Risk Researcher - One on One Comparison
Health

Provision Analysis

Cancer Treatment		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	B	C
Research Notes	STRENGTHS: + The policy provides up to $200,000 per life Insured per annum for chemotherapy or radiotherapy. LIMITATIONS: - Pharmaceuticals for chemotherapy are limited to those on the PHARMAC Pricing Schedule. COMMENTS: * Following hospitalisation for treatment of cancer, the policy may also provide a benefit of $3,000 for up to 5 consecutive years to cover the cost of any follow up treatment.	STRENGTHS: + Provides unlimited cover for radiotherapy provided in an approved facility. LIMITATIONS: - The policy only provides up to $60,000 per claims year for chemotherapy which must be performed by an affiliated provider. - Pharmaceuticals that do not appear on the PHARMAC subsidised list, may be covered but only up to a maximum of $10,000.
Extract	Cancer Treatment Benefit What we cover We cover the cost of the chemotherapy agent(s), and radiotherapy in an approved private hospital used in a cycle of treatment for cancer including the cost of a registered specialist or health service provider to administer these treatments. Where this policy has an excess, it will be applied to each cycle of chemotherapy, or radiotherapy treatment. Benefit maximum All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Medical Benefit. Other terms * This Benefit does not cover medical treatment that is not managed by a registered specialist. * Where surgery follows within six months of the last cycle of chemotherapy, or radiotherapy treatment, only one excess will apply to that surgery under the Hospital - Surgical Benefit and the chemotherapy and radiotherapy treatment during that six months. Any other excess paid for chemotherapy, or radiotherapy treatment during that six month period will be refunded.	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, parent accommodation allowance, palliative care and treatment allowance, diagnostic imaging, diagnostic tests and specialist consultations. Excess applies to this section. 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. Must be performed by an Affiliated Provider. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year maximum. Please note that not all procedures are available from all Affiliated Providers or in all areas. Includes cost of

	To qualify for reimbursement a cycle of chemotherapy treatment must meet the following definition: A specified number of sequentially administered doses of chemotherapy agent(s) where: * the chemotherapy agent is administered at prescribed intervals within a planned time frame; and * PHARMAC has approved the chemotherapy agent under Sections A to H of the PHARMAC Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and * the chemotherapy agent is prescribed by a registered specialist and administered in New Zealand by an appropriately qualified medical professional. - - - - Hospital - Medical Benefit Benefit maximum We pay up to $200,000 per insured person per policy year for all claims under this Hospital - Medical Benefit, less any excess. - - - - Follow-up Investigation for Cancer Benefit What we cover Following a hospitalisation approved by us for treatment of cancer, we cover one consultation with a registered specialist and one relevant diagnostic investigation relating to the cancer for which the initial treatment had been undertaken per policy year. Benefit maximum We pay up to a maximum of $3,000 per insured person per policy year, less any excess. We pay up to five consecutive policy years. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies).	materials and chemotherapy drugs, hospital accommodation in a single room and ancillary hospital charges. Radiotherapy - Unlimited Must be performed by an Affiliated Provider. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider we will pay 100% of the amount charged by your Affiliated Provider. Please note not all procedures are available from all Affiliated Providers or in all areas, and that a limited range of radiotherapy treatments are funded. 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). - - - - 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 in the Keeping Well and Day-to-day modules. 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 any drug you are prescribed would require a

		special authority from Pharmac if it was being administered in a public facility, you are only entitled to reimbursement of that drug under this policy once you have met that same special authority criteria. The definitions for all the terms can be found on pages 35 to 39 of this policy document.
Dental		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A (Optional Benefit)	A (Optional Benefit)
Research Notes	STRENGTHS: + The policy will reimburse up to 100% of the cost incurred for dental treatment by a registered dental practitioner up to $500 per person per policy year.	STRENGTHS: + 75% of costs incurred up to $750 per policy year for dental treatment, including dental hygenist. COMMENTS: * The above benefits only apply where the Vision and Dental Care Module has been included in the policy.
Extract	[Research Note: The following applies where the Dental and Optical Plan (an additional cost option) has been selected] What we cover The Dental and Optical Option can be added to the Base Cover for an additional premium. Your acceptance certificate or renewal certificate shows whether you have chosen the Dental and Optical Option. This Option provides the Benefits set out below during the policy period for a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). The Dental and Optical Option and the Benefit maximums apply to each insured person shown on your acceptance certificate or renewal certificate, unless stated otherwise in this policy. Stand-down period This Option has a six-month stand-down period before Benefits can be claimed, unless we have agreed otherwise. The medical condition and resulting treatment must first occur after the stand-down period. What we pay We will refund you 80% or 100% of the	[Research Note: The following Vision and Dental care module is an optional extra which can be added to the Wellbeing Two plan] VISION AND DENTAL CARE MODULE: Optical, dental and other benefits Dental consultations and treatment: 75% of expenses up to $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.

	applicable Benefit maximums for each Benefit (if you have selected this Option, refer to your acceptance certificate or renewal certificate for details).The Base Cover excess does not apply to the Dental and Optical Option. Dental Care Benefit What we cover We cover the cost of dental treatment by a registered dental practitioner or oral surgeon, including examination, cleaning and scaling, fillings, associated X-rays and removal of teeth. Benefit maximum We pay up to $500 per insured person per policy year. Other terms * This Benefit excludes treatment for dependent children covered under the school dental service or general dental benefit scheme. * The Benefit excludes the additional cost of gold or other exotic materials.	
Diagnostics		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A	B
Research Notes	STRENGTHS: + The policy provides cover for 11 diagnostic procedures: Arthroscopy, Capsule endoscopy, Colonoscopy, Colposcopy, CT Scan, CT Angiogram, Cystoscopy, Gastroscopy, MRI Scan, Myelogram, PET Scan. + There is no maximum limit. + The benefit is payable whether or not the Insured requires surgery or hospitalisation.	STRENGTHS: + Cover is provided for a large number of tests and diagnostic imaging procedures whether or not the procedure is in relation to surgery or hospitalisation. LIMITATIONS: - Diagnostic imaging is covered up to $60,000 per claims year. COMMENTS: * Cardiac tests are limited to $5,000 per claims year and diagnostic tests are limited to $3,000 per claims year, however, do not contribute to the diagnostic imaging maximum benefit.
Extract	Major Diagnostics Benefit What we cover We will cover the cost of the following diagnostic investigations after referral by a GP or registered specialist, even when the insured person has not been, or will not be, hospitalised for treatment. * Arthroscopy.	DIAGNOSTIC IMAGING Performed at an approved facility. Excess does not apply to this section. Eligibility criteria may apply. Up to $60,000 per claims year (in total) for the following: X-ray - Excludes x-rays performed by a

	* Capsule endoscopy. * Colonoscopy. * Colposcopy. * CT Scan. * CT Angiogram. * Cystoscopy. * Gastroscopy. * MRI Scan. * Myelogram. * PET Scan. Benefit maximum No limit per diagnostic investigation. Where the insured person is not hospitalised, an excess will apply per diagnostic investigation.	dentist. Ultrasound - Excludes obstetrics and varicose veins (legs) treatment. Nuclear scanning (scintigraphy) Myocardial perfusion scan - Must be referred by a Specialist in private practice. IMAGING THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following imaging must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas Mammography CT angiogram 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. TESTS Excess does not apply to this section. Eligibility criteria may apply On referral by a Specialist in private practice and in an approved facility. Must be performed within six months before or after related eligible surgery to be entitled to cover under Wellbeing One. Cardiac tests - $5,000 per claims year (in total) Diagnostic tests - $3,000 per claims year (in total)

