Managing the

Gloucestershire Police Federation Health Scheme

TriCare HEALTH FUND

TriCare Health Fund offers cover for the cost of treatment of short term acute conditions in private hospitals or as a private patient in an NHS hospital.

The cost of some complementary therapies may also be covered.

ISSUE 11

In this information book you will find details about the scheme together with the rules and other general information.

TriCare Health Fund has been established by the Police Federations of Gloucestershire, West Mercia and West Yorkshire to administer their discretionary health funds. We believe we offer excellent value for money comparing the cost of premiums and the amount of coverage on offer. However, as with all health funds, there are some exclusions.

These Rules, applicable from 1st January 2014, supersede all previous Rules of the Scheme.

The Federation Health Scheme is not an 'insured Scheme'. It is your own scheme, financed solely by the subscriptions of the members and benefits are payable at the discretion of the Scheme's Management Committee. It is therefore in your own interests to use the Scheme sensibly. The Fund Manager and staff have been appointed to monitor and process claims for benefit with a view to exercising a degree of control over spending and secure the long-term viability of the scheme.

Confidentiality – Access to medical information is strictly limited to the Directors and Staff of Tricare.

RULES OF THE HEALTH FUND

1. Application for membership of the scheme is open to former and serving police officers and police staff, their spouses/partners and dependant children up to the age of 21(or 24 if in full time education), and any other person that the Management Committee may, in their absolute discretion, admit.

2. The admission of any person to the scheme is in the absolute discretion of the Management Committee.

3. Membership of the scheme does not create an entitlement to benefits, which remain at the absolute discretion of the Management Committee.

4. The benefit paid shall be limited to admissible expenses, for pre-authorised procedures, after allowing for claims or refunds receivable from any other organisation or under any insurance policy or recoverable as damages.

5. Payment of benefit is normally made direct to the provider of treatment. Invoices must be submitted within 28 days of receipt by member.

6. Members and/or their dependants are required to notify the Fund Managers on behalf of the Management Committee of any expenses which relate to a claim upon the Fund which may be recoverable from third parties. In the event that such action is successful and the monies paid to the claimant, the claimant will be required to reimburse the Fund for any admissible expenses paid by the Fund.

7. Contribution rates for Fund membership shall be prescribed from time to time by the Management committee and shall be paid by members of the Fund by instalments and in such manner as the Management Committee shall require.

8. Changes to rates for Fund membership will be notified to fund members.

9. Failure to pay any instalment of the contribution due within 30 days of the due date, shall render membership null and void and any entitlement to benefit shall be forfeit.

10. Terminology used by TriCare is defined as set out under Definitions.

11. What is Covered by the Scheme, and What is Not Covered by the Scheme are set out on separate pages.

12. Should the Fund be terminated, then any surplus monies remaining in the Fund after due regard for settlement of all outstanding claims will be distributed to the membership as defined on the date of termination in such shares and proportion as shall be decided upon by the Management Committee.

13. The right is reserved to alter these rules of membership and the accompanying Benefit Schedule at any time. Any such alterations shall not affect benefit for an eligible, notified claim where the claim has been admitted by the Fund Managers prior to the date of the said alterations.

14. Members wishing to leave the scheme must give one month's notice in writing to the Tricare Office.

15. Existing members of the scheme who make their home in another EU country may remain in the scheme and obtain treatment in their country of residence providing that it costs the scheme no more than it would have cost at the preferred provider facility in the UK. Members will be responsible for any additional expense. Claims made by members living abroad will be subject to an administration fee of £100.

WHAT IS COVERED BY THE SCHEME

The Health Fund will normally consider benefit payments to members for the following, up to limits shown on the Discretionary Benefit Schedule, PROVIDING THE CLAIM HAS BEEN PRE-AUTHORISED.

