BLULINE
POLICE HEALTHCARE SCHEME

THE BLULINE POLICE HEALTHCARE SCHEME RULES

These rules are effective from 1st January 2025

1. INTRODUCTION

1.1 The Bluline Police Healthcare Scheme (the Scheme) is a self-funded not-for-profit healthcare scheme. The Scheme is a discretionary healthcare scheme (i.e. it is not insurance-based), and its primary purpose is to support Serving Officers, Police Staff employed (or contracted to) the Chief Constable and employees of the Police Federation Branch to return to work by making private medical healthcare available to Members and Associate Members of the Scheme (the Core Purpose).

1.2 Bluline Health Limited, a company limited by guarantee (the Company), created the scheme. Bluline Administration Limited operates the scheme's administration.

1.3 All benefits under the Scheme are payable at the absolute discretion of the Scheme's Directors and will depend on the Directors' view of the Scheme's financial position and the merits of each individual case.

1.4 These rules are also subject to the provisions of the Articles of Association of the Company. In the event of any conflict between the rules and the articles of association, the articles shall prevail.

1.5 The Healthcare Scheme shall maintain a register of members, but it is not open to inspection by the Members, the public, or any other party except to the extent (if any) required by law.

1.6 All defined terms in these rules are set out in the Glossary.

1.7 Reference to Members or Associate Members shall also include Immediate Family members who are included onto the Member or Associate Members membership.

2. SCHEME MEMBERSHIP

2.1 The Scheme offers two levels of Membership: Member and Associate Member.

2.2 The two membership levels are offered subject to the qualification criteria set out in paragraph 3 below.

2.3 The two levels of membership have been created so that the Scheme's Core Purpose outlined in the Introduction can be met. It is also to ensure that the Scheme remains financially viable.

3. MEMBERSHIP ELIGIBILITY

3.1 General:

3.1.1 The Directors may vary the conditions for eligibility for membership of the Scheme at any time and at their discretion.

3.1.2 The immediate family can be included in the Member or Associate Member's policy when the Member or Associate Member joins. The Immediate Family can be added or removed from the policy at a later date provided 30 days' notice is provided to process the request. Changes will be effective from the following month of cover.

3.1.3 Members or Associate Members with Immediate Family under the age of 21 will pay the child's rate of subscription. If the child continues with full-time education, the child's rate of subscription will continue to apply until the child ceases full-time education or their 24th birthday, whichever is earlier.

3.1.4 All Newborn dependants will have a 90-day joining period from the date of birth for the inclusion of any pre-existing conditions. If joining after the 90 days, the 2-year moratorium applies.

3.1.5 The Scheme may impose special terms on an individual membership, including, but not limited to, exclusions of specific medical conditions, restrictions on particular benefits, discounts or surcharges on the contribution rates. Any such special terms will be confirmed in writing by the Scheme at the time of registration or renewal.

3.1.6 In some instances, the Scheme may require additional information from a GP or other healthcare professional who is involved in the Member or Associate Member's treatment or care. Any expense incurred for this will have to be covered by the Member or Associate Member.

3.2 Member:

3.2.1 Subject to the conditions set out in these rules, the following persons are eligible to apply to become a Member of the scheme: -

- Warranted Police Officers serving in the Police (including, at the absolute discretion of the Directors, officers on a period of Unpaid/Paid Leave).
- Employees of the Police Federation Branch.
- Police Staff employed (or contracted to) the Chief Constable
- Employees of Bluline Administration (or other administrative body used by the Company to administer the Scheme);
- Employees of a police charity, the Directors agree to allow into the Scheme in accordance with the articles of association of the Company.
- The Immediate Family of a subscribing Member as 3.1.3 & 3.1.4*;
- At the absolute discretion of the Directors, subscribing spouses (including common law spouses/partners) under the age of 80 years are eligible to remain in the scheme upon the death of a subscribing

Member.

***Immediate Family – will not be members in their own right but will be part of the subscribing Member's membership.**

3.3 Associate Member:

3.3.1 Subject to the conditions set out in these rules, the following persons are eligible to apply for Associate Membership of the scheme: -

- Retired Police Officers under 80 years of age who served in the Police and who have been Members of the Scheme for at least 3 years prior to their retirement or leaving the Police Service;
- Retired Employees under the age of 80 years of the Police Federation Branch who have been Members of the Scheme for at least 3 years prior to their retirement or leaving employment.
- Retired Police Staff under the age of 80 years who were employed (or contracted to) the Chief Constable who have been Members of the Scheme for at least 3 years prior to their retirement or leaving employment;
- Retired Employees of Bluline Administration under the age of 80 years (or other administrative body used by the Company to administer the Scheme) who have been Members of the Scheme for at least 3 years prior to their retirement or leaving employment;
- Retired employees of a police charity under the age of 80 years connected to the Police, the Directors agree to allow into the Scheme in accordance with the articles of association of the Company who have been Members of the Scheme for at least 3 years prior to their retirement or leaving employment;
- The Immediate Family (who are under the age of 80 years) of a subscribing Associate Member*;
- At the absolute discretion of the Directors, subscribing spouses (including common law spouses/partners) under the age of 80 years are eligible to remain in the scheme upon the death of a subscribing Associate Member.

***Immediate Family – will not be members in their own right but will be part of the subscribing Member's membership.**

3.4 In the event any Retired Police Officer, Retired Police Staff, Retired employee of Bluline Administration or Police Charity has not been a member of the Scheme for three years before their transfer to Associate Membership, in exceptional circumstances, the Directors may at their absolute discretion allow that applicant to join the Scheme as an Associate Member. Any decision made by the directors in relation to membership will be final.

3.5 Persons eligible above for membership of the scheme shall become a Member or Associate Member of the Scheme upon being accepted into membership by the

Directors and upon paying the appropriate subscription or upon having the appropriate subscription paid on their behalf.

3.6 Such persons shall remain Members or Associate Members of the scheme until their membership is terminated.

3.7 Transition from Member to Associate Member:

3.7.1 If a Member ends their employment or contract and is considered to be a Good Leaver, their membership, together with any Immediate Family, will have their membership converted to Associate Membership.

3.7.2 The Director's will write to the Member and any Immediate Family to explain the change in membership criteria. The membership will be transferred with effect from the following month.

3.7.3 If the Member does not wish to have their membership converted to Associate Membership, they may terminate their membership by providing 30 days written notice to the Scheme. Where such notice is to be provided, the provisions of paragraph 7.1 shall apply.

4. MEMBERSHIP APPLICATION PROCESS

4.1 Any person wishing to join the Scheme must complete the appropriate application form. Upon enquiry, the applicant will be advised which membership they are eligible for.