		TESTS THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. 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 (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Cardiac tests Advanced electrocardiogram (A-ECG) Diagnostic tests Optical Coherence Tomography Heidelberg Retinal Tomography (HRT) GDx Retinal scanning Fundus fluorescein angiography Fundus photography Visual fields Corneal topography Retinal photography Optic disc photos Matrix screen Intraocular pressure test (IOP) Laboratory tests 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 Wellbeing One - No cover Wellbeing Two - $70 per claims year
General Medical Expenses		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	B (Optional Benefit)	A (Optional Benefit)
Research Notes	STRENGTHS: + The policy provides up to $55 per GP clinic visit and $80 per GP home visit. + The policy provides up to $30 per visit to/by an independent nurse or nurse practitioner. + Physiotherapy after referral from a GP is covered up to $40 per visit and $400 per policy year. + The policy provides up to $300 per policy year for prescriptions. LIMITATIONS: - However, prescription cover is limited to $15 per script. - Only 12 GP visits and 6 nurse consultations	STRENGTHS: + The policy provides up to $65 per GP consultation. + The policy provides up to $30 per visit to/by a registered nurse. + The policy provides up to $600 per claims year for prescriptions. + Physiotherapy is covered up to $300 per policy year. COMMENTS: * This benefit only applies where the Day to Day care module is included in the policy.

	are covered per annum. COMMENTS: * The policy also provides a Pre-existing cover for Newborns Benefit when a dependant child is added to the policy within four months of birth.	
Extract	[Research Note: This benefit is an optional benefit that requires the payment of an additional premium] GP Option Introduction What we cover The GP Option can be added to the Base Cover for an additional premium. Your acceptance certificate or renewal certificate shows whether you have chosen the GP Option. This Option provides the Benefits set out below during the policy year for each insured person for that insured person's medical conditions (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). Stand-down period The GP Option has a 90-day stand-down period before Benefits can be claimed, unless we have agreed otherwise. The medical condition and resulting treatment must first occur after the stand-down period. What we pay We will refund you 80% or 100% of the applicable Benefit maximums for each Benefit (if you have selected the GP Option, refer to your acceptance certificate or renewal certificate for details). The Base Cover excess does not apply to the GP Option. General Practitioners Benefit What we cover We cover the cost of GP visits, including home visits, ECG, cervical smears and minor surgery under local anaesthetic. Benefit maximum We pay up to $55 per GP clinic visit, including after hours.	[Research Note: The following Day to Day care module is an optional extra which can be added to the Wellbeing Two plan] Day-to-day Module - day-to-day medical care Can be added to Wellbeing Two plan only. Annual health check - $90 per claims year: Performed by a General Practitioner or Specialist. Flu Vaccination - One vaccination per claims year General Practitioner - $65 per consultation 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 - $300 per claims year: Performed by a physiotherapist registered with the Physiotherapy Board of New Zealand. Includes acupuncture and manipulations.

	We pay up to $80 per home visit. We pay up to $25 per visit for ACC Top-up. You cannot use the $55 / $80 per clinic / home visit Benefit to add to this. We pay up to 12 GP visits per insured person per policy year. Minor surgical procedures are not counted in the 12 visits. We pay up to $200 per minor surgical procedure. You cannot use the $55 / $80 per clinic / home visit Benefit to add to this. Prescription Benefit What we cover We cover the cost of medicines and drugs listed under Sections A to H of the Ministry of Health PHARMAC Pharmaceutical Schedule prescribed by a GP or registered specialist that meet the eligibility criteria for funding. Benefit maximum We pay up to $15 per item. We pay up to $300 per insured person per policy year. Other terms * This excludes after hours fees. * You must submit pharmacist receipts stating the name of the patient, prescription number, the name of the medication prescribed and the cost of each item. The reason for the medication must be stated on the claim form. * Any claim for reimbursement of prescription costs must relate to the insured person, regardless of whether the insured person paid the account or bill. * We will only reimburse the cost of the prescription. We will not reimburse administration costs (for example faxing costs incurred between the prescribing GP, registered specialist or pharmacy). Physiotherapy Benefit What we cover We cover the cost of physiotherapy treatment after referral by a GP or registered specialist. Benefit maximum	

	We pay up to $40 per visit. We pay up to $15 per visit for ACC Top-up. You cannot use the $40 per visit Benefit to add to this. We pay up to $400 per insured person per policy year. Independent Nurse and Nurse Practitioner Benefit What we cover We cover the cost of visits to / by an independent nurse or nurse practitioner. Benefit maximum We pay up to $30 per visit. We pay up to six visits per insured person per policy year. Loyalty Benefit - Active Wellness What we cover After 24 months' continuous cover under the GP Option, and at the end of every 24 months thereafter, providing claims for events that occurred within the preceding 24 month period under the GP Option are less than $150, each insured person aged 21 or over will receive a reimbursement towards the cost of either: * membership to a recognised gym or sports club; or * sports / fitness equipment purchased from a recognised sporting retailer. If you submit a claim for events which occurred within the preceding 24-month period after this Benefit has been paid, we will deduct the amount paid to you for this Active Wellness Benefit from the claim. Benefit maximum We pay up to $150 per insured person, aged 21 or over, after each 24 months of continuous cover under the GP Option. Other terms * Receipts or evidence of membership should be submitted at time of claim. * The Benefit must be taken in the policy year after entitlement and cannot be accumulated over subsequent years. * This Benefit does not apply to dependent children.	

	* Once a dependent child reaches age 21, this Benefit is available to him or her and the period of 24 months of continuous cover begins on the policy anniversary date, on or immediately after that insured person reaches age 21 if that insured person remains on this policy, or from the commencement date of that insured person's own policy. * If cover is suspended, the suspended period is included when calculating the 24 months' continuous cover. * Where an insured person is added to this policy, each period runs from that insured person's join date. - - - - Adding a newborn to your health policy If you add a dependent child within four months of birth, we will cover that child for pre-existing conditions, other than a known congenital medical condition or the standard policy exclusions.	
General Surgery		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A	A
Research Notes	STRENGTHS: + The policy provides up to $300,000 per life Insured per policy year. + The benefit covers all costs associated with the surgery during hospital admission.	STRENGTHS: + The policy provides an unlimited amount per operation subject to prostheses and specialised equipment maximums. + The benefit covers all costs associated with the surgery during hospital admission.
Extract	Hospital - Surgical Benefit What we cover We cover the cost of major surgery requiring an anaesthetic in an approved private hospital in relation to a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). This includes (for example, without limitation): general and cancer surgery, cardiac surgery, orthopaedic surgery, laparoscopic surgery, oral surgery, angiography, angioplasty, dilation and curettage, and lithotripsy. We also cover the cost of associated intensive nursing care, X-rays, disposables and consumables, dressings, and drugs listed under Sections A to H of the PHARMAC Pharmaceutical Schedule, where they meet PHARMAC's funding criteria, arising from that surgery. Benefit maximum	SURGICAL TREATMENT Eligibility criteria may apply. Surgical procedures - $500,000 per claims year: Performed by a Specialist or Affiliated Provider contracted for that healthcare service in an approved facility. Surgeon's operating fee/s Anaesthetist's fee/s Intensivist's fee Hospital fees Surgically implanted prostheses and specialised equipment - Maximums apply: Refer to the List of Prostheses and Specialised Equipment. Cardiac surgery - $100,000 per claims year: Performed by a Specialist or Affiliated Provider contracted for that healthcare service in an approved facility. Surgeon's operating fee/s

