Southern Cross Health Insurance

southerncross.co.nz/society

KiwiCare and RegularCare

Policy document

Effective from 22 October 2024

Contents

Southern Cross Health Insurance

You can have a KiwiCare plan or a RegularCare plan

When your *policy* is taken out, the *policyholder* chooses either a KiwiCare plan or a RegularCare plan.

The KiwiCare and RegularCare plans are shared cover plans – this means you're responsible for some of the cost for *eligible healthcare services* you receive.

Both plans offer an excess option of $500. Read more about how excesses work from **page 39**.

What KiwiCare covers

The KiwiCare plan provides a contribution towards cancer care, surgical treatment, diagnostic imaging and tests as well as other *healthcare services* outlined under 'What the KiwiCare and the RegularCare plans cover' from **page 11**.

What RegularCare covers

The RegularCare plan provides the same cover as KiwiCare, with extra cover for some day-to-day treatments.

Underwritten by:
Southern Cross Medical Care Society, Level 1, Te Kupenga, 155 Fanshawe Street, Auckland 1010.

WriteMark Plus®
Plain Language Standard

As part of our commitment to you, this document meets the WriteMark Plus Plain Language Standard. The WriteMark Plus is a quality mark awarded to documents that achieve a high standard of plain language.

Our financial strength rating is A+ (Strong)

Southern Cross Medical Care Society, trading as Southern Cross Health Society, is the insurer of this *policy*.

Standard & Poor's (Australia) Pty Limited has given Southern Cross Health Society an A+ (Strong) financial strength rating.

The rating scale is:

- AAA (Extremely Strong)
- AA (Very Strong)
- A (Strong)
- BBB (Good)
- BB (Marginal)
- B (Weak)
- CCC (Very Weak)
- CC (Extremely Weak)
- SD or D (Selective Default or Default)

Ratings from 'AA' to 'CCC' may be modified with a plus (+) or minus (-) sign to show relative standing within the major rating categories. Full details of the rating scale are available at **spglobal.com/ratings/en/about/intro-to-credit-ratings**

Standard & Poor's is an approved rating agency under the Insurance (Prudential Supervision) Act 2010.

All dollar amounts are in New Zealand dollars and include GST

All references to dollar amounts in this policy document mean New Zealand currency and include GST.

How to contact us

If you want to get in touch, you can reach us in a few ways.

- Enquire online, at **southerncross.co.nz/contact**
- Phone us from New Zealand on **0800 800 181**, or from overseas on **+64 9 979 9212**
- Send us a letter, to **Southern Cross Health Society, Private Bag 99934, Newmarket, Auckland 1149, Freepost Authority 1440**.

If you would like to make a complaint

If you have a complaint about our treatment of your *policy* or the service we've provided (including financial advice, a claim, a benefit entitlement, or our decision to cancel your *policy*), please tell us so we can work with you to resolve your concerns.

> **To make a complaint, contact us directly using our details above. Or, visit our website for more information on our complaints and dispute resolution process at southerncross.co.nz/complaints**

To resolve a complaint about your membership of Southern Cross, please refer to the Rules of Southern Cross at **southerncross.co.nz/rules** or contact us.

You can contact the Ombudsman if you're not satisfied

We're part of the Insurance & Financial Services Ombudsman's approved dispute resolution scheme (IFSO). This scheme is a free and independent dispute resolution service that helps investigate or resolve complaints for consumers.

If you're not satisfied with our response to your complaint or your complaint is not resolved, you can refer it on to IFSO.

> **For more information about IFSO or to contact them about a complaint, call 0800 888 202, or visit ifso.nz**

A

Welcome to your health insurance plan

Thank you for choosing us to take care of your health insurance needs.

We want to make sure you understand your health insurance

Take your time to read this policy document and the other documents that make up your health insurance *policy* listed on **page 7** to make sure you understand your cover.

This policy document explains the benefits, and terms and conditions of your policy

This policy document explains what is and isn't covered, the *policy limits,* the terms and conditions of cover, how to make a claim, and your responsibilities under this *policy*.

Some parts of this policy document will only apply to you if you have a specific plan or Cancer Cover Plus upgrade. We'll make it clear throughout this policy document if a certain part applies only to a specific plan or Cancer Cover Plus upgrade.

Check your *membership certificate* to see which plan you're covered by and any Cancer Cover Plus upgrade that applies.

We may make changes to this policy document from time to time, and this may change your cover under this *policy*. See the heading 'We may make changes that affect your policy' on **page 9**.

> **To access the latest policy document, contact us (see page 5 for contact details) or visit southerncross.co.nz/plans**

Some words in this policy document have specific meanings

When we use the following words in this policy document, here's what we mean.

- 'We', 'us', 'our' and 'Southern Cross' mean Southern Cross Medical Care Society trading as Southern Cross Health Society – our registered office is at Level 1, Te Kupenga, 155 Fanshawe Street, Auckland 1010
- 'You' and 'your' mean the *policyholder* and any *dependant* listed on the *membership certificate*
- 'Cover' means the amount we'll pay for *eligible* claims as detailed under each benefit in the section 'What the KiwiCare and the RegularCare plans cover' from **page 11**.

Words in italics are defined in the 'Glossary of terms'

You'll also notice that some words and phrases in this policy document are in italics, *like this*. These words and phrases have specific meanings. They are defined in the 'Glossary of terms' from **page 51**.

Headings in this document are for your convenience only

We have used descriptive headings in this policy document to help you find information. You should not rely on these headings to interpret the terms and conditions of your *policy*.

The documents that make up your health insurance policy

Your health insurance *policy* is made up of:

- this policy document
- your application form
- your health insurance medical declaration (where relevant)
- your *membership certificate*
- the *eligibility criteria*
- the list of *unapproved healthcare services*
- the *list of prostheses and specialised equipment*
- the list of Affiliated Provider-only healthcare services
- the list of policy variations
- any changes made to the above documents from time to time.

These documents are designed to be read together to outline the cover your *policy* provides.

Your application form, health insurance medical declaration, and *membership certificate* are specific to your *policy* only. The *policyholder* can request a copy of these by contacting us or they can view the *membership certificate* on MySouthernCross.

We may make changes from time to time that could affect your cover under this *policy*. See the heading 'We may make changes that affect your policy' on **page 9**.

> To access the latest versions of the other documents listed above, contact us (see page 5 for contact details) or visit southerncross.co.nz/plans

Your membership certificate contains information specific to your policy

Your *membership certificate* contains:

- the key dates relevant to your *policy*
- the people covered under your *policy*
- the name of your plan and any Cancer Cover Plus upgrade and excess that applies to your *policy*
- the *policyholder's* Southern Cross membership number
- any *pre-existing conditions* that you've made us aware of for the people covered under your *policy*
- any other information specific to your *policy*.

If information on your *membership certificate* contradicts what's stated in this policy document, the information on your *membership certificate* takes precedence over this policy document.

The eligibility criteria set out any additional requirements that must be met for some healthcare services

We'll only cover certain *healthcare services* if the additional terms and conditions set out in the *eligibility criteria* have been met. The terms of each benefit (starting on **page 11**) state if *eligibility criteria* apply.

The list of unapproved healthcare services sets out specific healthcare services that we don't cover

This list sets out the specific *drugs*, devices, techniques, tests, or other *healthcare services* that are not covered under any Southern Cross health insurance plans.

The list of prostheses and specialised equipment sets out the specific items we cover as part of eligible surgical treatment

This list sets out the *prostheses*, specialised equipment and consumables, and donor tissue preparation charges that we cover as part of *eligible* surgical treatment under your *policy*. We'll only cover *prostheses*, specialised equipment and consumables, and donor tissue preparation charges that are included on this list unless we tell you otherwise.

The list of Affiliated Provider-only healthcare services sets out all the services that must be performed by an Affiliated Provider

Certain *healthcare services* must be performed by an *Affiliated Provider* to be *eligible* for cover under your *policy*. The terms of each benefit (starting on **page 11**) state if this requirement applies.

Please note that *Affiliated Providers* may not offer all of the *healthcare services* covered under this *policy* and there may not be an *Affiliated Provider* available in your hometown or city.

> **To find an *Affiliated Provider* or to see the types of services they offer, visit healthcarefinder.co.nz**

The list of policy variations sets out variations to your policy terms and conditions

This is a list of variations to your policy terms and conditions that may apply from time to time. These variations include the way we treat some *exclusions* (those listed from **page 29**) and certain benefit terms, or new ways of delivering *healthcare services* we're testing. This may mean you can access additional cover while these variations are included on the list of policy variations published on our website.

When cover starts under your policy

The *policyholder's* cover under this *policy* starts on the *policy start date* and a *dependant's* cover starts on the date we add them to this *policy*. These dates are specified on your *membership certificate*.

We may make changes that affect your policy

We regularly review our health insurance plans to ensure they remain relevant. So, from time to time we may change the *healthcare services* that are *eligible,* the scope of cover, terms and conditions of your *policy,* and your premiums.

If we change this policy document or your premiums, we'll tell the *policyholder* in writing what the changes are and the date that the changes will apply (this might be through MySouthernCross). The *policyholder* is responsible for telling *dependants* about any changes to the *policy*.

We regularly update certain documents that form part of your policy

The following documents that form part of your *policy* are regularly updated as we continuously review how we cover *healthcare services* and certain technology. So, you should always refer to our website at **southerncross.co.nz/plans** for the latest versions.

- The *eligibility criteria*
- The list of *unapproved healthcare services*
- The *list of prostheses and specialised equipment*
- The list of Affiliated Provider-only healthcare services
- The list of policy variations

The policyholder can cancel this policy if they don't like the changes

If you're unhappy with any changes we're making, the *policyholder* can contact us within 1 month of the notification of changes to discuss options (see **page 5** for contact details), or they can cancel this *policy*.

If the *policyholder* chooses to cancel this *policy*, we'll keep covering you for any period for which the premiums have been paid.

Who can be covered under the KiwiCare plan and the RegularCare plan

Both the KiwiCare plan and the RegularCare plan are only available to:

- New Zealand citizens
- New Zealand residents, and
- those who are entitled to publicly funded healthcare for all services as determined by the New Zealand Ministry of Health from time to time.

How these plans work with ACC and the public health system

The New Zealand public healthcare system provides cover for all New Zealand residents for *acute care* and some elective treatment.

ACC provides no-fault injury cover for everyone in New Zealand.

The KiwiCare plan and the RegularCare plan are designed to complement the services provided by *ACC* and the New Zealand public healthcare system. This is why the plans do not provide cover for *healthcare services* related to *acute care* or to an *accident, treatment injury* or *work-related gradual process injury* 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* – refer to the 'Accident and treatment injury top-up' benefit on **page 27**.

How your Southern Cross membership works

By applying for this *policy*, the *policyholder* has also applied for membership of Southern Cross for themselves and any *dependants* covered under this *policy*.

By applying for membership, the *policyholder* agrees (both for themselves and on behalf of their *dependants*) to be bound by the Rules of Southern Cross Medical Care Society.