4.2 Membership enquiries must be made to the Bluline Administration office on **01905 796682.**

4.3 If the membership application is to also include any of the applicant's Immediate Family members, such Immediate Family members must complete the appropriate application form (as the Directors shall require) where possible.

4.4 Upon receipt of an application form, the Directors may request additional information, such as medical records or other information, before accepting the application for membership.

4.5 Any application for membership made may be refused at the Directors' absolute discretion. The Directors will be under no obligation to provide reasons for such refusal. The Directors' decision as to whether or not to admit the applicant to the Scheme shall be final and binding. The Directors reserve the right to refuse admission, notwithstanding the fact that an applicant would normally be eligible.

4.6 Upon acceptance of membership being confirmed by the Directors and the applicant(s) making payment of the relevant subscription fee, the Member or Associate Member will be entitled to receive the full benefits of the Scheme.

5. MEMBERSHIP FEES

5.1 Each membership shall be for a period of 12 months, which shall automatically renew unless terminated in accordance with paragraph 7. Membership is subject to a subscription fee being paid. Each Member or Associate Member shall pay their subscription fee in monthly instalments. The subscription rates shall be such sums as the Directors shall, from time to time, determine.

5.2 The subscription fee will be paid by any of the following methods as agreed by the Directors:

5.2.1 Deduction from the Member or Associate Member's salary where they remain in employment or

5.2.2 By direct debit; or

5.2.3 Such other payment methods as the Directors may agree from time to time.

5.3 Members or Associate Members must make sure that subscription payments are paid on time and at the agreed amount for all those named under the Member or Associate Member's policy. Membership will commence on the 1st of the month following acceptance onto the scheme. A subscription payment is deemed due on the date the Member or Associate Member is accepted onto the Scheme and will be collected on set payment dates advised to the Member each month thereafter.

5.4 The Directors may increase the subscription fee levels from time to time. The Directors will notify the Members and Associate Members in writing of the change in subscription fees. Upon notification, the Member or Associate Member may write to the Scheme Directors within 28 days to terminate their membership. Where no such notification is received, the Members and Associate Members will be subject to the new subscription fee levels.

5.5 Where the subscription fee is increased, the Members and Associate Members must alter their monthly payments to incorporate the increase. Where the Member or Associate Member fails to do so, they may not receive the full benefits of the Scheme they would otherwise be entitled to receive.

5.6 Any alteration determined by the Directors will automatically void any previously published subscription rates.

5.7 If a change of circumstances occurs which would entitle a Member or an Associate Member to a reduced subscription rate, the onus is on the Member or Associate Member to inform the Scheme in writing. If the Scheme receives no notification and an overpayment is made, then the Directors may, at their discretion, agree to a refund of all or part of any such overpayment provided that such refund of the overpayment does not exceed:

5.7.1 A total of three months of monthly subscription fees or

5.7.2 A total of twelve months of monthly subscription fees which have continued to be paid after the death of a Member or Associate Member.

5.8 If a monthly subscription payment is not paid within 30 consecutive days of the due date, the Scheme will automatically cancel the Member or Associate Member's membership in accordance with paragraph 7, and all claim entitlements will cease.

5.9 Where there are subscription arrears, benefits will not be payable for any treatment received during the arrears period until the arrears have been settled in full. Policy changes or amendments are not permitted while a policy is in arrears.

6. RENEWING

6.1 Each membership period is 12 months from the annual Scheme renewal date. At the end of that time, membership will automatically renew on the same terms (unless the Member or Associate Member advises the Scheme otherwise in writing) for another year if the membership level is still being offered.

6.2 The Directors will write to advise the Member or Associate Member of any changes to their membership within a reasonable time frame before the renewal date.

7. TERMINATION OF MEMBERSHIP

7.1 Members:

7.1.1 A Member or Associate Member may terminate their membership by giving the Scheme notice in writing. The termination will take effect 30 days after receipt of the notice to terminate by the Scheme.

7.1.2 Where such notice to terminate their membership has been provided, the Member or Associate Member will not be entitled to receive a refund of subscriptions or other sums that have been paid in advance.

7.1.3 Where the Member or Associate Member has failed to provide adequate notice to terminate the Scheme and the termination required is with immediate effect, the Member or Associate Member will be liable to pay a further monthly subscription as would have been payable had the Member not given such notice.

7.1.4 Upon the expiry of the notice period, the Member or Associate Member and their Immediate Family will not receive any further benefit or payment from the Scheme.

7.2 The Scheme:

7.2.1 The Directors of the Scheme shall be entitled to immediately terminate by notice in writing, a Member's or Associate Member's membership (including that of any Immediate Family) if:

7.2.1.1 The Member or Associate Member fails to pay any sum due to the Scheme within 30 days of the due date;

7.2.1.2 Upon the Member or Associate Member reaching their 80th birthday;

7.2.1.3 The Member is no longer employed or working for any of the Police, the Police Federation, Bluline Administration or a connected police charity and is considered to be a Bad Leaver;

7.2.1.4 The Member is no longer employed or working for any of the Police, the Police Federation, Bluline Administration or a connected police charity and is considered to be a "Good Leaver" but does not want their membership to be converted to Associate Member status and has failed to notify the Scheme in accordance with paragraph 3.7;

7.2.1.5 The Member or Associate Member dies. Membership of the Scheme shall cease on the death of a Member or Associate Member. Membership may be transferred to the Immediate

Family at the discretion of the Directors. Where membership is not transferred, membership for Immediate Family will also cease subject to their being invited to apply for membership in their own right;

7.2.1.6 The Member or Associate Member obtains any benefit or payment in circumstances where such benefit or payment has been received as a result of the Member or Associate Member knowingly or recklessly furnishing or omitting to furnish the Scheme with all material facts or otherwise dishonestly securing such benefit or payment.

7.2.1.7 The Member or Associate Member completes a Medical Claim Form in a manner in which the Member or Associate Member knowingly or recklessly omits a material fact or knowingly or recklessly includes any incorrect facts or fails to supply such other documents as may be requested by the Scheme;

7.2.1.8 The Member or Associate Member makes a dishonest or fraudulent claim of whatever kind;

7.2.1.9 The Member or Associate Member commits any material breach of these rules;

7.2.1.10 In the reasonable opinion of the Directors, the Member or Associate Member's behaviour is likely to prejudice the interests or reputation of the Scheme.

7.2.2 The Directors shall be entitled to treat any failure of any Immediate Family in exactly the same way as a failure by a Member or Associate Member to abide by the rules.

7.2.3 The Directors of the Scheme shall be entitled to immediately remove from the Scheme the spouse or partner of a Member or Associate Member without affecting the Member or Associate Member's ongoing membership where the Scheme:

7.2.3.1 Is notified of the divorce of the Member or Associated Member from their spouse, and the Member or Associate Member is in receipt of the "decree absolute".