	We pay up to a maximum of $300,000 per insured person per policy year for all claims under this Hospital-Surgical Benefit, less any excess. This Benefit maximum also applies to the associated cover available under the following Benefits: Specialist Consultations Benefit; Hospital Related Diagnostics Benefit; Major Diagnostic Benefit; Follow-up Investigation for Cancer Benefit; Ambulance Transfer Benefit; Travel and Accommodation Benefit; Parent Accommodation Benefit; Physiotherapy Benefit; Therapeutic Care Benefit; Home Nursing Care Benefit; Cover in Australia Benefit; ACC Top-up Benefit. Individual limits for these Benefits may also apply. Other terms * This Benefit does not cover surgery that is not performed by a registered specialist. * This Benefit does not cover skin lesion surgery (except for melanoma). Cover for skin lesion surgery is provided under the Specialist Skin Lesion Surgery Benefit (refer to Benefit 20). 2.4 Prostheses costs We cover certain prosthesis costs (replacement implants only) up to fixed specified maximums set by us. A prosthesis schedule specifies the prostheses which have a specified maximum applicable. The prostheses schedule is reviewed annually and is available from our website or from us on request. The cost of prostheses is included in the Benefit maximum. Oral surgery * We only cover the cost of oral surgery if it is performed by a registered oral or maxillofacial surgeon. * We only cover the cost of removal of unerupted and impacted teeth if a registered oral surgeon or registered dentist performs the procedure. * A 12-month stand-down period from the join date of each insured person applies to the extraction of wisdom teeth. * We do not cover any other dental treatments, including periodontal, orthodontic and endodontal procedures, implants and orthognathic surgery. Cover may be available under the Dental and Optical Option if you have selected that Option.	Anaesthetist's fee/s Intensivist's fee Perfusionist's charges Hospital fees Surgically implanted prostheses and specialised equipment - Maximums apply: Refer to the List of Prostheses and Specialised Equipment. SURGICAL TREATMENT THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following surgical treatments must be performed by an Affiliated Provider to be eligible for cover under your policy. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged up to policy limits. To receive cover the surgical treatment must meet applicable eligibility criteria. Please be aware that not all surgical treatments are available from all Affiliated Providers or in all areas. Cardiac: Coronary artery bypass graft surgery (CABG), valve replacement, valvuloplasty, Bentall's procedure, coronary angiogram and/or angioplasty, electrophysiology studies, ablation of cardiac arrhythmias, percutaneous patent foramen ovale (PFO) closure, percutaneous atrial septal defect (ASD) closure, transcatheter aortic valve implantation/replacement (TAVI/TAVR), left atrial appendage occlusion. Gastroenterology: Gastroscopy, colonoscopy, balloon enteroscopy, wireless pH capsule and wireless capsule endoscopy, endoscopic ultrasound, contrain biofeedback and electrostimulation for faecal incontinence, sacral nerve stimulation for faecal incontinence (no reimbursement will be made towards the cost of the stimulation device used to treat faecal incontinence). General surgery Cholecystectomy: Open and laparoscopic cholecystectomy. Hernia: Femoral, hiatus, inguinal and umbilical hernia repair. Skin lesion removal: See skin surgery benefit. Lung and chest: Microwave ablation of lung tumours, endoscopic ultrasound. Neurosurgery: Endoscopic third ventriculostomy.

	Varicose vein surgery We will cover varicose vein surgery if the surgery is performed by a registered specialist, vocational GP or medical practitioner who is registered with the Medical Council of New Zealand and a fellow of the Australasian College of Phlebology.	Ophthalmology: Posterior vitrectomy, entropion and ectropion repair, upper eyelid blepharoplasty, correction of ptosis, removal of tarsal cyst, probing/syringing of lacrimal passage, bleb needling, minor eyelid surgery, cataract surgery (cover is limited to the surgical insertion of a standard monofocal intraocular lens only, there is no cover for the additional cost of any other type of surgically implanted intraocular lens or associated costs), excision of pterygium, excision of pinguecula, YAG laser capsulotomy, laser iridotomy, laser iridoplasty, laser trabeculoplasty, cyclodiode laser cyclophotocoagulation, photocoagulation of the retina, pan retinal laser, macular laser, corneal crosslinking, intravitreal injections (cover for drug costs is limited to $100 per injection regardless of the type of drug used). Oral and maxillofacial: Tooth extraction. Orthopaedic directly required for the treatment of cancer: Synthetic ligament repair and reconstruction. Otolaryngology Ear: Insertion and/or removal of grommets in theatre, aural toilet, KTP laser mastoidectomy, KTP laser revision mastoidectomy, KTP laser tympanoplasty, KTP laser second look tympanoplasty, KTP laser middle ear adhesiolysis, KTP laser stapedectomy, KTP laser medial canalplasty, and KTP laser myringotomy. Nose: Balloon sinuplasty, endoscopic modified Lothrop, functional endoscopic sinus surgery (FESS), septoplasty, nasal cautery. Throat: Adenoidectomy, tonsillectomy, laser treatment for pharyngeal, laryngeal and oesophageal conditions, transoral robotic surgery. Urology directly required for the treatment of cancer: Resection of bladder tumour, ureteroscopy, laparoscopic renal cryotherapy, nephrectomy, robotic partial nephrectomy. Prostate directly required for the treatment of cancer: Laparoscopic prostatectomy, prostate brachytherapy, external beam radiotherapy, prostate cryotherapy, radical retropubic prostatectomy, perineal prostatectomy, transurethral resection of prostate (TURP), open enucleation of prostate, laser resection of prostate, robotic assisted laparoscopic prostatectomy, prostate biopsy.

		Vascular: Peripheral angiogram and/or angioplasty, varicose vein (legs) treatment via endovenous laser treatment, ultrasound guided sclerotherapy, varicose vein surgery, endovenous radiofrequency (RF) ablation, duplex vein mapping, (cover is limited to 2 varicose vein procedures per leg per lifetime), superficial vascular malformation sclerotherapy and embolisation - simple (cover is limited to 2 procedures per vascular malformation per lifetime).
Hospital Medical Benefits		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A	C
Research Notes	STRENGTHS: + The policy provides up to $300,000 per life Insured per annum for costs associated with hospitalisation that does not result in surgery.	LIMITATIONS: - The benefit only provides $700 per night up to $60,000 per policy year for hospital accommodation. - Additionally only $200 per claims year is provided for ancillary hospital charges. COMMENTS: * The policy provides cover on a per night basis. This approach is considered less flexible than a policy which provides an overall maximum for all costs associated with non-surgical hospitalisation.
Extract	Hospital - Medical Benefit What we cover We cover the cost of medical treatment (not involving surgery) in an approved private hospital in relation to a medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). This includes (for example, without limitation): heart disease, treatment of respiratory disease (for example asthma, pneumonia) and treatment for endocrine disease (for example diabetes). We also cover the cost of associated intensive nursing care, X-rays, disposables and consumables, dressings and drugs listed under Sections A to H of the PHARMAC Pharmaceutical Schedule where they meet PHARMAC's funding criteria arising from that medical treatment. Benefit maximum We pay up to $200,000 per insured person per policy year for all claims under this Hospital - Medical Benefit, less any excess.	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, rehabilitation, geriatric care, hospice and psychiatric hospitalisation. 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 day stay Ancillary hospital charges - $200 per claims year

	This Benefit maximum also applies to the associated cover available under the following Benefits: Cancer Treatment Benefit; Specialist Consultations Benefit; Hospital Related Diagnostics Benefit; Major Diagnostic Benefit; Follow-up Investigation for Cancer Benefit; Ambulance Transfer Benefit; Travel and Accommodation Benefit; Physiotherapy Benefit; Therapeutic Care Benefit; Home Nursing Care Benefit; Cover in Australia Benefit; ACC Top-up Benefit. Individual limits for these Benefits may also apply. Other terms * This Benefit does not cover medical treatment that is not managed by a registered specialist. * This Benefit does not cover medical treatment where the sole or main purpose of the medical treatment is administration of an injection, for example without limitation, intravitreal injections or pain management injections (except where the contrary is expressly specified in this policy).	Allergy services - $750 per claims year - Provided by or under the care of an Affiliated Provider. Cover for allergy related healthcare services including allergy testing and desensitisation. Excludes the cost of non-Pharmac approved drugs.
Optical		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	B (Optional Benefit)	B (Optional Benefit)
Research Notes	LIMITATIONS - The policy will reimburse the costs incurred for glasses and contact lenses up to $330 per policy year. - The policy will reimburse the costs incurred for Optometrist, Optician and Orthoptist consultations up to $55 per contulations or $275 per policy year.	STRENGTHS: + Cover is provided for $50 per consultation for Optometrists and $200 per year for Orthoptists. + This policy will also cover 75% of the cost of prescription glasses, sunglasses and contact lenses up to $500 per claims year. COMMENTS: * The above benefits only apply where the Vision and Dental Care Module has been included in the policy.
Extract	[Research Note: The following applies where the Dental and Optical Plan (an additional cost option) has been selected] What we cover The Dental and Optical Option can be added to the Base Cover for an additional premium. Your acceptance certificate or renewal certificate shows whether you have chosen the Dental and Optical Option. This Option provides the Benefits set out below during the policy period for a medical condition (for medical conditions that are not	[Research Note: The following Vision and Dental care module is an optional extra which can be added to the Wellbeing Two plan] Vision and Dental Module - vision, dental and other benefits Can be added to Wellbeing Two plan only. Prescription glasses, sunglasses and contact lenses - 75% of expenses incurred up to $500 per claims year: Prescription glasses/sunglasses (frames and lenses) and contact lenses for change of vision, replacement for loss or breakage when

	covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). The Dental and Optical Option and the Benefit maximums apply to each insured person shown on your acceptance certificate or renewal certificate, unless stated otherwise in this policy. Stand-down period This Option has a six-month stand-down period before Benefits can be claimed, unless we have agreed otherwise. The medical condition and resulting treatment must first occur after the stand-down period. What we pay We will refund you 80% or 100% of the applicable Benefit maximums for each Benefit (if you have selected this Option, refer to your acceptance certificate or renewal certificate for details).The Base Cover excess does not apply to the Dental and Optical Option. Eye Care Benefit What we cover We cover the cost of optometrist, orthoptist and optician examination fees and the cost of glasses and contact lenses when these are required as a result of a vision change. Benefit maximum We pay up to $55 per consultation / examination. We pay up to $275 per insured person per policy year for consultations / examinations. We pay up to $330 per insured person per policy year for each insured person for glasses and contact lenses. Other terms * We do not cover the cost of changing glasses and contact lenses for fashion reasons. * We only cover the cost of treatment by an orthoptist on referral by an optometrist, GP or registered specialist. * We require written confirmation from the insured person's optometrist that the consultation, examination, glasses or contact lenses are required as a result of a vision change.	prescribed by a registered ophthalmologist, optometrist, or optician. Optometrist - $50 per claims year: Consultations with an optometrist registered with the New Zealand Optometrists and Dispensing Opticians Board. Orthoptist - $200 per claims year: Treatment by a registered orthoptist.

Pre & Post Surgery/Hospitalistion Cover		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A	B
Research Notes	STRENGTHS: + All specialist consultations and diagnostic testing procedures are covered in the six months prior to and following surgery/hospitalisation. + There is no benefit limit.	STRENGTHS: + Specialist consultations and diagnostic tests are covered under the Diagnostic imaging, Tests and Consultations sections. + There is no time frame in which the consultation or test must take place. LIMITATIONS: - Each test and consultation has a low individual maximum which is claimable per consultation or year.
Extract	Specialist Consultations Benefit What we cover We cover the cost of registered specialist or vocational GP consultations up to six months prior to admission to an approved private hospital and up to six months after being discharged from that approved private hospital in relation to a medical condition where the consultation directly relates to the medical condition, after a referral from a GP or a registered specialist. Benefit maximum No limit per consultation. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Other terms We do not cover the cost of registered specialist or vocational GP consultations that do not relate to a medical condition covered under the Hospital - Surgical Benefit or Hospital - Medical Benefit or does not occur within the six months prior or six months following such a medical condition. Cover may be available under the Specialist Option if you have selected that Option. Hospital Related Diagnostics Benefit What we cover We cover the cost of any diagnostic investigation (such as X-rays, ultrasound, mammogram, echocardiograms, visual field tests), up to six months prior to admission to	DIAGNOSTIC IMAGING Performed at an approved facility. Excess does not apply to this section. Eligibility criteria may apply. Up to $60,000 per claims year (in total) for the following: X-ray - Excludes x-rays performed by a dentist. Ultrasound - Excludes obstetrics and varicose veins (legs) treatment. Nuclear scanning (scintigraphy) Myocardial perfusion scan - Must be referred by a Specialist in private practice. IMAGING THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following imaging must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas Mammography CT angiogram 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.

	an approved private hospital and up to six months after being discharged from that approved private hospital, where those diagnostic investigations directly relate to a medical condition after a referral from a GP or a registered specialist. Benefit maximum No limit per diagnostic investigation. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Other terms We do not cover the costs of diagnostic investigations that do not relate to a medical condition covered under the Hospital - Surgical Benefit or Hospital - Medical Benefit or does not occur within the six months prior or six months following such a medical condition (except where the contrary is expressly specified in this policy).	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. TESTS Excess does not apply to this section. Eligibility criteria may apply On referral by a Specialist in private practice and in an approved facility. Must be performed within six months before or after related eligible surgery to be entitled to cover under Wellbeing One. Cardiac tests - $5,000 per claims year (in total) Diagnostic tests - $3,000 per claims year (in total) TESTS THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. 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 (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Cardiac tests Advanced electrocardiogram (A-ECG) Diagnostic tests Optical Coherence Tomography Heidelberg Retinal Tomography (HRT) GDx Retinal scanning Fundus fluorescein angiography Fundus photography Visual fields Corneal topography Retinal photography Optic disc photos Matrix screen Intraocular pressure test (IOP) Laboratory tests 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 Wellbeing One - No cover Wellbeing Two - $70 per claims year CONSULTATIONS Excess does not apply to this section. Eligibility criteria may apply. Excess does not apply to this section. Eligibility criteria may apply Specialist consultations - $5,000 per claims year (in total): Must be performed by an Affiliated Provider. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. Consultations with an oncologist are not subject to this rule. Excludes psychiatrist consultations. Psychiatrist consultations - $750 per claims year: Must be performed by an Affiliated Provider vocationally registered in psychiatry. Dietitian consultations - $100 per consultation up to $500 per claims year: Consultations with a dietitian registered with the New Zealand Dietitian Board. On referral by a Specialist in private practice. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One.
Pre-Existing Conditions		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A	B
Research Notes	STRENGTHS: + Cover for pre-existing conditions is provided, however all conditions must be disclosed at the time of application.	LIMITATIONS: - Pre-existing conditions are excluded including but not limited to conditions specifically set out in the Membership Certificate. COMMENTS: * Southern Cross allow for reviews of pre-existing conditions, however, the removal of an exclusion is at the total discretion of Southern Cross
Extract	1.1 We will not provide any cover under any of the Benefits in respect of: j) Any pre-existing condition as determined by us, this exclusion does not apply: - To any medical condition declared on the	Exclusions No reimbursement or payment shall be made for any costs incurred in relation to, or as a consequence of, any of the following:

	application form and accepted by us - Where it is noted on the acceptance certificate or renewal certificate that pre-existing conditions are covered, but subject to the other exclusions in this policy and any special terms on the acceptance certificate or renewal certificate - To the Benefits covered under the Proactive Health Option	* 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, crutches; * Breast reduction except as specifically provided by the bilateral breast reduction allowance; * Chronic conditions; * Congenital conditions except for 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; * Gender reassignment surgery and directly related healthcare services; * Gynaecomastia; * Health screening except as specifically provided by mammography (under diagnostic imaging) and colonoscopy (under gastroenterology in Affiliated Provider surgical treatment) benefits; * Healthcare services performed by a dentist, periodontist, endodontist or orthodontist except as specifically provided by the Keeping Well and Vision and Dental modules; * 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 36 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 Keeping Well and Vision and Dental modules; * 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 under the Day-to-day Module) 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 and psychiatric hospitalisation benefits, and by the Keeping Well Module; * Obesity except as specifically provided by the gastric banding / bypass allowance and the Body Care Module; * Organ transplants, transfusions/injections of autologous blood/blood products (except cellsaver 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 except as specifically provided by the robotic prostatectomy, robotic partial nephrectomy and transoral robotic surgery benefits; * Self-inflicted illness or injury; * Sterilisation except as specifically provided by the sterilisation benefit or its reversal; * Subsequent breast reconstruction 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 Keeping Well and Vision and Dental modules; * Surgically implanted lens(es) other than monofocal lens(es); * Termination of pregnancy; * Treatment of any condition not detrimental to health except as specifically provided by the Keeping Well and Day-to-day modules; * Vaccination except as specifically provided by the Keeping Well and Day-to-day modules. Review of pre-existing conditions For some pre-existing conditions which have been excluded from cover, you can request a review of that exclusion after the person affected by that pre-existing condition has had continuous cover under the policy for a specified period of time. If the review procedure applies to you, your Membership Certificate will state the review period which applies to that excluded pre-existing condition. The review period commences from the date the exclusion was applied. If we do not offer cover for the excluded pre-existing condition after the first review you can request further reviews after time intervals equivalent to the review period. A review is initiated when either the policyholder or the dependant affected by the excluded pre-existing condition asks us to conduct the review (following the expiry of the relevant review period). The person requesting the review must supply us with appropriate medical and other documentation. The decision as to whether the excluded pre-existing condition will be removed as an exclusion will be made by Southern Cross, acting reasonably.
Specialist Option		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	A (Optional Benefit)	B (Optional Benefit)

