Southern Cross
Health Society

UltraCare

Health insurance policy document

Apricots are a great source of dietary fibre and also contain vitamin A, which helps promote good vision.

Effective from 10 December 2018

Welcome

to your UltraCare plan.

Thank you for choosing us to help you take care of your health. This policy document sets out the benefits of your UltraCare plan.

UltraCare Base provides cover for cancer care, surgical treatment, diagnostic imaging, tests, consultations, non-surgical treatment and day-to-day treatment, as well as the other **healthcare services** listed in the **Coverage Tables**.

UltraCare 400 offers the same cover as the UltraCare Base plan, as well as $750 per **claims year** for dental care, $500 per **claims year** for glasses or contact lenses and $100 per **claims year** for an annual health check.

Financial strength rating

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

The rating scale is:

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)
R (Regulatory Action)	NR (Not Rated)	

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

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

Please note that we may record and store telephone calls to and from **Southern Cross**. We do this to have a record of the information we receive and give over the telephone. This also helps us with quality assurance, continuous improvement and staff training. Your call will be handled in complete confidence, except to the extent we are authorised to discuss any aspect of your **policy**, any claim or health information relating to a claim or other information relating to your **policy** with other persons, as described in section 08 of this **policy** document.

Contents

Your policy document

This policy document should be read in conjunction with your Membership Certificate, the List of Prostheses and Specialised Equipment and any subsequent information we send to you regarding changes to this policy document or any of these related documents.

Terminology used in this policy document

When we have used **bold type** in this **policy** document, it means that the word has a special medical or legal meaning. We define some of these terms throughout this **policy** document, and the remaining terms are defined in section 09 at the end of this **policy** document.

Throughout this **policy** document, when we refer to **we/our/us** we mean **Southern Cross** and when we refer to **you/your** we mean the **policyholder** and any **dependant** listed on the **Membership Certificate** (unless otherwise specified).

If you do not understand any aspect of your **policy**, please contact us and we will be pleased to answer your query.

Changes to your policy

We may change or update which **healthcare services** are **eligible**, the scope of cover, terms and conditions of your **policy** and premiums for this **policy** from time to time. If we make any such changes, we will notify you in writing (including on our website or by email). The **policyholder** is responsible for advising **dependants** of any changes to the **policy**. If you are not happy with any of the changes we wish to make the **policyholder** can contact us within 1 month of the notification of changes to discuss alternatives or to cancel this **policy**. If the **policyholder** cancels this **policy**, cover will be provided until the date the **policy** is paid to.

Contents of this policy document

In the remainder of this introductory section **you/your** means the **policyholder**. Benefits under this **policy** are part of your entitlement as a member of **Southern Cross**.

The **policy** comprises:
- the **Membership Certificate**,
- this **policy** document, and any document that is incorporated by reference (ie **eligibility criteria**),
- the **List of Prostheses and Specialised Equipment**,

and any amendment or variation made to them from time to time.

The **Membership Certificate** details:
- the key dates in respect of your **policy**,
- the people covered under your **policy**,
- the name of your plan and level of cover which applies,
- your **Southern Cross** membership number,
- any specific **exclusions** from cover for **pre-existing conditions** known to **Southern Cross** at the time of issue of the **Membership Certificate** applicable to the people covered under your **policy**, and
- any other information specific to your **policy**.

This **policy** document details:
- the terms and conditions of your **policy**, including limitations and **exclusions**,
- the process involved in making a claim,
- administration details relating to your **policy**, including how to make a change to it, and
- additional information relevant to your **policy**.

Certain terms and conditions of your **policy** are set out in this **policy** document as easy-to-understand questions and answers. It is important that you read all of this **policy** document to ensure that you fully understand the terms and conditions of your **policy**.

The **List of Prostheses and Specialised Equipment** forms part of this **policy** and is available on our website or by calling us.

The **List of Prostheses and Specialised Equipment** is important in determining the prostheses, specialised equipment and consumables or donor tissue preparation charges covered by this **policy**, as there is no cover for any prostheses, specialised equipment and consumables or donor tissue preparation charges that are not on this list.

Membership of Southern Cross

Your Application Form for this **policy** also constitutes an application by the **policyholder** for membership of **Southern Cross**. Therefore, you should read the Rules of **Southern Cross** which are available on our website southerncross.co.nz/rules or by calling us.

By applying for membership you agree (both for yourself and on behalf of your **dependants**) to be bound by the Rules of **Southern Cross**. On this **policy** being terminated (for whatever reason) your (and your **dependants**') **Southern Cross** memberships will cease. Likewise, if the **policyholder's** membership is terminated, this **policy** will be cancelled. If you join **Southern Cross** and cancel your **policy** during the 14 day period referred to under "How do I cancel my **policy**?" on page 28 of this **policy** document, then you will not become a **Southern Cross** member.

01

Your policy

This UltraCare **policy** document sets out the benefits and the terms and conditions of the UltraCare Base and UltraCare 400 plans. Your **Membership Certificate** sets out the plan type that applies to you – based on what you selected on your Application Form.

The **policy limits** set out in the **Coverage Tables** are set at a level which reflects the premium charged for the corresponding UltraCare plan.

In return for payment of the premium, we agree to provide you with cover for **eligible healthcare services** as set out in this **policy** document. When we say "cover" throughout this **policy** document we mean cover for claims calculated in accordance with the chart on page 6.

To be **eligible** to claim under your **policy**, your premium payments must be up to date.

Please remember that this **policy** is designed to complement the services provided by **ACC** and the public health service. This is why we have limited cover for **healthcare services** related to an **accident** or **treatment injury** and no cover for **acute care**.

This **policy** is only for New Zealand citizens, New Zealand residents or those otherwise entitled to publicly funded healthcare for all services as determined by the Ministry of Health from time to time.

