Healthcare 99

Information Brochure Oct 2018
Rules & Contribution Rates

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Healthcare 99 Mutual Health Fund

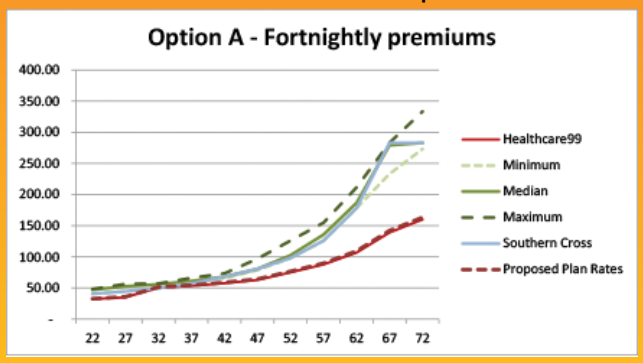
(not an insurance plan)

Healthcare 99 is Self Funded - operates under a Trust Deed and Healthcare 99 Rules

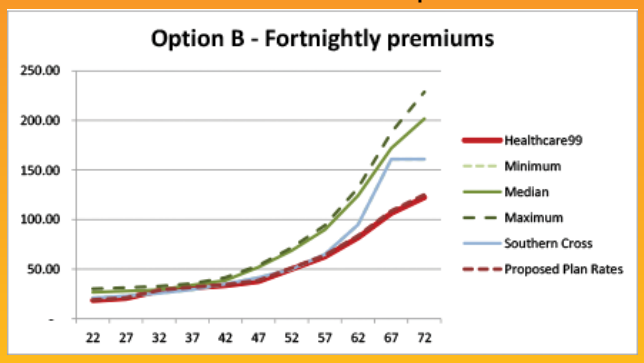
Established under the objects of the Society's rules (Rule 4) & Board Policy

How does the cost of Healthcare 99 compare to Health Providers

Market Premium Comparison



Market Premium Comparison



In June 2017, Healthcare 99 asked Aon to research the relative costs of healthcare in New Zealand to try to determine how the cost of Healthcare 99 related to marketplace healthcare providers.

These graphs are presented with the proviso that it is difficult to compare plans exactly because many offer slightly different options. The two graphs show how Option A and Option B of Healthcare 99 compare to healthcare insurers. The lines labelled "maximum," "median" and "minimum" indicate the highest, the median and the lowest premium comparisons by all Healthcare insurances surveyed.

Healthcare 99 is not an insurance so it does not figure into those figures. The red dotted line labelled "proposed plan rates" show how small the rise of the contribution rate is this year for Option A and Option B for Healthcare 99. These graphs show Healthcare 99 to be very good value for money.

Please read this brochure carefully

For more information contact thesec@firefighters.org.nz

firefighters helping firefighters and their families

awhi atu awhi mai

Healthcare 99

1. Is Self Funded and operates under a Trust Deed (**NOT** an insurance)
2. You (the members) own it.
   the NZFF Welfare Society are the Trustee
3. After operating costs ALL of the contributions are available for assisting the medical welfare needs of the members and their families.
4. Since its launch in 1999 Healthcare 99 has paid out over $17,000,000 in medical welfare assistance to the members and their families.
5. Regular scrutiny of the fund (i.e. Actuarial Reviews)
6. All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11.19)
7. Members have right of appeal according to the rules.

Ask yourself these simple questions

- Can I afford **NOT** to protect myself and my family against the rising cost for medical care?
- Can I afford **NOT** to become a member of Healthcare 99?
- Is Healthcare 99 a Health Fund that I should be a member of, so that my family has the security it deserves?
- Do I help fellow firefighters and their families by joining Healthcare 99?
- How does Healtcare 99 compare to other plans in the marketplace.
  see graph below for a recent comparison of contribution costs,
  data gathered by benchmarking exercise.

