>
</tr>
</tbody>
</table>

*See the chart under “How to receive treatment and make a claim” in section 02 for how your refund will be calculated.*
Cancer Assist Benefit Summary - financial support should you have a confirmed cancer diagnosis
Can be added to either Wellbeing One or Wellbeing Two plans.

Supplement the benefits already included in this policy by adding Cancer Assist.

Cancer Assist provides you with a one-off payment if you are diagnosed with a qualifying cancer. You can use this payment for whatever you need, for example, additional non-Pharmac approved drugs, alternative treatment not covered by this policy, mortgage payments or travel. You can choose the following maximums:

- $20,000
- $50,000
- $100,000
- $200,000
- $300,000

We will pay you the applicable Cancer Assist maximum selected if:

- you have a confirmed cancer diagnosis;
- the cancer is not excluded by the Cancer Assist policy exclusions, including, but not limited to those cancers specifically listed on your Cancer Assist Certificate;
- you are still alive 14 days after your confirmed cancer diagnosis. This period of 14 days will be increased by 1 day for every day you are kept alive on a life support system;
- your confirmed cancer diagnosis (or related health condition symptom, sign or event) first occurs at least 3 months after your Cancer Assist policy start date or the date you increase your Cancer Assist maximum;
- your Southern Cross health insurance policy and Cancer Assist policy are active and premiums are up to date; and
- all terms and conditions of the policy are met.

For a copy of the Cancer Assist policy document, including full terms and conditions, please go to southerncross.co.nz/plans or contact us.
No reimbursement or payment shall be made for any costs 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;
- **Unapproved healthcare services** which are specific drugs, devices, techniques, tests and/or other healthcare services that have not been approved by Southern Cross prior to treatment. Please see the list of unapproved healthcare services at southerncross.co.nz/unapprovedservices;
- **Acute care**;
- Appliances or equipment (surgical, medical or dental) for example CPAP machines, cochlear implants, nerve stimulators, orthotics, crutches;
- Breast reduction except as specifically provided by the bilateral breast reduction allowance;
- **Chronic conditions**;
- **Congenital conditions** except for umbilical hernia, inguinal hernia, undescended testes, hydrocele, tongue tie, phimosis and squint;
- Contraception or intrauterine devices except for Mirena when used for medical reasons and approved by us prior to treatment;
- Correction of refractive visual errors or astigmatism by surgery, surgically implanted intraocular lens(es), or laser treatment;
- **Cosmetic treatment/procedures**;
- Dementia;
- Diagnosis, management and treatment of developmental or congenital deformities or abnormalities of the facial skeleton and associated structures;
- Extraction of teeth except as specifically provided by extraction of unerupted or impacted teeth (under oral and maxillofacial in Affiliated Provider surgical procedures) benefit, or by the Keeping Well and Vision and Dental modules;
- Gender reassignment surgery and directly related healthcare services;
- Gynaecomastia;
- **Health screening** except as specifically provided by mammography (under diagnostic imaging) and colonoscopy (under gastroenterology in Affiliated Provider surgical procedures) benefits;
- Healthcare services performed by a dentist, periodontist, endodontist or orthodontist except as specifically provided by the Keeping Well and Vision and Dental modules;
- Healthcare services provided 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 health services provider as defined in section 09 of this policy document;
- Healthcare services provided in relation to, or as a consequence of, any accident or treatment injury except as specifically provided in the chart under “How does my Southern Cross policy fit with ACC?” in section 02;
- Healthcare services provided outside New Zealand except as specifically provided by the overseas treatment allowance;
- Healthcare services relating to the management and treatment of snoring and/or upper airways resistance;
- Healthcare services that are not approved treatment;
- Healthcare services using technology such as digital computer images to aid in the monitoring and diagnosis of skin cancers and other skin lesions for example, mole mapping;
- HIV, HIV disorders including AIDS, and any medical condition that arises in any way from HIV infection;
- Hospital charges of a personal convenience nature for example, newspapers, spouse/family meals, alcohol, TV rental;
- Implantation of teeth and/or titanium dental implants except as specifically provided by the Keeping Well and Vision and Dental modules;
- Infertility or assisted reproduction;
• 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;
• Long term care including geriatric in-patient care and disability support services;
• Maintenance examinations, medical checkups (except as specifically provided by the annual health check under the Day-to-day Module) or any examination required for a third party (including preparation of reports) for example physical examinations for life insurance, travel insurance and driver licence;
• Mental health healthcare services except as specifically provided by the psychiatrist consultation and psychiatric hospitalisation benefits, and by the Keeping Well Module;
• Obesity except as specifically provided by the gastric banding / bypass allowance and the Body Care Module;
• Organ transplants, transfusions/injections of autologous blood/blood products (except cell-saver when related to eligible surgical treatment), autologous chondrocyte implantations and stem cell transplants, including related expenses for both donors and recipients;
• Pathology and laboratory tests except as specifically provided by the laboratory tests benefit;
• Pregnancy and childbirth except as specifically provided by the obstetrics allowance;
• Prophylactic healthcare services except as specifically provided by the prophylactic treatment allowance;
• Prostheses, specialised equipment and consumables or donor tissue preparation charges except as specifically listed in the List of Prostheses and Specialised Equipment;
• Respite and convalescent care;
• Robotic assisted surgery except as specifically provided by the robotic prostatectomy, robotic partial nephrectomy and transoral robotic surgery benefits;
• Self-inflicted illness or injury;
• Sterilisation or its reversal;
• Subsequent breast reconstruction surgery or symmetry surgery unless completed within 2 years of the first eligible breast reconstruction surgery (following an eligible mastectomy);
• Surgery designed to assist or allow the implementation of orthodontic healthcare services except as specifically provided by the Keeping Well and Vision and Dental modules;
• Surgically implanted lens(es) other than monofocal lens(es);
• Termination of pregnancy;
• Treatment of any condition not detrimental to health except as specifically provided by the Keeping Well and Day-to-day modules;
• Vaccination except as specifically provided by the Keeping Well and Day-to-day modules.
This section applies to all levels and modules. In this section, when we say you/your we refer to the policyholder.