7.2.3.2 Is notified of the Member's or Associate Member's separation from their partner or civil partner, including one of the parties moving out of any shared accommodation.

7.2.4 For the avoidance of doubt, if a Member or Associate Member or their spouse, partner or civil partner fails to inform the Scheme of the circumstances contained in paragraph 7.2.3 above, it will be considered a material breach of these rules. The Directors may terminate the Member or Associate Member's membership in accordance with paragraph 7.2.1.9 above.

7.2.5 Once a Member or Associate Member has ceased to be a Member or Associate Member, the Member or Associate Member's name shall be removed from the register of Members, and neither they nor any of their Immediate Family shall be entitled to any further benefit or payment from

the Scheme. Full details of our data protection policy can be obtained from our data protection officer. Please contact the Bluline Administration to request a copy.

7.3 Appeals:

7.3.1 Where the Directors of the Scheme have terminated Membership in accordance with paragraph 7.2 above, the Member or Associate Member are entitled to appeal against the decision.

7.3.2 To appeal, the Member or Associate Member must set out in a written statement of no more than 500 words the reasons for their appeal. The Member or Associate Member must deliver the written statement to the Bluline Administration within 14 days of being notified of the termination of their membership. No appeals will be considered if the written statement is delivered after the expiry of the 14 days without the express permission of the Directors.

7.3.3 Upon receipt of the written statement, the Directors will meet within 30 working days of the written statement having been received. Once the Directors have considered the written statement, the Directors will deliver their decision in writing within 10 working days.

7.3.4 The decision of the Directors will be final and binding.

7.3.5 If the appeal is upheld, the Member or Associate Member, together with any Immediate Family members, will be reinstated onto the Scheme on the same terms as previously enjoyed. If the appeal is not upheld, the membership of the Member or Associate Member and any immediate Family will remain terminated from the Scheme.

8. BENEFITS

8.1 Summary points applicable for both Members and Associate Members:

8.1.1 All benefits payable under the Scheme are only payable at the absolute discretion of the Directors and will depend on the Directors' view of the Scheme's financial position and the overriding objectives of the Scheme. Payment of any benefit or authorisation of treatment under the Scheme is not guaranteed. Payments will also be subject to the financial limits set out in the applicable appendix.

8.1.2 It is intended that the benefits, subject to any financial limit outlined in the applicable Appendices, are to cover the cost of investigation, hospitalisation and specialist medical fees for treatment to procure or alleviate medical conditions, both as an in-patient and out-patient. The Scheme is not intended to provide for the cost of emergency treatment or the treatment or control of long-term or chronic illness.

8.1.3 Payment of benefits under the Scheme is subject to a Member's Contribution or an Associate Member's Contribution.

What does this mean?

The Member's Contribution or Associate Member's Contribution is the amount you will pay towards the cost of any eligible treatment. The amount of the Member's Contribution or Associate Member's Contribution to be paid should a claim be submitted will be determined by the Directors on an annual basis, and Members and Associate Members will be notified at the start of each financial year. This will be deducted from the first eligible invoice(s) processed by the Scheme. The Scheme will inform you where you need to pay this amount directly to a treatment provider.

8.1.4 The Directors may decide that if NHS treatment is available within the same or similar time frame, benefits within the Scheme may be limited to NHS benefit.

8.1.5 No benefits shall be payable unless the claims procedure set out in paragraph 9 is followed.

8.1.6 All benefits under the Scheme are subject to the Exclusions for treatment as listed below in paragraph 8.4.

8.1.7 Subject to the above requirements, where possible, the Scheme will provide the following benefits to members of the Scheme:

8.1.7.1 The cost of private medical treatment and medical advice, which is recommended by a suitably qualified medical general practitioner and carried out by a medical specialist of Consultant status, subject to such limitations as the Directors may, at their absolute discretion, from time to time, impose;

8.1.7.2 The cost of hospital accommodation within such limits as the Directors may, at their absolute discretion, from time to time, impose;

8.1.7.3 Specialist fees charged by surgeons, physicians and anaesthetists;

8.1.7.4 Consultation fees and charges for x-rays, pathology and computerised tomography;

8.1.7.5 The cost of outpatient treatment of a specialist nature, including diagnostic procedures and operations performed on a day-case basis;

8.1.7.6 The cost of in-patient physiotherapy received following surgery;

8.1.7.7 The cost of physiotherapy, chiropractic and osteopathic treatment received as an outpatient, payable at the rate specified in Appendix 1 & 2 or within such other limits as the Directors may, from time to time, determine;

8.1.7.8 Such other treatment as the Directors shall, from time to time, at their discretion, decide.

8.1.7.9 In the case of day-case surgery performed as an out-patient free of charge on the NHS calculated at the rate specified in Appendix 1 & 2. The cost of hospital or other accommodation

for the sole reason of facilitating such treatment will not be payable;

8.1.7.10 The scheme will provide for a cash benefit payment (cash back) where, with the exception of emergency admissions/treatment, a Member or Associate Member is required to undertake treatment or care and use the facilities in any NHS hospital or a Member or Associate Member opts to use NHS facilities instead of private facilities made available under the scheme. Where emergency admissions/treatment has been undertaken, the scheme will only provide cash back on treatments otherwise covered under the scheme, excluding the first 3 nights.

8.2 Members Benefits

8.2.1 Members will be entitled to all benefits and payments outlined in Appendix 1. Claims for treatment made by Members living within the UK will be subject to an administration fee of £50

8.2.2 Existing Members or Associate Members who subsequently leave the UK and take up residence in another country may remain a Member or Associate Members of the Scheme. Members or Associate Members who move to another country may, at the discretion of the Directors, obtain treatment in their country of residence. The same benefits and payments as outlined in Appendix 1 or 2 will apply. Any costs of treatment over and above the thresholds outlined in Appendix 1 or 2 will be the responsibility of the Member or Associate Member. Claims for treatment made by Members living abroad will be subject to an administration fee of £100.

8.3 Associate Members Benefits

8.3.1 Associate Members will be entitled to all benefits and payments outlined in Appendix 2.

8.3.2 For the avoidance of doubt and as outlined in Appendix 2, Associate Members will not receive the In-Patient and Day Case for treatment benefit in relation to joint replacement and reconstruction, spinal surgery and/or fusions. Associate Members, however, will be covered for the costs of diagnostic procedures and investigations into these conditions.