02

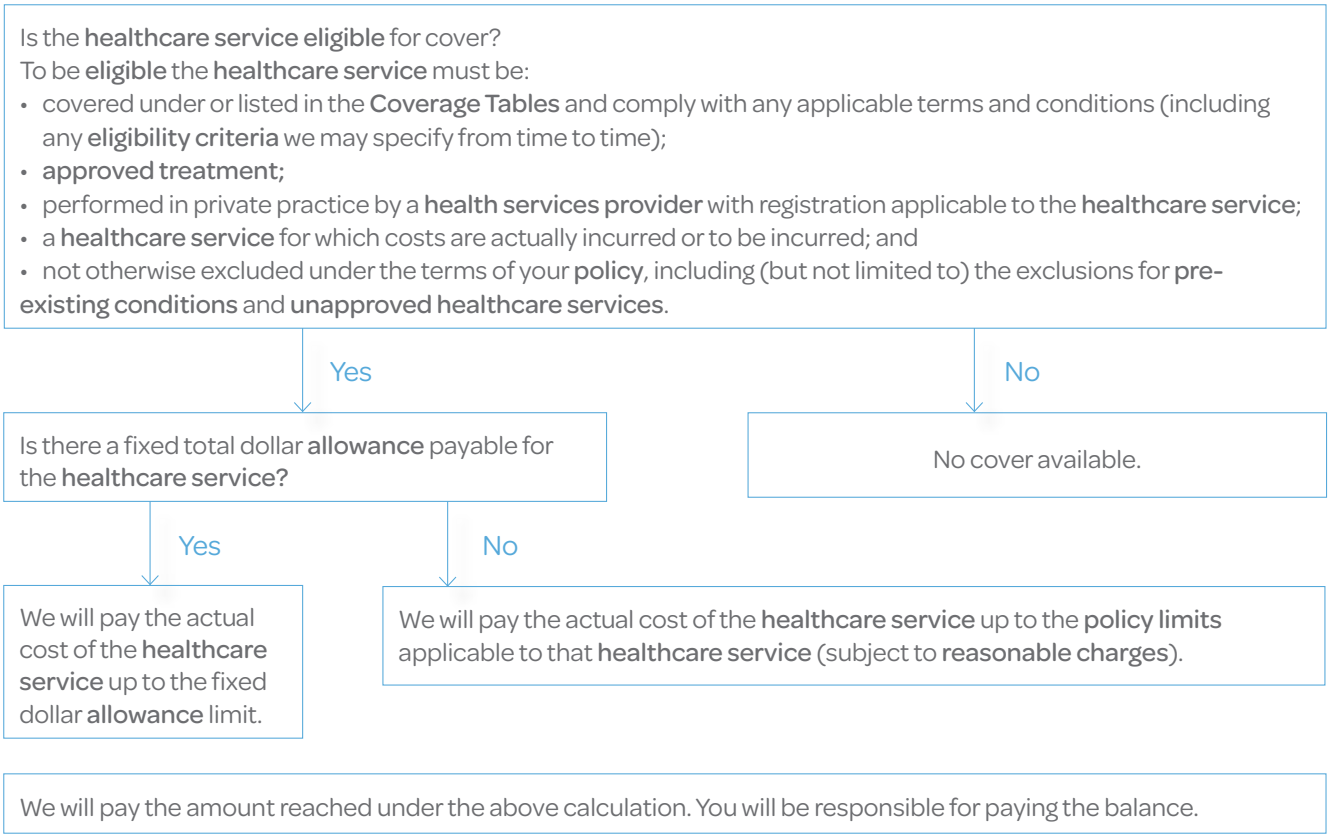
How to receive treatment and make a claim

How does cover work under my policy?

The following chart has been included to describe how your cover for **healthcare services** works under the **policy** in an easy-to-understand format. Please note that in situations where you could claim all or part of the cost of your **healthcare service** from another insurer or other person (including **ACC**) you will need to refer to pages 10 to 12 to fully understand how your cover works.

You should note that this calculation applies to each **eligible** component from the **Coverage Tables** so your claim may be broken down before being assessed if it encompasses more than one component.

This chart does not relate to prescription **drugs**. To understand what cover is available for prescription **drugs** refer to page 9.



What is an allowance?

An **allowance** is a fixed amount we pay towards the actual charges for certain **eligible healthcare services**. Details of the **healthcare services** which are covered by **allowances** and the amounts of such **allowances** are set out in the **Coverage Tables** on pages 16 to 23. Some **allowances** are only available as a one-off payment as specified in the **Coverage Tables**. You should note that almost always the **allowances** will be significantly less than the actual charges for the **healthcare services** and you must pay the balances of the charges yourself. If the actual charges are less than the fixed total dollar **allowance** limit, we will pay the actual charges.

What does Southern Cross mean by "reasonable charges"?

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

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

Which health service providers are covered?

In order for a **healthcare service** to be **eligible**, it must be performed by a **Specialist**, **General Practitioner**, **Nurse** or by another **health services provider** practising in private practice with registration applicable to the **healthcare service**. If you are unsure whether any **health services provider** you are intending to use has appropriate registration or is a member of an appropriate organisation, please contact us.

The prior approval process

You can confirm whether your **healthcare service** is **eligible** for cover and the conditions that apply by requesting approval in My **Southern Cross** or via the mobile app. You need to provide estimated charges from your **health services provider**, we can then inform you of your level of cover and whether or not the estimated charges exceed **policy limits** or the **reasonable charges** for your intended **healthcare service**.

You must contact us for prior approval if the cost of your **healthcare service** is likely to be over $1,000 or where the **healthcare service** involves any hospitalisation (including day stay or in-patient surgery) regardless of the cost, unless you are using an **Affiliated Provider**. You should do this at least 5 working days prior to the **healthcare service** being provided.

If you do not contact us for prior approval before using the **healthcare service**, you will have to pay for the **healthcare service** yourself and then submit a claim. We will process the claim in accordance with your **policy**. By not contacting us for prior approval, you will not know what you are entitled to receive under this **policy** and what you are responsible to pay yourself. Amounts you are responsible for could arise due to an excess applying or due to the **healthcare service** not being **eligible** for cover under your **policy**, or the actual charges exceeding **reasonable charges** or the **policy limits**.

What is an Affiliated Provider and what are the benefits of using one?

Southern Cross has entered into contracts with certain **health services providers**. These providers are called **Affiliated Providers**.

By having agreed prices for certain procedures, the **Affiliated Provider** can tell you what (if anything) you will be required to pay for your **healthcare services**. Unless you are advised otherwise by **Southern Cross** and/or your **Affiliated Provider**, we will pay 100% of the amount charged up to the **policy limits**.

The **Affiliated Provider** will organise prior approval and claim directly from us for the **healthcare service**. When an **Affiliated Provider** provides a **healthcare service** to you, we deem this to be a claim under your **policy**.

A full list of **Affiliated Providers** and the **healthcare services** they offer can be found at healthcarefinder.co.nz. The **Affiliated Provider** network varies in services, and **Affiliated Providers** may not be available for all **healthcare services** covered by this **policy** or in all geographic areas.

Can I use a health services provider that is not an Affiliated Provider?

Yes, you can.

Will my health services provider give me an estimate of the charges?

Under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 you have the right to receive an outline of the treatment, risks associated with the treatment and an estimate of charges from your **health services provider** before treatment takes place. Please provide this to us when you apply for prior approval. You should note that this is an estimate only. If the actual charges vary this may affect your level of reimbursement from us.

What if I have two or more surgical procedures at the same time?

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

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

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

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

Your **policy** provides reimbursement for one surgeon per **operation** only. If you are going to have more than one surgeon, an assistant surgeon or a registered nurse first surgical assistant involved in the **operation** you should inform us at the time of prior approval so that we can help you determine the extent of cover.

What if I need follow-up healthcare services after surgery?

After surgery, if you require additional surgery in connection with the initial surgery, you should contact us to discuss the additional surgery and apply for further prior approval. If the additional treatment relates to a **treatment injury** refer to page 12 for information.

Which prescription drugs qualify for cover?

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

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

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

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

As an exception to the requirement for all **drugs** to be **Pharmac approved**, we do allow you to claim non-Pharmac approved chemotherapy drugs but only as specifically listed under chemotherapy treatment in the **Coverage Tables**.

If the **drug** you are prescribed requires a Special Authority from **Sector Services**, you are responsible for ensuring that your **health services provider** applies for and obtains such authority from **Sector Services** to receive the maximum subsidy you qualify for, prior to submitting your claim.