Read the fine print

1. Healthcare 99 is not an insurance plan.
2. No claim/s shall be payable to any Member or any Dependant for a period of 12 weeks starting from the date of members first contribution payment received.
3. Pre-existing medical and congenital conditions must be declared on the application form and are excluded.
4. Claims will only be considered upon receipt of a full completed official claim form.
5. Members are expected to claim first with ACC/AES if applicable and to lodge an appeal if necessary.
6. All In-Hospital procedures/events must have pre-approval of the claims manager.
7. Pre-Approval amounts can only be up to the amounts set out in this brochure.
8. Members must claim within thirty (30) days of the date of treatment or event (Rule 14).
9. Healthcare 99 pays the member directly, not the hospital or surgeon.
10. All claims submitted are subject to reimbursement at the sole discetion of the Trustee (Rules 11. 19.).
11. ACC claims including part charges will not be covered by Healthcare 99.

Schedule A

HEALTHCARE '99

RULES

AIMS AND OBJECTIVES

1 To provide members of the New Zealand Firefighters' Welfare Society and their families with assistance in health care during any sickness by providing a mutual fund to assist in meeting medical costs.

TRUSTEESHIP AND CLAIMS MANAGEMENT

2 The Trustee of Healthcare '99 shall be the New Zealand Firefighters' Welfare Society.

3 The Claims Manager of Healthcare '99 shall be determined from time to time by the Trustee but shall initially be AON Risk Services NZ Limited.

MEMBERSHIP

4 All members of the New Zealand Firefighters' Welfare Society are eligible to become members of Healthcare '99 upon completion and submission of the application form to the Trustee provided no pre-existing medical conditions exist. If pre-existing medical conditions exist applicants will only be accepted for membership if approved by the Trustee.

5 Existing members of Healthcare '99 may terminate their own membership from the fund by giving fourteen (14) days notice in writing to the Trustee of that member's intention to cease membership of the fund.

6 Membership of the fund shall cease immediately upon that member's termination of membership of the New Zealand Firefighters' Welfare Society.

7 The Trustee may give notice to any member that their membership shall be terminated by the Trustee if arrears of contributions are not paid in full to the Trustee within fourteen (14) days of the date such notice is sent to the member by ordinary post to the last known address of the member. In the event that the member fails to pay all arrears of contributions within the time allowed the Trustee may terminate that member's membership at any time from expiry of that date and notify the member accordingly by notice in writing to the last known address of the member.

CONTRIBUTIONS

8 The level of contributions shall be determined from time to time by the Trustee after obtaining professional advice. The level of contributions is set out on the back page.

9 The contributions may be made to provide benefits for the member, his or her spouse and dependant children, which shall be based upon the option chosen by the member.

10 Contributions are deducted fortnightly, monthly or annually in advance from wages, salary or by direct debit from a bank account.

CONSIDERATION OF CLAIMS AND PAYMENT OF BENEFITS

11 After payment of all expenses and other charges related to the fund the Trustee may in its absolute discretion, at any time or times:

- 11.1 Accumulate all or any part of the contributions as an addition to the capital of the fund;
- 11.2 Retain out of, or charge against the contributions for a financial period any reserves or other provisions that the Trustee thinks fit against any liabilities of the fund;
- 11.3 Consider claims by financial members for assistance with the costs of medical treatment and determine in its absolute discretion whether to accept any claim and the amount of any benefits to be paid.

12 In exercising its discretion the Trustee may obtain and consider professional advice and may be guided by:

- 12.1 The contributions available;
- 12.2 The nature and extent of the claims received; and
- 12.3 The advice of the Claims Manager.

13 A member is not a financial member if contributions are in arrears.

CLAIMS

14 Members must claim within thirty (30) days of the date of the treatment or event.

15 Claims will only be considered upon receipt of a full completed official claim form. Claim forms are available during office hours from the Trustee or the Claims Manager.

16 Claims should be addressed to the Claims Manager.

17 Except in exceptional circumstances, the Trustee shall not pay any benefit entitlement to any person other than the member.

18 Whenever a member expects the cost of medical treatment or hospitalisation to exceed his or her own financial resources, the member may apply for urgent consideration of the member's claim.

19 In the event that the Trustee or the Claims Manager acting as the Trustee's agent declines a claim made by a member, that member may appeal by notice in writing to within twenty eight (28) days of the decision, to the Trustee for reconsideration of the member's claim. Upon receiving notice of such an appeal the Trustee shall reconsider the claim of the member and either declines it or accepts in whole or in part as the Trustee in exercise of its absolute discretion deems appropriate. The decision of the Trustee shall be final.

