Southern Cross Health Insurance

Summary of changes to your Westpac First Cover policy document Effective from 1 April 2026

Please read this summary carefully to help you understand the changes we're making to your *policy*. *Policy* terms and conditions, including *policy limits* and *exclusions* still apply to all the benefits we have summarised. Words in italics have specific meanings and are defined in the policy document.

Your updated policy document is available to read now

To read the full policy wording that takes effect on 1 April 2026, please visit schs.nz/wp-updates. The updated policy document and summary are available online now. If you'd prefer a copy sent to you, just get in touch at southerncross.co.nz/contact

Ever changed your plan?

If you currently have cover for *pre-existing conditions* under a previous plan, check your *membership certificate* to see what those conditions are. Then visit our website to check if any updates to your previous plan affect your cover. View changes to all our plans at southerncross.co.nz/society/for-members/updates-to-your-policy

To find your *membership certificate* visit MySouthernCross, our online member portal at mysoutherncross.co.nz or contact us for a copy.

What's changing?	Existing policy document (effective until 31 March 2026)	New policy document (effective from 1 April 2026)
Changing how some skin-related procedures are covered		
Relocating cover for Mohs surgery (including excision and closures) to the 'Skin lesion services' benefit, except for closure requiring general anaesthesia.	Mohs surgery, including excision and closure following surgery is covered under the 'Surgical procedures' benefit.	Mohs surgery, including excision and closure is covered under the 'Skin lesion services' benefit. where it is performed under local anaesthetic, no anaesthetic or oral sedation. This benefit has a *policy limit* of $5,000 each *claims year*, with a sub-limit of $1,000 for skin lesion services performed by a *general practitioner*. The 'Surgical procedures' benefit provides cover for the following procedures when performed under general anaesthetic or IV sedation: • Excision and biopsy of skin lesions, or • closure of the wound following a Mohs surgery
Introducing a $150 sub-limit each claims year for skin cryotherapy.	Skin cryotherapy performed under local anaesthetic, or no anaesthetic is covered under the 'Skin lesion services' benefit. Skin cryotherapy performed under general anaesthetic or sedation is covered under the 'Surgical procedures' benefit. No sub-limit each *claims year*.	Skin cryotherapy is covered under the 'Skin lesion services' benefit with a sub-limit of $150 each *claims year*.

What's changing?	Existing policy document (effective until 31 March 2026)	New policy document (effective from 1 April 2026)
Changing how some skin-related procedures are covered - continued		
Moving skin lesion procedures performed by non-skin specialists from the 'Surgical procedures' benefit into the 'Skin lesion services' benefit.	The 'Skin lesion services' benefit only covers *healthcare services* performed by a skin *specialist*. Eligible skin lesion procedures performed by non-skin *specialists* are covered under the 'Surgical procedures' benefit.	*Eligible* skin lesion procedures performed by non-skin *specialists* will now be covered under the 'Skin lesion services' benefit.
Changing how we define and cover tooth extraction		
We are extending the period that members must have continuous cover under their plan for healthcare services relating to impacted or unerupted tooth extraction from 1 year to 3 years.	**Continuous cover period is 1 year** After 1 year of continuous cover on this plan, cover is provided for extractions of unerupted or impacted teeth.	**Continuous cover period is 3 years** After 3 years of continuous cover on this plan, cover is provided for the complete extraction or partial removal of unerupted or impacted teeth.
We are clarifying that removing teeth—either partly or completely—is covered under the 'Surgical procedures' benefit when removal of teeth is required before an eligible surgical treatment, chemotherapy, or radiotherapy.	**No cover for tooth extraction when it is required for eligible surgical treatment, chemotherapy or radiotherapy** No exception in tooth extraction *exclusion* for teeth required to be removed for eligible surgical treatment, chemotherapy or radiotherapy.	**Cover for tooth extraction or partial removal of teeth when it is required for eligible surgical treatment, chemotherapy or radiotherapy** Cover is provided for complete extraction or partial removal of teeth if removal is required before an eligible surgical treatment, chemotherapy or radiotherapy. Must be on referral from the treating *specialist*.
We are making changes to the wording of the exclusion for 'Extraction of teeth' to clarify that extraction of teeth includes the complete extraction or partial removal of any part of a tooth, tooth root or tooth remnant.	**Exclusion wording** No cover for extraction of teeth except for what is covered under the 'Surgical procedures' benefit for extraction of unerupted or impacted teeth.	**Exclusion wording** No cover for extraction of teeth, including the complete extraction or partial removal of any part of a tooth, tooth root or tooth remnant, except for what is covered under the 'Surgical procedures' benefit for tooth extraction.
Introducing a requirement for 3 years of continuous cover for varicose vein procedures for legs		
Cover for varicose vein procedures for legs and related duplex vein mapping will only be available after 3 years of continuous cover.	No continuous cover period required for *varicose vein procedures* for legs and related duplex vein mapping. Members are eligible for up to two procedures for each leg during your *lifetime*. If you have multiple procedures during a single *operation*, we count these as separate procedures under the *lifetime* limit for each leg.	Cover for *varicose vein procedures* for legs and related duplex vein mapping is available after 3 years of continuous cover on this plan. Members are eligible for up to two procedures for each leg during your *lifetime*. If you have multiple procedures during a single *operation*, we count these as separate procedures under the *lifetime* limit for each leg. The *lifetime* limit does not apply to duplex vein mapping.

