transport friendly society

# YOUR TFS HEALTH CASH PLAN

## 2. CLAIMS

***Welcome to the TFS Health Cash Plan***

*Please read this document carefully before committing to treatment and keep it safe for future reference*

**Inside this Plan document:**

- Details about what You can and cannot claim for
- How to make a claim

*If You have any questions about the validity of an intended claim or would like to clarify therapy treatment practitioners before submitting a claim, please visit www.tfs.uk.com or call our membership team on 020 7833 2616.*

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## Levels of Cover

| LEVEL OF COVER | PREMIUM | | | | | |
|---|---|---|---|---|---|---|
| | Silver | | Gold | | Platinum | |
| | weekly | monthly | weekly | monthly | weekly | monthly |
| **Individual** | £2.19 | £9.49 | £5.99 | £25.96 | £10.84 | £46.97 |
| **Individual + Partner** | £4.38 | £18.98 | £11.99 | £51.96 | £21.68 | £93.95 |
| **Add up to four of your children** under the age of 18 | FREE | | FREE | | FREE | |

## Benefits

| EVERYDAY HEALTHCARE: | CHILD COVER | CASHBACK LEVEL | MAXIMUM ANNUAL BENEFIT | | |
|---|---|---|---|---|---|
| **Dental** incl. fillings, hygienist, crowns, bridges, dentures | ✓ | 100% | £55 | £130 | £225 |
| **Dental Accident** | ✓ | 100% | £90 | £240 | £400 |
| **Optical** incl. sight tests, contact lenses, frames | ✓ | 100% | £55 | £130 | £225 |
| **Chiropody/Podiatry** assessments and treatments | ✓ | 75% | £50 | £125 | £220 |
| **Prescriptions** | ✗ | Items | - | 2 | 4 |
| **Health Screening** | ✓ | 50% | - | - | £300 |
| **Therapy Treatments** Physiotherapy, Acupuncture, Chiropractic, Osteopathy, Homeopathy | ✓ | 75% | £120 | £360 | £650 |
| **HOSPITAL AND OTHER BENEFITS:** | | | | | |
| **Specialist Consultation** incl. ECG, EEG, X-ray, MRI scans, hearing aids | ✓ | 75% | £130 | £350 | £600 |
| **Hospital In-patient** (per night) | ✓ | Maximum of 25 nights or days | £16 | £42 | £74 |
| **Hospital Day Surgery and Treatment** (per day) | ✓ | | | | |
| **Parental Hospital Stay** (per night) | ✗ | | - | £20 | £35 |
| **Birth / Adoption of a child** | ✗ | A single payment | £130 | £300 | £650 |
| **Convalescence** | ✗ | 100% | - | £450 | £900 |

### 1. Benefit guidelines and conditions

Welcome to Your Health Cash Plan. Inside this Plan document You will find all You need to know about submitting a claim, rules around what is covered and not covered for each benefit and general Plan exclusions.

We want to help You make the most of Your cover so please read these rules and the Frequently Asked Questions which follow, and feel free to contact us if there is anything further You would like to know.

**MAKING A CLAIM**

We aim to process our members' claims as quickly as possible. In order to do this, we require

You to submit Your claim form fully completed and signed along with the original official receipts or other documentation requested. Once we have received all of the relevant documentation, we will process Your claim promptly.

**How do I claim?**
After receiving and paying for Your treatment, simply complete a claim form and send it to the Society with the original receipt. If claiming any hospital-related benefits please send the original hospital admission and discharge documentation provided to You by the hospital. Subject to the Plan's terms the Society will reimburse You up to Your maximum benefit limit. Benefits are paid directly to You by credit transfer to Your bank or building society account.

**Qualifying period**
You will be eligible to begin to claim after 13 weeks from the start date shown on Your Plan documents with the exception of the Birth or Adoption benefit, which carries a 10 month qualifying period.

**Claim levels**
You will be able to claim up to the maximum level of cover of Your Plan within the eligible benefit period. Refer to the table on page 3 for details of the annual limits for each level of cover.

## 2. USEFUL GUIDANCE

**12 months to submit Your claim**
Please submit Your claim within 12 months. The 12 months starts from:
• Your payment of treatment, goods or services
• the date You were discharged as an in-patient
• the date You attended for day surgery
• the child's date of birth or adoption placement if claiming Birth or Adoption of a child benefit

**Understanding Your benefit periods**
Every benefit has its own benefit period.
• each benefit period will be activated when You submit Your first claim, and will start from the date You attended Your first practitioner appointment or purchased goods or services
• for Hospital Benefit, Your benefit period begins on the first day or night that we pay benefit for
• for Birth or Adoption, Your benefit period begins on the child's date of birth or the date the child is placed with You for adoption as shown on the adoption certificate

You can continue to claim a benefit until You reach Your maximum annual benefit allowance or Your benefit period expires. When Your benefit period expires, the full annual benefit allowance will renew but Your next benefit period will not be activated until You submit Your next claim.