> **Read the Rules of Southern Cross Medical Care Society on our website at southerncross.co.nz/rules, or contact us if you have questions or want to request a copy (see page 5 for contact details)**

If the *policyholder's* membership of Southern Cross is terminated for any reason (including death), this *policy* will be terminated.

If this *policy* is terminated (for whatever reason), the *policyholder* and any *dependant's* membership of Southern Cross will end.

The *policyholder* can cancel this *policy* during the 14-day review period referred to under 'Making changes or cancelling within 14 days' on **page 45**. If this happens, then the *policyholder* and any *dependant*'s membership of Southern Cross will end from the date that the 14-day review period started.

B

What the KiwiCare and the RegularCare plans cover

This section details the *healthcare services* covered by the KiwiCare plan and the RegularCare plan. Check your *membership certificate* to see which plan you're covered by.

The *policy limits* outlined under the benefits in this section apply to each person covered under your *policy* individually.

We'll cover up to 80% of the cost of *eligible healthcare services*. *Eligible* means all of the following apply:

- it's a *healthcare service* covered under or listed in this section
- it complies with any applicable terms and conditions (such as *eligibility criteria)* that we may specify from time to time
- it's an *approved treatment*
- costs have been incurred, or will be incurred for the *healthcare service*
- it's not excluded under your *policy*
- it's performed in private practice by a *health services provider* with registration relevant to the *healthcare service*.

Contact us (see **page 5** for contact details) if you're unsure whether a *healthcare service* is covered under your *policy*.

> **Some *healthcare services* must be performed by an *Affiliated Provider* to be *eligible* for cover. To see the list of Affiliated Provider-only healthcare services, visit southerncross.co.nz/plans**

> **To view *eligibility criteria* that apply to certain benefits, visit southerncross.co.nz/eligibilitycriteria**

We're not liable for the quality of the healthcare services you receive

We're not liable for the quality, standard, or effectiveness of any *healthcare services* you receive. This includes any actions of the *health services provider* or any of their employees or agents.

Consultations

Consultations are covered with certain *specialists,* psychiatrists, and dietitians.

Specialist consultations

$4,000 each *claims year*

This benefit provides cover for consultations performed by a *specialist* who is an *Affiliated Provider*. This includes cover for getting a second opinion on your diagnosis or treatment plan by a *specialist* who is an *Affiliated Provider*.

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for consultations, to a maximum of $4,000 each *claims year*. No excess applies to this benefit.

This benefit does not cover:

- consultations with a psychiatrist, which are covered under the 'Psychiatrist consultations' benefit below, or
- consultations related to skin lesions, which are covered under the 'Skin lesion services' benefit on **page 19**.

Psychiatrist consultations

$600 each *claims year*

This benefit provides cover for psychiatrist consultations performed by a *specialist* who is vocationally registered in psychiatry.

We'll cover 80% of the actual costs incurred for consultations, to a maximum of $600 each *claims year*. No excess applies to this benefit.

Dietitian consultations

$80 each consultation up to $400 each *claims year*

This benefit provides cover for dietitian consultations only when you're referred by a *specialist* in private practice. The consultation must be performed by a dietitian registered with the New Zealand Dietitian Board.

We'll cover 80% of the actual costs incurred for each consultation up to $80, to a maximum of $400 each *claims year*. No excess applies to this benefit.

Imaging and tests

The following diagnostic imaging and tests are covered.

Diagnostic imaging

$8,000 each *claims year*

This benefit provides cover for diagnostic imaging performed by an *Affiliated Provider*.

For certain imaging procedures, *eligibility criteria* need to be met before we'll cover them.

This benefit covers the following imaging procedures.

- 2D and 3D mammography
- Computed tomography (CT scan)
- CT angiogram (CTA)
- Nuclear medicine scan (scintigraphy)
- Ultrasound, except when related to obstetrics and varicose veins (legs)
- X-ray, except when performed by a dentist or chiropractor

This benefit also covers the following imaging procedures only when you're referred by a *specialist* in private practice.

- Cone beam computed tomography (CBCT)
- CT coronary angiogram (CTCA)
- Magnetic resonance imaging (MRI scan)
- MR angiogram (MRA)
- Myocardial perfusion scan
- Positron emission tomography/computed tomography (PET/CT) for specific diagnosed cancers and cardiac conditions

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for imaging procedures, to a maximum of $8,000 each *claims year*. No excess applies to this benefit.

Cardiac tests

$3,000 each *claims year*

This benefit provides cover for cardiac tests performed by an *Affiliated Provider* only when you're referred by a *specialist* in private practice.

For certain tests, *eligibility criteria* need to be met before we'll cover them.

This benefit covers the following cardiac tests.

- Advanced electrocardiogram (A-ECG)
- Dobutamine stress echocardiogram
- Echocardiogram
- Exercise ECG
- Holter monitoring
- Resting ECG
- Stress echocardiogram
- Transoesophageal echocardiogram (TOE)

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for cardiac tests, to a maximum of $3,000 each *claims year*. No excess applies to this benefit.

Diagnostic tests

$2,000 each *claims year*

This benefit provides cover for diagnostic tests performed in an *approved facility* only when you're referred by a *specialist* in private practice.

Some diagnostic tests must be performed by an *Affiliated Provider* to be *eligible* for cover under this benefit.

> **To see which diagnostic tests must be performed by an *Affiliated Provider* to be *eligible* for cover, visit southerncross.co.nz/plans**

For certain tests, *eligibility criteria* need to be met before we'll cover them.

Diagnostic tests (continued)

This benefit covers the following diagnostic tests.

- Ambulatory blood pressure monitoring (ABPM)
- Ankle brachial index
- Anorectal physiology studies
- Bone marrow aspiration
- Caloric reflex test
- Colposcopy with or without biopsy under local anaesthetic or no anaesthetic
- Compartment pressure study
- Corneal pachymetry
- Corneal topography
- Electroencephalogram (EEG)
- Electromyogram (EMG)
- Electrooculogram (EOG)
- Electroretinogram (ERG)
- Endometrial biopsy under local anaesthetic or no anaesthetic
- Fractional exhaled nitric oxide (FeNO) test
- Full urodynamic assessment
- Fluorescein angiography
- Heidelberg retinal tomography (HRT)
- Hydrogen breath test
- Intraocular pressure (IOP) test
- Laryngoscopy (in rooms)
- Lumbar puncture
- Lung diffusion study
- Lung function test
- Nasendoscopy (in rooms)
- Oesophageal 24hr pH monitoring (gastric function study)
- Oesophageal manometry test
- Optical coherence tomography (OCT)
- Overnight pulse oximetry
- Proctoscopy
- Retinal photography
- Scanning laser polarimetry (SLP)
- Segmental pressure test
- Sigmoidoscopy (in rooms)
- Simple urinary flow study
- Sleep study
- Specular microscopy
- Spirometry
- Ultrasound of the eye
- Urea breath test (H. pylori breath test)
- Vascular laboratory testing
- Vestibular evoked myogenic potential (VEMP)
- Video-assisted head impulse test (vHIT)
- Videonystagmography (VNG)
- Visual evoked potential (VEP)
- Visual field test
- Vulvoscopy with or without biopsy under local anaesthetic or no anaesthetic

Where the diagnostic tests are performed by an *Affiliated Provider,* we'll cover 80% of the amount charged by your *Affiliated Provider,* unless we or your *Affiliated Provider* tell you otherwise. In other cases, where the diagnostic tests are performed in an *approved facility* but not by an *Affiliated Provider,* we'll cover 80% of the actual costs incurred.

The maximum we'll cover is $2,000 each *claims year.* No excess applies to this benefit.

Laboratory tests

$56 each *claims year*

This benefit covers laboratory tests performed for diagnostic purposes but not funded by a government agency.

The test must be performed by an accredited hospital, community-based or regional referral laboratory that's approved by International Accreditation New Zealand.

We'll cover 80% of the actual costs incurred for laboratory tests, to a maximum of $56 each *claims year*. No excess applies to this benefit.

Surgical treatment

The following outlines your cover for surgical procedures, skin lesion services, and GP minor surgery.

Surgical procedures

$100,000 each *operation*
(Individual *prostheses* limits apply)
Excess applies

This benefit provides cover for surgical procedures performed in an *approved facility* by a *specialist* or an *Affiliated Provider* contracted for that *healthcare service*.

Some surgical procedures must be performed by an *Affiliated Provider* to be *eligible* for cover under this benefit.

> To see which procedures need to be performed by an *Affiliated Provider* to be *eligible* for cover, visit southerncross.co.nz/plans

For certain surgical procedures, *eligibility criteria* need to be met before we'll cover them. If you're having two or more surgical procedures at the same time, or if your *operation* involves more than one surgeon (including an assistant surgeon), let us know at the time of prior approval so that we can determine the extent of your cover.

This benefit provides cover for the following costs associated with the procedure.

- Operating fees for one surgeon for each *operation* (unless we've accepted cover for more than one at the time of prior approval)
- Anaesthetist's fees
- Intensivist's fee
- Perfusionist's charges
- *Hospital fees*
- Surgically implanted *prostheses*, specialised equipment and consumables, and donor tissue preparation charges. The *list of prostheses and specialised equipment* sets out which of these we'll cover and the maximum amount we'll pay towards each one

> To see the *list of prostheses and specialised equipment*, contact us (see page 5 for contact details) or visit southerncross.co.nz/plans

Surgical procedures (continued)

This benefit includes cover for some less invasive procedures and medical treatments which a *specialist* or *Affiliated Provider* may consider more appropriate for your condition. Contact us to check eligibility for cover before getting treatment.

Where the procedure is performed by an *Affiliated Provider*, we'll cover 80% of the amount charged by your *Affiliated Provider* for the costs associated with the procedure, unless we or your *Affiliated Provider* tell you otherwise. In other cases, where the procedure is performed by a *specialist* who is not an *Affiliated Provider*, we'll cover 80% of the actual costs incurred associated with the procedure.

The maximum we'll cover is $100,000 for each *operation*. Excess applies to this benefit.

The costs associated with the following procedures are also covered under this benefit and additional *policy limits* and criteria apply as stated below:

Major diagnostic procedures

This benefit provides cover for major diagnostic procedures including, but not limited to, angiograms and endoscopies. Endoscopies include colonoscopy, gastroscopy, hysteroscopy, and cystoscopy.

Intravitreal injections (eyes)

This benefit provides cover for intravitreal injections. Only $100 is available towards the cost of the drug used for each injection, regardless of the type of drug used.

Breast reconstruction

This benefit provides cover for breast reconstruction procedures of the affected breast following an *eligible* mastectomy.

Any reconstruction procedures after the initial reconstruction procedure are only covered when performed within 2 years from either:

- placement of the first permanent implant
- the first fat grafting procedure
- therapeutic mammoplasty, or
- flap surgery.

No time limit restrictions apply for nipple reconstruction, including tattooing.