- Accommodation in the Preferred Provider Hospital – details of the Preferred Provider Hospitals in the TriCare scheme are available from the office.
- Overnight parent accommodation can be claimed for up to ten days when children up to the age of twelve years are being treated.
- Operating Theatre Charges
- Drugs dressings and medicines prescribed for in-patient treatment.
- Consultations, Pathology, X-Rays, ECG's and other diagnostic procedures.
- Special Hi-Tech procedures, to allow member access to the latest medical technology - CT Scans, MRI Scans, endoscopies etc., when requested by a consultant physician/surgeon.
- Physiotherapy on referral by General Practitioner (GP).
- Consultations in relation to a specific condition or complaint, when referred by a GP or GDP will be limited to two specialists per condition except at the discretion of the Directors.
- Alternative Medical Treatment - Homeopathy, Chiropractic, Osteopathy and Acupuncture (when referred by a Specialist)
- NHS Cash Benefit - Payable for each pre-authorised night spent in an NHS hospital without charge (for treatment of conditions that would otherwise be covered for private

treatment). In the case of emergency admissions, NHS benefit may be payable for the fourth and subsequent nights of a continuous in-patient stay directly following on from an emergency admission.

- Joint replacements are limited to one replacement per joint (no refashioning of a previously replaced joint). In the case of spinal surgery, this will be considered as joint replacement. The rule will apply to each of three regions of the spine - the cervical spine, the thoracic spine and the lumbo-sacral spine.

Please remember - ALWAYS CONTACT THE CLAIMS HELPLINE TO RESOLVE ANY DOUBTS OR CONCERN ABOUT TREATMENT. The discretionary benefits which are payable for various items of treatment are shown on the Discretionary Benefits Schedule. Check these limits carefully and if in doubt, contact the Claims Helpline on 01905 796682.

EMERGENCY TREATMENT IS NOT COVERED IN ANY CIRCUMSTANCES.

WHAT IS NOT COVERED BY THE SCHEME

The following will not be considered under the Medical Scheme Rules:-

- ANY EMERGENCY TREATMENT
- Any treatment which has not been pre-authorised.
- Any medical condition existing prior to membership until two years of membership have passed without treatment.
- Alcoholism or substance abuse or conditions arising as a result of alcoholism or substance abuse.
- Accommodation or treatment received in Health Hydros, Nature Cure Clinics or similar establishments or private beds registered as a Nursing Home attached to such establishments.
- Cosmetic treatment except where treatment is required as a direct result of bodily injury arising from a police officer's duty.
- Chronic conditions that require continuous, recurrent or on-going treatment, e.g. asthma, diabetes, arthritis (this list is not exhaustive).
- Drugs, medicines and dressings prescribed on an Out Patient basis, Surgical/Dental appliances, Spectacles, Contact Lenses or Hearing Aids, except where prescribed in the Discretionary Benefits Schedule.
- Dental Treatment unless carried out as an Oro-Surgical procedure under general anaesthetic and with admission to hospital.
- Fertility, contraception, operations for sterilisation or reversal of sterilisation or procedures relating to such treatment.
- General Practitioner or General Dental Practitioner services
- Hormone replacement therapy unless performed immediately following or in conjunction with surgical procedure that is covered under the terms of the fund.

- Nursing at Home or residential stay in a Private Hospital arranged wholly or partly for domestic reasons or which is not directly related to the treatment of a medical condition.
- Organ transplants or any treatment prior to and following such transplants.
- Personal expenses incurred in hospital such as telephone calls, guest meals and newspapers.
- Pregnancy and childbirth or any treatment or investigations relating to pregnancy or childbirth.
- Psychiatric treatment.
- Sight testing or medical examination of a routine or preventative nature.
- Supportive treatments of renal failure, including dialysis.
- Transferred treatment. Treatment as an In-patient where the initial treatment was provided by the NHS and where the patient remains under NHS care.
- Treatment received outside the UK unless specifically agreed by the Management Committee.
- Treatment which in any way arises from, is attributable to, or is consequent upon any Human Immunodeficiency Virus (HIV) infection or related syndromes.
- Expenditure arising from any consequence whether directly or indirectly as a result of nuclear or chemical contamination, war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil wars, riot, civil disturbance, rebellion, revolution, insurrection or military usurped power, other than arising directly from a Member's employment as a Police Officer.
- Treatment in non-Preferred Hospitals without the prior written agreement of the Fund Manager.
- Iatrogenic conditions (that is where medical treatment for one condition has caused another) will only be treated at the discretion of the Directors.

