The Benefit Review process

Our healthcare environment is constantly changing. To ensure Southern Cross plans' remain relevant to the needs of New Zealanders, we have a regular benefit review process to consider and update the cover available under our health insurance plans.

We aim to:

- simplify our products and enhance the benefits that are important to members as well as make them easier to use and understand
- address coverage for specific healthcare services to ensure our members have access to services they require while balancing the cost so we remain sustainable
- support the growth of the Affiliated Provider Network and prepare our products for the future
- ensure our cover meets members' expectations and delivers on our promise.

Key dates

Printed Policy documents available to order	**11 May 2017**
Member mailing	17 May - 16 June 2017
Benefit Review Effective Date	17 July 2017

What's changing this year?

- We're expanding our Affiliated Provider-only procedures
- We're adding cover for new technology
- We're removing the limit for radiotherapy on UltraCare
- We're adding the Being Active benefit to UltraCare
- We're adding cover for Clinical Geneticists
- We've reviewed the Master Procedures List
- We're adding Easy-Claim GP's to our allergy services benefit
- We're adding cover for PET/CT scans for specific cardiac conditions
- We're making changes to the minor surgery benefit
- We're increasing the HealthEssentials GP benefit
- We're increasing the post mastectomy symmetry allowance
- We're removing the Non-Underwritten (NU) concession
- We're making system changes as part of our Rainbow Tick initiative
- We're making some wording changes

We're expanding our Affiliated Provider-only procedures

All plans Except UltraCare and HealthEssentials

New Affiliated Provider-only procedures

Cardiac tests – note all cardiac tests are now AP-only

- Resting ECG
- Exercise ECG
- Holter monitoring
- Echocardiogram
- Stress echocardiogram
- Dobutamine stress echocardiogram
- Transoesophageal echocardiogram

Urology

- Prostate biopsy
- Resection of bladder tumour
- Nephrectomy
- Circumcision
- Ureteroscopy

Otolaryngology

- Functional endoscopic sinus surgery (FESS)
- Septoplasty
- Nasal cautery (performed by a specialist)
- Aural toilets (performed by a specialist)

Imaging – note all imaging is now AP-only

- Ultrasound (includes obstetric ultrasound)
- X-ray
- Nuclear scanning (scintigraphy)
- Myocardial perfusion scan

Diagnostic tests

- Ambulatory blood pressure monitoring

Consultations

- All specialist consultations
- Psychiatrist consultations

Provider specialties going AP-only

Note: this includes all consultations under the specialist consultation benefit, as well as consultations under the psychiatrist consultations benefit, the obstetrics allowance, the gastric banding/bypass allowance, the bilateral breast reduction allowance, and the prophylactic treatment allowance

Anaesthetist
Cardiac Surgeon
Cardiologist
Clinical Geneticist (see page 13)
Dermatologist
Endocrinologist
Ear Nose & Throat
Gastroenterologist
General Physician
Breast medicine
General Surgeon
Geriatrician
Haematologist
Intensivist
Physician – Internal Medicine
Musculoskeletal medicine
Nephrologist
Neurologist
Neuro Surgeon
Obstetrician/Gynaecologist
Occupational Medicine
Oral Surgeon
Orthopaedic Surgeon
Paediatrician
Palliative medicine
Plastic Surgeon
Psychiatrist
Radiation Oncologist
Radiologist
Rehabilitation medicine
Respiratory Physician
Rheumatologist
Sexual health medicine
Sports Medicine
Urologist
Vascular Surgeon

Prior approvals will not automatically result in communications for specialist consultations, x-rays and ultrasounds by Affiliated Providers. In many cases approval is retrospective, or would only be generated on the day of their appointment, which is of no value to the member.

To ensure our members are not negatively impacted by this, they are able to call and query anything about an approval if they have not been sent a letter.

Cardiac tests performed by GPs

To ensure that members having cardiac tests with GPs who we have not contracted with continue to receive cover, all cardiac tests performed by a GP will pay out of the GP consult benefit. This includes the following tests:

- ECG
- Holter Monitoring
- Stress Echocardiogram

We're adding cover for new technology

All plans Except HealthEssentials

Advances in medical technology can significantly improve health outcomes for members. Where results show improved patient outcomes at an acceptable cost we aim to include coverage so members can access the most appropriate treatment.