Surgical procedures (continued)

Varicose vein procedures (legs)

This benefit provides cover for up to two varicose vein procedures for each leg during your lifetime. If you have multiple procedures during a single *operation*, we count these as separate procedures under the lifetime limit for each leg.

The procedures we cover for treatment of varicose veins (in legs) are:

- endovenous laser treatment
- ultrasound guided sclerotherapy
- varicose vein surgery
- cyanoacrylate embolisation
- endovenous radiofrequency ablation (EVRFA).

We'll also cover duplex vein mapping, but the lifetime limit does not apply.

Sclerotherapy or embolisation of simple vascular malformation

This benefit provides cover for up to two sclerotherapy or embolisation procedures for each simple vascular malformation during your lifetime.

Percutaneous medial branch thermal radiofrequency neurotomy

This benefit provides cover for up to two percutaneous medial branch thermal radiofrequency neurotomy procedures during your lifetime.

Skin lesion removal under general anaesthetic or sedation, and Mohs surgery

This benefit provides cover for the following procedures:

- excision, biopsy, cryotherapy, curettage, and diathermy of skin lesions performed under general anaesthetic or sedation
- Mohs surgery (including excision and closure).

Skin lesion services

$5,000 each *claims year*
(only $800 of this limit is available when performed by a *general practitioner*)

This benefit provides cover for skin lesion consultations and removal services performed under local anaesthetic or no anaesthetic by an *Affiliated Provider* or *general practitioner*.

For skin lesion services, *eligibility criteria* need to be met before we'll cover them.

This benefit covers:

- all consultations related to skin lesions
- excision, biopsy, cryotherapy, curettage, and diathermy of skin lesions performed under local anaesthetic or with no anaesthetic.

Where the skin lesion services are performed by an *Affiliated Provider,* we'll cover 80% of the amount charged by your *Affiliated Provider*, unless we or your *Affiliated Provider* tell you otherwise. In other cases, where the skin lesion services are performed by a *general practitioner* who is not an *Affiliated Provider,* we'll cover 80% of the actual costs incurred.

The maximum we'll cover is $5,000 each *claims year*. Only $800 of this *claims year* limit is available towards these services when performed by a *general practitioner*. No excess applies to this benefit.

Skin lesion removal procedures performed under general anaesthetic or sedation, and any Mohs surgeries, are covered under the 'Surgical procedures' benefit on **page 16**.

GP minor surgery

$800 each *claims year*

This benefit provides cover for minor surgeries performed by a *general practitioner*. This includes, for example, the removal or resection of ingrown toenails, steroid or cortisone injections, and abscess drainage.

We'll cover 80% of the actual costs incurred for minor surgeries, to a maximum of $800 each *claims year*. No excess applies to this benefit.

This benefit does not cover consultations or skin lesion services.

Surgical allowances

The following outlines your cover for gastric banding or bypass, breast reduction, breast symmetry, and prophylactic treatments.

Gastric banding or bypass allowance

$5,000 during a lifetime

After 3 years of *continuous cover* on this plan, this benefit contributes towards one of the following bariatric procedures, including any follow-up treatment that may be required.

- Gastric banding
- Gastric bypass, for example, Roux-en-Y, mini gastric-bypass
- Sleeve gastrectomy
- Single anastomosis duodeno-ileostomy with sleeve (SADI-S)
- Endoscopic sleeve gastroplasty

For the above bariatric procedures, *eligibility criteria* need to be met before we'll cover them. We also need a medical report by a *specialist* to assess your eligibility for cover.

An *Affiliated Provider* must perform all *specialist* consultations and diagnostic imaging related to this procedure.

We'll cover 80% of the actual costs incurred for the procedure and any follow-up treatment, to a maximum of $5,000 during your lifetime. No excess applies to this benefit.

Breast reduction allowance

$15,000 during a lifetime

After 3 years of *continuous cover* on this plan, this benefit contributes towards breast reduction procedures, including any follow-up treatment that may be required.

For breast reduction procedures, *eligibility criteria* need to be met before we'll cover them. We also need a medical report by a *specialist* to assess your eligibility for cover.

An *Affiliated Provider* must perform all *specialist* consultations and diagnostic imaging related to this procedure.

We'll cover 80% of the actual costs incurred for the procedure and any follow-up treatment, to a maximum of $15,000 during your lifetime. No excess applies to this benefit.

Breast symmetry allowance

$10,000 during a lifetime

This benefit contributes towards breast symmetry procedures by augmentation or reduction of the unaffected breast following an *eligible* mastectomy. This benefit also covers any follow-up treatment that may be required.

For breast symmetry procedures, *eligibility criteria* need to be met before we'll cover them.

An *Affiliated Provider* must perform all *specialist* consultations and diagnostic imaging related to this procedure.

We'll cover 80% of the actual costs incurred for the procedure and any follow-up treatment, to a maximum of $10,000 during your lifetime. No excess applies to this benefit.

Prophylactic treatment allowance

$30,000 during a lifetime

After 3 years of *continuous cover* on this plan, this benefit contributes towards prophylactic treatment to address a highly increased risk of developing a disease due to your medical history or genetic predisposition. This benefit also covers any follow-up *healthcare services* that are related to the prophylactic treatment.

Unless your *membership certificate* specifically states otherwise, this benefit is not available to you if you've been confirmed as having a high risk of developing the disease that the prophylactic treatment is designed to prevent before your *original date of joining*.

For prophylactic treatments, *eligibility criteria* need to be met before we'll cover them.

You must get prior approval from us before the treatment is performed.

> Find out how to apply for prior approval on page 36.

An *Affiliated Provider* must perform all *specialist* consultations and diagnostic imaging related to the treatment provided.

We'll cover 80% of the actual costs incurred for the treatment and any follow-up *healthcare services*, to a maximum of $30,000 during your lifetime. No excess applies to this benefit.

Cancer treatment

Healthcare services to support cancer diagnosis, surgery, treatment, and recovery are covered under a range of benefits under the KiwiCare plan and the RegularCare plan.

The following outlines cover for chemotherapy for cancer and radiotherapy.

Chemotherapy for cancer (base)

$48,000 each *claims year*
(includes $8,000 for *chemotherapy drugs* that are not *Pharmac approved* but *Medsafe*-indicated)
Excess applies

This benefit provides cover for chemotherapy treatment for cancer. The chemotherapy treatment must be performed by an *Affiliated Provider* who is vocationally registered in *internal medicine*.

This benefit provides cover for the following costs associated with chemotherapy treatment.

- *Pharmac approved chemotherapy drugs*
- Up to a maximum of $8,000 each *claims year* for *chemotherapy drugs* that are not *Pharmac approved* but are *Medsafe*-indicated for treatment of the cancer you've been diagnosed with
- Administration of the *chemotherapy drugs*
- Hospital accommodation in a single room
- *Ancillary hospital charges*

This benefit does not cover consultations.

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for the costs associated with chemotherapy treatment, to a maximum of $48,000 each *claims year*. This amount includes the $8,000, mentioned above, for *chemotherapy drugs* that are not *Pharmac approved* but are *Medsafe*-indicated.

Excess applies to this benefit.

Cancer Cover Plus – Optional chemotherapy for cancer upgrades

Chemotherapy 100: $100,000 each *claims year*
Chemotherapy 300: $300,000 each *claims year*
Excess applies

You can upgrade from your 'Chemotherapy for cancer (base)' benefit set out above to one of the Cancer Cover Plus options: Chemotherapy 100 and Chemotherapy 300.

Your current *membership certificate* will confirm whether you have one of these upgraded options. This upgrade replaces your cover under the 'Chemotherapy for cancer (base)' benefit except where the *exclusion* for family history of cancer applies.

The chemotherapy treatment must be performed by an *Affiliated Provider* who is vocationally registered in *internal medicine*.

Cancer Cover Plus (continued)

What the Chemotherapy 100 and Chemotherapy 300 optional upgrades cover

Chemotherapy 100 and Chemotherapy 300 provide cover for the following costs associated with chemotherapy treatment.

- *Pharmac approved chemotherapy drugs*
- *Chemotherapy drugs* that are not *Pharmac approved* but are *Medsafe*-indicated for treatment of the cancer you've been diagnosed with
- Administration of the *chemotherapy drugs*
- Hospital accommodation in a single room
- *Ancillary hospital charges*

This benefit does not cover consultations.

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for the costs associated with chemotherapy treatment, to a maximum of:

- $100,000 each *claims year* under Chemotherapy 100
- $300,000 each *claims year* under Chemotherapy 300.

Excess applies to these upgrades.

Cancer Cover Plus excludes cover for family history of cancer

If the *policyholder* or any *dependant* has a family history of cancer as defined below, the specific cancer which they have a family history of will be excluded for them under Cancer Cover Plus.

The *exclusion* for family history of cancer will not apply to the 'Chemotherapy for cancer (base)' benefit.

Family history of cancer means the following two statements apply to someone covered by this *policy*.

- They have two or more biological siblings or parents (living or dead) who have been diagnosed with colorectal, breast, ovarian, or prostate cancer before the age of 55.
- They were aware of, or should reasonably have been aware of, the diagnosis before the:
  - date the *policyholder* applied for Cancer Cover Plus, or
  - date they were added to the *policy*, if they were a *dependant* added after the *policyholder* applied for Cancer Cover Plus.

Radiotherapy

Unlimited
Excess applies

This benefit provides cover for radiotherapy planning and treatment performed by an *Affiliated Provider*.

Please note that only a limited range of radiotherapy treatments are covered and *eligibility criteria* will need to be met before we'll cover them.

Unless we or your *Affiliated Provider* tell you otherwise, we'll cover 80% of the amount charged by your *Affiliated Provider* for radiotherapy treatment. Excess applies to this benefit.

This benefit does not cover *specialist* consultations, *drugs*, follow-up imaging, or any other *healthcare services*.

IV infusions (non-cancer)

$600 each *claims year*

This benefit provides cover for IV infusions of *drugs* that are *Medsafe*-indicated for treatment of the condition you've been diagnosed with. The IV infusion must be provided in an *approved facility* by, or under the care of, a *specialist*.

This benefit does not cover consultations related to infusions or the cost of drugs that are not *Pharmac approved*.

We'll cover 80% of the actual costs incurred for infusions, to a maximum of $600 each *claims year*. No excess applies to this benefit.

Allergy services

$600 each *claims year*

This benefit provides cover for allergy-related services, including allergy testing and desensitisation. The services must be provided by, or under the care of, either:

- an *Affiliated Provider*, or
- a *general practitioner* who has an *Easy-Claim* agreement with us.

> You can find a *general practitioner* who has an *Easy-Claim* agreement with us or an *Affiliated Provider* at healthcarefinder.co.nz

This benefit does not cover consultations or the cost of drugs that are not *Pharmac approved*.

Where the allergy services are performed by an *Affiliated Provider*, we'll cover 80% of the amount charged by your *Affiliated Provider*, unless we or your *Affiliated Provider* tell you otherwise. In other cases, where the allergy services are performed by a *general practitioner* with an *Easy-Claim* agreement with us, we'll cover 80% of the actual costs incurred.