The definitions for all the terms can be found on pages 31 to 35 of this **policy** document.

The claiming process

How can I make a claim under my policy?

You can make a claim under your **policy** by submitting a completed claim form (online at My Southern Cross, via the My Southern Cross app, or by post), claiming electronically using **Easy-claim** for a **healthcare service** or visiting an **Affiliated Provider** for a **healthcare service**. When you claim electronically via **Easy-claim** for **eligible healthcare service**s (and your claim is accepted by us) or an **Affiliated Provider** provides a **healthcare service** to you, we deem this to be a claim under your **policy**. All claims are subject to the provisions of your **policy**.

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

Unless you are visiting an **Affiliated Provider** or claiming electronically using **Easy-claim**, you need to submit a completed claim form and original itemised receipts, which include the date treatment was provided, for the **healthcare services** listed on the claim form. We do not accept EFTPOS or credit card receipts. The claim form must be fully completed to ensure that your claim can be processed promptly. If the claim form is being posted to us, please ensure the form is signed by you and that the original copies of the itemised receipts are included.

What rules apply when claiming electronically via Easy-claim?

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

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

How long do I have to send in my receipts?

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

Do I need to provide further information?

When you request a prior approval, we may ask you to provide us with a medical report. This will enable us to assess and advise you of the amount of your cover.

Sometimes we may not be able to assess your claim from the Claim Form, invoices and receipts and we may need to contact you or the **health services provider** to clarify some details to enable us to assess the claim correctly.

In exceptional circumstances, we may need to ask a **health services provider** chosen by us, to advise us about the medical facts or examine you in relation to the claim. We will only do this when there is uncertainty as to the level of cover under the **policy** or the nature or extent of the medical condition. This examination and advice will be at our expense. You must co-operate with the **health services provider** chosen by us, or we will not pay your claim.

I might have cover under another insurance policy, or I could claim the cost of my treatment from someone else. What should I do?

First of all make claims against the other insurer or other person who may be liable, then complete a Claim Form for the full extent of your claim and send it to us, together with details of the level of payment you have received.

We will deduct that payment from the amount we will reimburse to you in accordance with this **policy**.

It is your responsibility to inform us of the other insurer or other person liable to pay towards the cost of the **healthcare service** and to make every reasonable effort to obtain payment from them. We have the right to recover from the **policyholder** any payment made by **Southern Cross** for a **healthcare service** where the cost is recoverable from another insurer or other person.

If you have two or more policies with **Southern Cross**, you are not entitled to claim for, or be reimbursed for, an amount higher than the actual cost of the **healthcare service** provided.

What else do I need to know about my claim?

We reimburse claims either directly to the **health services provider** if prior approval has been obtained or you have visited an **Affiliated Provider** or claimed electronically via **Easy-claim** at a selected **health services provider** (and your claim has been accepted by us) or to the **policyholder** (current at the time the **healthcare service** was provided, not at the time the claim is submitted).

We may decline any claim that we reasonably consider to be invalid or unjustified. We may examine any claims for **healthcare services** and where appropriate investigate any aspect of the **healthcare services** provided.

If your **policy** is still in force and your premium is not paid up to date (by you and/or your employer) for the period in which treatment was received, then we will not pay your claim until we receive full payment of any arrears.

If the **policyholder** has been overpaid on any claims, we may seek to recover the amount incorrectly paid out.

Does Southern Cross have the right to deduct money owing from the payment of any claims I make?

Yes, if we are entitled to recover any money from you in relation to this **policy** at any time, we can deduct the amount you owe us from any claim payment or other payment we make to you.

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

Does Southern Cross not reimburse any health services providers?

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

HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACUTE CARE?

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

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

HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACC?

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

Special conditions apply to **accident** and **treatment injury** related surgery. Under the **ACC** legislation, you can choose between full cover (where your **health services provider** is fully contracted by **ACC** to provide your procedure at no cost to you) or partial cover (where your **health services provider** is partially contracted by **ACC** to provide your procedure and you will be required to contribute towards the surgery costs). The full cover option should be your first choice as you may not have to make any contribution to your surgery costs. By comparison, under the partial cover option you will have to make a contribution towards the costs of the **healthcare service**.

The following chart has been included to describe how your cover for **healthcare services** related to an **accident** or **treatment injury** works under your **policy** in an easy-to-understand format.

Where you require a **healthcare service** related to an **accident** or **treatment injury** you must first make every reasonable effort to obtain **ACC** approval for payment of the cost of your **healthcare service**. This includes signing all documents and performing all acts necessary to permit **Southern Cross** to fully protect and realise any entitlement either on your behalf or in its own right.

ACC cover your claim.

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

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

Day-to-day treatment, consultations, imaging and diagnostics claims will be assessed in accordance with the chart on page 6.

Successful review by **ACC**

ACC do not cover your claim.

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

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

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

No cover under your **policy**.

ACC declines to review or your review is unsuccessful

You can make a claim under the **policy** which will be assessed in accordance with the chart on page 6.

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

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

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

*If you withdraw from a review without consulting us we may seek reimbursement of any payment we have already made to you.

03

Existing medical conditions and commencement of cover

Are pre-existing conditions covered?

Health insurance is primarily meant to provide cover for the treatment of health conditions, signs and symptoms that arise after the **policy** has been taken out. There is no cover for **pre-existing conditions** under the **policy** unless we agree in writing to offer cover for **pre-existing conditions**.

However after 3 years of **continuous cover** a **healthcare service** relating to:

- any **pre-existing condition** may be covered under your **policy**;
- any congenital **pre-existing condition** may be covered under your **policy**;

provided that the **healthcare service** is **eligible** for cover.

When the **policyholder** completed the Application Form for this **policy** the **policyholder** declared the conditions, signs, symptoms and events for which the **policyholder** or any **dependant** knew about at the date of application. We assess the conditions, signs, symptoms and events disclosed in the application and make a decision whether to offer cover for any **pre-existing conditions** or not. **Pre-existing conditions** which we know of at the time of issuing the **Membership Certificate** and which we decline to cover will be set out on your **Membership Certificate**.

The **exclusions** for **pre-existing conditions** (including any specific conditions listed on the **Membership Certificate**) are in addition to the standard **exclusions** noted in this **policy** document.

Declaration of pre-existing conditions

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

When does cover under the policy commence?

The **policyholder's** cover commences from the **policy start date**. **Dependant's** cover commences from the date they are added to the **policy**. Newborn **dependants** added to the **policy** within 3 months following their date of birth are covered from the date of their addition.

04

Private healthcare services to which this policy applies

The **Coverage Tables** set out on pages 16 to 23 give details of **healthcare services** which are covered under UltraCare, together with details of **policy limits** and other terms and conditions of cover.

List of Prostheses and Specialised Equipment

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

We may change the **List of Prostheses and Specialised Equipment** from time to time and these changes will be notified to you in the same way as any other changes to the **policy**, as set out on page 2 of this **policy** document.

Treatment in a public facility

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

Quality of healthcare services

We are not liable to you for the quality, standard or effectiveness of any **healthcare service** provided to you by, or any other actions of, any **health services provider** or any of their employees or agents.