The following new technologies will be covered by Southern Cross. All procedures (except fat grafting and therapeutic mammoplasty) will be Affiliated Provider-only on all applicable plans (excludes UltraCare). The prostheses used as part of these procedures will also be added to the List of Prostheses and Specialised Equipment.

New Technology - Affiliated Provider-only

- Microwave ablation of lung tumours
- Endoscopic ultrasound
- Digital breast tomosynthesis (DBT)*
- KTP Laser ear surgery
- Endoscopic third ventriculostomy EVT)
- Breath nitric oxide testing
- Transcatheter aortic valve implantation/replacement (TAVI/TAVR)
- Trans oral robotic surgery (TORS)
- Left atrial appendage occlusion (LAAO)
- Laser cyclophotocoagulation (CPC)
- Percutaneous medial branch radiofrequency neurotomy of spinal nerves

New Technology - Fee For Service

- Therapeutic mammaplasty
- Fat grafting (lipo-filling)

Details of each new technology

Please check the appendix at the end of this document for more detail about the specific procedures

We're adding cover for Clinical Geneticists

All plans Except HealthEssentials

Clinical genetics is the provision of diagnostic services and genetic counselling for individuals or families with, or at risk of, conditions which may have a genetic basis. Genetic disorders can affect any age group. We have added Geneticist to the definition of "Specialist" so consultations can be covered according to plan maximums and terms. This cover will be Affiliated Provider only (other than for UltraCare). Genetic counsellors will not be covered, and there is no change to cover for genetic testing, current coverage rules apply.

We've reviewed the Master Procedures List

All plans Except HealthEssentials. Prosthesis maximums don't apply to UltraCare

The prosthesis maximums we pay has been reviewed to ensure it is reasonable coverage for our members. Some prosthetics or procedures appear to reduce this year as they have been split into multiple parts eg Knee revision partial is now listed separately from a total Knee revision.

We're adding Easy-Claim GP's to our allergy services benefit

All plans Except HealthEssentials

Since the implementation of the allergy benefit there has been feedback from members that they are not able to access local treatment with a specialist for follow-up desensitisation injections, so we have extended the cover to allow this to be provided through our Easy-claim GPs. Non Easy-claim GP treatment will be paid to the GP consultation benefit (if available).

We're adding cover for PET/CT scans for specific cardiac conditions

All plans Except HealthEssentials.

Previously PET/CT scans have been covered for specific oncology only. This has now been extended to include three cardiac conditions where eligibility criteria is met.

1) Cardiac sarcoidosis
2) Evaluation for infection of prosthetic valves or cardiac implantable devices
3) Assessment of myocardial viability in patients with ischaemic heart failure

We're making changes to the minor surgery benefit

All plans Except HealthEssentials, SureCare & SureCare Concessionary

The minor surgery benefit has been renamed to GP minor surgery to remove confusion between minor surgery performed by Specialists (covered under surgical), and those performed by GP's. The benefit has changed from $450 per operation to $1000 per claims year.

A small number of members will be disadvantaged by this change. Last year 136 members claimed more than $1,000.

We're increasing the HealthEssentials GP benefit

The HealthEssentials GP consultation benefit will be increased from $100 to $150 per claims year. The benefit stand-down period and other terms and conditions will remain the same.

We're increasing the post mastectomy symmetry allowance

All Wellbeing plans | UltraCare | KiwiCare | RegularCare

The post mastectomy allowance maximum is being increased to $6,500 on Wellbeing, UltraCare, KiwiCare and RegularCare plans. No changes will be made to the other plans.

Plan	Current state	Future state
UltraCare Base / 400 Wellbeing Starter / One / Two	**$2,500**	**$6,500**
KiwiCare, KiwiCare Budget RegularCare, RegularCare Budget	**$2,000**	**$6,500**
First Cover, VIP	$2,500	$2,500

All existing benefit rules and eligibility criteria will remain in place.