The maximum we'll cover is $600 each *claims year*. No excess applies to this benefit.

Psychiatric hospitalisation

$2,250 each *claims year*

This benefit provides cover for admission and care by a *specialist* who is vocationally registered in psychiatry in an *approved facility*.

We'll cover 80% of the actual costs incurred for psychiatric admission and care, to a maximum of $2,250 each *claims year*. This limit includes:

- up to $450 for each night or day-stay in hospital accommodation
- up to $160 each *claims year* for *ancillary hospital charges*.

No excess applies to this benefit.

Overseas treatment allowance

$5,000 each *claims year*

This benefit provides a reimbursement towards medical expenses for *approved treatment* that you receive overseas if that treatment is not available in public or private health facilities within New Zealand.

A *specialist* must recommend the treatment. You must send us a medical report and get prior approval from us before the treatment is performed.

> Find out how to apply for prior approval on page 36.

General *exclusions* apply to overseas treatment (see the section 'What the KiwiCare and the RegularCare plans don't cover' from **page 29**). This benefit does not cover accommodation or travel.

We'll reimburse 80% of the actual costs incurred for overseas treatment, to a maximum of $5,000 each *claims year*. No excess applies to this benefit.

Recovery services

We cover the following services to aid your recovery after treatment.

Post-operative home nursing

$150 each day up to $900 each *claims year*

After 1 year of *continuous cover* on this plan, this benefit provides cover for home nursing care performed by a *nurse*. You must be referred by a *specialist* in private practice.

The home nursing care must start within 14 days of related *eligible* surgical treatment, chemotherapy, or radiotherapy.

We'll cover 80% of the actual costs incurred for each day of nursing care up to $150, to a maximum of $900 each *claims year*. No excess applies to this benefit.

Post-operative speech and language therapy

$56 each visit up to $280 each *claims year*

This benefit provides cover for treatment by a speech and language therapist who is registered with the New Zealand Speech-language Therapists' Association. You must be referred by a *specialist* in private practice.

The treatment must be performed within 6 months of related *eligible* surgical treatment, chemotherapy, or radiotherapy.

We'll cover 80% of the actual costs incurred for each visit up to $56, to a maximum of $280 each *claims year*. No excess applies to this benefit.

Post-operative physiotherapy

$30 each visit up to $180 each *claims year*

This benefit provides cover for physiotherapy treatment performed by either:

- a physiotherapist registered with the Physiotherapy Board of New Zealand, or
- a hand therapist registered with Hand Therapy New Zealand.

The treatment must be performed within 6 months of related *eligible* surgical treatment, chemotherapy, or radiotherapy.

We'll cover 80% of the actual costs incurred for each visit up to $30, to a maximum of $180 each *claims year*. No excess applies to this benefit.

Support services

We provide the following benefits to support you during treatment.

Ambulance allowance

$144 each *claims year*

This benefit provides cover for ambulance transport to a public health facility.

We'll cover 80% of the actual costs incurred for ambulance transport, to a maximum of $144 each *claims year*. No excess applies to this benefit.

Travel and accommodation allowance

$400 each *claims year*

This benefit provides cover for travel and accommodation costs for any person covered under this *policy* if it's necessary for them to travel to receive an *eligible healthcare service*. This includes cover for travel and accommodation costs for one support person to travel with them.

Travel costs cover public transport charges for buses, trains, taxis, shuttles, planes, and ferries.

Accommodation costs cover charges for hotel rooms, motel rooms, or hospital rooming fees for the support person.

All the following must apply to be *eligible* for cover under this benefit.

- The *eligible healthcare service* that the *policyholder* or *dependant* needs is not available in their hometown or city.
- The *policyholder* or *dependant* must travel more than 100km away from their home to receive the *eligible healthcare service*.
- All travel and accommodation is within New Zealand.

This benefit does not cover car hire, mileage, or petrol costs.

We'll cover 80% of the actual costs incurred for travel and accommodation, to a maximum of $400 each *claims year*. No excess applies to this benefit.

Parent accommodation allowance

$80 each night up to $400 for each *operation*

This benefit provides cover for hospital accommodation costs for a parent who is accompanying a *dependant child* for an *operation*. Your *membership certificate* must list both the parent and the *child* as being covered by this *policy*. The accommodation must be in an *approved facility*.

We'll cover 80% of the actual costs incurred for each night of accommodation up to $80, to a maximum of $400 for each *operation*. No excess applies to this benefit.

Accident and treatment injury top-up

If your *ACC* entitlement doesn't cover you for the full amount charged for *healthcare services* related to an *accident, treatment injury* or *work-related gradual process injury*, you can make a claim for the shortfall under the relevant benefit if that *healthcare service* is covered under your *policy*. The *policy limits*, terms and conditions of that benefit will apply.

If you need a *healthcare service* related to an *accident, treatment injury,* or *work-related gradual process injury*, you must do everything you reasonably can to obtain *ACC* approval for payment of the cost of your *healthcare service*. This includes signing all documents and doing everything necessary to enable us to protect any entitlement from *ACC*.

We'll cover up to 80% of the remaining cost of the *eligible healthcare service* after the *ACC* contribution has been deducted, up to the *policy limits* for the relevant benefit.

Day-to-day treatment (only if you have RegularCare)

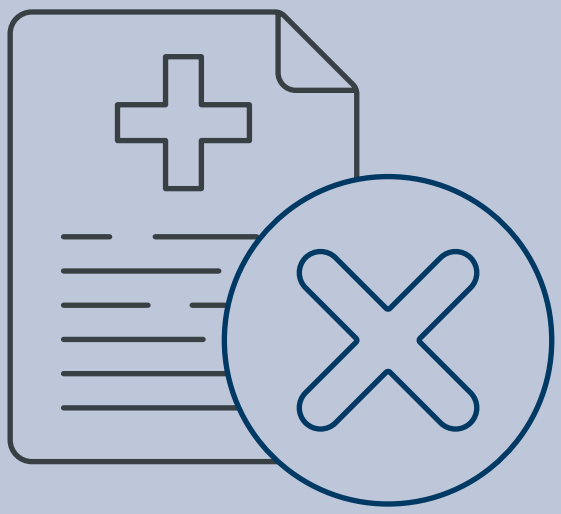
If you have the RegularCare plan, this benefit provides cover for *general practitioner* and *nurse* visits, prescriptions, and more.

No excess applies to this benefit.

What we'll cover	We'll cover 80% of the actual costs incurred up to the policy limits set out below:
***General practitioner* services** Consultations and treatment performed by a *general practitioner,* or a *nurse* at a general practice clinic.	$45 for each visit.
Nurse services Performed by a *nurse.* Services performed at a general practice clinic by a *nurse* are covered under *general practitioner* services as set out above.	$20 for each visit.
Prescriptions *Drugs* prescribed by a *general practitioner, specialist,* or *nurse.* This excludes cover for drugs that are not *Pharmac approved.*	$400 each *claims year.*
Physiotherapy Performed by a physiotherapist who is registered with the Physiotherapy Board of New Zealand.	$30 for each visit, to a maximum of $180 each *claims year.*
Orthoptist services Consultations and treatment performed by a registered orthoptist.	$128 each *claims year.*
Audiology services Performed by an audiologist who is a member of the New Zealand Audiological Society.	$40 for each visit, to a maximum of $128 each *claims year.*
Hearing tests This includes pure-tone audiometry, impedance audiometry, tympanometry, and brainstem auditory evoked response tests.	$128 each *claims year.*

C

What the KiwiCare and the RegularCare plans don't cover



Your *policy* doesn't cover any costs related to, or incurred as a consequence of, certain conditions, *healthcare services*, or situations.

These *exclusions* apply to all benefits available under your plan unless we've specified otherwise in this policy document, or the list of policy variations published on our website at **southerncross.co.nz/plans**

Conditions that we don't cover

We don't cover any costs related to, or incurred as a consequence of, the following conditions.

Pre-existing conditions

We don't cover any costs related to, or incurred as a consequence of, any *pre-existing conditions* unless we've clearly stated otherwise on your *membership certificate*. This *exclusion* doesn't apply to cover provided under the 'Day-to-day treatment' benefit on **page 28** if you have the RegularCare plan.

> For more information about *pre-existing conditions*, see page 42.

Chronic conditions

We don't cover any costs related to, or incurred as a consequence of, the following chronic conditions.

- Cystic fibrosis
- Kyphosis
- Loeys-Dietz syndrome
- Marfan syndrome
- Pectus carinatum
- Pectus excavatum
- Polycystic kidney disease
- Scoliosis
- Spina bifida

Congenital conditions

We don't cover any costs related to, or incurred as a consequence of, any *congenital conditions* except for umbilical hernia, inguinal hernia, undescended testes, hydrocele, tongue tie, phimosis, and squint.

Dementia

We don't cover any costs related to, or incurred as a consequence of, dementia.

Gynaecomastia

We don't cover any costs related to, or incurred as a consequence of, gynaecomastia.

Illnesses or injuries related to substance abuse or self-harm

We don't cover any costs related to, or incurred as a consequence of:

- illnesses, injuries, conditions or disabilities that are caused or contributed to by the abuse of substances such as alcohol or drugs
- self-inflicted illnesses or injuries.

Injuries or disabilities related to war, active duty, or terrorism

We don't cover any costs related to, or incurred as a consequence of, injuries or disabilities from:

- war, or any act of war (whether declared or not)
- active duty in the military of any country or international authority
- terrorism.

Healthcare services that we don't cover

Below is a list of *healthcare services* that we don't cover unless we've specifically stated otherwise.

Unapproved healthcare services

We don't cover any costs related to, or incurred as a consequence of, specific *drugs*, devices, techniques, tests, and other *healthcare services* that haven't been approved by us before you receive the treatment.

> **To read the list of *unapproved healthcare services*, contact us (see page 5 for contact details) or visit southerncross.co.nz/unapprovedservices**

ACC covered healthcare services

We don't cover any costs for *healthcare services* that are related to, or incurred as a consequence of, any *accident*, *treatment injury,* or *work-related gradual process injury*, except for what you're entitled to under the 'Accident and treatment injury top-up' benefit on **page 27**.

Cosmetic treatments and procedures

We don't cover any costs related to, or incurred as a consequence of, any surgery, procedure or treatment that changes, improves, or enhances appearance, regardless of whether it was done for medical, physical, functional, psychological, or emotional reasons.

Pregnancy and childbirth

We don't cover any costs related to, or incurred as a consequence of, pregnancy and childbirth, except for what we cover under the 'Day-to-day treatment' benefit for prescriptions and physiotherapy if you have the RegularCare plan (**page 28**).

Termination of pregnancy

We don't cover any costs related to, or incurred as a consequence of, termination of a pregnancy.

Infertility or assisted reproduction

We don't cover any costs related to infertility or assisted reproduction.

Contraception and sterilisation

We don't cover any costs related to, or incurred as a consequence of:

- contraception, including the insertion or removal of intrauterine devices, except when used for medical reasons
- sterilisation or its reversal, for example, vasectomy.