8.4 Exclusions

8.4.1 The following types of treatment will not be eligible for benefit under this Scheme; the list and any examples are to provide a guide only and are not exhaustive:

8.4.1.1 Pre-existing conditions within the first 2 years of membership (No cover for any medical condition which exists or is known about 5 years prior to joining until a period of 2 years has elapsed and there has been a continuous period of 24 months free of symptoms or treatment of that condition.)

8.4.1.2 The Member's Contribution or Associate Member's Contribution in relation to eligible treatment claimed per person per Membership Year.

8.4.1.3 The cost of treatment (including payment for consultations) which is in excess of the Financial Limitations in any one Membership Year.

8.4.1.4 Radiotherapy or Chemotherapy Treatment for Cancer.

8.4.1.5 Repeat procedures not covered (exception of skin condition: up to 3 skin lesions to be removed)

8.4.1.6 Repeat injections (maximum of 3 within a consultation room or 1 X-ray guided)

8.4.1.7 Revision surgery not covered

8.4.1.8 Medical devices of any type, such as pacemakers, CPAP machines, blood glucose meters, and blood pressure monitors, are not covered.

8.4.1.9 Metalwork revision or removal not covered

8.4.1.10 Any cosmetic or aesthetic surgery or treatment (except at the Director's discretion, where treatment is required as a direct result of bodily injury arising from a police officer's duty) or any surgery or treatment which relates or is connected to any previous cosmetic or aesthetic surgery or treatment. However, the Directors will consider payments for initial reconstructive surgery where the Directors are satisfied that it is necessary after medical treatment. Cosmetic or aesthetic surgery or treatment. However, the Directors will consider payments for initial reconstructive surgery where the Directors are satisfied that it is necessary after medical treatment.

8.4.1.11 Surgery which can be performed within the same timescales and under the same conditions through the NHS will not be covered. In exceptional circumstances, the Directors will consider each case on its merits. However, their decision will be final.

8.4.1.12 Blood tests must be directed to the GP; however, under exceptional circumstances, they will only be covered with prior authorisation from the administration team.

8.4.1.13 Chronic conditions that require continuous, recurrent or ongoing treatment, for example, asthma, diabetes, epilepsy, sleep apnoea or arthritis.

8.4.1.14 Life-threatening conditions that require immediate or emergency treatments, for example, sepsis, stroke, heart attack, pneumonia and anaphylaxis

8.4.1.15 Monitoring of any condition over an extended period of time.

8.4.1.16 Treatment for family planning or infertility.

8.4.1.17 Genetic screening.

8.4.1.18 Any treatment/procedure not approved by the National Institute for Healthcare Excellence (NICE) (or other Government body that replaces the functions of NICE).

8.4.1.19 Any treatment/procedure that the NHS does not provide.

8.4.1.20 Accommodation or treatment received in hospitals is not approved by the administration team.

8.4.1.21 Establishments or private beds registered as a Nursing Home or attached to such establishments.

8.4.1.22 Treatment for conditions resulting or arising from drug, alcohol or substance abuse.

8.4.1.23 Treatment related to pregnancy and/or childbirth.

8.4.1.24 Termination of pregnancy or any consequences of it.

8.4.1.25 Investigations into and treatment of erectile dysfunction (impotence) or any consequences of it.

8.4.1.26 Any procedure or treatment relating to gender reassignment or reversal.

8.4.1.27 Fertility, contraception, operations for sterilisation or reversal of sterilisation or procedures relating to such treatment.

8.4.1.28 Diagnosis or treatment for psychiatric or mental disorders, for example, anxiety, depression, or PTSD

8.4.1.29 Supportive treatments of renal failure, including dialysis.

8.4.1.30 The services of a general practitioner, dentist, optician, homeopath, reflexologist, chiropodist or other practitioners not of Consultant status, except that the Directors may grant benefit for any of the above if such treatment is recommended by and remains under the supervision of a specialist of Consultant, when limited benefits may be approved.

8.4.1.31 Dental Treatment unless carried out as an Oro-Surgical procedure under general anaesthetic and with hospital admission.

8.4.1.32 The cost of dental or other appliances such as braces.

8.4.1.33 The cost of any lenses and frames.

8.4.1.34 Laser eye surgery for vision correction or cosmetic purposes.

8.4.1.35 Where cataract surgery is required, we will only cover the cost of a basic-level lens.

8.4.1.36 The cost of residence in a nursing home or nursing at home other than short-term post-operative care under the direction of a specialist.

8.4.1.37 Any treatment relating to AIDS/HIV/CJD/STD.

8.4.1.38 Any obesity-related treatment, even if medically necessary, includes dieticians, weight loss medication, and bariatric surgery.

8.4.1.39 Any treatment relating to organ/tissue transplant.

8.4.1.40 Private prescriptions or outpatient drugs.

8.4.1.41 Any testing for allergies, for example, environmental, food or drugs.

8.4.1.42 Treatment is covered outside the UK as we allow members to continue membership outside the UK - however, we only pay up to our UK preferred provider rates & this is reimbursed to the member

8.4.1.43 Non-medical expenses such as travel, meals or other out-of-pocket expenses unless, in the opinion of the Directors, payment would be in the best interests of members as a whole.

8.4.1.44 Treatment for any injury that is deliberately self-inflicted, a result of attempted suicide or caused by another with the Member's/Associate member's consent.

8.4.1.45 Any diagnosis or treatment regarding developmental delay, whether physical, neurological, psychological or learning difficulties, for example, dyslexia, dyspraxia, ADHD or autism.

8.4.1.46 Preventative treatment.

8.4.1.47 Vaccination and immunisations.

8.4.1.48 Routine examinations, annual check-ups or health screening.

8.4.1.49 The cost of providing or fitting any external prosthesis or appliance.

8.4.1.50 Any treatment of injuries or conditions resulting from any dangerous or extreme sport or activity including, but not limited to:- Sky-diving, parachuting, hand-gliding, bungee jumping, mountaineering, rock climbing, lugeing, bobsleigh, ski jumping or heli-skiing.

8.4.1.51 Any complimentary or alternate medicine including, but not limited to, aromatherapy, reflexology, sports massage or acupuncture, except as part of an approved course of physiotherapy treatment.

8.4.1.52 Medical appliances or equipment including, but not limited to, walking aids, dialysis equipment, breathing apparatus, hearing aids, mobility devices or drips.

8.4.1.53 Any treatment following an emergency admission or transfer from an NHS or other hospital.

8.4.1.54 Hormone replacement therapy unless performed immediately following or in conjunction with a surgical procedure that is covered under the terms of the fund.

8.4.1.55 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.

8.4.1.56 Organ/tissue transplants or any treatment prior to and following such transplants.

8.4.1.57 Sight testing or medical examination of a routine or preventative nature.

8.4.1.58 Iatrogenic conditions (where medical treatment for one condition has caused another) will only be treated at the discretion of the Directors.