- Any condition where medical advice has not been followed by the claimant
- Where emergency treatment on the NHS has been declined by the claimant.
- Routine examinations, annual check ups or health screening.
- Occupational Therapy.

APPEALS AGAINST THE APPLICATION OF THE RULES BY THE FUND MANAGER MUST BE MADE IN WRITING TO THE MANAGEMENT COMMITTEE. PERSONAL OR TELEPHONE APPEALS WILL NOT BE CONSIDERED.

PREMIER PLAN DISCRETIONARY BENEFIT SCHEDULE

This schedule is intended as a guide to the level of benefit normally considered by the Management Committee.

There is an overall maximum of £17,500 per claim and an overall maximum of £30,000 per person in any scheme year which runs from 1st September

A In-patient and Day Care Benefit for Treatment at Preferred Provider Hospital
Benefit in connection with a specified medical procedure or procedures for authorised treatment

1. Hospital Accommodation & Nursing } Operating Theatre & Recovery Room } Prescribed Drugs & Dressings } FULL COVER
2. Surgeons & Anaesthetists Fees FULL COVER
3. Pathology, Radiology, Consultations & Physiotherapy FULL COVER
4. Parent accompanying child under 12 max 10 days FULL COVER
5. Specialist Physician Fees - for regular attendance in a hospital for up to 14 days FULL COVER

B In-patient and Day Care Benefit for Treatment NOT at a Preferred Provider Hospital
Members may be asked to obtain self-pay patient costs and obtain cash benefit from the scheme

C Hi-tech Investigations
Hi-tech diagnostic procedures including (but not limited to) Endoscopy, MRI & CT scans, angiography £2,000*

D Out-patient

1. Consultations, Pathology, Radiology & Physiotherapy £1,500*
2. Complementary Medical Treatment (including Chiropractic treatment, Osteopathy, Acupuncture and Homeopathy) not including medicines. £500*
3. Radiotherapy, Chemotherapy and Oncology only at the discretion of the Directors

E Private Ambulance
Charges for transport by a registered ambulance service to or from a hospital or nursing home when required for medical reasons £150*

F Home Nursing by a registered Nurse recommended by a Specialist for medical (not domestic) reasons £1,000

G NHS Cash Benefit (not available for WHAT IS NOT COVERED BY THE SCHEME) Up to an overall limit of £2000* (not payable if other benefit limits have been reached)
For each night of a planned admission, spent as a patient in an NHS bed without charge £200 per Night

OR

For each treatment undertaken on a planned Day Care basis in the NHS without charge £200 per Treatment

Emergency admissions to the NHS are not eligible for benefit

H Second Opinions
In certain circumstances and only at the discretion of the Directors FULL COVER

I Dental Treatment cash back £100
(This does not cover routine check-ups or hygiene)
OPTIONAL DENTAL BENEFIT -
Subsidised Simply Health Dental Cash Back Plan
Please contact TriCare for details or visit www.tchf.org.uk

J Claims Helpline 01905 796682
The Helpline is available Monday to Friday 9.30am - 3.30pm excluding Public Holidays

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Notes :-

a) * Benefit payable in each Fund Year

b) Cash Limits will apply to any treatment undergone at a Non-Preferred Provider. These will be advised when approval is given to use such facilities. Members may be asked to act as Self-pay patients and claim reimbursement from the fund when using such facilities.

c) All treatment undertaken at Preferred Providers is invoiced direct to our Managers at special prices that have been pre-negotiated. It is essential that you identify yourself as a member of the Fund prior to receiving treatment.

d) Failure to comply with the claims procedure will result in the member being responsible for all treatment costs incurred.

DEFINITIONS OF TERMINOLOGY USED BY TRICARE
Wherever the following expressions appear, they shall have the meanings set out below.