**Always use a qualified practitioner**
The practitioner You use must be registered with, or be a member of an approved Professional Organisation.

For all benefits where You (or a person insured on Your Plan) have paid for treatment, goods or services You must get a full receipt

detailing the payment You have made and You must send us the receipt with the completed claim form.

**Make sure You complete the claim form in full and submit ALL supporting documentation, including:**

• the original receipt
• the full name and title (Mr, Mrs, Ms or Miss or Master) of the person who has received the treatment, goods or services
• details of treatment, goods or services provided
• the date and amount of each payment (we cannot pay for anything You have paid for in advance and not yet received)
• the supplier or practitioner's name, address and contact details
• the supplier or practitioner's official stamp or the hospital discharge papers
• separate list of any sundry items purchased
• qualifications that the practitioner holds or the Professional Organisation that the practitioner is registered with. This is required for dental, optical and therapy treatment practitioners (see p 8)

**Hospital claims:** please ensure that Your claim form is completed, signed and stamped by Your hospital or treatment facility.

**Birth claims:** please arrange to forward a copy of Your baby's full birth certificate along with Your claim form.

**Adoption claims:** we require You to send us proof of Your adopted child's name and age along with certification from the adoption agency confirming the date that the child was adopted by You. Please note that you will not be able to claim under this benefit if the Adoption process commenced before you started Your plan.

**WE DO NOT ACCEPT:**

• claims for treatment or purchases of goods or services provided outside the United Kingdom
• invoices
•credit or debit card receipts without supporting evidence
• photocopies of receipts
• receipts that have been altered
• receipts which show either a deposit or part payment paid or an amount still outstanding for payment
• bank statements
• claims for payments made in advance unless the receipt also confirms that prior to claiming You have received the treatment, goods or services*

* The only exception to this is when You provide us with written evidence that You have entered into a payment arrangement/ credit agreement for treatment, goods or services that You have received. The date that You pay the first instalment determines the benefit period that Your claim falls into and we will pay You up to the benefit balance available on that date ONLY towards the full cost of the treatment, goods or services purchased by the credit agreement. We do not cover administration/interest charges. Dental insurance or care scheme premiums or payments are not covered on the Plan.

## 3. FREQUENTLY ASKED QUESTIONS

**How do I make a claim?**
You must first pay for the costs of the treatment, goods or services and You can then claim those costs back from us up to Your maximum annual benefit.

**What do I need to provide so my claim can be paid?**
Before we can pay Your claim, we need to check that it is covered by the Plan, for example, we need to be sure that the person who received the treatment or service is an Insured Person and that no exclusion applies. You will need to send us supporting documentation that shows:
• who the patient is
• who gave the treatment or service and how much they charged
• the details and date of the treatment or service and
• the amount that You paid

*Claims for children must be supported by a copy of their birth or adoption certificate which can be sent to the Society at the time of the child's first claim.*

We will not be able to pay a claim if You do not send us everything that we need to assess Your claim.

**What happens if more information is needed to assess my claim?**
We may need to ask the person who provided the service or treatment for more details. We will not pay if there is a charge for this. We may ask for a second opinion and if we do, we would pay the cost of this.

**Will my claim be paid if I have not paid my premium?**
No. We will only pay claims if we have received the full premium for Your cover.

**Can I claim if I have paid for treatment but not yet had it?**
No. We will only pay for treatment that You have already received, been charged for and paid in full.

**Will You assess my claim using the treatment date or the date I paid for it?**
We will assess Your claim using the treatment date which may be different to the date that You paid for it. We will pay Your claim from the amount of benefit You have available at the treatment date in the benefit year in which You are claiming.

**How will my claim be paid?**
We will pay claims by direct credit into Your bank or building society account.

**How quickly should I submit my claim?**
As quickly as possible and no later than 12 months after the date that You paid for the treatment, goods or services. If we are unable to validate Your claim, Your claim will not be paid.

**What happens if You pay me more than I am entitled to?**
If we pay You more than You are entitled to, we will either ask You to repay that money, or we will deduct it from any other claim that You make. You are not entitled to keep any overpayment.

**What happens if I get a refund for the treatment or service I have had from the person who provided it but You have already paid me?**
If You get a refund, You need to tell us. We will ask You to repay that money, which we will reallocate to Your benefit entitlements or we may decide to deduct it from the next claim You make.

