




Your policy update

Effective from 22 October 2024

Here are the key changes to your Wellbeing Starter policy that took effect on 22 October 2024. Please read them carefully so you understand the changes that are being made to your policy.

This information is to help you understand the changes to your plan. Your health insurance policy is made up of a number of documents, including your membership certificate and the policy document. Together all these documents, outline your cover.

You should check your membership certificate to see if you have cover for pre-existing conditions under any previous Southern Cross plans and select those plans to view changes that might affect your cover.

What's changing?	Existing policy document (effective until 22 October 2024)	New policy document (effective from 22 October 2024)
 Breast symmetry allowance		
Limit of one surgical procedure per lifetime will be removed.	Cover is limited to one surgical procedure and any follow-up treatment required per lifetime.	No limit on the number of surgical procedures you can have during your lifetime, including any follow-up treatment required.
Removal of 2-year restriction. The requirement that breast symmetry surgery must be completed within 2 years of the first eligible breast reconstruction surgery will be removed.	Breast symmetry surgery must be completed within 2 years of the first eligible breast reconstruction surgery following an eligible mastectomy.	Breast symmetry procedures can be completed at any time following an eligible mastectomy.
Clarification of cover. We're changing the name of this allowance to clarify that it will cover breast symmetry surgery that's performed after, or at the same time as an eligible mastectomy.	Current name is 'Post mastectomy allowance to achieve breast symmetry'.	New name is 'Breast symmetry allowance'.
 Other changes to your plan		
Introduction of cover for physiotherapy related to pregnancy and childbirth.	Physiotherapy related to pregnancy and childbirth is not covered .	Physiotherapy related to pregnancy and childbirth is covered (up to the policy limits).
 Certain healthcare services will need to be performed by an Affiliated Provider		

Certain procedures under the Surgical procedures benefit or Cardiac procedures benefit must be performed by an Affiliated Provider to be eligible for cover under your plan.

- LLETZ loop under local anaesthetic or no anaesthetic (in rooms) (Large loop excision of the transformation zone)
- Excision of vulval/vaginal cyst or lesion under local anaesthetic or no anaesthetic (in rooms)
- Cervical polypectomy under local anaesthetic or no anaesthetic (in rooms)
- Cautery of cervix under local anaesthetic or no anaesthetic (in rooms)
- Hysteroscopy under local anaesthetic or no anaesthetic (in rooms)
- Cone biopsy of cervix under local anaesthetic or no anaesthetic (in rooms)
- Genital biopsy under local anaesthetic or no anaesthetic (in rooms)
- Lingual/labial frenectomy/frenotomy
- Cochlear implant surgery
- Pacemaker surgery.

The listed surgical or cardiac procedures are covered when performed by an appropriate specialist of your choice.

The listed surgical or cardiac procedures remain covered, but they must be performed by an Affiliated Provider to be eligible for cover under your plan.

Certain tests under the Diagnostic tests benefit must be performed by an Affiliated Provider to be eligible for cover under your plan.

- Colposcopy with or without biopsy under local anaesthetic or no anaesthetic
- Endometrial biopsy under local anaesthetic or no anaesthetic
- Single fibre electromyogram (SFE)
- Vulvoscopy with or without biopsy under local anaesthetic or no anaesthetic.

The listed diagnostic tests are covered when performed in an approved facility of your choice.

The listed diagnostic tests remain covered, but they must be performed by an Affiliated Provider to be eligible for cover under your plan.

Introduction of cover for certain prostheses when used as part of the listed procedures. The procedures must be performed by an Affiliated Provider to be eligible for cover under your plan.

- Initial pacemaker device (Pacemaker surgery)
Prosthesis maximums apply:
 - Single chamber pacemaker \$2,760
 - Dual chamber pacemaker \$4,485
 - Biventricular/complex pacemaker \$10,260
- Cochlear implant device (Cochlear implant surgery)
Prosthesis maximum applies:
 - Unilateral \$17,000.

The procedures are covered when performed by an appropriate specialist of your choice. The related prostheses are **not included**.

The listed prostheses **are included** when used as part of the specified procedures and when performed by an Affiliated Provider. The individual prosthesis limits apply.

Improved accessibility to psychiatrist consultations

We're removing the requirement that psychiatrist consultations must be with an Affiliated Provider. We're changing this in response to the current long wait lists and limited availability of contracted psychiatrists.

View the healthcare services which will be included under the Surgical procedures benefit or Cardiac procedures benefit

These procedures must be performed by an Affiliated Provider to be covered under your plan.

- Intravascular lithotripsy for coronary artery disease
- Drug-eluting balloon angioplasty for in-stent restenosis
- Transcatheter aortic valve replacement (TAVI)
- Liposuction for secondary lymphoedema following an oncological intervention
- Thyroid nodule ablation
- Peripheral sensory nerve ablation for cancer-related pain
- Peroral endoscopic myotomy & Zenker's peroral endoscopic myotomy (POEM, ZPOEM)
- Implantation of prosthetic iris device
Prosthetic iris device including custom-made artificial iris
Prosthesis maximum limit applies: unilateral \$10,250
- Minimally invasive glaucoma surgery (MIGS)
Kahook dual blade goniotomy, iTrack canaloplasty, implantation of trabecular bypass microstent – Glaukos iStent, implantation of minimally invasive subconjunctival filtration device (microshunt) – Allergan XEN or Glaukos PreserFlo, micropulse transscleral cyclophotocoagulation
Prosthesis maximum limits apply:
 - Category 1 \$1,000 (Kahook dual blade)
 - Category 2 \$1,500 (iTrack canaloplasty microcatheter, MicroPulse P3 Delivery Device)
 - Category 3 \$2,000 (iStent trabecular Micro-bypass stent, PreserFlo MicroShunt, Xen Gel Stent)
- Botulinum toxin for laryngeal dystonia
Prosthesis maximum limits apply:
 - Botulinum toxin type A for approved procedures only (1 ampoule/100 units) \$600
 - Botulinum toxin type A for approved procedures only (2 or more ampoules/200+ units) \$1,200
- Temporomandibular joint (TMJ) total joint replacement (TJR)
Prosthesis maximum limits apply:
 - Unilateral \$26,000
 - Bilateral \$45,000

View changes to general policy terms and conditions

A new list of policy variations is being introduced and will form part of your policy.