Treatment of obesity

We don't cover any costs related to, or incurred as a consequence of, treatment of obesity (including weight loss surgery), except for what we cover under the 'Gastric banding or bypass allowance' on **page 20**.

Breast reduction

We don't cover any costs related to, or incurred as a consequence of, breast reduction, except for what we cover under the 'Breast reduction allowance' on **page 20**.

Subsequent breast reconstruction or symmetry surgery

We don't cover any costs related to, or incurred as a consequence of, subsequent breast reconstruction surgery (including replacing *prostheses*) or breast symmetry surgery, except for what we cover under the following:

- the 'Surgical procedures' benefit for breast reconstruction on **page 16**
- the 'Breast symmetry allowance' for breast symmetry procedures on **page 21**.

Gender affirmation surgery

We don't cover any costs for *healthcare services* directly related to, or incurred as a consequence of, gender affirmation (confirmation) surgery.

Correction of refractive errors or astigmatism

We don't cover any costs related to, or incurred as a consequence of, correction of refractive visual errors or astigmatism by surgery, or by surgically implanted intraocular lenses, or by laser treatment.

Dental healthcare services

We don't cover any costs related to *healthcare services* performed by a dentist, periodontist, endodontist, or orthodontist.

Dental implants

We don't cover any costs related to, or incurred as a consequence of, implantation of teeth, including titanium dental implants.

Extraction of teeth

We don't cover any costs related to, or incurred as a consequence of, extraction of teeth.

Surgery to assist or allow for orthodontic healthcare services

We don't cover any costs related to, or incurred as a consequence of, surgery that's designed to assist or allow for orthodontic *healthcare services*.

Health screening and maintenance services

We don't cover any costs related to:

- *health screening*, except for what we cover under the following:
  - the 'Diagnostic imaging' benefit for mammography on **page 13**
  - the 'Surgical procedures' benefit for colonoscopy on **page 16**
- maintenance examinations or medical check-ups
- any examination required by a third party (including preparing reports) such as physical examinations for life insurance, travel insurance and driver licence.

Vaccinations

We don't cover any costs related to vaccinations.

Prophylactic healthcare services

We don't cover any costs related to, or incurred as a consequence of, *prophylactic healthcare services,* except for what we cover under the 'Prophylactic treatment allowance' on **page 21**.

Treatment for any condition not detrimental to health

We don't cover any costs related to, or incurred as a consequence of, treatment for any medical condition that's not causing significant problems to your physical health.

Healthcare services that are not approved treatment

We don't cover any costs related to, or incurred as a consequence of, *healthcare services* that are not *approved treatment,* as defined in the 'Glossary of terms' on **page 52**.

Healthcare services provided at a public facility

We don't cover any costs for *healthcare services* provided at a public facility that is directly or indirectly controlled by *Health NZ Te Whatu Ora,* except where we've approved it in writing before you receive the treatment.

Healthcare services provided outside of New Zealand

We don't cover any costs related to, or incurred as a consequence of, *healthcare services* provided outside of New Zealand, except for what we cover under the 'Overseas treatment allowance' on **page 25**.

Healthcare services provided by a person who is not a health services provider

We don't cover any costs related to *healthcare services* provided by a person who is not a *health services provider*, as defined in the 'Glossary of terms' on **page 54**.

Healthcare services for skin using digital imaging technology

We don't cover any costs related to *healthcare services* using technology (such as digital computer images) to help monitor and diagnose skin cancers and other skin lesions – for example, mole mapping.

Robot-assisted surgery

We don't cover any costs related to, or incurred a consequence of, robot-assisted surgery, except for the following selected procedures which we cover under the 'Surgical procedures' benefit on **page 16**:

- robot-assisted hysterectomy (with or without oophorectomy or salpingectomy, or both)
- robot-assisted sacrocolpopexy
- robot-assisted ventral hernia repair
- robot-assisted prostatectomy
- robot-assisted partial nephrectomy
- robot-assisted total hip replacement
- robot-assisted knee replacement
- robot-assisted transoral surgery.

Pathology and laboratory tests

We don't cover any costs for pathology and laboratory tests, except for what we cover under the 'Laboratory tests' benefit on **page 16**.

Tissue, cell and organ transplants

We don't cover any costs related to, or incurred as a consequence of, any of the following for either the donor or recipient:

- organ transplants
- transfusion or injection of autologous blood or blood products, except when used as part of *eligible* chemotherapy treatment, or where cell saver is used as part of *eligible* surgical treatment
- autologous chondrocyte implants
- stem cell transplants.

Healthcare services related to abnormalities of the facial skeleton

We don't cover any costs related to, or incurred as a consequence of, any *healthcare services* provided for the diagnosis, management, or treatment of developmental or congenital abnormalities of the facial skeleton and associated structures.

Healthcare services related to mental health

We don't cover any costs related to *healthcare services* for mental health, except for what we cover under the following:

- the 'Psychiatrist consultation' benefit on **page 12**
- the 'Psychiatric hospitalisation' benefit on **page 25**.

Healthcare services provided to manage or treat snoring or upper airways resistance

We don't cover any costs related to, or incurred as a consequence of, any *healthcare services* provided to manage or treat either snoring, or upper airways resistance, or both.

Treatment of HIV

We don't cover any costs related to, or incurred as a consequence of, treatment of HIV.

Other costs that we don't cover

Below are some other costs that we don't cover.

Appliances, equipment, devices, or prostheses

We don't cover any costs for:

- appliances or equipment (surgical, medical, or dental), for example, CPAP machines, hearing aids, orthotics, crutches, surgically implanted lenses (except monofocal lenses)
- prostheses
- specialised equipment and consumables, or
- donor tissue preparation.

This *exclusion* doesn't apply to *prostheses,* specialised equipment and consumables, or charges for donor tissue preparation when used as part of an *eligible* surgical treatment and specifically included in the *list of prostheses and specialised equipment*.

> **To view the *list of prostheses and specialised equipment,* contact us (see page 5 for contact details) or visit southerncross.co.nz/plans**

Acute care

We don't cover any costs related to *acute care*.

Acute care is covered by the public health system – read more about how these plans work with *ACC* and the public health system on **page 10**.

Administrative charges

We don't cover any administrative charges such as statement fees, cancellation fees, or non-attendance fees.

Personal costs related to a stay in hospital

We don't cover any hospital charges incurred for your personal convenience that are related to, or a result of, your stay in hospital, such as newspapers, meals for your family, alcohol, and TV rental.

Long-term care

We don't cover any costs related to, or incurred as a consequence of, long-term care where hospitalisation lasts, or is expected to last, more than 90 days. This includes, but is not limited to, geriatric in-patient care and disability support services.

Disability support services are support services 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.

Respite and convalescent care

We don't cover any costs related to, or incurred as a consequence of, respite and convalescent care.

D

How to make a claim

This section explains the ways you can apply for prior approval or make a claim on your *policy*. It also explains the terms and conditions that apply to your *policy*.

Before your *healthcare service* is provided, you should apply for prior approval to understand your eligibility under your *policy*.

If the *healthcare service* is being provided by an *Affiliated Provider* who is contracted for that service or an *Easy-Claim* partner, your provider will let you know if they can arrange prior approval or claim on your behalf. If you're unsure, you can ask us.

If we need any further information, we'll either contact you or your *health services provider* directly. We'll normally do this if information is missing or if we need extra information to process your prior approval or claim.

Apply for prior approval or make a claim online, through our app or by contacting us

You can apply for prior approval or make a claim:

- online through MySouthernCross, at **mysoutherncross.co.nz**
- through our MySouthernCross app, available through the Apple App Store or Google Play
- by contacting us using our details on **page 5**.

When to apply for prior approval

Through prior approval we confirm whether a *healthcare service* is *eligible* for cover and the conditions that apply.

We recommend that you apply for prior approval at least 5 working days before the *healthcare service* is being provided. You'll need to give us the estimated charges from your *health services provider* so we can determine the cover you're entitled to (including any excess you need to pay) and whether the estimated charges exceed any *policy limits* for that *healthcare service*.

You do not need to apply for prior approval if you're using an *Affiliated Provider* for a contracted *healthcare service* because they will organise this on your behalf.

Applying for prior approval can help you understand your eligibility

If you don't apply for prior approval and you're not using an *Affiliated Provider*, you'll have to pay for the *healthcare service* yourself and then make a claim. We'll assess your claim under the terms of this *policy* and let you know if you're *eligible* for a reimbursement.

Without a prior approval, you won't know if the *healthcare service* is *eligible* for cover under your *policy*. You also won't know how much you'll need to pay yourself. You may have to pay towards a *healthcare service* because it's not *eligible* for cover, an excess applies, or the actual charges exceed *policy limits*.

Our Affiliated Providers provide added convenience

Affiliated Providers are *health services providers* that we have contracts with to provide certain *healthcare services*.

When you seek treatment from an *Affiliated Provider,* we'll cover 80% of the amount they charge for the *healthcare services* they're contracted for, up to the relevant *policy limits* – unless we or your *Affiliated Provider* tell you otherwise.

Affiliated Providers will organise prior approval and claim directly with us on your behalf

Affiliated Providers will organise prior approval and claim directly from us for any contracted *healthcare service*. So, you don't need to get prior approval or make a claim for *eligible healthcare services* from an *Affiliated Provider*. When an *Affiliated Provider* provides a *healthcare service* to you, we treat this as a claim under your *policy*.

Some healthcare services must be performed by an Affiliated Provider

Some *healthcare services* must be performed by an *Affiliated Provider* to be covered under this *policy*.

It's important to note that *Affiliated Providers* may not offer all *healthcare services* covered under this *policy* and an *Affiliated Provider* may not be available in your hometown or city.

> **For more information on what *healthcare services* must be performed by an *Affiliated Provider* under your *policy*, contact us (see page 5 for contact details) or visit southerncross.co.nz/plans**

> **You can find a full list of *Affiliated Providers* and the *healthcare services* they offer at healthcarefinder.co.nz**

You can use Easy-Claim to claim for everyday healthcare services

Easy-Claim is a convenient way to authorise *health services providers* to claim electronically on your behalf for *eligible healthcare services* they've provided to you at the time of purchase or service. The providers that offer *Easy-Claim* are our *Easy-Claim* partners and they can check whether you're covered for a particular product or *healthcare service* immediately and make a claim on your behalf.

> **You can see which *health services providers* offer electronic claiming via *Easy-Claim* on our website at healthcarefinder.co.nz**

Your Southern Cross Member card is an accepted form of identification to enable you to authorise claims electronically. Any claim you make using *Easy-Claim* is treated by us as a claim under your *policy* and lets us know that you've authorised us to pay the *health services provider* directly. You'll need to pay the provider any remaining balance that you're responsible for.

The first time you claim electronically through *Easy-Claim* for *eligible drugs* at a pharmacy, you're electing to electronically claim for that and any future *eligible drugs* that you get from that pharmacy. You must tell us or the pharmacy if you don't want any future *eligible drugs* to be automatically processed through *Easy-Claim*.