Research Notes	STRENGTHS: + Unlimited cover is provided for specialist consultations upon referral from a GP. + Diagnostic radiology and imaging tests are covered for up to $3,000 per policy year. + Up to $60,000 per policy year will be provided for cardiac investigations in response to a preliminary diagnosis. + The policy also provides a Pre-existing cover for Newborns Benefit when a dependent child is added to the policy within four months of birth.	STRENGTHS: + Cover is provided for Specialist consultations for up to $5,000 per policy year. + Diagnostic imaging tests are covered for up to $60,000 per policy year. + Up to $5,000 per year is available for Cardiac Tests and $3,000 for Diagnostic Tests. + Osteopathy, Naturopathy, Homeopathy, Chiropractic, Acupuncture and massage therapy can be covered as an optional benefit for up to a total of $500 per claims year. LIMITATIONS: - However, specialist consultations (except those covered under the optional Body Care module), diagnostic imaging and tests are only covered if performed within 6 months of related surgical treatment or cancer care.
Extract	[Research Note: This benefit is an optional benefit that requires the payment of an additional premium] Specialist Option Introduction What we cover The Specialist Option can be added to the Base Cover for an additional premium. Your acceptance certificate or renewal certificate shows whether you have chosen the Specialist Option. The Specialist Option provides the Benefits set out below during the policy year for each insured person for that insured person's medical condition (for medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate). Benefits under the Specialist Option apply to each insured person shown on your acceptance certificate or renewal certificate, unless stated otherwise in this policy. It is highly recommended that you obtain pre-approval before an insured person visits a registered specialist or undergoes any diagnostic investigations. What we pay We will refund you up to the applicable Benefit maximums for each Benefit. The Base Cover excess does not apply to the Specialist Option. Specialist Consultations Benefit	DIAGNOSTIC IMAGING - MUST BE PERFORMED BY AN AFFILIATED PROVIDER All Diagnostic imaging must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $60,000 per claims year (in total) listed below. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Excess does not apply to this section. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. $60,000 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.

	What we cover We cover the cost of registered specialist or vocational GP consultations, after referral by a GP or registered specialist, even when the insured person has not been, or will not be, hospitalised. If consultations result in hospitalisation in an approved private hospital within six months of the consultation, the cost of the consultation will be covered under the Base Cover and is included within the applicable Benefit maximum. Benefit maximum No limit per consultation. No limit per insured person per policy year. General Diagnostics Benefit What we cover We cover the cost of diagnostic investigations after referral by a GP or registered specialist, even when the insured person has not been, or will not be, hospitalised for treatment. This includes (for example, without limitation) X-rays, arteriogram, ultrasound, scintigraphy, mammogram, visual field tests. Benefit maximum We pay up to $3,000 per insured person per policy year. Other terms If any of the diagnostic investigations result in hospitalisation to an approved private hospital within six months of the diagnostic investigation, the cost of the diagnostic investigation will be covered under the Base Cover and is included within the applicable Benefit maximum. Cardiac Investigations Benefit What we cover We cover the cost of cardiac investigations after referral from a GP or a registered specialist, even when the insured person has not been, or will not be, hospitalised. Investigations such as treadmills, holter monitoring, ambulatory blood pressure monitoring, cardiovascular ultrasound, echocardiography, myocardial perfusion scans	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 Excess does not apply to this section. Eligibility criteria may apply Cardiac tests - $5,000 per claims year (in total): On referral by a Specialist in private practice. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. ALL CARDIAC TESTS MUST BE PERFORMED BY AN AFFILIATED PROVIDER All cardiac tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $5,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. The following cardiac tests are covered under this benefit: Advanced electrocardiogram (A-ECG) Resting ECG Exercise ECG Holter monitoring Echocardiogram Stress echocardiogram Dobutamine stress echocardiogram Transoesophageal echocardiogram (TOE) Diagnostic tests - $3,000 per claims year (in total): On referral by a Specialist in private practice and in an approved facility. Must be performed within 6 months of related eligible surgical treatment or cancer care to

	and cardioversion are included. Benefit maximum We pay up to $60,000 per insured person per policy year. Other terms If these cardiac investigations result in hospitalisation to an approved private hospital within six months of the investigation, the cost of the cardiac investigation will be covered under the Base Cover and is included within the applicable Benefit maximum.	be entitled to cover under Wellbeing One. For a list of all diagnostic tests covered under this benefit please see the definition of diagnostic tests on page 36. DIAGNOSTIC TESTS THAT MUST BE PERFORMED BY AN AFFILIATED PROVIDER The following diagnostic tests must be performed by an Affiliated Provider and meet applicable eligibility criteria. Unless you are advised otherwise by Southern Cross and/or your Affiliated Provider, we will pay 100% of the amount charged by your Affiliated Provider up to the $3,000 per claims year (in total) listed above. Please be aware that not all procedures are available from all Affiliated Providers or in all areas. Ambulatory blood pressure monitoring Breath nitric oxide test Corneal topography Fundus fluorescein angiography Fundus photography GDx Retinal scanning Heidelberg Retinal Tomography (HRT) Intraocular pressure test (IOP) Matrix screen Optical Coherence Tomography (OCT) Optic disc photos Visual fields Retinal photography Laboratory tests 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. Wellbeing One: No cover Wellbeing Two: $70 per claims year CONSULTATIONS Excess does not apply to this section. Eligibility criteria may apply. Specialist consultations - $5,000 per claims year (in total) Must be performed by an Affiliated Provider. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. Consultations with an oncologist are not

		subject to this rule. Excludes psychiatrist consultations. Psychiatrist consultations - $750 per claims year: Must be performed by an Affiliated Provider vocationally registered in psychiatry. Dietitian consultations $100 per consultation up to $500 per claims year: Consultations with a dietitian registered with the New Zealand Dietitian Board. On referral by a Specialist in private practice. Must be performed within 6 months of related eligible surgical treatment or cancer care to be entitled to cover under Wellbeing One. [Research Note: The following Body Care module is an optional extra which can be added to the Wellbeing One plan] Body Care Module - preventative, allied and natural healthcare services Can be added to Wellbeing One or Wellbeing Two plans. Dietitian or nutritionist - $250 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 - $250 per claims year: Performed by a podiatrist registered with the Podiatrists Board of New Zealand. Cover for the following alternative healthcare services is limited to $500 per claims year in total: Acupuncturist: Performed by an acupuncturist registered with Acupuncture New Zealand, the NZ Acupuncture Standards Authority (NZASA) or the NZ Chinese Medicine and Acupuncture Society (NZCMAS). Chiropractor or osteopath: Performed by a chiropractor registered with the New Zealand Chiropractic Board or by an osteopath registered with the Osteopathic Council of New Zealand. Excludes the cost of medication. Homeopath or naturopath: Performed by a homeopath registered with the New Zealand Council of Homeopaths or by a naturopath registered with the New Zealand Society of Naturopaths or the Naturopaths of New Zealand Inc. Excludes the cost of medication. Registered massage therapist: Performed by a Registered Massage Therapist level 6 or

		higher registered with Massage New Zealand.
ACC Top Up		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	Yes
Research Notes	STRENGTHS: + The policy provides an ACC top up benefit which will cover any shortfall between ACC payments and actual costs for surgical/medical treatment.	STRENGTHS: + The policy provides an ACC top up benefit which will cover any shortfall between ACC payments and actual costs for surgical/medical treatment, subject to the policy limits.
Extract	ACC Top-up Benefit What we cover We cover any shortfall between what ACC pays for a physical injury and the actual costs incurred for the surgical and / or medical treatment in an approved private hospital, less any excess. This is limited to the applicable Benefit maximum, less any excess. A copy of ACC's decision must be supplied to us prior to treatment being undertaken. Benefit maximum All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies) Other terms * An insured person must obtain ACC's acceptance of their claim prior to the treatment being performed, and provide us with evidence of ACC's acceptance of their claim and the amount payable by ACC in respect of that treatment. * We may require an insured person to apply for a review of ACC's decision. You must reimburse us for any cost subsequently covered by ACC as a result of the review. We may request your permission to seek legal advice at our cost to address the review of ACC's decision.	HOW DOES MY SOUTHERN CROSS POLICY FIT WITH ACC? Your Wellbeing 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. 1. 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. 2. ACC cover your claim. ACC cover the costs in part then you can make a claim for the balance only under your policy. 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. Day-to-day treatment, consultations, imaging and diagnostics claims will be assessed in accordance with the chart on page 6. 3. 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.* [If] 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. 4. ACC do not cover 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. 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.
Funeral Benefit		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	No
Research	STRENGTHS:	LIMITATIONS:

Notes	+ Provides a benefit of $3,000 to assist with funeral expenses.	- The policy does not provide a funeral benefit.
Extract	Funeral Support Grant What we cover We make a cash payment when an insured person dies between the age of 16 and 64 (inclusive). This grant is payable to the policyowner or the policyowner's estate. Benefit maximum We pay $3,000 in respect of that insured person. Other terms * No excess will be deducted from the Funeral Support Grant. * When claiming for a Funeral Support Grant, please provide the original death certificate or a certified copy of the similar documentation acceptable to us.	[Research Note: The policy contains no specific provision directly relevant to this criterion]
Home Nursing Benefit		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	a	b
Research Notes	STRENGTHS: + Post hospital admission nursing care is provided for up to $150 per day for a maxmium of $6,000 per year. + The benefit is available up to six months after being discharged from an approved private hospital on referral by a GP or specialist.	STRENGTHS: + Post-surgery nursing care is provided for up to $175 per day for a maxmium of $2,800 per year (16 days at $175 per day). LIMITATIONS: - The benefit is available for only 14 days after related surgery or cancer treatment.
Extract	Home Nursing Care Benefit What we cover We cover the cost of home nursing care posthospitalisation by a registered nurse, up to six months after being discharged from an approved private hospital, on referral by a GP or registered specialist. Benefit maximum We pay up to $150 per day. We pay up to $6,000 per insured person per policy year. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies).	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.

	Other terms All accounts presented to us for payment must show the qualifications of the home nurse, dates of visits and fees charged. A GP or registered specialist letter stating the reason why home nursing care is required and the length of time for which it is required must be submitted with the claim.	
Medical Misadventure		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	No	No
Research Notes	LIMITATIONS: - The policy does not provide a Medical Misadventure benefit.	LIMITATIONS: - The policy does not provide a Medical Misadventure benefit.
Extract	[Research Note: The policy contains no specific provision relevant to this criterion]	[Research Note: The policy contains no specific provision directly relevant to this criterion]
Minor Surgery		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	Yes
Research Notes	STRENGTHS: + The policy provides a Minor Surgery benefit for up to $750 per year.	STRENGTHS: + The policy provides a Minor Surgery benefit of up to $1,000 per operation.
Extract	GP Minor Surgery Benefit What we cover We cover the cost of treatment for minor surgery, performed by a GP. Benefit maximum We pay up to $750 per insured person per policy year, less any excess. Other terms We recommend pre-approval as some GP minor surgery is deemed cosmetic surgery and is not covered. This Benefit does not include any GP consultation costs. Specialist Skin Lesion Surgery Benefit What we cover We cover the cost of treatment for skin lesion surgery performed by a registered specialist,	GP minor surgery: $1,000 per claims year Performed by a General Practitioner. Excludes consultations and skin lesion services.

	on referral from a GP. Benefit maximum We pay up to $6,000 per insured person per policy year, less any excess. Other terms * We recommend pre-approval as some surgery is deemed cosmetic surgery and is not covered. * This Benefit includes cover for one pre-surgery registered specialist consultation for skin lesions. * This Benefit does not cover cryotherapy, pulse light therapy and photodynamic therapy.	
Non-PHARMAC Benefit (All Conditions)		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes (Optional Benefit)	No
Research Notes	STRENGTHS: + The policy provides an optional benefit that covers the costs associated with accessing Non-PHARMAC subsidised treatment up to the maximum limit selected under the Non-PHARMAC Plus Option. COMMENTS: * The Insured has the choice of yearly maximum limits of either $20K, $50K, $100K, $200K or $300K.	LIMITATIONS: - Non-PHARMAC subsided drugs are only covered for Chemotherapy (see Cancer Treatement provision for more information).
Extract	*[Research Note: the following is an optional benefit offered at additional cost]* **Non-PHARMAC Plus Option** This should be read together with your: - Policy document: the terms of your policy still apply. If any of them are inconsistent with this option, then the terms of this option apply. For example, if your policy document has an exclusion for non-PHARMAC funded drugs, it will not apply to this option. Any words in this document in italics have the same meaning as they do in your policy document. These words may be formatted differently in your policy document. - Your Acceptance Certificate or Renewal Certificate (whichever is more recent). Together, these make up your nib contract of insurance. All these documents can be viewed online, by logging into your my nib account and clicking 'My documents'.	[Research Note: The policy does not contain a benefit relevant to this criteria]

What am I covered for?

You're covered for:
- The cost of drugs approved for use by Medsafe and prescribed under Medsafe guidelines, but not funded under section A to H of the PHARMAC pharmaceutical schedule.
- Non-PHARMAC funded drugs used in a New Zealand-based private hospital, day stay unit, or a private wing of a public hospital that has been recognised by nib.
- Non-PHARMAC funded drugs used at home for up to six months after you're admitted to hospital for treatment. This hospital treatment must be approved by nib and the drugs must relate to it.
- Any drug administration costs.

Any claim under this option will only be payable if it is:
- Related to an approved claim under your Hospital Surgical Benefit, Hospital Medical Benefit, or your Cancer Treatment Benefit (if you have one of these as part of your policy).
- Supported with a recommendation letter from a registered specialist detailing the reasons for prescribing the non-PHARMAC funded drug(s) for you.

How much am I covered for?

The benefit limit is the maximum amount that nib will pay towards the cost of non-PHARMAC funded drugs, and any costs to administer those drugs in a 12-month period.

If you have added this option during your policy year, the benefit limit will start again at your next policy anniversary date. It will then renew every 12 months and then renew again every 12 months or your policy anniversary date (whichever is the latest).

Your benefit limit is listed on your Acceptance Certificate or Renewal Certificate (whichever is more recent).

Who can I get treatment from?

Any registered specialist who is:
- A health professional in private practice and holds a current annual practising certificate; and
- A member of an appropriately recognised specialist college with Medical Council of New Zealand vocational registration in that speciality; and
- Listed in nib's Find a Provider tool