Eligibility criteria

We may from time to time put new **eligibility criteria** in place or update the existing **eligibility criteria**.

Treatment overseas

There is an **allowance** for **approved treatment** not available in the public or private sector within New Zealand. This **allowance** is only to contribute towards the medical expenses you incur and does not pay towards accommodation or travel costs. The treatment must be recommended by a **Specialist** in private practice. **Southern Cross** must approve the treatment based on a medical report you provide before treatment takes place. Without this prior approval, the claim cannot be paid. Ordinary **policy exclusions** apply.

05

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 and skin surgery

CANCER TREATMENT	
✓ Cancer surgery	covered under surgical procedures and skin 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** and parent accommodation **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.

06

Coverage Tables

The following **Coverage Tables** set out the **healthcare services** included under the UltraCare Base and UltraCare 400 plans. The **Coverage Tables** specify **policy limits** and terms and conditions applicable to the listed **healthcare services**. The **Coverage Tables** should be read together with the **List of Prostheses and Specialised Equipment**, which is available at southerncross.co.nz/plans, or by calling us.

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

When reading the **Coverage Tables** you can refer to the chart on page 6 to understand how your cover will be calculated, and to the glossary of terms on pages 31 to 35 for the explanation of all bolded terms. All figures include GST.

Also included is a benefit summary for Cancer Assist.

UltraCare - Coverage Tables

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL TREATMENT	**Eligibility criteria** may apply.	
Surgical procedures (includes cardiac and cancer surgery) Surgeon's operating fee/s Anaesthetist's fee/s Intensivist's fee Perfusionist's charges **Hospital fees** Surgically implanted **prostheses** and specialised equipment	Unlimited	Performed by a **Specialist** or **Affiliated Provider** contracted for that **healthcare service** in an **approved facility**. Including bypass machine supplies and off-bypass cardiac stabilisation consumables. Refer to the **List of Prostheses and Specialised Equipment**.
Coronary angioplasty	Unlimited	Performed by a **Specialist** in an **approved facility**.
Angiography	Unlimited	Performed by a **Specialist** in an **approved facility**.
Sterilisation	Refunded as per surgical procedures	Performed by a **General Practitioner** or **Specialist** in an **approved facility**. After 1 year of **continuous cover** on this plan. Excludes reversals.
Skin surgery		
Skin lesion removal under general anaesthetic or sedation, and Mohs surgery	Refunded under surgical procedures	For excision, biopsy, cryotherapy, curettage and diathermy of skin lesions when performed under general anaesthetic or sedation and Mohs surgery (including excision and closure). Must be performed by a **Specialist** or **Affiliated Provider**. Mohs surgery must be performed by a **Specialist** who is accredited as a Mohs surgeon by the Australasian College of Dermatologists or the American College of Mohs Surgery (or has their qualification recognised as equivalent to such accreditation by such colleges).
Skin lesion services under local anaesthetic or with no anaesthetic	$10,000 per **claims year** (includes $1,000 per **claims year** when performed by a **General Practitioner**)	For excision, biopsy, cryotherapy, curettage and diathermy of skin lesions when performed without anaesthetic or under local anaesthetic. Must be performed by a **Specialist**, **Affiliated Provider** or **General Practitioner**. Includes all consultations related to skin lesions.
GP minor surgery	$1,000 per **claims year**	Performed by a **General Practitioner**. Excludes consultations and skin lesion services.
Varicose veins (legs)	Refunded as per surgical procedures	Performed by a **Specialist** or **Affiliated Provider** in an **approved facility**. Cover is limited to 2 **varicose vein** procedures per leg per **lifetime**. In order to receive cover the treatment must not be **cosmetic treatment**.
Percutaneous medial branch thermal radiofrequency neurotomy	Refunded as per surgical procedures	Performed by a **Specialist** or **Affiliated Provider** in an **approved facility**. Cover is limited to 2 procedures per **lifetime**.
Extraction of unerupted or impacted teeth	Refunded as per surgical procedures	After 1 year of **continuous cover** on this plan. Performed by a **Specialist** or **Affiliated Provider** in an **approved facility**.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SURGICAL ALLOWANCES	Eligibility criteria may apply.	
Gastric banding/bypass **allowance**	$7,500 per **lifetime**	After 3 years of **continuous cover** on this plan. Payable on receipt of a medical report by a **Specialist** prior to surgery. This **allowance** includes 1 surgical procedure and any subsequent treatment that may be required.
Bilateral breast reduction **allowance**	$5,000 per **lifetime**	After 3 years of **continuous cover** on this plan. Payable on receipt of a medical report by a **Specialist** prior to surgery. This **allowance** includes 1 surgical procedure and any subsequent treatment that may be required.
Post mastectomy **allowance** to achieve breast symmetry	$6,500 per **lifetime**	Payable on receipt of a medical report by a **Specialist** prior to surgery. Cover is for symmetry procedures performed on the unaffected breast. This **allowance** includes 1 surgical procedure and any subsequent treatment that may be required.
Prophylactic treatment **allowance**	$50,000 per **lifetime**	After 3 years of **continuous cover** on this plan. Covers prophylactic treatment to address a highly increased risk of developing a disease. Approval must be granted prior to treatment. This **allowance** is the total amount available for both the prophylactic treatment and all subsequent associated costs. Cover is not available where the high risk status was present prior to the **original date of joining**.
Overseas treatment **allowance**	$30,000 per **claims year**	Reimbursement of medical expenses for **approved treatment** not available in the public or private sector within New Zealand. The treatment must be recommended by a **Specialist**. **Southern Cross** must approve the treatment based on a medical report you provide before treatment takes place. Ordinary **policy exclusions** apply. No reimbursement for accommodation or travel.

*See the chart on page 6 for how your refund will be calculated.