We're removing the Non-Underwritten (NU) concession

All plans — Except HealthEssentials & Wellbeing Starter

Currently members with the NU concession who leave their employer group within 12 months lose all cover and must be underwritten at the time they leave the group. Each year members have to leave a group for ill health after developing a condition, meaning they lose cover for that developed condition. We have removed the 12 month rule, so members who join on non-underwritten groups retain their pre-existing condition cover no matter when they leave their employer.

We're making system changes as part of our Rainbow Tick initiative

As part of the steps to attain the Rainbow Tick accreditation, Southern Cross will start to roll out a series of process changes to show ongoing commitment to lesbian, gay, bisexual, transgender, takatāpui and intersex (LGBTTI) members and employees..

Biological sex

The first of these changes is to help members understand what we mean when we ask if a person is male or female.

To establish cover under Cancer Assist and Critical Illness policies, and to apply the Healthy Lifestyle Rewards on Health Insurance, Southern Cross need to know about the biological make-up of an

applicant which is called their ‘biological sex’.

In most cases a person’s ‘biological sex’ is that assigned at birth – however this may be different for people who are intersex or have had surgical gender reassignment. To give this some context every year 1 baby in every 2000 are born intersex – meaning their internal reproductive anatomy could comprise of both male and female biology. On their birth records rather than being classed as male or female they may be given an X classification.

To support members who are unsure of how they should answer this question, the Product and Underwriting teams have worked with Rainbow Tick to create guidelines so members can refer to these in private if they wish, rather than having to call and talk to someone. The information below is taken from the guidelines.

To view the guidelines please go to www.southerncross.co.nz/inclusive

Gender identified with

To help Southern Cross build better relationships, based on understanding and respect, members will also have the option to advise the gender they identify with, and this may be different to their biological sex.

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A new title option

Mx will become available where we provide salutations options. The gender-neutral title Mx is used by those who do not identify as being of a particular gender, or for people who simply don't want to be identified by gender.

Healthy Lifestyle Reward

All plans

When applying for the Healthy Lifestyle Reward discount we currently ask if a person is Male or Female in order to determine if the person’s alcohol consumption is classified as meeting the criteria for the discount. As part of the steps to attain the Rainbow Tick Southern Cross will base the alcohol question on the person’s biological sex.

The following wording will be updated on the online application, long printed application, and Plan Finder:

Have you been a **non**-smoker continually for the last 12 months? Yes ☐ No ☐

Do you eat at **least 5** servings* of fruit and vegies a day? Yes ☐ No ☐
**A serving is about a handful*

Do you exercise **30 mins** or more, at least **5 days** a week? Yes ☐ No ☐

Biological sex = Female
Do you drink 2 or less units* of alcohol a day (14 per week)? Yes ☐ No ☐

Biological sex = Male
Do you drink 3 or less units* of alcohol a day (21 a week)? Yes ☐ No ☐

**A unit is 100mL wine or 330mL beer or 30mL spirit*

Wording changes

In addition to updating policy wording to reflect benefit changes, changes have also been made to clarify cover in areas where there is confusion and create consistency. (Examples and page references below are from the Wellbeing One and Two Policy Document, unless otherwise stated)

Cover under the policy
A reference to unapproved healthcare services has been added to the final bullet point. The list is an important part of determining a members eligibility for cover (pg6)

Cancer cover
New wording has been added to help members understand cancer cover under their plan.