Other Supplementary Benefits

	nib - Medical Business - Premier Health	Sth Cross - Health - Wellbeing 2
Rating	Yes	Yes
Research Notes	STRENGTHS: 1. Loyalty Benefit Wellness 2. Loyalty Benefit Suspension of Cover 3. Therapeutic Care Benefit 4. Intravitreal Eye Injections Benefit 5. Speech, Occupation and Eye Therapy Benefit 6. Podiatric Surgery Benefit 7. Ambulance Transfer Benefit 8. Physiotherapy Benefit 9. Serious Condition Financial Support Option (optional) 10. Proactive Health Option (optional)	STRENGTHS: + The policy provides six additional supplementary benefits: 1. Gastric banding/bypass allowance 2. Bilateral breast reduction allowance 3. Post mastectomy allowance 4. Ambulance 5. Post-operative speech and language therapy 6. Being Active 7. Palliative care
Extract	[Research Note: The following extracts are summaries of the other available benefits] Loyalty Benefit Wellness: After an insured person aged 21 or over has been continuously covered under the Base Cover for 36 months, we cover the cost of a medical examination of that insured person by a GP including, for example, the cost of laboratory tests, ECG, blood pressure checks, breast examinations, cervical smears and prostate examinations. Benefit maximum: We pay up to $100 after each 36 months of continuous cover. Loyalty Benefit Suspension of Cover: After 12 months' continuous cover under this policy, the cover (including the premium payments) can be suspended if the Insured travels outside New Zealand for longer than three consecutive months or if the Insured is registered unemployed. Therapeutic Care Benefit: covers the cost of osteopathic and chiropractic treatment, speech and occupational therapy and dietician consultations post-hospitalisation, up to six months after being discharged from an approved private hospital on referral by the treating registered specialist. No limit per treatment / consultation. We pay up to $250 per hospitalisation. Intravitreal Eye Injections Benefit: covers the cost for intravitreal injections administered by a registered specialist, on referral from a GP or registered specialist. We pay up to $3,000 per insured person per policy year, less any excess. Speech, Occupation and Eye Therapy Benefit: This Benefit covers the cost of Speech Therapy, Occupational Therapy and / or eye therapy after referral by a GP or Registered	[Research Note: The following extracts are only summaries of the other benefits available] Gastric banding / bypass allowance (after three years of continuous cover on this plan): $7,500 one-off payment Bilateral breast reduction allowance (after three years of continuous cover in this plan): $5,000 one-off payment Post mastectomy allowance to achieve breast symmetry: $6,500 one-off payment per lifetime. Ambulance allowance: $180 per claims year (only for public facility or an Affiliated Provider in-patient admission) Post-operative speech and language therapy: $70 per visit up to $350 per claims year. Being Active: up to $50 (after three years of continuous cover. Payable on receipt of proof of completion of a sports event) Palliative care and treatment allowance (after three years of continuous cover in this plan): $2,400 per claims year

	Specialist. We will pay up to $40 each visit, up to a maximum of $300 for each Insured Person every Policy Year. Podiatric Surgery Benefit: This Benefit covers the cost of Surgery performed by a Podiatric Surgeon under local anaesthetic, including up to one pre and one post Surgery Consultation and related x-rays. We will pay a total maximum of $6,000 for each Insured Person every Policy Year. Ambulance Transfer Benefit: This Benefit covers the cost of road ambulance transfer from a Public Hospital or Recognised Private Hospital to the closest Recognised Private Hospital. The road ambulance transfer must be recommended by a Registered Specialist who has cared for the Insured Person for at least 24 hours as an Admitted Patient. The maximum we will pay is included in the Hospital Surgical Benefit Limit or Hospital medical Benefit Limit (whichever applies). [Research Note: The following are optional benefits that require the payment of an additional premium] Physiotherapy Benefit: covers the cost of physiotherapy after referral by a GP or Registered Specialist. It covers the cost up to $40 for each visit up to a maximum of $400 per year. Serious Condition Financial Support Option: If the insured person suffers one of the Trauma Conditions (summarised in section 2 and defined in section 3 in this Option) for the first time on or after the effective date and before or on the end date of the Serious Condition Financial Support Option (refer to section 6 of this Option), we will pay you the sum insured that applies at that time. a. Heart and circulation: Aortic Surgery, Coronary Artery Bypass Grafting Surgery, Major Heart Attack (Myocardial Infarction), Heart Valve Surgery b. Cancer: Cancer - Life Threatening c. Functional Loss/Neurological: Benign Tumour of the Brain or Spinal Cord, Paralysis, Stroke d. Major Organ Transplant & Pneumonectomy Proactive Health Option: covers the cost of a variety of health screening tests, allergy testing and vaccinations administered by a GP, consultations with a dietician or nutritionist, and the cost of gym memberships or weight management programs. After 24 months the policy will cover the cost of a full	

	health check performed by a GP.	
Overseas Cover - Australia		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	b	No
Research Notes	LIMITATIONS: - The policy reimburses up to 75% of medical expenses incurred in Australia.	LIMITATIONS: - The policy does not provide Overseas Cover in Australia.
Extract	Cover in Australia Benefit What we cover We will reimburse the costs incurred by the insured person for treatment in Australia for a medical condition which arises whilst the insured person is in Australia for all Benefits listed under the Base Cover except for Travel and Accommodation Benefit; Overseas Treatment Benefit; ACC Top-up Benefit and Loyalty Benefit - Suspension of Cover. For medical conditions that are not covered, refer to the Exclusions section on page 69 and any limitations set out in your acceptance certificate or renewal certificate. We will reimburse up to 75% of the EMP which would be payable in New Zealand for treatment performed in New Zealand. Benefit maximum All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Other terms * You must call us for pre-approval. * We will not cover you for any treatment undertaken relating to an accident or injury which would normally be covered under ACC in New Zealand. * All medical facilities / treatment providers must have an equivalent accreditation / registration as per New Zealand standards approved by us. * You must provide us with all appropriate medical and other information we might reasonably require to assess your claim. Payment method and currency All reimbursements, excesses and Benefit maximums are in New Zealand dollars and reimbursements will be direct credit into your nominated New Zealand bank account.	[Research Note: The policy contains no specific provision directly relevant to this criterion]

	Chemotherapy for cancer treatment To qualify for reimbursement a cycle of chemotherapy treatment must meet the following definition: A specified number of sequentially administered doses of chemotherapy agent(s) where: * the chemotherapy agent is administered at prescribed intervals within a planned time frame; and * PHARMAC has approved the chemotherapy agent under Sections A to H of the PHARMAC Pharmaceutical Schedule (or as subsequently amended) for funded use in New Zealand; and * the chemotherapy agent is prescribed by a registered specialist and administered in Australia.	
Pregnancy/Childbirth Complications		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	Yes
Research Notes	STRENGTHS: + The policy provides an Obstetrics Benefit of up to $2,000 per policy year. COMMENTS: * Ceasarean sections and ectopic pregnancies are specifically excluded.	STRENGTHS: + The policy provides an Obstetrics allowance of up to $750 per policy year. COMMENTS: * A 1 year waiting period applies to this benefit.
Extract	Obstetrics Benefit What we cover We cover the cost of treatment by an obstetrician when the diagnosis is made of a medical condition that is affecting or may affect the pregnancy, after a referral by the GP or registered specialist, but excluding caesarean sections and ectopic pregnancies. Benefit maximum We pay up to $2,000 per insured person per pregnancy, less any excess. Other terms * Any conditions arising post birth are not covered. * We do not pay this Benefit if a fee-paying insured person is admitted to a public hospital. * We do not pay this Benefit in relation to a pregnancy conceived prior to the join date.	Obstetrics allowance: $750 per claims year After 1 year of continuous cover on this plan. For obstetric care 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. Excesses apply.
Public Hospital Cash Benefit		

	nib - Medical Business - Premier Health	Sth Cross - Health - Wellbeing 2
Rating	a	No
Research Notes	STRENGTHS: + The policy will provide a public hospital cash benefit of $300 per night (max per annum $3,000) if the Insured remains in a public hospital for three or more consecutive nights. + Admissions due to accident are covered.	LIMITATIONS: - The policy does not provide a public hospital cash benefit.
Extract	Public Hospital Cash Grant What we cover We make a cash payment when an insured person is admitted to a public hospital in New Zealand and is in the public hospital for three or more consecutive nights. Benefit maximum We pay $300 per night for the third and each subsequent night. We pay up to $3,000 per insured person per policy year. Other terms * We do not pay this Benefit if a fee-paying insured person is admitted to the private wing of a public hospital. * The excess does not apply. * For the Public Hospital Cash Grant, you must obtain a certificate from the hospital stating the reason and the date of the admission, and the date of the discharge to support your claim.	[Research Note: The policy does not contain a benefit relevant to this criterion]
Seeking Treatment Overseas		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	c	c
Research Notes	STRENGTHS: + The policy provides an Overseas Treatment Benefit, which covers the reasonable cost of overseas treatment that cannot be performed in New Zealand. LIMITATIONS: - The policy does not provide an Overseas Waiting List Benefit. - The policy does not provide a Medical Tourism Benefit.	STRENGTHS: + The policy provides an Overseas Treatment Benefit, which covers the reasonable cost of overseas treatment that cannot be performed in New Zealand. LIMITATIONS: - The policy does not provide an Overseas Waiting List Benefit - The policy does not provide a Medical Tourism Benefit.
Extract	Overseas Treatment Benefit What we cover	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