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, skin surgery, post mastectomy **allowance** to achieve breast symmetry, prophylactic treatment **allowance**, overseas treatment **allowance**, post-operative home nursing, post-operative speech and language therapy, post-operative physiotherapy, travel and accommodation **allowance**, **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**. Excludes consultations.
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 Hand Therapy New Zealand. Must be performed within 6 months of related **eligible** surgical treatment or cancer care.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
SUPPORT		
Ambulance **allowance**	$180 per **claims year**	For emergency transportation to a public facility.
Travel and accommodation **allowance**	$500 per **claims year**	For when private treatment is not available in your home town or city and you have to travel more than 100km from home to receive an **eligible healthcare service**. **Allowance** payable to cover the person covered by the **policy** receiving the **eligible healthcare service** and a support person. **Allowance** payable for public transport costs (includes buses, trains, taxis, shuttles, planes and ferries) and hotel/motel rooms (or hospital rooming fees for the support person) within New Zealand only. No cover for car hire, mileage or petrol costs.
Obstetrics **allowance**	$1,000 per **claims year**	After 1 year of **continuous cover** on this plan. For obstetric care and services carried out by a **Specialist** vocationally registered in obstetrics and gynaecology or anaesthesia and/or for accommodation in an **approved facility** and 2D and Doppler ultrasounds.
Palliative care and treatment allowance	$2,400 per **claims year**	After 3 years of **continuous cover** on this plan. Cover for **palliative care and treatment** when diagnosed with a progressive terminal illness.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
DIAGNOSTIC IMAGING	Performed at an Approved Facility. **Eligibility criteria** may apply.	
	$100,000 per **claims year** (in total) for all diagnostic imaging:	
X-ray		Excludes x-rays performed by a dentist or chiropractor.
Ultrasound		Excludes obstetrics and varicose veins (legs) treatment.
Mammography		
Digital breast tomosynthesis		
Nuclear scanning (scintigraphy)		
Myocardial perfusion scan		Must be referred by a **Specialist** in private practice.
CT angiogram		
CT coronary angiogram		Must be referred by a **Specialist** in private practice.
MR angiogram		Must be referred by a **Specialist** in private practice.
Computed Axial Tomography (CT scan)		Cone Beam Computed Tomography (CBCT) must be referred by a **Specialist** in private practice.
Magnetic Resonance Imaging (MRI scan)		Must be referred by a **Specialist** in private practice.
Positron Emission Tomography / Computed Tomography (PET/CT)		Must be referred by a **Specialist** in private practice. Cover is limited to specific diagnosed cancers and cardiac conditions.
TESTS	**Eligibility Criteria** may apply.	
Cardiac tests	$5,000 per **claims year**	On referral by a **Specialist** in private practice and in an **approved facility**. For a list of all **cardiac tests** covered under this benefit please see the definition of **cardiac tests** on page 31.
Diagnostic tests	$3,000 per **claims year**	On referral by a **Specialist** in private practice and in an **approved facility**. For a list of all **diagnostic tests** covered under this benefit please see the definition of **diagnostic tests** on page 32.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
CONSULTATIONS	Eligibility criteria may apply.	
Specialist consultations	$10,000 per **claims year** (in total)	Consultations with a **Specialist**. Excludes psychiatrist and all skin lesion consultations.
Psychiatrist consultations	$750 per **claims year**	Consultations with a **Specialist** vocationally registered in psychiatry.
Dietitian consultations	$125 per consultation up to $625 per **claims year**	Consultations with a dietitian registered with the New Zealand Dietitian Board. On referral by a **Specialist** in private practice.
NON-SURGICAL TREATMENT	Eligibility criteria may apply.	
Non-surgical hospitalisation	$60,000 per **claims year** (in total) for the following:	For non-surgical treatment in a hospital performed by or on referral of a **Specialist** or **Affiliated Provider** in private practice and in an **approved facility** (does not include cover for consultations, imaging and tests). Excludes **long term care**, accommodation following surgery, rehabilitation, geriatric care, hospice, respite and convalescent care, psychiatric hospitalisation and the cost of non-Pharmac approved drugs.
Hospital accommodation	$700 per night or per day stay	Single room, excludes suites.
Ancillary hospital charges	$200 per **claims year**	
Psychiatric hospitalisation	$3,500 per **claims year** (in total) for the following:	For admission and care by a **Specialist** vocationally registered in psychiatry in an **approved facility**.
Hospital accommodation	$700 per night or per day stay	
Ancillary hospital charges	$200 per **claims year**	
Allergy services	$1,000 per **claims year**	Provided by or under the care of a **Specialist** or a **General Practitioner** who has an **Easy-claim** agreement with us. Covers allergy related services including allergy testing and desensitisation. Excludes consultations and the cost of non-Pharmac approved drugs.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
DAY-TO-DAY TREATMENT		
General Practitioner	$100 per consultation	Treatment and consultations (including dressings, acupuncture and ECG) by a **General Practitioner**.
Annual health check UltraCare Base UltraCare 400	 No cover $100 per **claims year**	Performed by a **General Practitioner** or **Specialist**.
Nurse	$30 per consultation	Only applicable where no **General Practitioner** fee applies.
Prescriptions	$600 per **claims year**	Charges for prescription **drugs** prescribed by a **General Practitioner**, **Specialist** or **Nurse**. Excludes the cost of non-Pharmac approved drugs.
Physiotherapist	$60 per visit up to $300 per **claims year**	Performed by a physiotherapist registered with the Physiotherapy Board of New Zealand. Includes acupuncture and manipulations.
Laboratory tests	$70 per **claims year**	Performed for diagnostic purposes but not funded by a government agency. Performed by an accredited hospital, community based or regional referral laboratory approved by International Accreditation New Zealand.
Chiropractor	$60 per visit up to $300 per **claims year**	Performed by a chiropractor registered with the New Zealand Chiropractic Board. Excludes the cost of medication.
Osteopath	$60 per visit up to $300 per **claims year**	Performed by an osteopath registered with the Osteopathic Council of New Zealand. Excludes the cost of medication.
Audiologist Hearing tests	$200 per **claims year** $210 per **claims year**	Performed by an audiologist who is a member of the New Zealand Audiological Society. Including puretone, audiometry, impedence, tympanometry and brain stem evoked responses.
Dietitian or nutritionist	$440 per **claims year**	Performed by a dietitian registered with the New Zealand Dietitian Board or a nutritionist registered with the Nutrition Society of New Zealand or Clinical Nutrition Association. Excludes the cost of food and food substitutes.
Podiatrist	$400 per **claims year**	Performed by a podiatrist registered with the Podiatrists Board of New Zealand.
Clinical psychologist	$150 per visit up to $600 per **claims year**	Performed by a psychologist registered as a clinical psychologist with the New Zealand Psychologists Board.
BEING ACTIVE		
Being active	$50 per **claims year**	After 3 years of **continuous cover** on this plan. Payable on receipt of proof of completion of a sports event and payment of the related entry fees.

*See the chart on page 6 for how your refund will be calculated.

HEALTHCARE SERVICE	MAXIMUM*	OTHER TERMS AND CONDITIONS
VISION CARE		
Orthoptist	$200 per **claims year**	Treatment by a registered orthoptist.
Optometrist	$70 per visit up to $350 per **claims year**	Consultations with an optometrist registered with the New Zealand Optometrists and Dispensing Opticians Board.
Prescription glasses UltraCare Base UltraCare 400	 No cover $500 per **claims year**	Prescription glasses/sunglasses (frames and lenses) and contact lenses for change of vision, replacement for loss or breakage when prescribed by a registered ophthalmologist, optometrist, or optician.
DENTAL TREATMENT		
Dental UltraCare Base UltraCare 400	 No cover $750 per **claims year**	Performed by an oral health practitioner including a dental hygienist registered with the Dental Council of New Zealand or **Specialist** vocationally registered in oral & maxillofacial surgery.

*See the chart on page 6 for how your refund will be calculated.