Understanding your cover for cancer

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

CANCER SCREENING AND PREVENTION	
✓ Prophylactic treatment to address a highly increased risk of developing cancer	covered under the prophylactic treatment **allowance**
✓ Screening mammograms	covered under diagnostic imaging
✓ Screening colonoscopies (when confirmed to have a 'moderately high risk' or 'high risk' for colorectal cancer because of family history as defined in the **eligibility criteria**)	covered under surgical procedures
CANCER DIAGNOSIS	
✓ Diagnostic imaging for cancer	covered under diagnostic imaging
✓ Tests for cancer	covered under **diagnostic tests**
✓ Consultations for cancer	covered under **specialist** consultations
CANCER TREATMENT	
✓ Cancer surgery	covered under surgical procedures and GP minor surgery
✓ Chemotherapy treatment in an **approved facility** or at home	covered under chemotherapy treatment
✓ **Pharmac** approved chemotherapy drugs	covered under chemotherapy treatment
✓ Non-**Pharmac** approved **MedSafe** indicated chemotherapy drugs	covered under chemotherapy treatment
✓ Radiotherapy	covered under radiotherapy treatment
✓ Breast symmetry surgery post mastectomy	covered under the post mastectomy **allowance** to achieve breast symmetry
✓ Overseas cancer treatment	covered under the overseas treatment **allowance**
✓ Recovery from cancer	covered under post-operative home nursing, post-operative speech and language therapy and post-operative physiotherapy
✓ Support for cancer	covered under the travel and accommodation **allowance**, parent accommodation **allowance** and public hospital cash **allowance**
CANCER PALLIATIVE CARE	
✓ Palliative care for cancer	covered under the **palliative care and treatment allowance**

Optional Cover: Cancer Assist

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

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

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

See page 23 for the Cancer Assist benefit summary.
For a copy of the Cancer Assist policy document, including full terms and conditions please go to southerncross.co.nz/plans or contact us.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
CANCER CARE Cancer related healthcare services are also covered under the following benefits listed in the Coverage Tables: surgical procedures, minor skin surgery, GP minor surgery, post mastectomy allowance to achieve breast symmetry, prophylactic treatment allowance, overseas treatment allowance, post-operative home nursing, post-operative speech and language therapy, post-operative physiotherapy, travel and accommodation allowance, public hospital cash allowance, palliative care and treatment allowance, diagnostic imaging, diagnostic tests and specialist consultations. Eligibility criteria may apply.		
Chemotherapy treatment	$60,000 per claims year Maximum also includes reimbursement of the actual cost up to $10,000 per claims year for non-Pharmac approved MedSafe indicated chemotherapy drugs.	Provided by a Specialist vocationally registered in internal medicine. Includes the cost of materials and chemotherapy drugs, hospital accommodation in a single room and ancillary hospital charges.
Radiotherapy	Unlimited	Performed by a Specialist vocationally registered in radiation oncology in an approved facility. This benefit is inclusive of any radiotherapy planning and radiation treatment (does not include cover for initial or follow-up Specialist consultations, drugs, other healthcare services, or follow up imaging). Please note that a limited range of radiotherapy treatments are funded.
RECOVERY	The preceding related surgical treatment must have been eligible for cover under your policy.	
Post-operative home nursing	$175 per day up to $2,800 per claims year	Post-operative home nursing commencing within 14 days of related eligible surgical treatment or cancer care and performed by a Nurse on the referral of a Specialist in private practice.
Post-operative speech and language therapy	$80 per visit up to $400 per claims year	Treatment by a speech and language therapist registered with the New Zealand Speech-language Therapists' Association, on the referral of a Specialist in private practice.
Post-operative physiotherapy	$60 per visit up to $300 per claims year	Treatment by a physiotherapist registered with the Physiotherapy Board of New Zealand. Includes cover for treatment by a hand therapist registered with the New Zealand Association of Hand Therapists. Must be performed within 6 months of related eligible surgical treatment or cancer care.

Surgical Treatment
The heading has been updated to help make it clear that some procedure are AP-only. If something is covered under surgical treatment it is in the AP-only table. If it is covered under another benefit. It is listed under the benefit (pg16)

6 month rule wording
Aligned 6 month rule wording across all documents to state "Must be performed within 6 months of related eligible surgery or cancer care"

Recovery
Home nursing and speech and language therapy have both had post-operative added to the benefit name, to help clarify the intention of the benefit for members (pg19)

Support
Two changes have been made in the support section, wording was added to confirm the travel and accommodation allowance can be used for a support person to stay in hospital accommodation and that policy exclusions apply to the hospital cash allowance (pg20)