Acupuncturist: A practising acupuncturist who is a current member of the British Acupuncture Association and Register.
Acute Illness: A disease or illness of rapid onset, severe symptoms and brief duration.
Chiropractor: A practising chiropractor who is a current member of the British Chiropractors' Association.
Chronic Illness: A disease or illness of long duration involving very slow changes and often of gradual onset. The term does not imply anything about the severity of an illness or condition.
Claim: a course of treatment undergone in relation to a specific medical condition which has been authorised by the Fund Manager, but excluding ongoing and routine treatment to monitor such a condition.
Commencement Date: the date upon which members who have applied for membership are accepted by the Management Committee and from which benefit may be payable.
Complementary & Alternative Therapies: shall mean acupuncture, homeopathy, chiropractic treatment, osteopathy and other complementary medicine treatments as approved by the Fund Manager.
Consultant/Specialist: A Medical or Dental practitioner who is currently registered under the Medical Acts and holds a Consultant's appointment in an NHS hospital and holds a Specialist Accreditation issued by the General Medical Council in accordance with EC Medical Directives, or for the provision of Complementary Medicine, a registered practitioner as defined in the rules of the Fund.
Claims Helpline: available Monday to Friday 9.30am - 3.30pm excluding Public Holidays, 01905 796682.

Day Case: Hospital treatment which requires some form of preparation or period of recovery, or both, involving the provision of accommodation and other services but not involving an overnight stay and where the patient is admitted to the care of the hospital.

Day Patient: A patient who receives day case treatment in a hospital.

Dental Condition: Any dental condition or dentistry, including gum conditions (periodontal treatment) and malocclusion (orthodontic treatment).

Dental Practitioner: A registered Dental Practitioner in general practice in the UK

Emergency: Immediate or early treatment for a medical condition requiring urgent attention.

Fund Manager: A person or persons appointed by the Management Committee to administer the membership records and claims of the Fund.

General Practitioner: A registered Medical or Dental Practitioner in general practice.

'Hi-Tech' Investigation: Specialist investigation used as an alternative or in addition to routine diagnostic procedures only when ordered by a consultant physician/surgeon.

Homeopath: A practising homeopath who is a current member of the British Homeopathic Association.

Hospital Charges: Charges directly related to the treatment received as an In-patient or Day patient, including Accommodation, Theatre Fees, Nursing, Pathology, Radiology, Physiotherapy, Drugs and Dressings, or any additional items which form part of an integral pre-agreed procedural price.

In-patient: A patient who occupies a bed overnight in a hospital for the sole purpose of receiving treatment.

Management Committee: A committee appointed by the Federation to administer all matters relating to the operation of

the Fund. The Management Committee may retain the services of such preferred bodies or individuals to assist in the operation of the Fund as they may decide from time to time.

Medical Condition: Any disease, illness or injury other than a Dental Condition as defined.

Member: A person who has applied for membership of the Fund and who has been accepted for membership by the Management Committee and whose contributions are fully paid up to date.

Nursing at Home: The attendance of a Registered Nurse in the patient's home to provide nursing services for treatment covered under the Rules of the Fund immediately following treatment in a hospital if such services are necessary and recommended by the Consultant/Specialist who treated the patient. Such services must be for medical and not domestic reasons.

Osteopath: A practising osteopath who is a current member of the Register of Osteopaths (MRO) or College of Osteopaths.

Out-Patient: A patient who receives treatment other than as an In-patient or Day patient at a hospital or Consultant/Specialist's consulting rooms or other facility where the patient does not remain overnight and is not required to sign an admission form.

Physiotherapist: A State Registered Physiotherapist who, for the purposes of Outpatient cases, is deemed to be a Specialist. Physiotherapy must be given under the direction of a specialist.

Pre-Claim Authorisation: The process required under fund rules to validate a claim before treatment is undergone.

Pre-Existing Condition: Any Injury, Illness or Condition or related injury, illness or condition:-

i) For which medical advice or treatment has been received, or

ii) of which the Member, or Dependant, was aware or ought reasonably to have been aware, and for which medical advice or treatment was not sought, before the confirmed date of joining.