DISPUTE RESOLUTION

20 Unless any dispute or difference is resolved by mediation or other agreement the same shall be submitted to the arbitration of one arbitrator who shall conduct the arbitral proceedings in accordance with the Arbitration Act 1996 and any amendment thereof or any other alternative statutory provision then relating to arbitration.

21 If the parties are unable to agree on the arbitrator, an arbitrator shall be appointed, upon request of any party, by the President for the time being of the Wellington District Law Society. The appointment shall be binding on all parties to the arbitration and shall be subject to no appeal. The provisions of Article 11 of the First Schedule of the Arbitration Act 1996 are to be read subject to this clause and varied accordingly.

TERMS AND CONDITIONS

Consideration for benefits under this mutual fund are available only to persons who have been accepted and remain acceptable by the Society for participation in Healthcare 99 and at all times during the currency of the fund are current with all contributions required.

Contributions are payable in advance.

All benefits are payable in New Zealand currency.

No benefit shall be payable in respect to any event either directly or indirectly related to:

a) anything related to pregnancy or childbirth except for the initial consultation with the GP

b) all types of infertility or treatment thereof

c) all types of Psychiatric or psychological conditions, Geriatric care, including mental stress or depression

d) the use, existence or escape of nuclear weapons material or ionising radiation from or contamination by radioactivity from any nuclear fuel or nuclear waste from the combustion of nuclear fuel

e) being under the influence of intoxicating liquor and/or a drug (or combination of drugs), other than a drug taken or administered by and in accordance with the advice of a qualified and registered medical practitioner

f) any self inflicted illness, disability, injury or any accident or illness condition or disability arising from or caused by the taking of drugs or by intoxication or by nuclear contamination

g) any expense recoverable from any other source – such as ACC, other medical insurance or benefits

h) all types of cosmetic plastic/reconstructive treatment unless stated elsewhere

i) any condition not detrimental to the immediate health of the participant

j) all types of contraception unless recommended by a doctor for non-contraception use i.e. headaches

k) all types of sterilisation other than that on recommendation by a GP where the health of the member or spouse would be seriously affected by pregnancy. Letter from GP required with any claim.

l) all types of dental treatment, oral surgery and other associated treatments except solely the removal of impacted or unerupted teeth undertaken by a qualified dentist/surgeon that has preapproval from the claims manager or trustee

m) all types of obesity or the treatment and the arising consequences

n) all types of chronic or congenital conditions

o) all types of condition/s existing or which could have been reasonably expected to exist at the time of making application for membership to participate in Healthcare 99. Some pre existing condition/s may be considered as per board policy at the time of application.

p) all types of in hospital treatment for any accident related conditions as defined by the Accident Compensation Corporation Act and its amendments and any Accredited Employer Scheme

q) all types of treatment outside of New Zealand

r) all types of orthotics, and/or external artificial devices & heart pacemakers

s) all types of elective surgery removed from public hospitals by Government or its National Health Committee as from January 1, 2013 unless preapproved by the Claims Manager or Trustee

t) all types of mole mapping

u) all types of organ transplants or the treatment and the arising consequences.

v) all types of medical checkups for any reason and any related to a driving license, life insurance and travel

w) all types of vaccinations.

OPTION A

IN HOSPITAL –

1) Related imaging, scans, specialists consultations and surgically implanted prosthetic devices to a maximum of **$10,000** in total per operation/event.
2) All costs up to a maximum of **$60,000** per operation/event per person in total -

EXCEPT for –

1. Prior diagnostic imaging and scans performed out of hospital up to maximum of **$5000** for the one operation/event.
2. Cranial, and Cardiac surgery or treatment which is up to a maximum and limited to **$15,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
3. Angiogram will be covered up to a maximum of **$5000** in total, angioplasty up to **$10,000** in total.
4. Oncology and Liver surgery or treatment which is up to a maximum of **$10,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
5. Hip, Knee and Shoulder replacement or any approved reconstruction surgery or treatment which is up to a maximum of **$20,000** per operation/event per person in total, plus the implanted prosthetic devices to a maximum of **$10,000** in any one twelve month period, commencing from the date of the first diagnosis of any event.

   The Trustee at its sole discretion may approve a further operation/event in any one twelve month period.

   Includes all reasonable hospital room charges (except alcoholic beverages) of up to 10 consecutive 24 hour periods of **$500** in total for each 24 hour period.