8.4.1.59 Any condition where the Member or Associate Member has not followed medical advice.

8.4.1.60 Where the Member or Associate Member has declined emergency treatment on the NHS.

8.4.1.61 Occupational Therapy.

8.4.1.62 Treatment in non-preferred Hospitals without the prior written agreement of the administration team.

8.4.1.63 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 Directors.

8.4.1.64 Personal expenses incurred in the hospital, such as telephone calls, guest meals and newspapers.

8.4.2 The Scheme will not make payment of any benefits where:

8.4.2.1 The advice or treatment commenced prior to the claimant becoming a Member or Associate Member of the Scheme;

8.4.2.2 The Member or Associate Member has a Pre-existing Condition;

8.4.2.3 The Member or Associate Member fails to comply fully with the Claims Procedure set out below in paragraph 9.

8.4.2.4 The Member or Associated Members' membership has been terminated in accordance with paragraph 7, except where such treatment was approved and completed prior to the termination of the membership.

8.4.2.5 The Member or Associated Member is already receiving NHS in-patient treatment, and they wish to transfer to a private facility.

8.4.2.6 The NHS provided the initial treatment and where the patient wishes to transfer their care to private treatment under the Scheme.

8.4.2.7 A period of six months has elapsed since the last treatment or notification by the Member or Associate Member. The claim will be deemed closed, and any further treatment undertaken after this period will be regarded as a new claim.

8.4.2.8 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.

9. CLAIMS PROCEDURE AND RULES

9.1 A Member or Associate Member must seek Pre-Claim Authorisation and confirmation of cover before proceeding with treatment. Failure to pre-authorise a claim may lead to non-payment.

9.2 EMERGENCY TREATMENT IS NOT COVERED; IN AN EMERGENCY, a Member or Associate Member SHOULD CALL AN NHS AMBULANCE AND/OR VISIT AN NHS ACCIDENT & EMERGENCY DEPARTMENT. Emergency Treatment is defined as an admission to a hospital directly following an accident, a hospital ward

directly from the emergency department for urgent or unplanned treatment, or a hospital ward on the same day as a referral for treatment is made either by a GP or specialist, when immediate treatment or diagnostic tests are necessary, or a hospital to receive immediate lifesaving surgery

10. HOW TO MAKE A CLAIM:

10.1 Once you have consulted your GP about a problem, if they recommend that you consult a specialist, tell them that you are a member of the scheme in order for your GP to make a private referral. To benefit from the Scheme, you must in the first instance:

Contact the Bluline Administration office.
(Mon to Fri 9.00 am – 4.00 pm excluding public holidays) on **01905 796682** Or email **team@blulineadmin.co.uk.**

10.2 Steps:

10.2.1 If your referral falls within the Scheme rules, you will receive a claim form and 'Notes for Consultant/Specialist'. The Scheme uses Preferred Providers in each area. Bluline Administration will discuss this with you when opening a new claim. We will inform you if the Scheme determines that the referral does not fall within the Scheme rules. Please see the director review process at 10.3 below.

10.2.2 Complete the Claim Form and return it to the Bluline Administration office with the relevant administration fee (£50 for Members resident in the UK and £100 for Members living abroad). Bluline Administration Bluline Administration will only accept an original signature (non-digital).

10.2.3 At the consultation, present the signed 'Notes for Consultant/Specialist' to the consultant. This provides your consent for the consultant to supply a copy of your clinic letter to the Bluline Administration.

10.2.4 If the consultant states that further investigation or treatment is required, please contact the Bluline Administration office for pre-authorisation before any treatment takes place. All MRI and CT scans will be arranged at our Preferred Providers.

10.2.5 If any changes are proposed to the original schedule of treatments, let the Bluline Administration office know immediately.

10.3 What happens if the Scheme determines that the referral does not fall within the Scheme rules?

10.3.1 We will inform you that the referral is not covered by the Scheme rules. If this decision is made, a Member can ask the Directors to review it.

10.3.2 To ask the Directors to review the decision, the Member must state in a written statement of no more than 500 words the reasons for the review request. The Member must deliver the written statement to the Bluline Administration within 14 days of being notified of the decision. No review will be considered if the written statement is delivered after the expiry of the 14 days without the express permission of the Directors.

10.3.3 Upon receipt of the review request, the Directors will meet within 28 working days. Once the Directors have considered the review request, the Directors will deliver their decision in writing within 10 working days.

10.3.4 The decision of the Directors will be final and binding.

10.4 Important points to remember:

10.4.1 You may nominate a spouse, relative or friend to have authorisation to speak on your behalf on your new claim.

10.4.2 The Scheme relies on its Members or Associate Members to update the Bluline Administration at each stage of the claim. If we are unaware of treatment or appointments, then the Member or Associate Member may be liable for any costs.

10.4.3 Any change in personal circumstances must be notified to the Bluline Administration Office immediately, as delay may invalidate future claims.

10.4.4 Claims, where a period of six months has elapsed since the last treatment or notification by the Member or Associate Member will be deemed to be closed. Further treatment undertaken after this period will be regarded as a new claim if applicable within the Scheme rules.

10.4.5 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 Directors shall be final and binding on the Member or Associate Member (please refer to paragraph 10.3 above).

10.4.6 It is essential that you identify yourself as a member of the Scheme prior to receiving treatment.

10.4.7 Please be aware that in most cases, for a procedure or surgery to be authorised, we will need to see the clinic letter and have the procedure code and costs from the hospital. You may need to contact the consultant or their secretary for this information and inform the Bluline Administration.

10.4.8 All invoices and correspondence must be sent to the Bluline Administration Office.

10.4.9 Failure to comply with the claims procedure will result in a Member or Associate Member being responsible for all treatment costs incurred and not being eligible for benefits under the Scheme.

10.4.10 The Scheme shall not accept liability for any approved expenses incurred by a Member or Associate Member or claims for 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.

10.4.11 Any unattended appointments that are not cancelled within the provider's cancellation policy timeframe will result in a Member or Associate Member being responsible for all treatment costs incurred.

10.5 If the Member or Associate Member break any of the terms of membership or makes or attempts to make any dishonest or reckless application or claim, the Scheme shall be entitled to:

10.5.1 refuse to pay any benefit;

10.5.2 terminate the membership immediately.

10.6 If the Scheme makes any payments to the Member or Associate Member as a result of fraud, recklessness or negligence, the following actions may take place:

10.6.1 membership will be terminated immediately;
10.6.2 the Scheme may demand that any benefits paid to the Member or Associate Member are reimbursed to the Scheme;
10.6.3 the Scheme may take legal action against the Member or Associate Member for the return of such monies paid out to the Member or Associate Member in benefit. It may be demanded that the Member or Associate Member reimburse the Scheme for any investigation costs incurred.