What's changing?	Existing policy document (effective until 31 March 2026)	New policy document (effective from 1 April 2026)

Changing the way we manage cover for robot-assisted surgeries

We are removing the exclusion for robot-assisted surgery from policy documents and adding it to the list of 'Unapproved healthcare services', with cover available for selected procedures.	Costs related to, or incurred as a consequence of, robot-assisted surgery are excluded as a *healthcare service* that we don't cover in section C of the policy document except for the following selected procedures which are covered under the 'Surgical procedures' benefit: • Robot-assisted hysterectomy (with or without oophorectomy and/or salpingectomy, or both) • Robot-assisted sacrocolpopexy • Robot-assisted ventral hernia repair • Robot-assisted prostatectomy • Robot-assisted partial nephrectomy • Robot-assisted total hip replacement • Robot-assisted knee replacement • Robot-assisted transoral surgery.	Robot-assisted surgery is excluded through its inclusion on the list of '*Unapproved healthcare services*' except for the following procedures which are covered under the 'Surgical procedures' benefit when performed by an *Affiliated Provider*: • Robot-assisted hysterectomy (with or without oophorectomy and/or salpingectomy, or both) • Robot-assisted sacrocolpopexy • Robot-assisted prostatectomy • Robot-assisted partial nephrectomy • Robot-assisted total hip replacement • Robot-assisted knee replacement • Robot-assisted transoral surgery. **There is no cover for robot-assisted ventral hernia.** The *policy exclusion* for robot-assisted ventral hernia repair will be removed from the list of policy variations and robot-assisted ventral hernia repair is instead being added to the list of unapproved healthcare services

Changes to policy variations

We're moving some policy variations currently published on the list of policy variations into the policy document

In October 2024, we introduced a list of policy variations that form part of your *policy*. These variations may provide access to additional cover and outline changes to *policy* terms and conditions, such as how *exclusions* are treated, updates to benefit terms, or new ways of delivering *healthcare services* we're testing.

Until now, these policy variations have only been available to view on our website at southerncross.co.nz/variations. However, we are now incorporating some of them directly into your policy document and removing them from the list of policy variations on our website.