Who is responsible for my policy?

As the policyholder you are ultimately responsible for this policy, for making any changes to it and ensuring the premium is paid. We rely on you to provide complete and accurate information about yourself and your dependants. Your dependants can perform certain functions in respect to the policy however you remain responsible for their acts and omissions.

When does my policy commence?

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?

All policyholders registered for My Southern Cross will receive the majority of communications electronically, unless they choose otherwise, and will be notified of the availability of these communications by email. For communications received electronically via My Southern Cross, notice shall be considered to have been delivered 3 days after having been posted.

Southern Cross relating to the policyholder, this policy, or any dependant, to the policyholder at the 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 or update these details in My Southern Cross. Where the policyholder can no longer be contacted at the last known address and has not provided Southern Cross with an up to date address, we will cease to send notices or other communications to the policyholder at that address until they notify us of an up to date address. In these circumstances, the policyholder acknowledges and agrees that Southern Cross will be deemed to have satisfied its requirements regarding the sending of these notices or communications.

When can I add dependants on to my policy?

You can add dependants onto 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.

Cover will commence on the date the dependant was added to your policy.

If you wish to add a newborn child, the application must be submitted within 3 months of birth. Provided you have held your policy for more than 3 months at the date of application, 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 of this policy document. Cover will commence on the date the child was added to your policy.

If you have not held your policy for more than 3 months at the date of application or don’t add the 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.

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 1 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 Southern Cross. 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.

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

You can upgrade or downgrade your policy at any time by contacting Southern Cross. The change will take effect from the date we advise. Upgrading or downgrading your policy can affect your cover for pre-existing conditions, annual limits, excesses, loyalty periods and premiums so it is important you discuss your proposed changes with us to fully understand the implications of upgrading or downgrading your policy.

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 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 will start over again from the date of the upgrade or downgrade;
• if you add a module to your policy, it may only be removed at your next policy anniversary date.

Southern Cross can decline a request for an upgrade or downgrade (or the addition or removal of a module) if it appears the member is seeking to manipulate their cover or take advantage of Southern Cross by making such a change.

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 1 claims year to the next, nor can they be transferred to other people covered under the policy.