11. RIGHTS OF RECOVERY BY THE SCHEME AGAINST THIRD PARTIES

11.1 If a claim for benefits is made under the Scheme for treatment for an injury, condition or illness that a third party caused, and the Member or Associate Member makes a claim against a third party for compensation, the Member or Associate Member concerned must immediately inform the Directors of this fact and provide the details of their solicitor and/or insurance company.

11.2 The Directors will write to the Member or Associate Member's solicitor or insurance company giving details of the medical expenses for which the Member or Associate Member have claimed, asking them to include the cost of these expenses in the Member or Associate Member's claim with the third party, if appropriate.

11.3 If the Member or Associate Member's case is successful and compensation is paid (whether in full or part settlement), the Member or Associate Member will need to pay the Scheme's outlay to the Scheme. In the event of part settlement, the Member or Associate Member will need to pay the Scheme the percentage of medical expenses and costs recovered. The Member, Associate Member, solicitor, or insurance company must keep the Scheme informed about the progress and outcome of any claim.

12. OTHER INSURANCE POLICIES

12.1 If the Member or Associate Member thinks that the costs of the medical consultation or treatment may be claimed from another medical expense scheme or health insurance policy, the Member or Associate Member must immediately inform the Directors of this fact.

12.2 The Scheme reserves the right to pursue an alternative medical expense scheme or health insurance provider in the name of the Member or Associate Member to recover the costs of the consultation and/or treatment. If the Scheme chooses to do this, the Member or Associate Member must provide all reasonable assistance to the Scheme and account to the Scheme for any amount recovered.

13. USE OF CONFIDENTIAL INFORMATION

13.1 Data Protection:

13.1.1 The confidentiality of patient and member information is of paramount concern to the Scheme. To this end, the Scheme fully complies with current Data Protection legislation and Medical Confidentiality Guidelines.

The Scheme will not use patient or member information other than to provide the scheme's benefits. Bluline Administration staff may need access to medical records to review them for the purposes of claims made under the Scheme. Where such information is required, staff will only have access to it once the necessary consent of the Member and medical advisers has been provided. Such information will only be disclosed to relevant third parties in line with paragraphs 13.1.5 and 13.2 below.

The Directors may also have access to medical records when reviewing a decision about medical claims falling outside of the Scheme rules (paragraph 10.3 above). The Directors will only be sent the information if the Member has provided the relevant consent for the disclosure of the information for the purposes of the review request. All other medical information sent to the Directors will be anonymised.

13.1.2 Full details of our data protection policy can be obtained from our data protection officer. Please contact the Bluline Administration to request a copy. Below are some important summary points:

13.1.3 As a Member or Associate Member whose membership includes Immediate Family, the Member or Associate Member has sought and agreed to act on behalf of any other person included within the membership. As such, all membership documents and confirmation of how the Scheme have dealt with any claim/s under the membership will be sent to the Member or Associate Member.

13.1.4 All telephone calls to the Bluline Administration may be recorded and monitored for training, quality assurance purposes, and/or the prevention and detection of crime.

13.1.5 Medical information or records will only be disclosed to those involved with treatment or care, including GP, or to their agents and, if applicable, to any person or organisation responsible for meeting the treatment expenses or their agents. Such disclosure will not be made without first obtaining your authority to do so.

13.1.6 The Scheme sometimes uses third parties to process data on its behalf. If you would like further information about these third parties, please write to the Data Protection Officer.

13.1.7 To aid the Scheme in detecting and preventing fraudulent claims, the Scheme may disclose personal information about a Member or Associate Member to fraud prevention agencies that may record, use and distribute this personal information to other organisations. In addition, the Scheme works collectively with other organisations to share information about fraudulent/suspicious claims. If the Member or Associate Member would like further information about these third parties, please write to the Data Protection Officer.

13.1.8 A Member or Associate Member is entitled to request a copy of the information the Scheme holds about them. You will also have the following rights in relation to your personal information:

13.1.8.1 to be informed about how, why and on what basis that information is processed;

13.1.8.2 to obtain confirmation that your information is being processed and to obtain access to it and certain other information, by making a subject access request;

13.1.8.3 to have data corrected if it is inaccurate or incomplete;

13.1.8.4 to have data erased if it is no longer necessary for the purpose for which it was initially collected/processed or if there are no overriding legitimate grounds for the processing (this is sometimes known as 'the right to be forgotten');

13.1.8.5 to restrict the processing of personal information where the accuracy of the information is contested, or the processing is unlawful (but you do not want the data to be erased), or where the employer no longer needs the personal information, but you require the data to establish, exercise or defend a legal claim; and

13.1.8.6 to restrict the processing of personal information temporarily where you do not think it is accurate (and the employer is verifying whether it is accurate) or where you have objected to the processing (and the employer is considering whether the organisation's legitimate grounds override your interests).

13.1.9 If a Member or Associate Member would like to exercise any of the rights in paragraphs 13.1.8.1 to 13.1.8.6, please write to the Data Protection Officer. For all data protection queries, please write to the Data Protection Officer at the Bluline Administration office.

13.2 Access to Medical Records

13.2.1 Sometimes, the Scheme needs to get a medical report from a doctor who has cared for a Member or Associate Member before the Scheme can make a decision on the Member or Associate Member's application/claim. Within the first two years of Membership, the Scheme will request medical records to identify pre-existing conditions. The Access to Medical Reports Act 1988 gives a Member or Associate Member certain legal rights, which are:

13.2.1.1 The Scheme need the Member or Associate Member's agreement before the Scheme can apply for a medical report from the Member or Associate Member's doctor.

13.2.1.2 The Member or Associate Member can refuse, but if they do, the Scheme will not be able to assess their application and may not be able to process the claim.

13.2.1.3 The Member or Associate Member can ask to see the report before the doctor sends it to the Scheme or for up to 6 months after. If the Member or Associate Member wishes to see the

report, please tick the relevant box on the Access to Medical Reports Form. This may delay the assessment of any application, and the doctor can charge the Member or Associate Member a reasonable fee to cover costs.

13.2.1.4 If the Member or Associate Member thinks a part of the report is incorrect or misleading, the Member or Associate Member can ask the doctor to change it. If the doctor will not agree to do this, the Member or Associate Member may attach a statement of their own. The Member or Associate Member will not be entitled to see any part of the report which:

13.2.1.4.1 The doctor believes it could seriously harm the Member or Associate Member's physical or mental health or that of others.

13.2.1.4.2 Indicates the doctor's intentions in respect of the Member or Associate Member.

13.2.1.4.3 Reveals information about another person or the identity of someone who has given the doctor information about the Member or Associate Member (unless that person consents or is a health professional involved in caring for the Member or Associate Member).