This list sets out variations to policy terms and conditions that may apply from time to time. These variations include the way we treat some exclusions (as listed in the policy document) 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](#).

The list of Affiliated Provider-only healthcare services is being removed from the policy document.

The list will still form part of your policy but will only be available on our [Affiliated Provider-only healthcare services page](#). We're removing this list from the policy document to enable us to update it more regularly. You'll need to check the website for updates or you can [contact us](#) to request a copy of the most up-to-date list.

The list of documents that form part of your health insurance policy is being updated.

Your application form, any health insurance medical declarations, the [list of Affiliated Provider-only healthcare services](#), the [eligibility criteria](#), the [list of unapproved healthcare services](#), the [list of Prostheses and Specialised Equipment](#) and the [list of policy variations](#) are included in the list of documents that form part of your policy.

We're changing how we communicate changes to certain documents that form part of your policy.

This means you may not receive direct communications for all changes, and you'll need to refer to our website for the latest versions of the following information: the [eligibility criteria](#), the [list of unapproved healthcare services](#), the [list of Affiliated Provider-only healthcare services](#), the [list of Prostheses and Specialised Equipment](#), and the [list of policy variations](#).

The financial strength rating summary is being updated – no changes to Southern Cross Health Society's financial strength rating.

To reflect the updates made by our rating agency, we're removing the 'R' (Regulatory Action) and 'NR' (Not Rated) ratings from the financial strength rating summary and updating the web address to spglobal.com/ratings/en/about/intro-to-credit-ratings.

References to the Southern Cross Medical library are being removed.

The Medical library on our website is no longer available so any references to it in the policy document are being removed.

References to 'DHB' have been updated to 'Health NZ Te Whatu Ora'.

'DHB' was an abbreviation for District Health Board. These have been disestablished. Health New Zealand Te Whatu Ora is the relevant national health entity.

The exclusion for illnesses, injuries, conditions or disabilities related to intoxication is being removed.

The exclusion for substance abuse, intoxication or drug taking has been revised to focus only on the abuse of substances such as alcohol or drugs, rather than intoxication on its own.

Unclaimed monies.

We're extending the length of time we will hold unclaimed monies for you from 2 years to 4 years.

The 3 month stand-down period for adding newborns without the need to complete a health insurance medical declaration is being removed.

Newborn children can be added without underwriting, provided they were born after the policy start date and the policyholder adds the child within 3 months of the child's birth date.

Removal of requirement to disclose if your surgical procedure requires a registered nurse first surgical assistant.

When you apply for prior approval, you won't need to let us know if a registered nurse first surgical assistant will be required as part of your surgery. But you'll still need to let us know if your surgery requires more than one surgeon, including an assistant surgeon.

[View changes to policy document for clarification purposes](#)



Exclusion for administrative charges.

Administrative charges are not covered by your policy. A specific exclusion will be added to clarify this.

Exclusion for transfusion or injection of autologous blood or blood products.

The exclusion for transfusion or injection of autologous blood or blood products does not apply when used as part of eligible chemotherapy treatment.

Pre-existing conditions exclusion.

The exclusion for pre-existing conditions does not apply to healthcare services covered under the Day-to-day treatment benefit.

Underwriting requirements for adult dependants taking out their own policy.

Adult dependants who apply for their own Southern Cross health insurance policy within 1 month of being removed from an existing policy do not need to complete a new health insurance medical declaration if they're applying for similar or a lower level of cover.

Impact of policy changes on claims year.

Any changes you make to your policy may reset your claims year.

Impact of changes to payment method or frequency on the policy anniversary date.

Changing the payment method or payment frequency may, but will not always, change your policy anniversary date. We advise you to check the policy anniversary date on your new membership certificate if you make any changes.

Disclosing pre-existing conditions.

If you haven't disclosed a pre-existing condition on the application form or relevant health insurance medical declaration, we may decline any cover for healthcare services relating to the pre-existing condition.

Clarification of the term 'Medsafe-Indicated'.

Clarification of the term 'Medsafe-indicated' when used in the IV infusion (non-cancer) benefit.

Cover for work-related gradual process injuries.

References to work-related gradual process injuries will be included in the Accident and treatment injury top-up benefit.

Terminology under the Accident and treatment injury top-up benefit.

The reference to 'annual limits' will be changed to 'policy limits' to reflect that different types of limits may apply, for example limits per operation, procedure, item, day, lifetime or annual limits.

Your responsibility under the Accident and treatment injury top-up benefit.

The existing requirement to do everything you reasonably can to obtain ACC approval for payment of the cost of any healthcare services which may be covered by ACC, includes signing all necessary documents.

Update to the procedure names under Diagnostic imaging and Diagnostic tests benefits.

The names of certain diagnostic imaging and diagnostic tests will be updated to the names they are more commonly known by and abbreviations will be added where appropriate.

Update to the definition of eligibility criteria in the Glossary of terms.

The reference to 'procedure' will be replaced with 'healthcare services' as 'procedure' was not sufficiently inclusive.