The following variations will now be included in your policy document:

We are updating the 'Travel and accommodation allowance' to include ride-sharing services and accommodation hosting platforms	**The policy document wording relating to the 'Travel and accommodation allowance' will be updated to include cover for less traditional but commonly used travel and accommodation providers such as ride-sharing services and accommodation hosting platforms.** Travel costs include public transport charges for buses, trains, taxis, shuttles, planes, ferries, and ride-sharing services. Accommodation costs include charges for hotel rooms, motel rooms, or hospital rooming fees for the support person, hospital flats and short-term rentals through recognised accommodation hosting providers.
Cover for in-hospital ultrasounds	The definition of *hospital fees* is being updated to include in-hospital ultrasounds to provide cover for in-hospital ultrasounds under the 'Surgical procedures' benefit.
Cover for breast screening ultrasounds where dense breast tissue is confirmed	Cover is included for breast screening ultrasounds where a mammogram alone is unsuitable due to confirmation of dense breast tissue by a mammogram or MRI. In all other circumstances, breast screening ultrasounds are not covered.

Affiliated Provider-only healthcare services

Healthcare services becoming Affiliated Provider-only healthcare services

We are always considering which *healthcare services* should only be performed by an *Affiliated Provider* to be eligible for cover. This helps us to manage overall healthcare costs, supporting keeping premiums affordable. It also provides members with a simpler and more certain process:

- The *Affiliated Provider* arranges prior approval for the healthcare service and submits claims directly on the member's behalf
- Agreed pricing with *Affiliated Providers* ensures members have clarity in advance.

A list of Affiliated Provider-only healthcare services is available on our website at southerncross.co.nz/ap-only. Please check this regularly as the list will change from time to time.

Gynaecology is becoming Affiliated Provider- only

Healthcare services related to Gynaecology are becoming *Affiliated Provider*-only. We have not set any timeframes as to when this change will happen, but we are notifying you now so that you are aware of the upcoming changes.

Please check the list of Affiliated Provider-only healthcare services at southerncross.co.nz/ap-only regularly as it will change from time to time or speak with your *health services provider*.

We are reviewing our Eligibility criteria

We are reviewing and clarifying our eligibility criteria to make sure that healthcare services are provided to those who need them, and we're adding new eligibility criteria where appropriate.

Certain *healthcare services* have *eligibility criteria* which need to be met before a *healthcare service* is *eligible* to be covered under your *policy*. This includes setting clear guidelines for when general anaesthesia can be used.

A list of the eligibility criteria is available on our website at southerncross.co.nz/eligibility. Please check this list regularly as the *eligibility criteria* may change from time to time.

Changes to our policy document

We have updated the wording of our policy document to better reflect current practice and to provide greater clarity around the cover available. These updates do not represent new benefits, but rather confirm and clarify the way cover is already applied.

We are removing reference to the specialist's vocational registration in internal medicine under the 'Chemotherapy for cancer' benefits.

This change is being made because *specialists* must work within their scope of practice.

We are removing the standalone exclusion for Dementia and adding it to the 'chronic conditions' exclusion

Dementia is a chronic condition so should be included under the 'chronic conditions' *exclusion*.

Removing the definition of 'approved treatment' from the 'Overseas treatment allowance'

We are making it easier to understand what the requirements are for the 'Overseas treatment allowance' by removing the definition of '*approved treatment*' and instead listing the relevant terms in the allowance wording.

Specialist consultations can be carried out by a health services provider working under specialist supervision

Cover has been extended to include consultations with a *health services provider* who is working under the supervision of a *specialist*, if the type of consultation is:

- included in the *Affiliated Provider's* agreement with us, and
- approved by us.

General tidy-up of policy wording

We've made some small changes to our policy document to fix grammar, tidy things up, and refresh some links.

Reminder about other documents that form part of your policy which are updated regularly

The following documents that form part of your *policy* are regularly updated as we continually review how we cover *healthcare services* and certain health technology. It's a good idea to check these documents if you are planning on accessing any *healthcare services* which you intend to claim for under your *policy*. These documents include:

- the *eligibility criteria*
- the list of *unapproved healthcare services*
- the list of Affiliated Provider-only healthcare services
- the list of *prostheses and specialised equipment*
- the list of policy variations.

You can refer to our website for the latest versions of these documents or contact us to request a copy.