13.2.2 The Scheme will write and tell the Member or Associate Member when it requests the report. If the Member or Associate Member has asked to see the report before the doctor sends it to the Scheme, the Member or Associate Member will have 21 days from the receipt of the Scheme's letter to contact the doctor. Once the Member or Associate Member have seen the report, the doctor needs the Member or Associate Member's agreement to send it to the Scheme. If the Member or Associate Member does not arrange to see the report within 21 days, the doctor will be free to send it to the Scheme.

14. GENERAL

14.1 Members and Associate Members must keep the Scheme informed about any changes to the original information that the Member or Associate Member provided to the Scheme. This includes but is not restricted to immediately notifying the Directors of change of address, name, email address and phone number or circumstances.

14.2 Any notice or other communication to be sent by the Scheme to a Member or Associate Member shall be sent to the last known address of the Member or Associate Member or by electronic communication to the Member or Associate Member's email address, which was given to the Scheme by the Member or Associate Member for communications. Any written communication sent by first-class post will be deemed to have been received 48 hours from the date of posting. Any electronic communication will be deemed to have been received 48 hours from the time of transmission.

14.3 Any notice or communication to be sent by a Member or Associate Member to the Scheme shall be in writing and sent to the Company's administration office. Any written communication sent by first-class post will be deemed to have been received 48 hours from the date of posting.

14.4 All benefits provided within this Scheme are at the discretion of the Directors, whose decision shall be final and binding.

14.5 If there is a dispute over the interpretation of any of these rules, the decision of the Directors shall be final and binding.

14.6 The Directors may, at any time, revoke, supplement, vary the rules or introduce new rules including, but without limiting the foregoing, for the following reasons: to enable the Scheme to meet its general legal and regulatory responsibilities; to allow the Scheme to respond to changes in the general law or regulation; to reflect legitimate cost increases or reductions associated with providing cover. The Scheme will give Members and Associate Members one month's notice of any such change by writing to them at their last known address according to the Scheme's records.

14.7 The Directors may at any time delegate their duties or powers to any person they deem appropriate on such terms as they may decide.

14.8 The Scheme and these rules shall be governed by and construed in accordance with English law.

15. DEFINITIONS:

Associate Member	A person who has retired from the Police, the Chief Constable, retired Police Staff employed (or contracted to) the Chief Constable and retired employees of the Police Federation Branches or of a Police Charity with at least 3 years of Bluline membership less than 80 years of age. Retired Bluline employees and immediate family of a subscribing member with at least 3 years of Bluline membership who is under the age of 80 years, see section 3.3.1
Bad Leaver	Means a Member who is not determined to be a Good Leaver;
Bluline Administration	Means the organisation appointed to administer the Scheme for the Company;
Chronic Illness	A disease or illness of long duration involving very slow changes and often a gradual onset. The term does not imply anything about the severity of an illness or a condition.
Consultant/Specialist	Means a medical 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;
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.
Director	Means any person appointed to be a director of the Company from time to time;
Emergency	Immediate or early treatment for a medical condition requiring urgent attention.
Financial Limitations	Means the financial limits contained in Appendix 1 and 2 as to the maximum available for claims;
Good Leaver	Means a Member who ceases to be employed or has their contract terminated by reason of: a) Redundancy; b) Retirement.
Immediate Family	Means spouse, partner or children (until the renewal immediately following on from their 21st birthday or their 24th birthday if they are in full-time education) of the Member or Associate Member;
In-Patient	A patient who occupies a bed overnight in a hospital for the sole purpose of receiving treatment.
Member	A person who is a Warranted Police Officer, Police Staff employee (contracted to) the Chief Constable, an employee of the Police Federation Branch, an employee of Bluline administration, an employee of a Police charity and immediate family of a subscribing member.
Membership Year	Means 12 months from the commencement of membership and subsequent years upon renewal;
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.
Out-Patient	A patient who receives treatment other than as an in-patient or day patient at a hospital, consultant/specialist's consulting rooms, or other facility where the patient does not remain overnight is not required to sign an admission form.
Pre-Claim Authorisation	The process required under Bluline Administration Limited rules to validate a claim before treatment is undergone.
Pre-Existing Condition	Any condition (e.g. injury/illness or related injury/illness) that the Member or Associate Member knows to exist within the 5 years prior to the Member or Associate Member joining the Scheme: • For which medical advice or treatment has been received or • Of which the Member or Associate Member was aware or ought reasonably to have been aware, and for which medical advice or treatment was not sought before their joining the Scheme. Benefits will not be paid for the first 24 months of the membership for a Member or Associate Member in relation to the pre-existing condition. The Scheme may pay benefits in relation to the pre-existing condition thereafter if during the first 24 months the Member or Associate Member have not received medical advice or treatment, including drugs and/or medication for the pre-existing condition. Medical records must be made available during the first 2 years of membership.
Preferred Provider	A hospital or group of hospitals or other providers of private medical care who have agreed on special pricing arrangements with Bluline Administration Limited.
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.

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 Directors.
Treatment	The diagnosis and /or treatment of any surgical or medical condition, including complementary treatment, as listed in the Benefits Schedule 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.
Unpaid/Paid Leave	Means the members absence from work which is unpaid including but not limited to sabbatical, medical and disciplinary matters. It shall not include holiday absence.

APPENDIX 1: MEMBERS

There is an overall maximum of £35,000 per person in any scheme year, which runs from 1st January. **In all cases, if NHS treatment or investigation is available within a similar timeframe, members will only be able to claim for NHS cash benefit.**