OPTIONAL COVER

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

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

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

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

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

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

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

Exclusions

No reimbursement or payment shall be made for any costs incurred in relation to, or as a consequence of, any of the following:

- **Pre-existing conditions** including but not limited to those conditions specifically set out in your **Membership Certificate**;
- **Unapproved healthcare services** which are specific **drugs**, devices, techniques, tests and/or other **healthcare services** that have not been approved by **Southern Cross** prior to treatment. Please see the list of **unapproved healthcare services** at southerncross.co.nz/unapprovedservices;
- **Acute care**;
- Appliances or equipment (surgical, medical or dental) for example CPAP machines, cochlear implants, nerve stimulators, orthotics, crutches;
- Breast reduction, except as specifically provided by the bilateral breast reduction **allowance**;
- **Chronic conditions**;
- **Congenital conditions**, except where accepted after 3 years **continuous cover** on the UltraCare plan. The following conditions are not considered **congenital conditions** by us: umbilical hernia, inguinal hernia, undescended testes, hydrocele, tongue tie, phimosis and squint;
- Contraception or intrauterine devices except for Mirena when used for medical reasons and approved by us prior to treatment;
- Correction of refractive visual errors or astigmatism by surgery, surgically implanted intraocular lens(es), or laser treatment;
- **Cosmetic treatment**/procedures;
- Dementia;
- Diagnosis, management and treatment of developmental or congenital deformities or abnormalities of the facial skeleton and associated structures;
- Extraction of teeth except as specifically provided by extraction of unerupted or impacted teeth (under surgical procedures) and dental benefits;
- Gender reassignment surgery and directly related **healthcare services**;
- Gynaecomastia;
- **Health screening**, except as specifically provided by mammography (under diagnostic imaging) and colonoscopy (under surgical procedures) benefits;
- **Healthcare services** performed by a dentist, periodontist, endodontist or orthodontist except as specifically provided by the dental benefit;
- **Healthcare services** provided at a public facility directly or indirectly controlled by a **DHB** unless specifically accepted in writing by **Southern Cross** prior to treatment;
- **Healthcare services** provided by a person who is not a **health services provider** as defined on page 33 of this **policy** document;
- **Healthcare services** provided in relation to, or as a consequence of, any **accident** or **treatment injury** except as specifically provided on page 12 of this **policy** document;
- **Healthcare services** provided outside New Zealand, except as specifically provided by the overseas treatment **allowance**;
- **Healthcare services** relating to the management and treatment of snoring and/or upper airways resistance;
- **Healthcare services** that are not **approved treatment**;
- **Healthcare services** using technology such as digital computer images to aid in the monitoring and diagnosis of skin cancers and other skin lesions for example, mole mapping;
- HIV, HIV disorders including AIDS, and any medical condition that arises in any way from HIV infection;

- Hospital charges of a personal convenience nature; for example, newspapers, spouse/family meals, alcohol, TV rental;
- Implantation of teeth and/or titanium dental implants except as specifically provided by the dental benefit;
- Infertility or assisted reproduction;
- Injury, illness, condition or disability arising from, or caused or contributed to by, substance abuse, intoxication or drug taking whether prescribed or recreational;
- Injury or disability suffered as a result of war or any act of war, declared or undeclared, or of active duty in the military, naval or air forces of any country or international authority, or as a direct or indirect result of terrorism;
- **Long term care** including geriatric in-patient care and **disability support services**;
- Maintenance examinations, medical checkups (except as specifically provided by the annual health check benefit under Day-to-day treatment on UltraCare 400) or any examination required for a third party (including preparation of reports) for example physical examinations for life insurance, travel insurance and driver licence;
- Mental health **healthcare services** except as specifically provided by the psychiatrist consultation, psychiatric hospitalisation and clinical psychology benefits;
- Obesity except as specifically provided by the gastric banding/bypass **allowance**;
- Organ transplants, transfusions/injections of autologous blood/blood products (except cell-saver when related to **eligible** surgical treatment), autologous chondrocyte implantations and stem cell transplants, including related expenses for both donors and recipients;
- Pathology and laboratory tests except as specifically provided by the laboratory tests benefit;
- Pregnancy and childbirth except as specifically provided by the obstetrics **allowance**;
- **Prophylactic healthcare services**, except as specifically provided by the prophylactic treatment **allowance**;
- Prostheses, specialised equipment and consumables or donor tissue preparation charges except as specifically listed in the **List of Prostheses and Specialised Equipment**;
- Respite and convalescent care;
- Robotic assisted surgery, other than when used to perform a prostatectomy, partial nephrectomy or transoral surgery;
- Self-inflicted illness or injury;
- Sterilisation except as specifically provided by the sterilisation benefit or its reversal;
- Subsequent breast reconstruction surgery or symmetry surgery unless completed within 2 years of the first **eligible** breast reconstruction surgery (following an **eligible** mastectomy);
- Surgery designed to assist or allow the implementation of orthodontic **healthcare services** except as specifically provided by the dental benefit;
- Surgically implanted lens(es) other than monofocal lens(es);
- Termination of pregnancy;
- Treatment of any condition not **detrimental to health**;
- Treatment of cleft palate;
- Vaccinations.

07

Administrative information

In this section, when we say **you/your** we refer to the **policyholder**.

Who is responsible for my policy?

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

When does my policy commence?

This **policy** commences on the **policy start date**. The **policy anniversary date** is the anniversary of the **policy start date**. The **policy anniversary date** is the same for all persons listed on the **Membership Certificate** as covered by the **policy** regardless of the **original date of joining**. If you change in any way the frequency or the manner in which you pay your premiums under the **policy**, then the **policy year** may be reset to start on the date of such change. The new **policy anniversary date** will be the anniversary of the date of the change.

If your **policy** is provided through a work scheme or association scheme, your **policy anniversary date**, however, is aligned to that of your scheme. This could mean that your first **policy anniversary date** may take place less than 12 months after the **policy start date**. However, from this time, the **policy anniversary date** will fall every 12 months unless changes are made to the scheme or you leave the scheme.

Where will Southern Cross send communications about my policy?

All **policyholders** registered for My Southern Cross will receive the majority of communications electronically, unless they choose otherwise, and will be notified of the availability of these communications by email. For communications received electronically via My Southern Cross, notice shall be considered to be delivered on the day email notification is sent. If the **policyholder** is not registered for My Southern Cross, unless the **policyholder** tells us otherwise, or unless the **policyholder** can no longer be contacted at the **policyholder's** last known address, we will send every notice or other communication required to be sent by **Southern Cross** relating to the **policyholder**, this **policy**, or any **dependant**, to the **policyholder** at the last known address and such notice shall be considered to have been delivered 3 days after having been posted.

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

When can I add dependants on to my policy?

You can add **dependants** onto the **policy** at any time, excluding children aged 21 years or older. You will need to complete a medical declaration for the **dependant** being added. We will determine whether we will cover any **pre-existing conditions** disclosed on the medical declaration. Cover will commence on the date the **dependant** was added to your **policy**.

If you wish to add a newborn **child**, the application must be submitted within 3 months of birth. Provided you have held your **policy** for more than 3 months at the date of application, the **child** will have cover for **pre-existing conditions** as long as they are not excluded under the general terms of this **policy** or are not **congenital conditions** or **chronic conditions** excluded under the exclusions section of this **policy** document. Cover will commence on the date the **child** was added to your **policy**.

If you have not held your **policy** for more than 3 months at the date of application or don't add the newborn **child** before he or she is 3 months old, you will have to complete a medical declaration for the **child** and we will determine whether we will cover any **pre-existing conditions** disclosed on the medical declaration.