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

You should note that in relation to some healthcare services, in addition to an annual limit there are other policy limits. These limits are all set out in the Coverage Tables and the List of Prostheses and Specialised Equipment.

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 overseas travel on 3 separate occasions over the lifetime of your policy, and your policy can be suspended for up to 5 years (60 months) in total.

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;
• any single period of suspension must be for a minimum of 2 months, and be for no more than 3 years (36 months);
• you or your dependant can each suspend cover up to 3 times per lifetime only;
• 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 36 months, contact us to discuss the options available to you.

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

For non-disclosure or misrepresentation of a pre-existing condition we will add such condition to your Membership Certificate and may decline any related claim.

We may cancel this policy on written notice to you for any other non-disclosure, misrepresentation, fraud or material breach of the terms of the policy by you or any dependant and/or we may take legal action against you and/or your dependant (as applicable).

Before we cancel your policy for any of the reasons set out above:
(a) we will notify you in writing of the reasons why we are considering cancellation; and
(b) you will have not less than 7 days to provide any written response you wish to be considered by us before we make our decision.

If you are unhappy with our decision to cancel you may consider the matter deadlocked and refer it to the Insurance & Financial Services Ombudsman in accordance with the relevant complaints procedure.

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 us.

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. Cover will be provided until the date the policy is paid to.

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

What happens if I do not pay my premium?

If you or your employer do not pay your premiums we will be unable to issue prior approval or pay claims under your policy.

If you or your employer don’t pay premiums for 3 months or more, we will cancel your policy.
PRIVACY STATEMENT

As a member of Southern Cross, your privacy is very important to us. We value the trust you place in us to handle your personal and health information the right way.

Our Member Privacy Statement sets out how we will collect, store, use and disclose your personal and health information, and how you can access and correct your personal information, in accordance with the Privacy Act 1993 and the Health Information Privacy Code 1994.

The Member Privacy Statement is available on our website at southerncross.co.nz/privacy. During the course of our relationship with you, we may also tell you more about how we will handle your information, for example when you make a claim.

If you have any queries about how we handle your personal and health information, or our Privacy Statement, please contact us on 0800 800 181.

FINANCIAL ADVICE

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 southerncross.co.nz/disclosure-statement.

INDUSTRY ORGANISATIONS

Southern Cross is registered as a Friendly Society and is a member of the Health Funds Association of New Zealand, the Insurance & Financial Services 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.
If you are unhappy with our service, our treatment of your **policy** or your membership of **Southern Cross**, you can follow the process outlined below.

**Is your complaint about financial advice, a claim or benefit entitlement?**

Contact us on 0800 800 181 or southerncross.co.nz. We will refer your complaint to the appropriate part of **Southern Cross**.

Still not satisfied? You can write to:
Chief Operating Officer
Southern Cross Health Society
Private Bag 99934
Newmarket
Auckland 1149

Still not resolved? Your complaint has reached deadlock.

**Is your complaint about our decision to cancel your policy? Your complaint is deemed to be ‘deadlocked’.**

**Is your complaint about your membership of Southern Cross?**

Refer to the Rules of **Southern Cross** which outline a process to resolve membership disputes. You can get a copy of the Rules from southerncross.co.nz/rules or by calling us.

You can write to the Insurance & Financial Services Ombudsman (Ombudsman) which is a free and independent service.

You must write to the Ombudsman within 3 months of being notified by us in writing that deadlock has been reached. You can find out more information on the Ombudsman at ifso.nz.

The Ombudsman’s address is:
Insurance & Financial Services Ombudsman
PO Box 10 845
Wellington 6143
Glossary of terms

For explanations of medical terminology please look at the Medical Terms Glossary at southerncross.co.nz/society or contact us.

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 Accident Compensation Act 2001 (or its successor).

**Accident** means an accident as defined in the Accident Compensation Act 2001 (or its successor).

**Acute care** means care provided in response to a sign, symptom, condition or disease that requires immediate 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, drugs (which are prescribed and taken in hospital), intravenous fluids, and irrigating solutions, used whilst the member is hospitalised for an eligible healthcare service.