Non-surgical hospitalisation
Wording was added to confirm that non-surgical hospitalisation cannot be claimed following surgery (pg23)

Prescriptions
Wording was added to confirm that non-Pharmac approved drugs are not covered under the prescription benefit (pg24)

Acupuncture registration
New Zealand Register of Acupuncturists is now Acupuncture New Zealand

Massage therapist
From 1 April 2017 Massage New Zealand changed their registration types to be in line with NZQA. Remedial massage therapist won't be used, instead these providers will be known as Registered Massage Therapist - Level 6 or higher (pg24)

Dental registration
The registration information in the dental benefit has been updated but there are no changes to coverage. Oral health practitioner is a term used by the Dental Council or New Zealand to refer to all providers registered with them, we are continuing to show dental hygienist separately to help members and mitigate the risk of people thinking they have lost cover (which happened the last time we removed the wording for dental hygienist). This wording is also impacted by the removal of the definition for oral surgeon (pg25)

Cancer Assist
An optional cover section has been added to the end of coverage tables and benefit sheets to ensure members are aware they can add Cancer Assist (pg26)

OPTIONAL COVER

Cancer Assist Benefit Summary - financial support should you have a confirmed cancer diagnosis

Can be added to either Wellbeing One or Wellbeing Two plans

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

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

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

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

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

For a copy of the Cancer Assist policy document, including full terms and conditions, please go to southerncross.co.nz/plans or contact us.

Exclusions
Several changes have been made to the exclusions:

- Unapproved healthcare services has been moved to the top of the exclusions section and the definition added
- Specific procedures have been removed from the exclusions and moved to the list of unapproved healthcare services, for example cochlear implants, renal dialysis and brow lifts
- Added injection and cell saver information to the organ transplants exclusion
- Changed sterilisation exclusions to refer to benefit rather than allowance
- Updated robotic and health screening exclusion based on new AP-only list

Upgrading and downgrading to influence claims year anniversaries
Additional wording has been added to confirm Southern Cross' ability to decline plan changes in the case of fraud (pg26)

Suspending a policy
Update overseas suspension wording

Privacy statement
Wording changes to make the privacy statement easier to understand and more user friendly (pg32)

Cardiac tests
A definition for cardiac tests has been added to UltraCare, all other plans are AP-only and list the tests under the benefit (UltraCare pg32)

Diagnostic tests
A definition for diagnostic tests has been added to all plans (36)

Congenital conditions
The definition has been updated so conditions can be deemed congenital if signs and symptoms are present prior to the members most recent membership (ODJ) rather than their very first time joining Southern Cross. (pg35)

Oral surgeon
The definition for oral surgeon has been removed, appropriate providers registered with the Dental Council of New Zealand been added to the definition of specialist. (pg38)

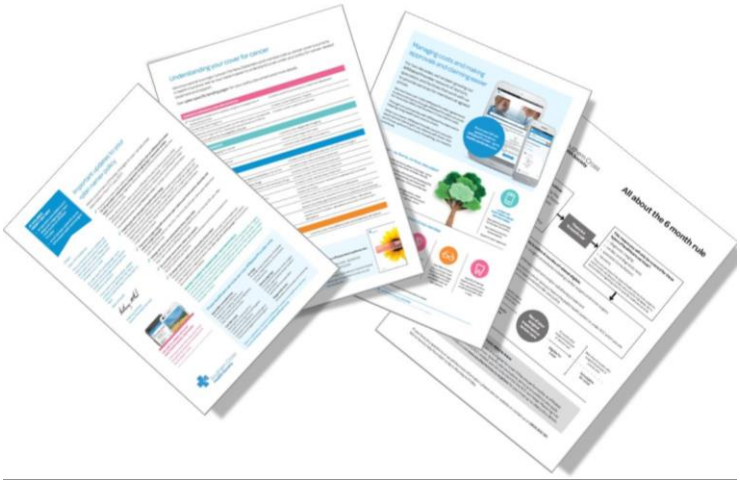
Palliative care and treatment
A definition for palliative care and treatment has been added to all applicable plans (pg37)

Varicose Vein procedures
The definition has been updated to clarify the procedures covered and cover for multiple procedures (pg39)

Communicating the changes

Member communications

Changes will be communicated to Policyholders either online or in the post in a phased approach from 17th May to 16 June. There will also be plan specific landing pages to help guide members through the changes.



