



Your policy update

Effective from 22 October 2024

Here are the key changes to your Westpac First Cover Policy that took effect on 22 October 2024. Please read them carefully so you understand the changes that are being made to your policy.

This information is to help you understand the changes to your plan. Your health insurance policy is made up of a number of documents, including your membership certificate and the policy document. Together all these documents, outline your cover.

You should check your membership certificate to see if you have cover for pre-existing conditions under any previous Southern Cross plans and select those plans to view changes that might affect your cover.

What's changing?	Existing Policy (effective until 22 October 2024)	New Policy (effective from 22 October 2024)
 Breast reduction allowance		
<p>Limit of one surgical procedure per lifetime will be removed.</p>	<p>Cover is limited to one surgical procedure and any follow-up treatment required per lifetime.</p>	<p>No limit on the number of surgical procedures you can have during your lifetime, including any follow-up treatment required.</p>
<p>Cover will expand to include procedures that affect a single breast only. We're expanding cover to include breast reduction procedures for a single breast, in addition to our existing cover for procedures involving both breasts. We're updating the name of this allowance to reflect this change.</p>	<p>Current name is 'Bilateral breast reduction allowance'. Only breast reduction procedures affecting both breasts are covered.</p>	<p>New name is 'Breast reduction allowance'. Breast reduction procedures affecting a single breast or both breasts are covered.</p>
 Breast symmetry allowance		
<p>Limit of one surgical procedure per lifetime will be removed.</p>	<p>Cover is limited to one surgical procedure and any follow-up treatment required per lifetime.</p>	<p>No limit on the number of surgical procedures you can have during your lifetime, including any follow-up treatment required.</p>
<p>Removal of 2-year restriction. The requirement that breast symmetry surgery must be completed within 2 years of the first eligible breast reconstruction surgery will be removed.</p>	<p>Breast symmetry surgery must be completed within 2 years of the first eligible breast reconstruction surgery following an eligible mastectomy.</p>	<p>Breast symmetry procedures can be completed at any time following an eligible mastectomy.</p>

Clarification of cover.

We're changing the name of this allowance to clarify that it will cover breast symmetry surgery that's performed after, or at the same time as an eligible mastectomy.

Current name is 'Post mastectomy allowance to achieve breast symmetry'.

New name is 'Breast symmetry allowance'.


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

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

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

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

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

- Colposcopy with or without biopsy under local anaesthetic or no anaesthetic
- Endometrial biopsy under local anaesthetic or no anaesthetic
- Single fibre electromyogram (SFE)
- Vulvoscopy with or without biopsy under local anaesthetic or no anaesthetic.

The listed diagnostic tests are covered when performed in an approved facility of your choice.

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

Introduction of cover for certain prostheses when used as part of the listed procedures. The procedures must be performed by an Affiliated Provider to be eligible for cover under your plan.

The procedures are covered when performed by an appropriate specialist of your choice. The related prostheses are **not included**.

The listed prostheses **are included** when used as part of the specified procedures and when performed by an Affiliated Provider. The individual prosthesis limits apply.

- Initial pacemaker device (Pacemaker surgery)

Prosthesis maximums apply:

- Single chamber pacemaker \$2,760
 - Dual chamber pacemaker \$4,485
 - Biventricular/complex pacemaker \$10,260
 - Cochlear implant device (Cochlear implant surgery)
- Prosthesis maximum applies:
- Unilateral \$17,000
- Periurethral bulking agent - Bulkamid (Periurethral injection for incontinence)
- Prosthesis maximum applies:
- \$3,000.

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

[View the healthcare services which will be included under the Surgical procedures benefit](#)



These procedures must be performed by an Affiliated Provider to be covered under your plan.

- Intravascular lithotripsy for coronary artery disease
- Drug-eluting balloon angioplasty for in-stent restenosis
- Transcatheter aortic valve replacement (TAVI)
- Liposuction for secondary lymphoedema following an oncological intervention
- Thyroid nodule ablation
- Peripheral sensory nerve ablation for cancer-related pain
- Image-guided percutaneous carpal tunnel release
- Image-guided percutaneous trigger finger release
- Robot-assisted knee replacement
- Robot-assisted total hip replacement
- Peroral endoscopic myotomy & Zenker's peroral endoscopic myotomy (POEM, ZPOEM)
- Implantation of prosthetic iris device
Prosthetic iris device including custom-made artificial iris
Prosthesis maximum limit applies: unilateral \$10,250
- Minimally invasive glaucoma surgery (MIGS)
Kahook dual blade goniotomy, iTrack canaloplasty, implantation of trabecular bypass microstent – Glaukos iStent, implantation of minimally invasive subconjunctival filtration device (microshunt) – Allergan XEN or Glaukos PreserFlo, micropulse transscleral cyclophotocoagulation
Prosthesis maximum limits apply:
 - Category 1 \$1,000 (Kahook dual blade)
 - Category 2 \$1,500 (iTrack canaloplasty microcatheter, MicroPulse P3 Delivery Device)
 - Category 3 \$2,000 (iStent trabecular Micro-bypass stent, PreserFlo MicroShunt, Xen Gel Stent)
- Botulinum toxin for laryngeal dystonia
Prosthesis maximum limits apply:
 - Botulinum toxin type A for approved procedures only (1 ampoule/100 units) \$600
 - Botulinum toxin type A for approved procedures only (2 or more ampoules/200+ units) \$1,200
- Temporomandibular joint (TMJ) total joint replacement (TJR)
Prosthesis maximum limits apply:
 - Unilateral \$26,000
 - Bilateral \$45,000.