Benefit will not be paid for the first 24 months of membership for a Member or a Dependant and then only after 24 continuous months have elapsed without further medical advice or treatment,

including drugs and/or medication.
Preferred Provider: A hospital or group of hospitals or other providers of private medical care, who have agreed special pricing arrangements with the Fund Managers.
Private Hospital: A Nursing Home or Independent Hospital registered in accordance with the Nursing Homes Act or NHS pay bed, and those hospitals opting out of Regional Health Funding control.
Registered Nurse: A nurse included in the professional register of nursing maintained by the Nursing and Midwifery Council.
Second Opinion: An alternative view of a Medical condition from a second Specialist. Second Opinions may only be sought following diagnosis by a first Specialist and after authorisation by the Fund Managers.
Surgical Appliance: Any external device prescribed by the consulting specialist.
Treatment: The diagnosis and /or treatment of any surgical or medical condition including Complementary Treatment defined as such in the Fund Rules, for the sole purpose of curing or permanently relieving a medical condition under the direction of a Specialist. Treatment does not extend to include alteration or relief of chronic or long-term disease, illness or injury.
United Kingdom: Great Britain and Northern Ireland including the Channel Islands and the Isle of Man.

PREFERRED PROVIDER HOSPITALS

Your Federation Health Scheme has a Preferred Provider Hospital which provides services at a preferential rate. As these may vary from time to time it is essential that you check with the Tricare Office for your nearest Preferred Provider Hospital at the time of starting your claim.

HOW TO MAKE A CLAIM

If, when you have consulted your G.P about a problem, he/she recommends that you consult a specialist, tell him/her that you are a member of the fund. In order to benefit from the scheme you must:-

- Contact the TriCare Health Fund Office - Monday to Friday, 9.30am - 3.30pm excluding Public Holidays, 01905 796682 to obtain a claim form and claim number.
- Consultations can take place at any location. However, all tests, X-rays, etc. must be undertaken at a preferred provider hospital – ask the office for the preferred hospital in your area.
- At the consultation, ask the specialist (or physiotherapist, in the case of physiotherapy treatment) to complete the medical statement on the claim form, sign it and return it promptly to the TriCare office.
- The medical statement should include an assessment of your condition and a proposal for investigations/treatment. If there is insufficient information on the form, there may be a delay while further information is obtained from the specialist. In the case of physiotherapy this must include an estimate of the number of treatments needed. If further investigation or treatment is needed, this must be pre-authorised by the Fund Office before making further arrangements. This will normally be within 24 hours.
- Proceed with authorised action and forward invoices as and when you receive them. Authorisation to undergo treatment expires three months after the date the authorisation was issued.
- If any changes are proposed to the original schedule of treatments, let the TriCare office know immediately.

- Claims, where a period of six months has elapsed since the last treatment or notification by the member will be deemed to be closed. Further treatment undertaken after this period will be regarded as a new claim.
- In the event of any dispute as to the nature of an illness, injury or condition or the date of commencement thereof, or as to the classification of any treatment, the decision of the Management Committee shall be conclusive and binding on the member.
- The scheme shall not accept liability for any approved expenses incurred by a member or claims for the benefits unless a claim is submitted on the prescribed form accompanied by the necessary invoices within three months of the expenses being incurred or in the case of a claim for cash benefit within three months of the date of commencement of the treatment.

PLEASE REMEMBER

If you do not follow the procedure for making a claim you will not be eligible for benefits.

All invoices and correspondence must be sent to TriCare.

Members are reminded that failing to supply information or misrepresenting circumstances in order to gain benefit constitutes fraud and will be taken seriously by the Directors.

Any change in personal circumstances must be notified to TriCare Health Fund immediately as delay may invalidate future claims.

PLEASE NOTE

1. There is a £50 administration fee on all claims (This does not apply to claims for cash benefit).

2. Members of the scheme may apply for membership of a dental plan that covers routine and expensive dentistry.

3. Members may apply for £50 of Optical Benefit in each scheme year. (There is no excess on these claims).

4. All tests and treatments must take place at the preferred hospital unless specifically authorised at another hospital.

5. Those paying the special probationer rate are not eligible for Cash Benefits or other reductions to subscriptions.

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