What to send us when making a claim

Include the following with your claim:

- all itemised invoices for the *healthcare service*
- all itemised receipts for any amount you've already paid for the *healthcare service*.

Make sure you keep your original itemised invoices and receipts, and send us legible photographs or scanned copies along with your claim. We do not accept EFTPOS or credit card receipts.

To help us process your claim, please send us your invoices and receipts within 12 months from the date you received the *healthcare service*.

If we need any further information, we'll either contact you or your *health services provider* directly. We'll normally do this if information is missing or if we need additional information to process your claim.

We'll assess the invoices and pay the *health services provider* directly. We'll reimburse the *policyholder* for any amounts you've already paid.

Other things you should know about making a claim

These additional terms and conditions apply to any claim you make under this *policy*.

We may seek the advice of a health services provider chosen by us, to advise us about the medical facts or examine you in relation to your claim

In exceptional circumstances, we may need to seek the opinion of a *health services provider* of our choosing, at our expense, to review and assess the medical facts or examine you in relation to a claim. We'll only do this when there's uncertainty on the level of cover under this *policy* or the nature or extent of your condition.

You must co-operate with the *health services provider* we choose, or we will not pay your claim.

Tell us if you have cover under another policy or are entitled to payment from someone else

When you submit a claim for a *healthcare service*, you must tell us if you have cover under another insurance policy or if you're entitled to payment for the *healthcare service* from someone else. The amount you're covered for under your *policy* will be reduced by any payment from the other insurer or person.

You must take all reasonable efforts to make a claim from the other insurer or get payment from the other person who is liable to pay for the *healthcare service*. It's your responsibility to let us know about any other cover or payment you get for any *healthcare services* you're claiming for under your *policy*.

We have the right to recover from the *policyholder* any amounts we've covered for a *healthcare service* where the cost is recoverable from another insurer or other person.

If you have more than one policy with us, you're not entitled to claim for, or receive payment for, any amount higher than the actual cost of the *healthcare service* provided.

If you have an excess on your policy, this will affect the amount we cover

This plan offers an excess option of $500. Check your current *membership certificate* to confirm if you have an excess on your *policy*.

The excess is the amount you're required to pay each *claims year* before we'll pay towards the cost of *eligible healthcare services* covered under the following benefits.

- 'Surgical procedures' benefit (**page 16**)
- 'Chemotherapy for cancer (base)' benefit including the 'Cancer Cover Plus' options (**page 22**)
- 'Radiotherapy' benefit (**page 24**)

You're responsible for paying this amount directly to your *health services provider*. Once the excess amount for a *claims year* has been paid for a person covered under this *policy*, you won't need to pay it again towards any other *eligible* claims for that person until the next *claims year*.

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

!

Point to note

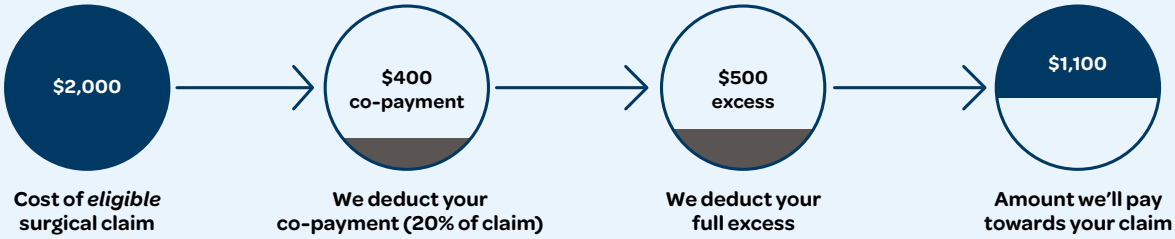
Always send in your *eligible* claims, even if the cost of the *healthcare service* is less than your excess amount, as it will reduce the excess balance for your current *claims year*.

How excesses work

Example 1: How a $500 excess applies

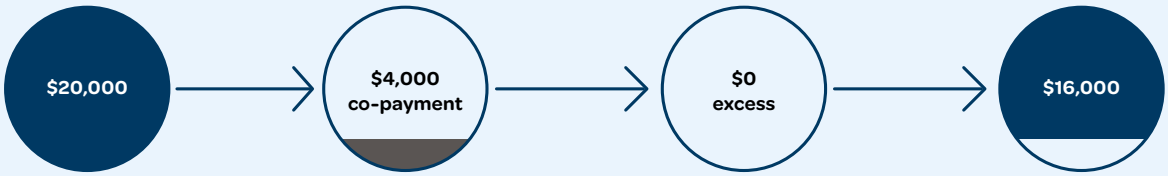
Say a $500 excess applies to your *policy,* an *eligible* surgical claim will be processed in the following way:

1st claim in the *claims year* where excess applies



Cost of *eligible* surgical claim — **We deduct your co-payment (20% of claim)** — **We deduct your full excess** — **Amount we'll pay towards your claim**

2nd claim in the *claims year* where excess applies



Cost of second *eligible* surgical claim — **We deduct your co-payment (20% of claim)** — **No excess is remaining for this *claims year*** — **Amount we'll pay towards your claim**

Policy limits apply to the amounts we pay

Policy limits are the maximum amount we'll pay for *eligible healthcare services* as stated in the section 'What the KiwiCare and the RegularCare plans cover' (from **page 11**), the *list of prostheses and specialised equipment,* or as specified in our contract with an *Affiliated Provider.*

All *policy limits* are for each individual person covered under this *policy.* These limits can't be carried over from one *claims year* to the next, and can't be transferred from one person to another.

We assign claims to the *policy limits* based on the date the *healthcare services* are provided, not the date of the invoice or the date you make a claim.

We may recover any amount you owe us

If we're entitled to recover any money from you relating to this *policy,* we can deduct the amount you owe us from any future claim payments or other payments we make to you.

We may not cover healthcare services provided by certain health services providers

In rare circumstances (such as fraud) where we don't recognise a *health services provider* for reimbursement, we will not cover any *healthcare services* they provide. In these instances, we will first let you know, and if the *healthcare service* is *eligible* for cover, we'll approve cover for it with another *health services provider.*

We may keep amounts you do not claim within 4 years

If you don't claim any payments or other amounts we owe you within 4 years, we may keep the payment.

Some conditions apply to cover for prescription drugs

Your *policy* provides cover for *drugs* under various benefits depending on what type of *healthcare service* they relate to.

- *Chemotherapy drugs* taken as part of chemotherapy treatment for cancer are covered under the 'Chemotherapy for cancer (base)' benefit (**page 22**), or 'Cancer Cover Plus' (**page 22**) if you have this upgrade.
- *Drugs* prescribed and taken in hospital during surgical treatment or psychiatric care are covered as *ancillary hospital charges* to the relevant *policy limits.*
- Any other *drugs* or prescriptions are only covered under the 'IV infusion (non-cancer)' benefit (**page 24**), 'Allergy services' benefit (**page 24**), and under the 'Day-to-day treatment' benefit for prescriptions if you have the RegularCare plan (**page 28**).

Unless specifically stated otherwise in the terms of the benefit, to qualify for cover the *drugs* must:

- be *Pharmac approved*
- be prescribed by a *medical practitioner* in private practice
- not be excluded under the terms of the *policy.*

You can claim the actual amount you pay for the *drug* up to the *policy limits* of the relevant benefit.

If any *drugs* you're prescribed would need special authority from *Pharmac* if they were being administered in a public health facility, we'll only cover them under this *policy* if you meet the same special authority criteria.

E

Your responsibilities under this policy

This section explains your responsibilities under this *policy*.

The *policyholder* is ultimately responsible for this *policy*, for making any changes to it and ensuring the premiums are paid. We rely on the *policyholder* to provide complete and accurate information about themselves and any *dependants*.

You must pay your premiums

Your premiums pay for the cover we provide you under this *policy*. The *policyholder* is responsible for making sure the premiums are paid. Payments must be up to date before we can provide prior approvals or pay claims under this *policy*.

If your premiums are not paid up to date, we may deduct any outstanding premiums from any claim payment or other payments we make to you.

If the premiums remain unpaid for 3 months or more, we will cancel this *policy*.

You must disclose any pre-existing conditions

Your *policy* is intended to cover *healthcare services* for signs, symptoms, and health conditions that arise after the *policy start date,* or after you've been added to this *policy,* whichever is later. So, the *policyholder* must disclose any health conditions, signs, symptoms, or events:

- for themselves and each *dependant* at the date of the application for this *policy*, and
- when they complete a health insurance medical declaration for any *dependant* added to this *policy* after the *policy start date*.

We'll use this information to decide whether we'll offer cover for any *pre-existing conditions*. However, any offer to cover any *pre-existing conditions* will not extend to 'Cancer Cover Plus' (**page 22**) – if you have this upgrade on your *policy*.

Your *membership certificate* shows all the *pre-existing conditions* that you've made us aware of for each person covered under this *policy* and whether cover is excluded for those *pre-existing conditions*. Where cover is offered, it shows the level of cover we've agreed to provide for that *pre-existing condition*.

We may decline cover relating to pre-existing conditions that were not disclosed

We may decline cover for *healthcare services* relating to a *pre-existing condition* if the *pre-existing condition* was not disclosed on the application form or relevant health insurance medical declaration.

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* for future claims.

We can review your pre-existing conditions

For some excluded *pre-existing conditions*, you can ask us to review that *exclusion* after any specified review period has ended.

Your *membership certificate* will confirm any review period that applies to a *pre-existing condition* noted on it (not all *pre-existing conditions* are open to review). Any review period starts on the first date we excluded the *pre-existing condition* for the relevant person under this *policy*.

Once the relevant person has had *continuous cover* for the specific review period, you can ask us to review the excluded *pre-existing condition*.

You must provide us with any appropriate medical documents that we request for the review. We'll then decide, acting reasonably, if we'll remove or change the *exclusion* related to the *pre-existing condition* and we'll send the *policyholder* an updated *membership certificate* reflecting any changes in cover.

If we decide to continue to exclude that *pre-existing condition* for the relevant person, you can request further reviews once the review period stated on your *membership certificate* has passed again.

You must not give us incomplete, false, or misleading information

For non-disclosure or misrepresentation of a *pre-existing condition* we will add the *pre-existing condition* to your *membership certificate* and may decline any claim related to it.

We may decline claims or cancel this *policy* on written notice to the *policyholder* for any other non-disclosure, misrepresentation, fraud, or material breach of the terms of the *policy* by the *policyholder* or any *dependant* if we find they have:

- provided incomplete, false or misleading information
- committed fraud or materially breached the terms of this *policy*.

We may take legal action for any of the above, including recovery of any money owed to us.

Before we cancel your *policy* for any of the above reasons, we'll tell the *policyholder* in writing of the reasons why we are considering cancelling your *policy*. You'll have at least 7 days to provide a written explanation (including any relevant evidence) that you wish us to consider, and we'll reasonably consider your explanation.