**Annual limit(s)** means the maximum amount in respect of any one person that can be reimbursed in any 1 claims year.

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

**Approved treatment** means a healthcare service that is necessary for treatment of the health condition involved, is not experimental or unorthodox, and is widely accepted professionally as effective, appropriate and essential based upon recognised standards of the healthcare specialty involved.

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

**Chemotherapy drugs** means prescription medicines, biologics and immunotherapy medicines for the treatment of cancer or neoplastic disease, that are prescribed or recommended by a registered oncologist or haematologist in private practice, 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, Loeys-Dietz 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 the 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.

**Complaints procedure** means the complaints procedure and process available to you as set out in section 08.

**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 the original date of joining,

(b) signs or symptoms of the condition within 3 months of birth, as reasonably 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 in section 06 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 and or any adult dependant (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.

Diagnostic tests means ambulatory blood pressure monitoring, ankle brachial index, anorectal physiology study (anorectal motility study), bone marrow aspiration, breath nitric oxide test, caloric reflex/vestibular caloric stimulation test, colposcopy with biopsies (in rooms), compartment pressure study, corneal pachymetry test, corneal topography, electroencephalogram (EEG), electromyogram (EMG), electrooculogram, electroretinogram, endometrial biopsy (in rooms), full urodynamic assessment, fundus fluorescein angiography, fundus photography, GDX retinal scanning, H. pylori breath test, Heidelberg retinal tomography (HRT), hydrogen breath test, intraocular pressure test (IOP), laryngoscopy (in rooms), lumbar puncture, lung diffusion study, lung function test, matrix screen, nasendoscopy (in rooms), oesophageal 24hr pH monitoring (gastric function study), oesophageal manometry test, optic disc photos, optical coherence tomography (OCT), overnight pulse oximetry, proctoscopy, retinal photography, segmental pressure test, sigmoidoscopy (in rooms), simple urinary flow study, sleep study, specular microscopy test, spirometry with or without flow volume loops, ultrasounds of the eye, urea breath test, vascular laboratory testing, vestibular evoked myogenic potential (VEMP), videonystagmography, visual evoked potential (VEP), visual fields, or vulvoscopy with or without biopsy (in rooms).

Disability support service(s) means support service(s) provided where a condition, disability or illness has been, or is likely to be, present for 6 months or more excluding surgical or medical treatment.

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

Easy-claim means Southern Cross Health Society Easy-claim which is made available to members via participating health services providers.

Eligibility criteria means any additional terms and conditions we put in place from time to time in respect to a particular procedure, the then current version of which will be available at southerncross.co.nz/eligibilitycriteria or upon request.

Eligible means those private healthcare services which are:
(a) covered under or listed in the Coverage Tables and comply with any applicable terms and conditions (including any eligibility criteria we may specify from time to time); and
(b) approved treatment; and
(c) performed in private practice by a 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) 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 as specified in the Membership Certificate.

General Practitioner means a Medical Practitioner vocationally registered in General Practice or who has general or provisional general registration and is practising in general practice.

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 General Practitioner, Specialist or registered practising member of certain professions allied to medicine practising in private practice who we approve for the provision of healthcare services under this policy.

Healthcare service(s) means any private surgery or other procedure, treatment investigation, diagnostic test, consultation or other private healthcare service including hospitalisation provided by a health services provider or an approved facility.
Hospital fees means hospital costs for accommodation (single room basis excludes suites), operating theatre fees, anaesthetic supplies, intensive care and special in-hospital nursing, in-hospital x-rays and ECG, ancillary hospital charges, laparoscopic disposables and in-hospital post-operative physiotherapy.

Internal medicine means internal medicine, cardiology, clinical immunology, clinical pharmacology, endocrinology, gastroenterology, geriatric medicine, haematology, infectious diseases, medical oncology, nephrology, neurology, nuclear medicine, palliative medicine, respiratory medicine and rheumatology, as defined by the Medical Council of New Zealand (MCNZ).

Lifetime means the duration of a policyholder or dependent’s relationship with Southern Cross whether or not continuous.

List of Prostheses and Specialised Equipment means the document published by Southern Cross from time to time which details the prostheses, specialised equipment and consumables, donor tissue preparation charges and associated levels of cover provided under this policy, the latest copy of which is available at southerncross.co.nz/plans or by calling us.