	We cover the cost of an overseas surgical or medical treatment that cannot be performed at all in New Zealand, and reasonable travel cost, where an application has been submitted to the Ministry of Health for funding under the 'Medical Treatment Overseas Scheme', and the Ministry of Health has declined funding. We cover the reasonable travel cost of the insured person requiring treatment plus the cost of the treatment performed overseas up to the Benefit maximum. Benefit maximum We pay up to $20,000 per overseas visit for treatment, per insured person, less any excess. Other terms * The treatment must be of a type which cannot be performed in New Zealand. * You must provide a copy of the Ministry of Health's decision regarding funding to us. * The treatment must be recommended by a registered specialist and must be recognised by us as a conventional form of treatment.	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 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.
Sterilisation Benefit		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	b	No
Research Notes	STRENGTHS: + The policy will provide a benefit to cover the reasonable cost of male or female sterilisation. LIMITATIONS: - However, the benefit is limited to $1,000 and only applies after two years of continuous cover.	LIMITATIONS: - The policy does not provide a sterilisation benefit.
Extract	Loyalty Benefit - Sterilisation What we cover After two years' continuous cover under this policy, an insured person is covered for the cost of male or female sterilisation as a means of contraception, performed by a GP or registered specialist. Benefit maximum We pay up to $1,000 per procedure. Other terms No excess will be deducted from the Loyalty	Exclusions - Sterilisation, or its reversal

	Benefit - Sterilisation Benefit.	
Suspension Benefit		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	Yes
Research Notes	STRENGTHS: + The policy provides a loyalty benefit which allows cover to be suspended.	STRENGTHS: + The policy provides a loyalty benefit which allows cover to be suspended if the Insured travels overseas for a period of 2 to 36 calendar months. + The benefit is available after the policy has been in force for 12 months. COMMENTS: * Cover may be suspended up to 3 times per lifetime. * Cover may be suspended for up to 5 years in total.
Extract	Loyalty Benefit - Suspension of Cover What we cover After 12 months' continuous cover under this policy, the cover (including the premium payments) can be suspended as follows: * Overseas travel / residence If the insured person lives or travels outside New Zealand for longer than three consecutive months the cover for the insured person can be suspended for between three and 24 months. To suspend cover you must tell us in writing before the insured person travels overseas, and provide any evidence of travel we require. * Unemployment If you are registered as unemployed, cover can be suspended for between three and six months. To suspend cover you must tell us in writing within 30 days of you registering as unemployed and provide evidence of registration. Other terms * You and the insured person cannot suspend cover for more than 24 months in any 10 year period. * While cover is suspended for an insured person no premium is payable and no cover is provided for that insured person affected. * We will reinstate cover without enquiring into the insured person's health so long as cover is reinstated before the suspension of cover period ends. * If cover is not reinstated at the end of the suspension of cover period, we will write to you at your last known address and give you 90 days within which to pay any arrears of	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 yourpolicy, 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.

	premium. If you do not pay the arrears by the end of 90 days where this policy is suspended, this policy will end and where an insured person's cover is suspended, the cover on that insured person will end. * If you have suspended an insured person's cover for overseas travel / residence and at the end of the suspension of cover period you do not wish to reinstate the cover on the insured person affected, this policy will end and we will issue a new policy to any remaining insured persons.	
Travel & Accommodation Benefits		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	b	c
Research Notes	STRENGTHS: + Reimburses costs associated with air or road transport to and from a private hospital within New Zealand for both the Insured and a support person. + Accommodation benefit will reimburse up to $3,000 per claim ($200 per night) for accommodation for the Insured and support person. LIMITATIONS: - A maximum of $2,000 per hospitalisation is payable for transport costs. COMMENTS: * If the Insured is undergoing radiotherapy, the above per hospitalisation maximums do not apply. Rather, accommodation for the Insured and a support person is capped at $200 per night, and the aggregate benefit payable for travel and accommodation is capped at $5,000 per hospitalisation. * Parent Accommodation Benefit is also available.	LIMITATIONS: - The Insurer will pay for travel and accommodation for the Insured and a support person up to $500 per claims year. - The allowance is only payable for public transport and hotel/motel costs. - $500 is also available for hospital accommodation when a parent accompanies a dependant child.
Extract	Travel and Accommodation Benefit Criteria This Benefit applies where a GP or registered specialist has recommended hospitalisation and where that hospitalisation cannot be performed in the insured person's local approved private hospital. We cover the travel and accommodation costs within New Zealand where the nearest approved private hospital is more than 100km one way from the insured person's usual residence.	Parent accommodation: $100 per night up to $500 per operation. For hospital accommodation expenses incurred by a parent when accompanying a dependant child. Both parent and child must be listed on the Membership Certificate. Accommodation must be in an approved 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

	Where a GP or registered specialist has recommended a support person for the insured person's hospitalisation, the support person must travel together with the insured person to and from the approved private hospital. What we cover Travel We will cover the cost of travel within New Zealand. We will reimburse the cost of: * return economy airfare within New Zealand; or * cost of a return rail or bus travel; or * mileage for road travel at the amount determined by us; and * taxi fares on admission and discharge from the approved private hospital to / from the airport for the insured person and the accompanying support person, where recommended. Accommodation We cover the cost of accommodation incurred by the insured person and the accompanying support person, where recommended, during an insured person's hospitalisation. Benefit maximum for hospitalisation / chemotherapy treatment Travel We pay up to a maximum of $2,000 per hospitalisation or per cycle of chemotherapy treatment. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Accommodation We pay up to $200 per night for the accommodation costs for the accompanying support person, where recommended during an insured person's hospitalisation, up to a maximum of $3,000 per hospitalisation or per cycle of chemotherapy. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Benefit maximum for radiotherapy treatment	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.

	Travel and accommodation We pay up to $200 per night for the accommodation costs for the insured person and the accompanying support person, where recommended, up to a maximum of $5,000 per hospitalisation or per cycle of radiotherapy for both travel and accommodation costs incurred by both the insured person and the accompanying support person. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Other terms * Any air travel cost to and from New Zealand is not covered, unless covered under the Overseas Treatment Benefit (refer to Benefit 16). * This Benefit does not cover any travel or accommodation costs for chemotherapy or radiotherapy treatment in a public hospital. Parent Accommodation Benefit What we cover We cover the cost per night of the accommodation incurred by a parent or legal guardian accompanying an insured person aged under 20 years (inclusive) listed in the acceptance certificate or renewal certificate, where that insured person is being treated in an approved private hospital for hospitalisation. Benefit maximum We pay up to $200 per night. We pay up to $3,000 per hospitalisation. All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). - - - - Ambulance Transfer Benefit What we cover We cover the cost of a road ambulance to and from an approved private hospital to another approved private hospital, within New Zealand for the insured person for hospitalisation, if a GP or registered specialist has recommended	

	the transfer by ambulance. Benefit maximum All costs paid under this Benefit are included within the Benefit maximum for the Hospital - Surgical Benefit or Hospital - Medical Benefit (whichever applies). Other terms The cost of ambulance society subscriptions is not covered.	
Waiver of Premium		
	nib - Medical Business - Premier Health	**Sth Cross - Health - Wellbeing 2**
Rating	Yes	No
Research Notes	STRENGTHS: + The benefit will pay the policy premiums for up to two years for any surviving Insured persons if the policy owner dies before age 65.	LIMITATIONS: - The policy does not provide a Waiver of Premium benefit.
Extract	Waiver of Premium Benefit What we cover We cover the premiums due on this policy for all surviving insured persons if a policyowner dies before the age of 65 from any cause. Benefit maximum We pay the premiums: * for two years; or * until anyone of the surviving insured persons turns 65 years of age, whichever occurs first. Other terms * No excess will be deducted from the Waiver of Premium Benefit. * The Benefit starts from the next premium payment date following the death of the policyowner. * When the Benefit ends, the premiums will recommence and be payable in respect of all surviving insured persons. * When claiming for a Waiver of Premium Benefit, please provide the original death certificate or a certified copy of the similar documentation acceptable to us.	[Research Note: The policy contains no specific provision directly relevant to this criterion]