Premiums for **dependants** added will be charged from the date of the addition of the **dependant** as part of your normal billing cycle. You are responsible for payment of premiums in respect of any **dependant** added to the **policy**.

How long can my adult children stay on my policy?

Your children are charged at the **child's** rate until they reach 21 years of age. On reaching 21 the premiums payable in respect of your children will be based on their age but they can remain on your **policy**. **Adult** children will automatically remain on your **policy** unless you, your work scheme or association scheme specifically request us to remove them.

If you wish to remove them from your **policy**, and they would like to continue cover with **Southern Cross**, they should apply for their own **Southern Cross** membership.

If they apply for the same level of cover as they had under your **policy** and they apply within 1 month of being removed from your **policy** they will not need to complete a new medical declaration.

How do I remove dependants from my policy?

The removal of a **dependant** can take place at any time – you should request to remove the **dependant** in writing or by calling **Southern Cross**. It is the responsibility of the **policyholder** to remove **dependants** from the **policy** where the circumstances change so that the **policyholder** no longer requires the **dependant** to be covered by the **policy** (for example, following a marital separation or a death).

You should note that if a **dependant** is removed from the **policy** and subsequently added back on, you will have to complete a new medical declaration for them. They will not have cover for **pre-existing conditions** existing prior to the date they are added back on to your **policy**.

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

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

In particular you should note:

- to upgrade your **policy** you will be required to complete a new medical declaration in relation to yourself and all **dependants**;
- if you upgrade or downgrade your **policy** any **pre-existing condition exclusions** affecting you or any **dependant** will remain;
- if you upgrade or downgrade your **policy** the **claims year** and excess for you and each **dependant** will start over again from the date of the upgrade or downgrade.

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

What is a claims year and how do annual limits work?

You and all of your **dependants** have the same **claims year** regardless of when a particular person was added to the **policy**. **Annual limits** applicable to UltraCare last for the duration of a **claims year** and revert to their maximum levels at the start of each **claims year**. If any **dependant** is added to the **policy** part way through a **claims year** that **dependant** will have the same **annual limits** as the people covered under the **policy** from the start of the **claims year**.

Annual limits cannot be carried over from 1 **claims year** to the next, nor can they be transferred to other people covered under the **policy**.

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

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

How does Southern Cross calculate 'continuous cover' for some of the elements of cover?

'**Continuous cover**' means that the person covered by the **policy** must have had no break in cover for the particular **healthcare service** in this plan to which the **continuous cover** qualification relates for the specified minimum period. Periods when the **policy** is suspended in relation to that person while that person is travelling overseas count as part of **continuous cover**. However, if that person is a **dependant** who is taken off the **policy** for any period and then added back on, then that will break the period of **continuous cover**.

I am going to travel overseas for a while, can I suspend my policy until I return?

It is possible to suspend cover under the **policy** in respect of you or any of your **dependants**, for overseas travel on 3 separate occasions over the **lifetime** of your **policy**, and your **policy** can be suspended for up to 5 years (60 months) in total.

There are certain conditions that apply as set out below.

Each of these conditions relates personally to the **policyholder** or each **dependant** who is travelling, and wishing to suspend their cover:

- you or your **dependant** must request suspension in writing before leaving New Zealand;
- you or your **dependant** must have been covered by the **policy** for at least 12 continuous months up to the date the suspension is to take effect;
- any single period of suspension must be for a minimum of 2 months, and be for no more than 3 years (36 months);
- you or your **dependant** can each suspend cover up to 3 times per **lifetime** only;
- you or your **dependant** must be continuously covered under the **policy** for a period of 12 months between the end of the last suspension and the commencement date of the next suspension.

If you or your **dependant** are leaving New Zealand for a period greater than 36 months, contact us to discuss the options available to you.

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

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

Before we cancel your **policy** for any of the reasons set out above:

(a) we will notify you in writing of the reasons why we are considering cancellation; and

(b) you will have not less than 7 days to provide any written response you wish to be considered by us before we make our decision.

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

How do I cancel my policy?

If you are joining **Southern Cross** for the first time and are not satisfied with the **policy** during the first 14 days after the date you have received this **policy** document and your **Membership Certificate**, you can cancel the **policy** and we will provide a full refund of all premiums paid. You can only do this if you have not made a claim under the **policy** during this period. If you wish to cancel the **policy** within the 14 day period please contact us.

You can cancel your **policy** at any other time but if you do so you will not be entitled to a refund of any premium already paid to us and you will remain liable for premium due up to the date the cancellation takes effect. Cover will be provided until the date the **policy** is paid to.

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

What happens if I do not pay my premium?

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

If you or your employer don't pay premiums for 3 months or more, we will cancel your **policy**.

08

Your regulatory protection

PRIVACY STATEMENT

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

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

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

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

FINANCIAL ADVICE

Southern Cross is a Qualifying Financial Entity (QFE). We take responsibility for any financial advice our staff and advisers provide on the **Southern Cross** range of health insurance products. We are licensed and regulated by the Financial Markets Authority for that financial advice. For more information and a copy of our disclosure statement please visit southerncross.co.nz/disclosure-statement.

INDUSTRY ORGANISATIONS

Southern Cross is registered as a Friendly Society and is a member of the Health Funds Association of New Zealand, the Insurance & Financial Services Ombudsman scheme and the International Federation of Health Plans. We are bound by any industry code issued by the Health Funds Association of New Zealand.

COMPLAINTS PROCEDURE

If you are unhappy with our service, our treatment of your **policy** or your membership of **Southern Cross**, you can follow the process outlined below.

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

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

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

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Still not resolved?
Your complaint has reached deadlock.

→

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

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

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

The Ombudsman's address is:
Insurance & Financial Services Ombudsman
PO Box 10 845
Wellington 6143

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

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Refer to the Rules of **Southern Cross** which outline a process to resolve membership disputes.

You can get a copy of the Rules from southerncross.co.nz/rules or by calling us.

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Glossary of terms

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

Some terms used in this **policy** document have been explained as they arose. Other terms are defined below:

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

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

Acute care means care provided in response to a sign, symptom, condition or disease that requires immediate treatment or monitoring.

Adult means a person 21 years of age and over.

Affiliated Provider means a **health service provider** who has entered into a contract with **Southern Cross** to provide certain **healthcare services** at agreed prices.

Allowance means the fixed amount that we will contribute towards the cost of certain **eligible healthcare services** as specified in the **Coverage Tables**.

Ancillary hospital charges means anaesthetic supplies, dressings, **drugs** (which are prescribed and taken in hospital), intravenous fluids, and irrigating solutions, used whilst the member is hospitalised for an **eligible healthcare service**.

Angiography means cardiac catheterisation and all coronary, renal and peripheral angiograms, and peripheral vascular angioplasty.

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

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

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

Cardiac tests means advanced electrocardiogram (A-ECG), resting ECG, exercise ECG, holter monitoring, echocardiogram, stress echocardiogram, dobutamine stress echocardiogram, or transoesophageal echocardiogram (TOE).