MEMBER DISCRETIONARY BENEFIT SCHEDULE 2025		**Scheme Cover** Maximum of £35,000 per claim year		**Additional Conditions relating to cover** Maximum of £35,000 per claim
In-patient and Day Case Benefit for Treatment at Preferred Provider Hospital in connection with a specified medical procedure or procedures for authorised treatment	Hospital Accommodation & Nursing	Full Cover	Maximum of £35,000 per claim year	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 a joint replacement. The rule will apply to each of three spine regions - the cervical spine, the thoracic spine and the lumbar-sacral spine.
In-patient and Day Case Benefit for Treatment NOT at a Preferred Provider Hospital Preferred Provider Hospital – Members may be asked to obtain self-pay patient costs and obtain cash benefits from the scheme	Operating Theatre & Recovery Room	Full Cover	Maximum of £35,000 per claim year	
	Prescribed Drugs & Dressings for in-patient treatment.	Full Cover	Maximum of £35,000 per claim year	
	Surgeons & Anaesthetists Fees	Full Cover	Maximum of £35,000 per claim year	
	Pathology, Radiology, Consultations, Consultations, Pathology, X-rays, ECG and other diagnostic procedures.	Full Cover	Maximum of £35,000 per claim year	
	Physiotherapy	Full Cover	Maximum of £35,000 per claim year	
	CT scans, MRI scans, endoscopies, etc., can be performed when requested by a consultant physician or surgeon.	Full Cover	Maximum of £35,000 per claim year	
	Theatre based diagnostics	Full Cover	Maximum of £35,000 per claim year	
	Parent accompanying child under 12 max 10 days	Full Cover	Maximum of £35,000 per claim year	
	Specialist Physician Fees - for regular attendance in a hospital for up to 14 days		Maximum of £35,000 per claim year	
Consultations	Out-patient	£1,750	Maximum benefit payable in each claim	
Diagnostic procedures including (but are not limited to) MRI & CT scans, Pathology, Radiology, Angiography, a Maximum of 3 Injections (in a consultation room or 1 X-ray guided)	Out-patient	£3,500	Maximum benefit payable in each claim	When referred by a GP, consultations regarding a specific condition or complaint will be limited to two specialists per condition, except at the discretion of the Directors.
Physiotherapy, chiropractic treatment, and osteopathy are available upon general practitioner (GP) or consultant referral.	Out-patient	£750	Maximum benefit payable in each claim	
Optical Cash Benefit – Reimbursement is payable for prescription lenses or prescription contact lenses.		£75	Maximum benefit payable in each Scheme Year	Not payable for any eye test or specialist examination. Reimbursement, if available, up to £75.
Cancer Treatment Follow-Up	5-year follow-up plan post-treatment	£1,500	Max 12 consultations over 5 years within the above limits	
Charges for transport by a registered ambulance service to or from a hospital or nursing home		£150	Maximum benefit payable in each Scheme Year	When required for medical (not domestic) reasons only
Home Nursing by a registered Nurse recommended by a Specialist for medical (not domestic) reasons		£1,000	Maximum benefit payable in each Scheme Year	
NHS Cash Benefit - Payable for each pre-authorized night spent in an NHS hospital without charge (for treatment of conditions that would otherwise be covered for private treatment).	£200 per Treatment or £200 per Night	£2,000	Maximum benefit payable in each Scheme Year	Not available for treatments not covered by scheme Not payable if other benefit limits have been reached, as a patient in an NHS bed without charge OR for each treatment undertaken on a planned Day Case basis in the NHS without charge Emergency admissions to the NHS are not eligible for the benefit. Still, NHS benefit may be payable for the fourth and subsequent nights of a continuous in-patient stay directly following an emergency admission (this is not available for treatments not covered by the scheme).

APPENDIX 2: ASSOCIATE MEMBERS

There is an overall maximum of £35,000 per person in any scheme year, which runs from 1st January. **In all cases, if NHS treatment or investigation is available within a similar timeframe, members will only be able to claim for NHS cash benefit.**

ASSOCIATE MEMBER DISCRETIONARY BENEFIT SCHEDULE 2025		**Scheme Cover** Maximum of £35,000 per claim year		**Additional Conditions relating to cover** Maximum of £35,000 per claim
In-patient and Day Case Benefit for Treatment at Preferred Provider Hospital in connection with a specified medical procedure or procedures for authorised treatment	Hospital Accommodation & Nursing	Full Cover	Maximum of £35,000 per claim year	Excluding all joint replacements, reconstruction or refashioning, all spinal surgery/fusions, applying to each of three regions of the spine - the cervical spine, the thoracic spine and the lumbar-sacral spine.
In-patient and Day Case Benefit for Treatment NOT at a Preferred Provider Hospital Preferred Provider Hospital – Members may be asked to obtain self-pay patient costs and obtain cash benefits from the scheme	Operating Theatre & Recovery Room	Full Cover	Maximum of £35,000 per claim year	
	Prescribed Drugs & Dressings for in-patient treatment.	Full Cover	Maximum of £35,000 per claim year	
	Surgeons & Anaesthetists Fees	Full Cover	Maximum of £35,000 per claim year	
	Pathology, Radiology, Consultations, Consultations, Pathology, X-rays, ECG and other diagnostic procedures.	Full Cover	Maximum of £35,000 per claim year	
	Physiotherapy	Full Cover	Maximum of £35,000 per claim year	
	CT scans, MRI scans, endoscopies, etc., can be performed when requested by a consultant physician or surgeon.	Full Cover	Maximum of £35,000 per claim year	
	Theatre based diagnostics	Full Cover	Maximum of £35,000 per claim year	
	Parent accompanying child under 12 max 10 days	Full Cover	Maximum of £35,000 per claim year	
	Specialist Physician Fees - for regular attendance in a hospital for up to 14 days		Maximum of £35,000 per claim year	
Consultations	Out-patient	£1,750	Maximum benefit payable in each claim	
Diagnostic procedures including (but are not limited to) MRI & CT scans, Pathology, Radiology, Angiography, a Maximum of 3 Injections (in a consultation room or 1 X-ray guided)	Out-patient	£3,500	Maximum benefit payable in each claim	When referred by a GP, consultations regarding a specific condition or complaint will be limited to two specialists per condition, except at the discretion of the Directors.
Physiotherapy, chiropractic treatment, and osteopathy are available upon general practitioner (GP) or consultant referral.	Out-patient	£750	Maximum benefit payable in each claim	
Optical Cash Benefit – Reimbursement is payable for prescription lenses or prescription contact lenses.		£75	Maximum benefit payable in each Scheme Year	Not payable for any eye test or specialist examination. Reimbursement, if available, up to £75.
Cancer Treatment Follow-Up	5-year follow-up plan post-treatment	£1,500	Max 12 consultations over 5 years within the above limits	
Charges for transport by a registered ambulance service to or from a hospital or nursing home		£150	Maximum benefit payable in each Scheme Year	When required for medical (not domestic) reasons only
Home Nursing by a registered Nurse recommended by a Specialist for medical (not domestic) reasons		£1,000	Maximum benefit payable in each Scheme Year	
NHS Cash Benefit - Payable for each pre-authorized night spent in an NHS hospital without charge (for treatment of conditions that would otherwise be covered for private treatment).	£200 per Treatment or £200 per Night	£2,000	Maximum benefit payable in each Scheme Year	Not available for treatments not covered by scheme Not payable if other benefit limits have been reached, as a patient in an NHS bed without charge OR for each treatment undertaken on a planned Day Case basis in the NHS without charge Emergency admissions to the NHS are not eligible for the benefit. Still, NHS benefit may be payable for the fourth and subsequent nights of a continuous in-patient stay directly following an emergency admission (this is not available for treatments not covered by the scheme).