For members whose policies are renewing and transitioning to new products in July and August, the renewal communication and Benefit Review information will be combined into one message to avoid multiple change communications in a very short period of time. The documentation will state that both the change in plan name and BR17 changes are one and the same taking place on the date of the members renewal.

This means that some members will receive a message showing that the policy changes take effect before or after 17 July. If a member is negatively affected because they believed a change was effective on their renewal date rather than 17 July please contact us and we will assist.

Changes will be made to the policy change website pages and Benefit comparison sheets to reflect the updated policy wording effective 17 May.

6 month rule

We are including information about the 6 month rule with these communications to help our members understand their cover better.

Southern Cross Health Society

All about the 6 month rule

On these plans:

- Wellbeing One
- Wellbeing Starter
- Hospital Care
- VIP1
- VIP1 Plus
- First Cover
- First Cover 1 Plus

There is a '6 month rule'

This means you will only be covered for these types of healthcare services*:

- diagnostic imaging
- cardiac and diagnostic tests
- specialist Consultations
- recovery

*This is an overview of the types of healthcare services subject to the 6 month rule. See your policy document for full details, terms and conditions regarding cover for specific healthcare services.

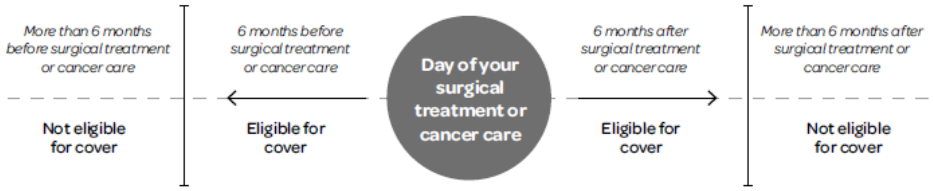
If the treatment date is within 6 months of related eligible:

- **surgical treatment** – surgical procedures including cardiac surgery and minor surgery

  or

- **cancer care** – chemotherapy treatment and/or radiotherapy treatment

This includes surgical treatment or cancer care you have in the public health system or under ACC which you are, or would have been, eligible to have covered under your policy.



Other important information you need to know

A number of healthcare services are only eligible for cover if they are performed by an Affiliated Provider. Contact us to find out more. Specific plan exclusions, terms and conditions also apply. If your healthcare service is ACC related, you can only claim for the ACC surcharge. Please log in to My Southern Cross or see **www.southerncross.co.nz/plans** for your most up-to-date policy details.

If you have any questions or would like more information, please see our website or contact us on **0800 800 181**. We're here to help from 8am to 6pm, Monday to Friday.

Appendix

Details of each new technology

Microwave ablation of lung tumours
Microwave ablation involves a microwave antenna being passed through the patients skin under image guidance directly into the tumour to heat and destroy it. This treatment can be used to treat malignant lung tumours typically less than 3cm in size.

- Eligibility criteria will apply.

Endoscopic ultrasound
Endoscopic ultrasound uses an endoscope with an ultrasound probe on the end to allow visualisation of internal structures from within the body. Through this method, all the layers of these internal structures are visualised, assisting with the diagnosis, staging and tissue sampling of tumors. \

- Eligibility criteria will apply.

Digital breast tomosynthesis (DBT)
\ DBT takes multiple images of the entire breast to provide a 3-dimensional view. \

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- Eligibility criteria will apply.

KTP Laser ear surgery
Southern Cross are adding cover for KTP laser when used to perform a select group of inner ear procedures for which KTP laser is used in place of a scalpel. Lasers provide a precise and bloodless method of operating on the delicate structures of the ear. The procedures that will be covered are:

- KTP Laser mastoidectomy
- KTP Laser tympanoplasty
- KTP Laser second look tympanoplasty
- KTP Laser middle ear adhesiolysis
- KTP Laser stapedectomy
- KTP Laser revision mastoidectomy
- KTP Laser medial canalplasty
- KTP Laser myringotomy

- Exclusions apply.
- Eligibility criteria will not apply.