Long term care means hospitalisation which is expected to last or lasts more than 90 days.

Medical Practitioner means a medical practitioner who has a current practising certificate, is practising in accordance with any restrictions placed on them by the Medical Council of New Zealand (MCNZ), is in private practice and whose scope of practise is relevant to the applicable healthcare service.

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.

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

Nurse means a Nurse who is registered with the Nursing Council of New Zealand (NCNZ), has a current practising certificate, is practising within their scope of practice and in accordance with any restrictions placed on them by the NCNZ.

Operation means all surgical procedures performed under one anaesthetic.

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.

Palliative care and treatment means any home nursing performed by a Nurse, healthcare equipment (excludes home alterations), private hospital fees for pain management or nursing care, General Practitioner visits (including home visits), nutritional support prescribed by a General Practitioner, Specialist, Nurse or Nutritionist, counselling consultations, or pharmacy and pain management costs, which provide support and comfort when diagnosed with a progressive terminal illness. Excludes entertainment, leisure, travel expenses or any costs which are covered under another policy benefit.

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 is specifically identified by Pharmac on the Pharmac Schedule as being approved for subsidy by the Government for use in your particular treatment. In determining this, we may take into account any criteria, prescribing guidelines, rules, conditions and/or restrictions published by Pharmac.

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

Policy means the contract between Southern Cross and the policyholder. The policy comprises the Membership Certificate, this policy document (including any document that is incorporated by reference ie eligibility criteria), the List of Prostheses and Specialised Equipment and any amendment or variation made to them from time to time.
Policy anniversary date means the date specified in the Membership Certificate, and:
(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 service the maximum amount payable by Southern Cross per operation, per procedure, per item, per day, per lifetime, or as an annual limit as specified in the Coverage Tables and List of Prostheses and Specialised Equipment, or as specified in our contract with an Affiliated Provider and advised to you by Southern Cross or your Affiliated Provider when you seek treatment.

Policy start date means 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, 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 relevant 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, specialised equipment and consumables and donor tissue preparation charges as set out in the List of Prostheses and Specialised Equipment.

Reasonable charges are charges for healthcare services that are determined as reasonable by us (acting reasonably) based on our review of our data.

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.

Specialist means a Medical Practitioner who is vocationally registered in one of the following scopes: anaesthesia, cardiothoracic surgery, clinical genetics, dermatology, diagnostic & interventional radiology, general surgery, intensive care medicine, internal medicine, musculoskeletal medicine, neurosurgery, obstetrics & gynaecology, occupational medicine, ophthalmology, oral & maxillofacial surgery, orthopaedic surgery, otolaryngology, paediatric surgery, paediatrics, pain medicine, palliative medicine, plastic & reconstructive surgery, psychiatry, radiation oncology, rehabilitation medicine, sexual health medicine, sport & exercise medicine, urology, vascular surgery, or
• has provisional vocational registration with the MCNZ and is under the supervision of a Medical Practitioner or
• holds a special purpose (locum tenens) scope of practice with the MCNZ and is under the supervision of a Medical Practitioner or
• is a Medical Practitioner who has been admitted to the Fellowship of the Australasian Society of Breast Physicians, or
• is an oral surgeon, oral medicine specialist or oral & maxillofacial surgeon registered with the Dental Council of New Zealand.
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 a treatment injury as defined in the Accident Compensation Act 2001 (or its successor).

Unapproved healthcare services which are specific drugs, devices, techniques, tests and/or other healthcare services that have not been approved by Southern Cross prior to treatment. Please see the list of unapproved healthcare services at southerncross.co.nz/unapprovedservices.

Varicose vein procedures means unilateral endovenous laser treatment, unilateral ultrasound guided sclerotherapy, unilateral varicose vein surgery, or unilateral radiofrequency (RF) endovenous ablation. Where a policyholder or dependant has multiple varicose vein procedures during a single operation, these are counted as separate procedures for the purposes of the per leg per lifetime limit.

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
southerncross.co.nz/society
or call us on
0800 800 181

Southern Cross Medical Care Society
Level 1, EY Building
2 Takutai Square, Auckland 1010
Private Bag 99934, Newmarket, Auckland 1149