



Your policy update

Effective from 22 October 2024

Here are the key changes to your Wellbeing Two 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 reduction allowance		
Lifetime limit increasing from \$5,000 to \$15,000.	Limit is \$5,000 per lifetime.	Limit is \$15,000 during a lifetime.
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, up to the \$15,000 lifetime limit.
Cover will expand to include procedures that affect a single breast only. We're expanding cover to include breast reduction procedures for a single breast, in addition to our existing cover for procedures involving both breasts. We're updating the name of this allowance to reflect this change.	Current name is 'Bilateral breast reduction allowance'. Only breast reduction procedures affecting both breasts are covered.	New name is 'Breast reduction allowance'. Breast reduction procedures affecting a single breast or both breasts are covered.
 Breast symmetry allowance		
Lifetime limit increasing from \$6,500 to \$10,000.	Limit is \$6,500 per lifetime.	Limit is \$10,000 during a lifetime.
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, up to the \$10,000 lifetime limit.

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'.

Removal of excess from certain benefits

If you've chosen to have an excess on your policy, the excess will only apply to claims under the Surgical procedures, Chemotherapy for cancer (including Cancer Cover Plus) and Radiotherapy benefits for healthcare services received on or after 22 October 2024.

Excesses apply to claims under the following benefits:

- Surgical procedures
- Chemotherapy for cancer, including Cancer Cover Plus
- Radiotherapy
- Skin lesion surgery under local anaesthetic or with no anaesthetic
- GP minor surgery
- Gastric banding/bypass allowance
- Bilateral breast reduction allowance
- Post mastectomy allowance to achieve breast symmetry
- Prophylactic treatment allowance
- Overseas treatment allowance
- Post-operative home nursing
- Post-operative speech and language therapy
- Post-operative physiotherapy
- Obstetrics allowance
- Psychiatric hospitalisation

Excesses only apply to claims under the following benefits:

- Surgical procedures
- Chemotherapy for cancer, including Cancer Cover Plus
- Radiotherapy.

Other changes to your plan

Introduction of cover for prescriptions and physiotherapy related to pregnancy and childbirth.

Prescriptions and physiotherapy related to pregnancy and childbirth are **not covered** under the Keeping Well Module or the Day-to-day Module.

Prescriptions and physiotherapy related to pregnancy and childbirth **are covered** (up to the policy limits). The Keeping Well Module provides cover for prescriptions. The Day-to-day Module provides cover for prescriptions and physiotherapy.

Certain healthcare services will need to be performed by an Affiliated Provider

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

- Bartholin's cyst/abscess surgery under local anaesthetic or no anaesthetic (in rooms)
- Cautery of cervix under local anaesthetic or no anaesthetic (in rooms)
- Cervical polypectomy under local anaesthetic or no anaesthetic (in rooms)

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

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

- Cone biopsy of cervix under local anaesthetic or no anaesthetic (in rooms)
- Excision of vulval/vaginal cyst or lesion under local anaesthetic or no anaesthetic (in rooms)
- Genital biopsy under local anaesthetic or no anaesthetic (in rooms)
- Hysteroscopy under local anaesthetic or no anaesthetic (in rooms)
- Insertion and/or removal of intrauterine device under local anaesthetic or no anaesthetic (in rooms)
- LLETZ loop under local anaesthetic or no anaesthetic (in rooms) (Large loop excision of the transformation zone)
- Lingual/labial frenectomy/frenotomy
- Pacemaker surgery
- Cochlear implant surgery
- Periurethral injection for incontinence.

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
- Periurethral bulking agent - Bulkamid (Periurethral injection for incontinence)
Prosthesis maximum applies:
 - \$3,000.

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.

Some of the following healthcare services may have already been approved for cover. You can call us to check.

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



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
- Image-guided percutaneous carpal tunnel release
- Image-guided percutaneous trigger finger release
- Robot-assisted knee replacement
- Robot-assisted total hip replacement
- 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](#) 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 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.

Update to the reference to the registration body for acupuncturists in New Zealand.

Removed references to Acupuncture New Zealand and the NZ Acupuncture Standard Authority as qualified registration bodies for acupuncturist registrations and replaced it with the Chinese Medicine Council of New Zealand (CMCNZ).

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](#)



The policy exclusions section is being revised to make it clearer.

This includes adding examples to help understanding, removing words where they do not change the meaning, updating terminology and combining some exclusions under the same heading where appropriate.

Exclusion for administrative charges.

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

Clarification on membership certificate and policy document information.

We're including wording to clarify that if information on your membership certificate contradicts what's stated in your policy document, the information on your membership certificate takes precedence over the policy document.

Cover under the obstetrics allowance.

Cover is only for members who receive obstetric care and services directly. It excludes cover for accommodation costs for any support person.

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 Keeping Well Module, Body Care Module, Day-to-day Module or the Vision and Dental Module.

Cover under the Day-to-day Module for general practitioner services and nurse services.

Consultations or treatment performed by a nurse at a general practice clinic are covered under general practitioner services to the higher limit of \$65 each visit, rather than the limit for nurse services (\$30 each visit). If you receive both general practitioner and nurse services during the same visit at a general practice clinic, this will be treated as one visit for the purposes of the general practitioner services policy limit.

Cover for second opinions under the Specialist consultations benefit.

The Specialist consultations benefit includes cover for obtaining a second opinion regarding a diagnosis or treatment plan from another specialist who is an Affiliated Provider.

Surgical procedures benefit covers Major diagnostic procedures.

Major diagnostic procedures are covered under the Surgical procedures benefit, including angiograms and endoscopies.

Cover for less invasive procedures and medical treatment.

Cover is available under the Surgical procedures benefit for some less invasive procedures and medical treatments if a specialist or an Affiliated Provider considers it more appropriate for your condition.

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 the same 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.

Updates to Gastric banding/bypass allowance.

The following procedures will be listed under this allowance: endoscopic sleeve gastropasty, single anastomosis duodeno-ileostomy with sleeve (SADI-S), sleeve gastrectomy, Roux-en-Y and mini gastric bypass.

Termination of Southern Cross membership.

A policyholder's death is one of the reasons their membership may be terminated. When a policyholder's membership is terminated, the policy will terminate and the membership of any dependants will also end.

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.

Application of the family history of cancer exclusion under Cancer Cover Plus.

Only the specific cancer which you have a family history of is excluded for cover under Cancer Cover Plus.

Clarification of the term 'Medsafe-Indicated'.

Clarification of the term 'Medsafe-indicated' when used in the Chemotherapy for cancer and IV infusion (non-cancer) benefits and Cancer Cover Plus.

Examples of general practitioner minor surgeries.

The removal or resection of ingrown toenails, steroid or cortisone injections and abscess drainage will be added as examples of procedures covered under the GP minor surgery benefit.

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.

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.

Explanation of the phrase 'highly increased risk of developing a disease' under the Prophylactic treatment allowance.

Wording from the existing eligibility criteria will be included in the policy document to increase awareness of what we consider when deciding if you have a 'highly increased risk of developing a disease' for the purposes of this benefit.

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.

Removal of unnecessary definitions from the Glossary of terms.

The definitions for 'lifetime' and 'allowance' will be removed from the Glossary of terms.