NB: No benefit above is payable under Option A unless the member is hospitalised (in a registered hospital).

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

NOTE: New Member Benefit Claim waiting period.
No claim/s shall be payable to any Member or any Dependant for a period of 12 weeks starting from the date of members first contribution payment received. Notwithstanding of the above waiting period the Trustee or HC 99 Committee may authorise the payment of a claim/s whether in whole or in part, if in the opinion of the Trustee or HC 99 Committee that exceptional circumstances exist.

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

Pre-Approval amounts can only be up to the amounts set out in this brochure.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

OPTION A

OUT OF HOSPITAL –

General practitioner fees up to a maximum of **$500** per annum per person.

Specialist Fees

Up to a maximum of **$5000** per annum per person.

Must be on **referral from a GP**:

Includes ECG, eye specialist doctor of physical medicine, diagnostic or investigatory examination by a consultant physician.

Prescriptions Charges

Of the government and pharmaceutical part of charges current at the time of the treatment up to a maximum of **$1,000** per annum per person.

This applies only to medicine on the New Zealand Pharmaceutical Schedule and any amendments at the time of any claim.

Other Medical Benefits

Only on referral from a GP or Specialist - Physiotherapy, chiropractor, osteopath and acupuncture.
Up to **$400** per annum in total per person.

Optometrist - visit consultancy fee only. - Corrective lenses cost not included.
Up to **$200** per annum per person.

OPTION A.1

Returns 75% of claims of the shown maximum amounts.

IN HOSPITAL –

1) Related imaging, scans, specialists consultations and surgically implanted prosthetic devices to a maximum of **$10,000** **($7500)** in total per operation/event.
2) All costs up to a maximum of **$60,000** per operation/event per person in total -

EXCEPT for –

1. Prior diagnostic imaging and scans performed out of hospital up to maximum of **$5,000** **($3,750)** for the one operation/event.
2. Cranial, and Cardiac surgery or treatment which is up to a maximum and limited to **$15,000** **($11,250)** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
3. Angiogram will be covered up to a maximum of **$5,000** in total, angioplasty up to **$10,000** in total.
4. Oncology and Liver surgery or treatment which is up to a maximum of **$10,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
5. Hip, Knee and Shoulder replacement or any approved reconstruction surgery or treatment which is up to a maximum of **$20,000** per operation/event per person in total, plus the implanted prosthetic devices to a maximum of **$10,000** in any one twelve month period, commencing from the date of the first diagnosis of any event.

   The Trustee at its sole discretion may approve a further operation/event in any one twelve month period.

   Includes all reasonable hospital room charges (except alcoholic beverages) of up to 10 consecutive 24 hour periods of **$500** in total for each 24 hour period.

NB: No benefit above is payable under Option A.1 unless the member is hospitalised (in a registered hospital).

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

NOTE: New Member Benefit Claim waiting period.
No claim/s shall be payable to any Member or any Dependant for a period of 12 weeks starting from the date of members first contribution payment received. Notwithstanding of the above waiting period the Trustee or HC 99 Committee may authorise the payment of a claim/s whether in whole or in part, if in the opinion of the Trustee or HC 99 Committee that exceptional circumstances exist.

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

Pre-Approval amounts can only be up to the amounts set out in this brochure.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

Returns 75% of claims of the shown maximum amounts.

OPTION A.1

Returns 75% of claims of the shown maximum amounts.

OUT OF HOSPITAL –

General practitioner fees up to a maximum of **$500** per annum per person.

Specialist Fees

Up to a maximum of **$5,000** per annum per person.

Must be on **referral from a GP**:

Includes ECG, eye specialist doctor of physical medicine, diagnostic or investigatory examination by a consultant physician.

Prescriptions Charges

Of the government and pharmaceutical part of charges current at the time of the treatment up to a maximum of **$1,000** per annum per person.

This applies only to medicine on the New Zealand Pharmaceutical Schedule and any amendments at the time of any claim.

Other Medical Benefits

Only on referral from a GP or Specialist - Physiotherapy, chiropractor, osteopath and acupuncture.
Up to **$400** per annum in total per person.

Optometrist - visit consultancy fee only. - Corrective lenses cost not included.
Up to **$200** per annum per person.

Returns 75% of claims of the shown maximum amounts.