> **If you're unhappy with our decision to cancel your *policy*, you can refer it to the Insurance & Financial Services Ombudsman (see page 5 for contact details).**

You must tell us if your contact details have changed

The *policyholder* must tell us immediately if their contact number, postal, residential, or email address has changed. They can also update their details in MySouthernCross.

We send all communications to the policyholder

We'll send all communications required to be sent by us relating to the *policyholder,* this *policy,* or any *dependant* to the *policyholder* only.

Policyholders will receive communications from us through MySouthernCross if they're registered. When we send communications in MySouthernCross, we'll also notify the *policyholder* by email, text, or in the MySouthernCross app that a communication is available to view. We consider a message delivered on the day we send the notification.

If the *policyholder* is not registered for MySouthernCross, we'll send the notice or communication to the *policyholder* at their last known email or postal address. When we send a notice or communication by email or to a postal address, we consider it to be delivered 3 working days after we send it.

The policyholder is responsible for keeping their dependants informed

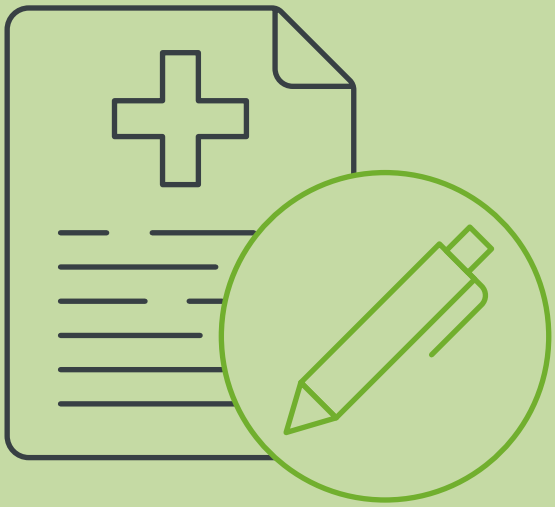
The *policyholder* is responsible for telling *dependants* about any changes or information relating to this *policy.* We don't send communications directly to *dependants* covered under this *policy*.

If we can't contact the policyholder

If we can't contact the *policyholder* at their last known postal or email address, we will stop sending notices or communications in relation to this *policy* until they've updated their contact details. If this happens, the *policyholder* acknowledges and agrees that we've met all our obligations to send notices or communications to them.

F

Changing, cancelling or suspending your policy



This section sets out what you need to know about making changes to your *policy*, including adding or removing *dependants*, cancelling your *policy*, or suspending your cover if you're travelling overseas.

Making changes or cancelling within 14 days

We provide a 14-day review period from the date the *policyholder* receives this policy document and the *membership certificate*.

During this review period, the *policyholder* can make changes or cancel this *policy*. If this *policy* is cancelled or changed during this review period, we'll refund all or any extra premiums that have been paid unless a claim has been made under this *policy*.

The *policyholder* can make changes and cancel this *policy* at any other time, but we will not refund any premiums already paid to us – instead we'll keep covering you for the period for which the premiums have been paid. The *policyholder* will remain liable for premiums due up to the date the cancellation takes effect.

Changing your policy

The *policyholder* can contact us at any time to make changes to this *policy* and we'll confirm when the change will take effect (see **page 5** for contact details).

Changing your policy can affect your cover

Changing your *policy* can affect your cover for *pre-existing conditions*, *annual limits*, excesses, *continuous cover*, and premiums. Talk to us about any proposed changes to fully understand the implications of changing your *policy*.

The policyholder must complete new health insurance medical declarations for certain upgrades

For certain upgrades to your *policy*, the *policyholder* must complete new health insurance medical declarations for themselves and all *dependants* on this *policy*. We'll tell the *policyholder* if a health insurance medical declaration is required for the changes.

Exclusions for pre-existing conditions will still apply after changing your policy

After making any changes to your *policy*, any *exclusions* for *pre-existing conditions* affecting the *policyholder* or any *dependants* will still apply.

Changing your policy may reset your claims year and any excess

After making any changes to your *policy*, depending on the change, the *claims year* may reset and any excess for the *policyholder* and any *dependants* under this *policy* will return to its full value on the date the change takes effect. If the *claims year* resets, a new *claims anniversary date* will apply to your *policy* – check your *membership certificate* for the new *claims anniversary date* if the *policyholder* has made changes to your *policy*.

Changing how or how often premiums are paid may change the policy anniversary date

The *policyholder* can change the way *policy* premiums are paid and how frequently they're paid. If the *policyholder* changes the payment method or frequency, a new *policy anniversary date* may apply – check your *membership certificate* for the new *policy anniversary date* if the *policyholder* has made changes to your *policy*.

If your *policy* is part of a work scheme or association scheme, your *policy anniversary date* will be the anniversary of the commencement date of the scheme. This date will be the same each year unless there are changes made to the scheme, or the *policyholder* leaves the scheme.

We may decline to change your cover

We can decline a request for a change of cover if it appears that you're trying to manipulate your cover or take advantage of us by making the change.

Adding and removing dependants

The *policyholder* can contact us at any time to add *dependants* to this *policy* and remove them from it (see **page 5** for contact details).

The policyholder can add dependants to this policy

The *policyholder* can add *dependants* to this *policy* at any time except for children aged 21 years or older.

We'll need a health insurance medical declaration for each *dependant* the *policyholder* adds to this *policy*. The declaration must disclose any *pre-existing conditions* the *dependant* has. We'll decide whether we'll cover any of those *pre-existing conditions*.

A *dependant's* cover starts on the date we've added them to this *policy*, as specified on your *membership certificate*, and this is the date we'll start charging premiums for their cover.

The *policyholder* is responsible for making sure the premiums are paid for any *dependant* added to this *policy* as part of the normal billing cycle.

We don't need a health insurance medical declaration for newborn children if they were born after the policy start date and they're added within 3 months of their birth

The *policyholder* can apply to add their newborn *child* onto this *policy* without the need to complete a health insurance medical declaration if:

- their newborn *child* was born after the *policy start date,* and
- they apply to add their newborn *child* within 3 months of that *child's* birth date.

Provided the above criteria are met, we'll cover the *child's pre-existing conditions* under this *policy*. This excludes *congenital conditions*, chronic conditions, and anything else this *policy* excludes.

> You can read more about the general *exclusions* of this *policy* in the section 'What the KiwiCare and the RegularCare plans don't cover' starting on page 29.

The *child's* cover starts on the date we've added them to this *policy,* as specified on your *membership certificate*.

The policyholder can remove dependants from this policy

The *policyholder* can remove a *dependant* from this *policy* at any time. The *policyholder* is responsible for removing *dependants* where the *policyholder* no longer requires the *dependant* to be covered by this *policy* (for example, following a marital separation or a death).

Adult children will automatically stay on the *policy* unless the *policyholder* specifically asks us to remove them, or the *policyholder's* work scheme or association scheme specifically asks us to remove them.

The policyholder can add dependants back on to this policy after they've been removed

If the *policyholder* removes a *dependant* from this *policy*, they can add that *dependant* back on later, except if the *dependant* is their child who is aged 21 years or older.

But, once a *dependant* has been removed, we'll need a new health insurance medical declaration for the *dependant* before we can add them to the *policy,* and they will not have cover for any *pre-existing conditions* they had before the date we added them back onto this *policy*.

Adult children can get their own policy if they're removed from this policy

If the *policyholder* wants to remove *adult* children from this *policy,* the *adult* children can apply for their own Southern Cross health insurance policy if they want to remain covered by us. They don't need to complete a new health insurance medical declaration if both of the following apply:

- they apply for the same or a lower level of cover as they had under this *policy*
- they apply within 1 month of being removed from this *policy*.

We charge child's rates for dependant children until they turn 21

The premiums for any children on this *policy* will be on *child* rates until they turn 21. Once they turn 21, we consider them *adults* and we'll base their premiums on their age.

Cancelling your policy

The *policyholder* can cancel this *policy* any time by contacting us (see **page 5** for contact details). Unless the *policyholder* cancels during the 14-day review period (**page 45**), we will not refund any premiums that have already been paid.

The *policyholder* remains liable for any premiums due up to the date the cancellation takes effect, and we'll continue to provide cover up to the date that the *policy* is paid to.

Your rights under the Consumer Guarantees Act

Nothing in this *policy* affects your rights under the Consumer Guarantees Act 1993.

Suspending cover while travelling overseas

The *policyholder* or any *dependant* can suspend their cover if they're going overseas for 2 months or longer.

While cover for that person is suspended, we will not charge premiums for their cover and we will not cover them for any *eligible healthcare services* they receive during the suspension period.

The premiums must be paid up to date on your *policy* before the suspension starts and any single period of suspension must be for a minimum of 2 months and not exceed more than 3 years (36 months). If the *policyholder* or *dependant* is leaving New Zealand for longer than 3 years, contact us (see **page 5** for contact details) to discuss the options available.

All the following must apply to the *policyholder* or *dependant* who is going overseas and wishes to suspend their cover:

- they've had cover for at least 12 continuous months (1 year) under this *policy* up to the start date of the suspension
- their cover under this *policy* has not been suspended 3 or more times, or for 5 years (60 months) or more in total over their lifetime.

Apply before you leave New Zealand

The *policyholder* or *dependant* should contact us to suspend their cover before they leave New Zealand. If they contact us after leaving New Zealand, we will not suspend cover retrospectively (from the date they left New Zealand).

G

Your regulatory protection

This section sets out information about your regulatory protection.

We protect your privacy

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'll collect, store, use, and share your information, and how you can access and correct your personal information. We'll do this in accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020.

Contact us (see **page 5** for contact details) if you have any questions about how we handle your personal and health information or to request access to or correction of your information.

> To read the Member Privacy Statement, visit southerncross.co.nz/privacy

We're licensed to provide financial advice

We're a licensed financial advice provider, which means that our sales staff can provide financial advice on our range of health insurance products.

We're regulated by the Financial Markets Authority and have duties under the Financial Markets Conduct Act 2013 and the Code of Professional Conduct for Financial Advice Services for that financial advice.

See our financial advice disclosure statement on our website to learn more about:

- the limits on the nature and scope of the financial advice service we provide
- how we address any conflicts of interest
- our duties
- our complaints and dispute resolution process.

> Go to southerncross.co.nz/disclosure-statement

We're part of several industry organisations

We're registered as a Friendly Society under the Friendly Societies and Credit Unions Act 1982.

We're also a member of:

- the Financial Services Council of New Zealand
- the Insurance & Financial Services Ombudsman scheme, and
- the International Federation of Health Plans.

H

Glossary of terms

This section explains the meanings of words and phrases that appear in italics throughout this policy document. Singular words in this section can also be taken to mean the plural and vice versa.

ACC

The Accident Compensation Corporation referred to in the Accident Compensation Act 2001 (or its successor).

Accident

An 'accident' as defined in the Accident Compensation Act 2001 (or its successor).

Acute care

Care provided in response to a sign, symptom, condition, or disease that needs immediate treatment or monitoring.