[View other changes to your Policy](#)



A new list of policy variations is being introduced and will form part of your Policy.

This list sets out variations to policy terms and conditions that may apply from time to time. These variations include the way we treat some exclusions (as listed in the policy document) and certain benefit terms, or new ways of delivering healthcare services we're testing. This may mean you can access additional cover while these variations are included on the list of [policy variations](#).

The list of Affiliated Provider-only healthcare services is being removed from the Policy.

The list will still form part of your Policy but will only be available on our [Affiliated Provider-only healthcare services page](#). We're removing this list from the policy document to enable us to update it more regularly. You'll need to check the website for updates or you can [contact us](#) to request a copy of the most up-to-date list.

The list of documents that form part of your health insurance Policy is being updated.

Your application form, any health insurance medical declarations, the [list of Affiliated Provider-only healthcare services](#), the [eligibility criteria](#), the [list of unapproved healthcare services](#), the [list of prostheses and specialised equipment](#) and the [list of policy variations](#) are included in the list of documents that form part of your Policy.

We're changing how we communicate changes to certain documents that form part of your Policy.

This means you may not receive direct communications for all changes, and you'll need to refer to our website for the latest versions of the following information: the [eligibility criteria](#), the [list of unapproved healthcare services](#), the [list of Affiliated Provider-only healthcare services](#), the [list of prostheses and specialised equipment](#), and the [list of policy variations](#).

Policyholders can change their cover at any time.

Update to the Policy amendment section to allow policyholders to change their cover at any time by [contacting us](#).

Removal of change period reference.

The reference to 30 days notice of change period is being removed.

The financial strength rating summary is being updated – no changes to Southern Cross Health Society's financial strength rating.

To reflect the updates made by our rating agency, we're removing the 'R' (Regulatory Action) and 'NR' (Not Rated) ratings from the financial strength rating summary and updating the web address to spglobal.com/ratings/en/about/intro-to-credit-ratings.

References to the Southern Cross Medical library are being removed.

The Medical library on our website is no longer available so any references to it are being removed.

References to 'DHB' have been updated to 'Health NZ Te Whatu Ora'.

'DHB' was an abbreviation for District Health Board. These have been disestablished. Health New Zealand Te Whatu Ora is the relevant national health entity.

The exclusion for illnesses, injuries, conditions or disabilities related to intoxication is being removed.

The exclusion for substance abuse, intoxication or drug taking has been revised to focus only on the abuse of substances such as alcohol or drugs, rather than intoxication on its own.

Unclaimed monies.

We're extending the length of time we will hold unclaimed monies for you from 2 years to 4 years.

The 3 month stand-down period for adding newborns without the need to complete a health insurance medical declaration is being removed.

Newborn children can be added without underwriting, provided they were born after the Policy Start Date and the policyholder adds the child within 3 months of the child's birth date.

Removal of requirement to disclose if your surgical procedure requires a registered nurse first surgical assistant.

When you apply for prior approval, you won't need to let us know if a registered nurse first surgical assistant will be required as part of your surgery. But you'll still need to let us know if your surgery requires more than one surgeon, including an assistant surgeon.

Update to the Applications section.

Removed clause 5.6 from the Applications section to clarify that any applications will be for dependants on existing policies only.

A suspension request can happen at any time.

Update to reflect that a suspension request can happen at any time, however it will not be applied retrospectively.

Removal of reference to adding or removing dependants at the Policy Anniversary Date.

Addition or removal of dependants on your Policy can be done at any time.

Update to prior approval requests.

Update to reflect that prior approval requests can happen at any time however we recommend that you apply at least 5 working days before the healthcare service is being provided.

Exclusion for administrative charges.

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

Exclusion for transfusion or injection of autologous blood or blood products.

The exclusion for transfusion or injection of autologous blood or blood products does not apply when used as part of eligible chemotherapy treatment.

Underwriting requirements for adult dependants taking out their own policy.

Adult dependants who apply for their own Southern Cross health insurance policy within 1 month of being removed from an existing policy do not need to complete a new health insurance medical declaration if they're applying for similar or a lower level of cover.

Clarification of the term 'Medsafe-Indicated'.

Clarification of the term 'Medsafe-indicated' when used in the IV infusion (non-cancer) benefit.

Update to the procedure names under Diagnostic imaging and Diagnostic tests benefits.

The names of certain diagnostic imaging and diagnostic tests will be updated to the names they are more commonly known by and abbreviations will be added where appropriate.

Update to the definition of eligibility criteria.

The reference to 'procedure' will be replaced with 'healthcare services' as 'procedure' was not sufficiently inclusive.