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

Chemotherapy drugs means prescription medicines, biologics and immunotherapy medicines for the treatment of cancer or neoplastic disease, that are prescribed or recommended by a registered oncologist or haematologist in private practice, **Pharmac approved**, and not otherwise excluded by the terms of your **policy**.

Child means a person under 21 years of age.

Chronic conditions means cystic fibrosis, polycystic kidney, marfans syndrome, Loeys-Dietz syndrome, spina bifida, scoliosis, kyphosis, pectus excavatum and pectus carinatum.

Claims anniversary date means the date 12 months following the date the **policyholder** started on the current plan and the anniversary each 12 months thereafter as specified on the current **Membership Certificate**.

Claims year means the first 12 months following the **policy start date** and each successive 12 month period from your **claims anniversary date**.

Complaints procedure means the complaints procedure and process available to you as set out on page 30.

Congenital condition(s) means congenital anomalies or defects which are present at birth and for which the **policyholder** or **dependant** had either:

(a) signs or symptoms of the condition prior to the **original date of joining**, or
(b) signs or symptoms of the condition within 3 months of birth, as reasonably determined by **Southern Cross**.

Continuous cover means that the person covered by the **policy** must have had no break in cover for the particular **healthcare service** in this plan to which the **continuous cover** qualification relates, for the specified minimum period.

Cosmetic treatment means any surgery, procedure or treatment that improves, alters or enhances appearance, whether or not undertaken for medical, physical, functional, psychological or emotional reasons.

Coverage Table(s) means the table(s) set out on pages 16 to 23 of this **policy** document, and any subsequent changes we make to those **Coverage Tables**.

Dependant means the husband/wife or partner (including any former husband/wife or partner) of the **policyholder** and any **child** and or any **adult** dependant (including any stepchildren or adopted children) of the **policyholder** (or the **policyholder's** husband/wife or partner) who are listed on the **Membership Certificate**.

Detrimental to health means a medical condition that is causing significant problems for the physical health of an individual.

DHB means a District Health Board established under the New Zealand Public Health and Disability Act 2000, or its successor.

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

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

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

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

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

Eligible means those private **healthcare services** which are:

(a) covered under or listed in the **Coverage Tables** and comply with any applicable terms and conditions (including any **eligibility criteria** we may specify from time to time); and
(b) **approved treatment**; and
(c) performed in private practice by a **health services provider** with registration applicable to the **healthcare service**; and
(d) a **healthcare service** for which costs are actually incurred or to be incurred; and
(e) not otherwise excluded under the terms of your **policy**.

Exclusion(s) means conditions, treatments or situations that are not covered by this **policy**, as listed in this **policy** document and/or as specified in the **Membership Certificate**.

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

Health screening means **diagnostic test**(s), investigation(s) or consultation(s) in the absence of any sign or symptom suggesting the presence of the illness, disease or medical condition the screening is designed to detect.

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

Healthcare service(s) means any private surgery or other procedure, treatment, investigation, **diagnostic test**, consultation or other private healthcare service including hospitalisation provided by a **health services provider** or an **approved facility**.

Hospital fees means hospital costs for accommodation, parent accommodation with a **child** in hospital, operating theatre fees, anaesthetic supplies, intensive care and special in-hospital nursing, in-hospital x-rays and ECG, **ancillary hospital charges**, laparoscopic disposables and in-hospital post-operative physiotherapy.

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

Lifetime means the duration of a **policyholder** or **dependant's** relationship with **Southern Cross** whether or not continuous.

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

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

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

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

Membership Certificate is the document we issue to the **policyholder** from time to time which details the key dates in respect of the **policy**, the people covered and the level of cover and plans applicable, the **policyholder's Southern Cross** membership number, any specific **exclusions** from cover for **pre-existing conditions** applicable to the people covered under the **policy** known to **Southern Cross** at the date of issue of the certificate, and any other information specific to the **policy**.

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

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

Operation means all surgical procedures performed under one anaesthetic.

Original date of joining means the most recent date of joining **Southern Cross** for each person covered by the **policy** as shown on the **Membership Certificate**.

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

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

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

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

Policy means the contract between **Southern Cross** and the **policyholder**. The policy comprises the **Membership Certificate**, this policy document (including any document that is incorporated by reference ie **eligibility criteria**), the **List of Prostheses and Specialised Equipment** and any amendment or variation made to them from time to time.

Policy anniversary date means the date specified in the **Membership Certificate**, and:

(a) in relation to a **policy** which is not part of a work scheme or association scheme, each anniversary of the **policy start date**, and is the date from which your **policy** will be renewed for the following year; and
(b) in relation to a **policy** which is part of a work scheme or association scheme, the anniversary of the commencement date of the scheme under which your **policy** is provided and the date from which your **policy** will be renewed for the following year.

Policyholder means the person in whose name the **policy** is issued and who is responsible for the payment of premiums and to whom claims relating to the **policyholder** and any **dependants** are paid.

Policy limits means in relation to any **eligible healthcare service** the maximum amount payable by **Southern Cross** per **operation**, per procedure, per item, per day, per **lifetime**, or as an **annual limit** as specified in the **Coverage Tables** and **List of Prostheses and Specialised Equipment**, or as specified in our contract with an **Affiliated Provider** and advised to you by **Southern Cross** or your **Affiliated Provider** when you seek treatment.

Policy start date means the date your **policy** commences as shown on your **Membership Certificate**.

Policy year means in relation to the first year of the **policy** the period from the **policy start date** to the first **policy anniversary date** and thereafter means the period from one **policy anniversary date** to the next.

Pre-existing condition means any health condition, sign, symptom or event occurring or existing:

(a) in relation to the **policyholder** and each **dependant** named in the Application Form, before the **policy start date**; and
(b) in relation to any **dependant** added to the **policy** after the **policy start date**, before the date the relevant **dependant** was added to the **policy**; and
(c) in relation to any upgrade after the **original date of joining**, before the date of upgrading;

where the **policyholder** or the **dependant** was aware, or ought **reasonably** to have been aware, of the health condition, sign, symptom or event.

Prophylactic healthcare services means **healthcare service(s)** provided in the absence of any relevant sign or symptom suggesting the presence of an illness, disease or medical condition, that seek to reduce or prevent the risk of an illness, disease or medical condition developing in the future.

Prostheses means surgically implanted items, specialised equipment and consumables and donor tissue preparation charges as set out in the **List of Prostheses and Specialised Equipment**.

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

Sector Services means the Ministry of Health agency responsible for prescription authorisations and payment of **Pharmac** benefits.

Southern Cross means Southern Cross Medical Care Society trading as Southern Cross Health Society, having its registered office at Level 1, Ernst & Young Building, 2 Takutai Square, Auckland 1010.

Specialist means a **Medical Practitioner** who is vocationally registered in one of the following scopes:

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

Sports event means involvement in an organised and competitive sporting event or tournament that requires human activity capable of achieving a result requiring physical exertion and/or physical skill which, by its nature and organisation, is competitive and is generally accepted as being a sport.

Treatment injury means a treatment injury as defined in the Accident Compensation Act 2001 (or its successor).

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

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

You/your means the **policyholder** and any **dependant** named on the **Membership Certificate** (unless otherwise specified).

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

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

Southern Cross
Health Society

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