Adult

A person who is 21 years of age or older.

Affiliated Provider

A *health services provider* who has a contract with us to provide certain *healthcare services* at agreed prices.

Ancillary hospital charges

Charges for the following when used as part of an *eligible healthcare service*.

- Anaesthetic supplies
- Dressings
- *Drugs* prescribed and taken in hospital
- Intravenous fluids
- Irrigating solutions

Annual limits

The maximum amount we'll pay for any one person in any 1 *claims year*.

Approved facility

Either of the following:

- a private surgical or medical facility certified by the Ministry of Health
- another healthcare facility that we approve.

Approved treatment

A *healthcare service* to which all the following apply:

- it's necessary to treat the health condition involved
- it's not experimental or unorthodox
- it's accepted and in common use by the relevant Australasian or New Zealand society or college
- it's widely accepted professionally as effective, appropriate, and essential based on recognised standards of the healthcare specialty involved.

Chemotherapy drugs

Prescription medicines, biologics, and immunotherapy medicines that meet all the following criteria:

- they are for cancer or neoplastic disease
- they are prescribed or recommended by a *specialist* registered in *internal medicine* in private practice
- this *policy* does not exclude them.

Child

A person who is 20 years of age or younger.

Claims anniversary date

The date 12 months after the *policyholder* started on the current plan, and each anniversary after that, as specified on your current *membership certificate*.

Claims year

The first 12 months after the *policy start date*, and after that every 12 months from your *claims anniversary date*.

Congenital conditions

Anomalies or defects which are present at birth and for which the *policyholder* or *dependant* had signs or symptoms of the condition either:

- before their *original date of joining*, or
- within 3 months of birth, as we reasonably determine.

Continuous cover

A person covered by this *policy* has continuous cover for the relevant benefit or *healthcare service* where they have had no break in cover for that benefit or *healthcare service* under this plan.

A person still has continuous cover when they suspend their *policy* while travelling overseas. However, if the person is a *dependant* who is taken off the *policy* and added back on later, then they break the period of continuous cover.

Dependant

Dependants are the *policyholder's* spouse or partner (or former spouse or partner), and any of their children (including stepchildren or adopted children), who are listed on your *membership certificate*.

Drugs

Pharmac approved subsidised prescription medicines (and non-subsidised diabetic test strips and needles only) that are not excluded under your *policy*.

Easy-Claim

The Southern Cross Health Society Easy-Claim which allows electronic claiming through participating *health services providers*.

Eligibility criteria

Any additional terms and conditions that we set from time to time for a particular *healthcare service*.

> You can find the current eligibility criteria on our website at southerncross.co.nz/eligibilitycriteria

Eligible

A private *healthcare service* to which all the following apply:

- it's covered under or listed in the section 'What the KiwiCare and the RegularCare plans cover' on **page 11**
- it complies with any applicable terms and conditions (such as *eligibility criteria*) that we may specify from time to time
- it's an *approved treatment*
- costs have been incurred or will be incurred for the *healthcare service*
- it's not excluded under your *policy*
- it's performed in private practice by a *health services provider* with the registration relevant to the *healthcare service*.

Exclusions

Conditions, treatments, or situations that this *policy* does not cover, either as listed in this policy document in the section 'What the KiwiCare and the RegularCare plans don't cover' (from **page 29**), or as specified on your *membership certificate,* or both.

General practitioner

A *medical practitioner* who either:

- is vocationally registered in general practice, or
- has general or provisional general registration and is practising in general practice.

Health NZ Te Whatu Ora

Health New Zealand Te Whatu Ora is the health entity established under the Pae Ora (Healthy Futures) Act 2022 (or its successor).

Health screening

Diagnostic tests, investigations, or consultations provided in the absence of any sign or symptom suggesting the presence of the illness, disease, or medical condition that the screening is designed to detect.

Health services provider

A *general practitioner*, *specialist*, or registered practising member of certain professions allied to medicine, who is practising in private practice and who we've approved to provide *healthcare services* under this *policy*.

Healthcare services

Any private surgery, procedure, treatment, investigation, diagnostic test, consultation, hospitalisation, or other private healthcare service provided by a *health services provider* or an *approved facility*.

Hospital fees

Hospital costs for:

- accommodation (on a single room basis and excluding suites)
- operating theatre fees
- anaesthetic supplies
- intensive care and special in-hospital nursing
- in-hospital x-rays and ECG
- *ancillary hospital charges*
- laparoscopic disposables
- in-hospital post-operative physiotherapy.

Internal medicine

Any of the following, as defined by the Medical Council of New Zealand.

- Internal medicine
- Cardiology
- Clinical immunology
- Clinical pharmacology
- Endocrinology
- Gastroenterology
- Geriatric medicine
- Haematology
- Infectious diseases
- Medical oncology
- Nephrology
- Neurology
- Nuclear medicine
- Palliative medicine
- Respiratory medicine
- Rheumatology

List of prostheses and specialised equipment

The document that we publish from time to time that details the *prostheses*, specialised equipment and consumables, and donor tissue preparation charges that we cover under this *policy*. It also details the maximum amount we'll cover for each one.

> To view the list of prostheses and specialised equipment, visit southerncross.co.nz/plans

Medical practitioner

A medical practitioner who is in private practice and holds a current practising certificate issued by the Medical Council of New Zealand (MCNZ). They must have a scope of practice that is relevant to the applicable *healthcare service* and be following any restrictions placed on them by the MCNZ.

Medsafe

The New Zealand Medicines and Medical Devices Safety Authority, a division of the Ministry of Health, responsible for regulating therapeutic products in New Zealand.

Membership certificate

The document we send the *policyholder* from time to time that contains:

- the key dates relevant to your *policy*
- the people covered under your *policy*
- the name of your plan and any Cancer Cover Plus upgrade and excess that applies to your *policy*
- the *policyholder's* Southern Cross membership number
- any *pre-existing conditions* that you've made us aware of for the people covered under your *policy*
- any other information specific to your *policy*.

Nurse

A nurse who holds a current practising certificate issued by the Nursing Council of New Zealand (NCNZ). They must be practising within their scope of practice and following any restrictions placed on them by the NCNZ.

Operation

All surgical procedures performed under one anaesthetic.

Original date of joining

The most recent date of joining Southern Cross for each person this *policy* covers, as shown on your *membership certificate*.

Pharmac

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

Pharmac approved

Any *drug* specifically listed by *Pharmac* on the New Zealand Pharmaceutical Schedule as being subsidised by the Government for use in your particular treatment.

We may consider any criteria, prescribing guidelines, rules, conditions, and restrictions that *Pharmac* publishes for that *drug*.

Policy

The insurance contract between the *policyholder* and us, which is made up of:

- this policy document
- your application form
- your health insurance medical declaration (where relevant)
- your *membership certificate*
- the *eligibility criteria*
- the list of *unapproved healthcare services*
- the *list of prostheses and specialised equipment*
- the list of Affiliated Provider-only healthcare services
- the list of policy variations
- any changes made to the above documents from time to time.

Policy anniversary date

The policy anniversary date as specified on your *membership certificate*. It's the anniversary date of your *policy start date*, from which we'll renew your *policy* for the following year.

The date is the same for all people this *policy* covers, regardless of when they joined.

If this policy is part of a work scheme or association scheme

If this *policy* is part of a work or association scheme, the policy anniversary date is the anniversary of the date that scheme started. It's the date from which we'll renew your *policy* for the following year, unless changes are made to the scheme, or the *policyholder* leaves the scheme.

Policyholder

The person in whose name this *policy* was issued, as stated on your *membership certificate.*

Policy limits

The maximum amount we'll pay for each person covered under this *policy* for any *eligible healthcare service*.

The policy limits are stated in this policy document under each benefit in the section 'What the KiwiCare and the RegularCare plans cover' from **page 11**, the *list of prostheses and specialised equipment*, or as specified in our contract with an *Affiliated Provider*. We or your *Affiliated Provider* will tell you the policy limit when you seek treatment. The policy limit may be a limit per *operation*, procedure, item, day, or lifetime, or it may be an *annual limit*.

Policy start date

The date your *policy* starts, as shown on your *membership certificate*.

Policy year

The period of time between your *policy start date* and the first *policy anniversary date*, and after that the period from one *policy anniversary date* to the next.

Pre-existing condition

Any health condition, sign, symptom, or event occurring or existing that the *policyholder* or *dependant* was aware of, or should reasonably have been aware of, for the relevant people before the dates set out below.

- For the *policyholder* and each *dependant* named in the application form – before the *policy start date*
- For any *dependant* added to the policy after the *policy start date* – before the date that *dependant* was added to the *policy*
- For any changes made to the *policy* after the *original date of joining* that required a health insurance medical declaration to be completed – before the date of the change

Prophylactic healthcare services

Healthcare services designed to reduce or prevent the risk of an illness, disease, or medical condition developing in the absence of any sign or symptom suggesting its presence.

Prostheses

Surgically implanted items, specialised equipment and consumables, and donor tissue preparation charges as set out in the *list of prostheses and specialised equipment*.

Specialist

A *medical practitioner* to which one of the following applies:

- they're vocationally registered in one of the specialist scopes listed below
- they have provisional vocational registration with the Medical Council of New Zealand (MCNZ), and they're under the supervision of a *medical practitioner* who is vocationally registered in one of the specialist scopes listed below
- they hold a special purpose (locum tenens) scope of practice with the MCNZ, and they're under the supervision of a *medical practitioner* who is vocationally registered in one of the specialist scopes listed below
- they're a *medical practitioner* who has been admitted to the Fellowship of the Australasian Society of Breast Physicians
- they're an oral surgeon, oral medicine specialist, or oral & maxillofacial surgeon registered with the Dental Council of New Zealand.

Specialist scopes

- Anaesthesia
- Cardiothoracic surgery
- Clinical genetics
- Dermatology
- Diagnostic and interventional radiology
- General surgery
- Intensive care medicine
- *Internal medicine*
- Musculoskeletal medicine
- Neurosurgery
- Obstetrics and gynaecology
- Occupational medicine
- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedic surgery
- Otolaryngology, head and neck surgery
- Paediatric surgery
- Paediatrics
- Pain medicine
- Palliative medicine
- Plastic and reconstructive surgery
- Psychiatry
- Radiation oncology
- Rehabilitation medicine
- Sexual health medicine
- Sport and exercise medicine
- Urology
- Vascular surgery

Treatment injury

A 'treatment injury' as defined in the Accident Compensation Act 2001 (or its successor).

Unapproved healthcare services

Specific *drugs*, devices, techniques, tests, and other *healthcare services* that we have not approved before treatment.

> **Read the list of unapproved healthcare services on our website at southerncross.co.nz/unapprovedservices**

Work-related gradual process injury

A personal injury caused by a work-related gradual process, disease, or infection as included in the definition of 'work-related personal injury' as defined in the Accident Compensation Act 2001 (or its successor).

Southern Cross
Health Insurance

Call us on **0800 800 181**
or visit **southerncross.co.nz/society**