

## Healthcare 99 Mutual Health Fund

[not an insurance plan]

- 1. Self Funded - operates under a Trust Deed**  
established under the objects of the Society's rules (Rule 4) & Board Policy
- 2. You [the members] Own it**  
the NZFF Welfare Board is the Trustee
- 3. After operating costs ALL of the contributions are available for assisting the medical welfare needs of the members**
- 4. Over \$900,000 in medical welfare assistance was paid to members last year**
- 5. Run by Firefighters for Firefighters**
- 6. Regular Expert Consultations [eg Actuarial Reports]**

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**FIREFIGHTERS HELPING FIREFIGHTERS**

[and their families]

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 initial level of contributions is set out in Appendix 2.
- 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 treatment.
- 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 decline it or accept 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.

# HEALTHCARE 99

## ***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) Pregnancy or Childbirth
- b) Infertility or treatment thereof
- c) Certifiable mental disease
- d) Psychiatric or psychological treatment of any type
- e) Senile illness and geriatric care
- g) 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
- h) Any expense recoverable from any other source
- i) Cosmetic plastic or reconstructive treatment
- j) Any condition not detrimental to the immediate health of the participant
- k) Contraception
- l) Sterilisation other than on recommendation by a GP where the health of the member or spouse would be seriously affected by pregnancy
- m) Oral Surgery dentistry and other associated treatments other than that undertaken by a member of the ANZ Association of Oral and Maxillo Facial Surgeons for work referred by a GP or Dentist solely for the removal of impacted or unerupted teeth, cysts, soft tissue swellings and enlargement
- n) Obesity or the treatment thereof
- o) Any chronic or congenital condition
- p) Any condition existing or which could have been reasonably expected to exist at the time of making application to participate in Healthcare99
- q) In hospital treatment for accident related conditions as defined by the Accident Compensation Corporation
- r) Treatment outside of New Zealand
- s) Orthotics, and/or external artificial devices & heart pacemakers

***All claims submitted are subject to reimbursement at the sole discretion of the Healthcare99 Committee.***

***ALL IN- HOSPITAL PROCEDURES MUST HAVE  
PRIOR APPROVAL OF THE CLAIMS MANAGER***

## TABLE OF BENEFITS AS AT 1<sup>st</sup> OCTOBER 2008

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### ***OPTION A***

**IN HOSPITAL - *Including related imaging and scans. Surgically implanted prosthetic devices to a maximum of \$8,000 per procedure***

For medical costs incurred inside a public or private hospital including Imaging and Scans associated therewith, performed out of hospital, for the one event. Includes hospital charges up to 10 consecutive 24 hour periods.

All costs up to a **maximum of \$60,000 per event in total except for Cranial, Liver, Oncology, Cardiac (except Angioplasty) surgery or treatment which is up to a maximum of \$15,000 per event in total.**

**OUT OF HOSPITAL - *General Practitioner Fees And Specialist Fees***

On referral from GP, includes ECG, Eye Specialist Doctor of Physical Medicine, Diagnostic or investigatory examination by a consultant Physician.

**NO LIMIT**

***Prescriptions Charges***

100% of the Government and pharmaceutical part of charges current at the time of the treatment. This applies only to medicine on the Health Department Tariff.

***Other Medical Benefits***

On referral from a GP: Physiotherapy, Chiropractor, Osteopath and Acupuncture  
**\$800.00 per annum.**

***Optometrist***

Up to **\$200.00 per annum.**

***Home nursing allowance***

On GP's written recommendation  
**\$20.00 per day \$400.00 per annum.**

***ALL IN HOSPITAL PROCEDURES MUST HAVE PRIOR APPROVAL OF THE CLAIMS MANAGER***

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### ***OPTION B***

**IN HOSPITAL - *Including related imaging, scans & specialists consultations. Surgically implanted prosthetic devices to a maximum of \$8,000 per procedure.***

For medical costs incurred inside a public or private hospital including Imaging, Scans & specialists associated therewith, performed out of hospital, for the one event. Includes hospital charges up to 10 consecutive 24 hour periods.

All costs up to a **maximum of \$60,000 per event in total except for Cranial, Liver, Oncology, Cardiac (except Angioplasty) surgery or treatment which is up to a maximum of \$15,000 per event in total..**

***NB No benefit is payable under Option B unless the member is hospitalized (in a registered hospital)***

***ALL IN HOSPITAL PROCEDURES MUST HAVE PRIOR APPROVAL OF THE CLAIMS MANAGER***

***ALL CLAIMS MUST BE SUBMITTED WITHIN 30 DAYS OF BEING INCURRED***

# CONTRIBUTION RATES per PERSON (effective Oct 2009)

## ***FORTNIGHTLY CONTRIBUTION RATES***

AGE GROUP	PLAN A	PLAN B Hospital plus Scans & Imaging
Under 19	\$12.99	\$6.45
19-29 years	\$25.19	\$13.29
30-39 years	\$34.46	\$18.49
40-49 years	\$44.01	\$25.19
50-59 years	\$52.84	\$31.14
60 years plus	\$71.15	\$50.10

## ***MONTHLY CONTRIBUTION RATES***

AGE GROUP	PLAN A	PLAN B Hospital plus Scans & Imaging
Under 19	\$28.22	\$14.02
19-29 years	\$54.73	\$28.87
30-39 years	\$74.86	\$40.17
40-49 years	\$95.62	\$54.73
50-59 years	\$114.80	\$67.65
60 years plus	\$154.59	\$108.85

## ***ANNUAL CONTRIBUTION RATES***

AGE GROUP	PLAN A	PLAN B Hospital plus Scans & Imaging
Under 19	\$338.65	\$168.24
19-29 years	\$656.75	\$346.50
30-39 years	\$898.30	\$482.01
40-49 years	\$1147.42	\$656.75
50-59 years	\$1377.61	\$811.74
60 years plus	\$1855.03	\$1306.20

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

*You do not make any contribution  
for any subsequent children*

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

### **POINTS TO NOTE**

- Existing conditions at the time of application will be considered only following full disclosure by the applicant
- Refunds are made on original invoices only
- Dependant children upon reaching 19 years of age may continue participation as an adult under the parents' membership or institute their own membership