OPTION B

(In Hospital only)

IN HOSPITAL –

1) Related imaging, scans, specialists consultations and surgically implanted prosthetic devices to a maximum of **$10,000** in total per operation/event.
2) All costs up to a maximum of **$60,000** per operation/event per person in total -

EXCEPT for –

1. Prior diagnostic imaging and scans performed out of hospital up to maximum of **$5000** for the one operation/event.
2. Cranial, and Cardiac surgery or treatment which is up to a maximum and limited to **$15,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
3. Angiogram will be covered up to a maximum of **$5000** in total, angioplasty up to **$10,000** in total.
4. Oncology and Liver surgery or treatment which is up to a maximum of **$10,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
5. Hip, Knee and Shoulder replacement or any approved reconstruction surgery or treatment which is up to a maximum of **$20,000** per operation/event per person in total, plus the implanted prosthetic devices to a maximum of **$10,000** in any one twelve month period, commencing from the date of the first diagnosis of any event.

   The Trustee at its sole discretion may approve a further operation/event in any one twelve month period.

   Includes all reasonable hospital room charges (except alcoholic beverages) of up to 10 consecutive 24 hour periods of **$500** in total for each 24 hour period.

NB: No benefit above is payable under Option A unless the member is hospitalised (in a registered hospital).

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

NOTE: New Member Benefit Claim waiting period.

No claim/s shall be payable to any Member or any Dependant for period of 12 weeks starting from the date of members first contribution payment received. Notwithstanding of the above waiting period the Trustee or HC 99 Committee may authorise the payment of a claim/s weather in whole or in part if in the opinion of the Trustee or HC 99 Committee that exceptional circumstances exist.

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

Pre-Approval amounts can only be up to the amounts set out in this brochure.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

OPTION B.1

(In hospital only)

Returns 75% of claims of the shown maximum amounts.

IN HOSPITAL –

1) Related imaging, scans, specialists consultations and surgically implanted prosthetic devices to a maximum of **$10,000** in total per operation/event.
2) All costs up to a maximum of **$60,000** per operation/event per person in total -

EXCEPT for –

1. Prior diagnostic imaging and scans performed out of hospital up to maximum of **$5,000** for the one operation/event.
2. Cranial, and Cardiac surgery or treatment which is up to a maximum and limited to **$15,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
3. Angiogram will be covered up to a maximum of **$5,000** in total, angioplasty up to **$10,000** in total.
4. Oncology and Liver surgery or treatment which is up to a maximum of **$10,000** per operation/event per person in total in any one twelve month period, commencing from the date of the first diagnosis of any event.
5. Hip, Knee and Shoulder replacement or any approved reconstruction surgery or treatment which is up to a maximum of **$20,000** per operation/event per person in total, plus the implanted prosthetic devices to a maximum of **$10,000** in any one twelve month period, commencing from the date of the first diagnosis of any event.

   The Trustee at its sole discretion may approve a further operation/event in any one twelve month period.

   Includes all reasonable hospital room charges (except alcoholic beverages) of up to 10 consecutive 24 hour periods of **$500** in total for each 24 hour period.

NB: No benefit above is payable under Option A.1 unless the member is hospitalised (in a registered hospital).

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

NOTE: New Member Benefit Claim waiting period.

No claim/s shall be payable to any Member or any Dependant for period of 12 weeks starting from the date of members first contribution payment received. Notwithstanding of the above waiting period the Trustee or HC 99 Committee may authorise the payment of a claim/s weather in whole or in part if in the opinion of the Trustee or HC 99 Committee that exceptional circumstances exist.

ALL IN HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

Pre-Approval amounts can only be up to the amounts set out in this brochure.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

Returns 75% of claims of the shown maximum amounts.

Changing Options.

Members wishing to change Options

1. When a member elects to move **downwards** from one option to another that has lesser benefits, then there will be a waiting period of twelve (12) weeks before the member can make a claim on their **new** option. The member continues to pay the higher contribution rate until the 12 week period has been completed. Any claim during that time will be for the lesser amounts.
2. When a member elects to move **upwards** from one option to another that has greater benefits, then there will be a waiting period of twelve (12) weeks before the member can make a claim on their **new** option, e.g. the member will continue to pay the higher amount until the 12 week period has ended and during that time any claims made will be for the lesser amounts.