Endoscopic third ventriculostomy (EVT)
ETV is a new approach for treating hydrocephalus. In an ETV a burr hole is drilled in the skull, a sheath is passed through the burr hole, an endoscope is passed through the sheath and a puncture made in the floor of the third ventricle. A balloon catheter is advanced through the opening in the floor and the balloon is inflated to widen it. The endoscope and sheath are then removed, gelfoam is placed in the burr hole, and the scalp is sutured.

- Eligibility criteria will apply.

Breath nitric oxide testing
Everyone breathes out nitric oxide in low concentrations but these levels increase when people experience airway inflammation, asthma and other lung diseases. Being able to measure this inflammation and monitor the patient's reaction to medication is regarded as gold standard in the management of respiratory diseases.

- Eligibility criteria will not apply.

Transcatheter aortic valve implantation/replacement (TAVI/TAVR)

- TAVI/TAVR is a less invasive alternative to an open aortic valve replacement. The procedure

- replaces the valve without removing the damaged one. Eligibility criteria will apply.

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Trans oral robotic surgery (TORS)
TORS uses an operating robot to remove tissue from the throat through the mouth. For certain oral cancers TORS results in a significant reduction in morbidity compared to the open approach and is standard practice internationally. TORS is faster than open surgery meaning shorter operating times which translates to lower incidence of complications and significant cost savings.

- Eligibility criteria will apply

Left atrial appendage occlusion (LAAO)
Left atrial appendage occlusion/occluder (LAAO) is a treatment strategy to reduce the risk of blood clots causing a stroke in patients with non-valvular atrial fibrillation (AF). LAAO provides an option for patients who find it difficult to tolerate Warfarin in the long term.

- Eligibility criteria will apply.

Laser cyclophotocoagulation (CPC)
Laser cyclophotocoagulation (CPC) is used to treat glaucoma by targeting and ablating the ciliary processes to reduce aqueous production and thus lower intraocular pressure (IOP). It can be performed either transcleral or endoscopically.

- Eligibility criteria will apply.

Percutaneous medial branch radiofrequency neurotomy of spinal nerves
Chronic nerve pain is a common problem that can arise from numerous causes, for which neurolysis is a therapeutic option. Causes include surgery, trauma, a neuroma, or it can be idiopathic. Percutaneous medial branch radiofrequency neurotomy coagulates the target sensory nerve using a hot needle tip. It allows for complete resolution of pain along the course of the target nerve. The needle is inserted percutaneously (though the skin) under fluoroscopic x-ray, ultrasound, or CT guidance (depending on the nerve involved). The nerve is anesthetised and a radiofrequency generator produces a current and an electric field is generated around the tip of the needle creating heat that coagulates the nerve.

- Eligibility criteria will apply.
- Cover will be limited to two procedures per lifetime across all percutaneous medial branch thermal radiofrequency neurotomy of spinal nerves.

Therapeutic mammoplasty
Therapeutic mammaplasty is a procedure carried out on large breasted woman who have breast cancer and require 20 – 50% of their breast tissue removed. It removes the cancer and reshapes the breast at the same time.

- Eligibility criteria will apply.

Fat Grafting (lipo-filling)
Fat grafting (lipo-filling) is a technique used after the removal of a cancerous tumour in the breast as part of a reconstruction. This technique has been used for many years as part of breast reconstruction, but has become more commonly used in the last ten years. Fat grafting can be
used both at the time of a partial mastectomy and/or at the time of a reconstruction. Fat grafting is used to correct soft tissue defects and to regenerate radiation damaged tissue following a partial mastectomy, or in smaller breasted women following a mastectomy. It is an alternative to the use of breast implants and more complicated invasive techniques.

- Eligibility criteria will apply.
- Procedures on the unaffected breast for symmetry purposes will continue to be subject to the post mastectomy allowance to achieve breast symmetry.