Note:

If you are to change your Healthcare Option to an Option that has increased benefits, during your 12 week stand down you will be charged a the higher Option contribution rate. Please note until your 12 week stand down has been completed you still have the ability to claim medical expenses against your former Healthcare option.

Once a member has elected to move upwards they cannot elect to move downwards to a lesser option for two (2) years. The member must declare any material facts or changes that may influence the decision to accept the change of cover.

The Trustee has the sole discretion to decline any member's request to move from one option to another.
Check the Terms and Conditions. *(See Page 5 of this Information Brochure Oct 2018)*

Healthcare 99 is not an insurance plan.

HOW TO MAKE A CLAIM

1. The Member must make the claim/s on the approved Healthcare 99 claim form only.

2. The Member checks that they, or the person they are claiming for, did not have any condition existing which could have been reasonably expected to exist at the time of making application for membership to participate in Healthcare 99.

3. The Member fills in and signs Healthcare 99 claim form.

4. The Member attaches all original receipts/invoices to claim form.

5. Only original receipts/invoices will be accepted and processed by the claims manager.

6. Check that receipts/invoices fall within 30 day rule (14).

7. Post claim/s to claims manager.

Note – Claims that don't have the correct paper work attached or have been filled out incorrectly may result in your claim/s taking longer to process or will be declined.

ALL IN HOSPITAL PROCEDURES/EVENTS
MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER

IMPORTANT NOTICE:

Accident Compensation Corporation (ACC)/Accredited Employer Scheme (AES)
Procedures, operations that your GP or specialist regard as ACC/AES claims.

1. You the member must first make a claim with ACC/AES.

2. If your claim is declined by ACC/AES, then you must first appeal that decision within the time frame allowed. Contact our claims manager or Society Secretary for help or go to our Website – Healthcare 99. The Fund may help with any cost incurred.

3. If again, your claim is declined by ACC/AES, then you may seek pre-approval from Healthcare 99 claims manager for the procedure or operation.

4. If you get pre-approval you will be required to work with and supply information to our agent who will look at making a claim from the ACC/AES for the cost of your procedure or operation/event. All cost incurred will be covered according to the current rules of Healthcare 99.

5. Once you have pre-approval and have supplied the information required by our agent you can go ahead and have your procedure or operation.

6. If you the member do not appeal the ACC/AES decision within the time frame allowed then your claim will be declined under rule 19 of Healthcare 99 rules.

7. Contact our claims manager for help or go to the Welfare Society website www.firefighters.org.nz and click on Healthcare 99.

Pre-Approval amounts can only be up to the amounts set out in this brochure.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

ALL IN-HOSPITAL PROCEDURES/EVENTS MUST HAVE PRE-APPROVAL OF THE CLAIMS MANAGER.

Whenever a Healthcare 99 member or members dependant requires a procedure/event to be carried out in a registered hospital they shall require the pre-approval of the claims manager.

PROCESS FOR PRE-APPROVAL

Check that procedure/event is not an ACC/AES claim.
If the procedure/event is ACC/AES related then Pre-Approval will be declined.

1. Request a Healthcare 99 Pre-Approval Form from Claims manager. This form will be sent to you.

2. Fill in all areas on Healthcare 99 Pre-Approval Form

3. Supply a letter of referral from your GP/Specialist

4. Supply estimated cost of procedure/event from hospital

5. Return form and required information to the claims manager

6. Failure to supply all the required information will mean a delay in getting Pre-Approval.

7. Pre-Approval will only be approved when all required information has been supplied and the request meets all of Healthcare 99 Rules, Table of Benefits of Option A, A1 or Option B, B1 and Terms and Conditions.

8. Once received by the claims manager it may take up to (five) working days or more to receive pre-Approval.

9. All Pre-approvals will expire within 90 days of date of approval. You will need to apply again for pre-approval if you wish to proceed with your operation or event.

POINTS TO NOTE

- Healthcare 99 Mutual Health Fund is a benefit **NOT** an insurance plan
- Please check the Information Brochure for Terms & Conditions before making any claim
- All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)
- Existing conditions at the time of application will be considered only following full disclosure by the applicant
- Refunds are made only to the member on original receipts/invoices only
- Check that receipts/invoices are less than 30 days old before sending to claims manager
- Dependant children upon reaching 19 years of age may continue participation as an adult under their parents' membership or institute their own membership
- For any ACC/AES claim/s you must first apply to the ACC/AES
- Making a claim on Healthcare 99 must be completed on the current official Healthcare 99 claim form
- ACC claims including part charges will not be covered by Healthcare 99.
- ALL IN-HOSPITAL PROCEDURES MUST HAVE PRIOR APPROVAL OF THE CLAIMS MANAGER.

All claims submitted are subject to reimbursement at the sole discretion of the Trustee. (Rules 11. 19.)

Please check that you or the person you are claiming for did not have any condition existing or which could have been reasonably expected to exist at the time of making application for membership to participate in Healthcare 99.

FIREFIGHTERS HELPING FIREFIGHTERS

(and their families)

awhi atu awhi mai

CONTRIBUTION RATES per PERSON (effective Oct 2018)

CONTRIBUTION RATES : ANNUALLY - MONTHLY - FOTNIGHTLY, OPTION A, OPTION A1

	Annual	Monthly	F/Night
Option A			
Under 19	$525.92	$43.83	$20.17
19-24 years	$903.25	$75.27	$34.65
25-29 years	$991.69	$82.65	$38.04
30-34 years	$1415.90	$117.99	$54.31
35-39 year	$1504.32	$125.36	$57.70
40-44 years	$1626.08	$135.50	$62.37
45-49 years	$1773.46	$147.79	$68.02
50-54 years	$2117.50	$176.46	$81.22
55-59 years	$2471.25	$205.94	$94.78
60-64 years	$3015.44	$251.29	$115.66
65-69 years	$3920.14	$326.68	$150.36
70 years +	$4508.28	$375.69	$172.92

	Annual	Monthly	F/Night
Option A1			
Under 19	$420.74	$35.06	$16.14
19-24 years	$722.60	$60.22	$27.72
25-29 years	$793.36	$66.11	$30.43
30-34 years	$1132.72	$94.39	$43.45
35-39 year	$1203.46	$100.29	$46.16
40-44 years	$1300.87	$108.41	$49.90
45-49 years	$1418.77	$118.23	$54.42
50-54 years	$1694.00	$141.17	$64.97
55-59 years	$1977.00	$164.75	$75.83
60-64 years	$2412.35	$201.03	$92.53
65-69 years	$3136.12	$261.34	$120.29
70 years +	$3606.62	$300.55	$138.34

CONTRIBUTION RATES : ANNUALLY - MONTHLY - FOTNIGHTLY, OPTION B, OPTION B1

	Annual	Monthly	F/Night
Option B			
Under 19	$272.37	$22.70	$10.45
19-24 years	$521.10	$43.43	$19.98
25-29 years	$579.45	$48.29	$22.23
30-34 years	$792.83	$66.07	$30.41
35-39 year	$880.41	$73.36	$33.77
40-44 years	$945.22	$78.77	$36.26
45-49 years	$1061.99	$88.49	$40.73
50-54 years	$1412.30	$117.69	$54.17
55-59 years	$1762.59	$146.88	$67.61
60-64 years	$2306.44	$192.20	$88.46
65-69 years	$2998.29	$249.86	$115.01
70 years +	$3448.13	$287.34	$132.26

	Annual	Monthly	F/Night
Option B1			
Under 19	$217.90	$18.16	$8.36
19-24 years	$416.86	$34.74	$15.99
25-29 years	$463.56	$38.63	$17.78
30-34 years	$634.27	$52.86	$24.33
35-39 year	$704.33	$58.69	$27.02
40-44 years	$756.18	$63.01	$29.00
45-49 years	$849.60	$70.80	$32.59
50-54 years	$1129.84	$94.15	$43.34
55-59 years	$1410.08	$117.51	$54.08
60-64 years	$1845.15	$153.76	$70.77
65-69 years	$2398.63	$199.89	$92.00
70 years +	$2758.50	$229.87	$105.80

NB: All of your dependants must come under the same option
i.e. you're either all Option A, or all A.1 or all Option B, or all B.1 (Hospital & related Scanning & Imaging)

You only pay for two children
i.e. dependants under 19 years of age

You do not make any contribution for any subsequent children

THE NEW ZEALAND FIREFIGHTERS Welfare SOCIETY
0800-65-3473 (OK FIRE)