If we ask You to refund all or part of any refund that You receive and You fail to do so, we may decide to suspend or terminate Your Plan until it is paid.

**Can I claim for treatment, goods or services using more than one benefit?**
No. You must choose which benefit to claim under for each treatment or service.

**What happens if I make a claim on this Plan but also have a Plan with a different company that covers the same claim?**
If You make a claim on this Plan and You have a Plan with a different company which would cover the same claim then You must tell us. We may contact the other company about the claim so that we don't pay benefits that they have already paid to You. If we find that we have paid more than we should have done then we will take action to recover the overpayment from You.

**Can I claim for treatment or services I received outside the United Kingdom?**
No. We will only accept claims for treatment, goods or services that You have received in the United Kingdom.

**What if I have a pre-existing medical condition?**
If You apply to join the Plan or You are an existing member applying to change Your level of cover, You, Your Partner or Your Insured Children will not be entitled to receive benefit for any pre-existing medical condition as the aim of the Plan is only to cover NEW medical conditions.

Please read the benefit rules concerning pre-existing medical conditions below.

## 4. BENEFIT RULES

**CLAIMS**
You, as the Plan holder, must submit claims on behalf of everyone covered on the Plan. If You are providing information about another person You should ensure that You have their consent to do so.

You should only submit a claim if the person who has received the treatment, goods or service is eligible to claim under that specific benefit. If the claim is for Your Partner or Insured Child we will require proof of Your relationship with them. It is Your responsibility to provide complete and accurate information with the claim.

The receipts You submit must only apply to the amount paid for the person who received treatment. We need separate receipts for each person insured. We will only pay claims to You directly. Payments of all benefits will be made by direct credit into Your bank account - not to the healthcare practitioner who provides the receipts.
Claims will only be accepted where the accumulated receipts total £5 or more.

Reimbursement of most claims is made on a rolling balance principle over any 12 consecutive months period. This period starts from the date You received treatment, goods or services (not from the date Your Plan was registered or when You increased or decreased Your benefits or from a calendar year).

The Health Cash Plan claim form must be completed, signed and dated by You and sent to us. Your claim form must be received by us within 12 months of the following:

• the date of Your payment to the practitioner or supplier for treatment, goods or services

• the date on which You were discharged as an in-patient for Hospital Benefit
• the date of each attendance for Day Surgery for Hospital Benefit
• the child's date of birth; the date a child is placed with You for adoption

We will not accept any responsibility for claims or supporting documentation being lost, delayed or damaged in the post.

We will not pay a claim until You, Your Partner or Insured Child (if applicable) have received and paid for the treatment, goods and services.

To be entitled to claim, the premium payments on Your Plan must be up to date and there must not be any arrears.

Claims for Birth of a child benefit must be supported with Your baby's full birth certificate. To claim the Adoption benefit You must send us proof of the child's name and age, together with confirmation from an adoption agency of the date that the child was placed with You for adoption and as shown on the adoption certificate.

To claim any hospital-related benefits the claim form must be completed, signed and stamped by the hospital. We will NOT accept photocopies of completed claim forms.

Any fee paid by You to a practitioner for any type of medical statement or to a hospital for a statement concerning admission to or discharge from a hospital will not be reimbursed by us.

If You can claim part or all of Your costs from another organisation or insurance company, the TFS Plan will limit or decline any benefit payable to You to ensure that You do not receive more than the total amount that You have paid.

We will not accept claims for benefits that are more than 12 months old at the time that we receive them.

When You submit a claim we will carry out checks on the information You and the practitioners provide to us and we will not process that claim or any further claims on this Plan until we have completed our checks. If we make a reasonable request to You for additional information, this must be provided to us at Your own expense. If You refuse or fail to provide the additional information requested, we may refuse to process Your claim.

If necessary, we may request a medical report from Your GP or Consultant, but we will only request a report when it is reasonably necessary and under the Access to Medical Reports Act 1988. If a medical report is required we will write to You first to tell You why we are making such a request. If You or where applicable, another person insured on Your Plan do not give us Your consent we may refuse to process Your claim and may terminate Your Plan.

**PRE-EXISTING MEDICAL CONDITIONS**

This Plan is only intended to cover a NEW medical condition and may NOT cover a Pre-existing medical condition.

A **pre-existing medical condition** is defined as any disease, illness or injury that You have received medication, advice or treatment for, or experienced symptoms of, no matter whether the condition has been diagnosed or not in the 12 months before the start of Your cover.

Pre-existing medical conditions are covered after a 12 month qualifying period, **excluding chronic conditions requiring ongoing treatment.**

No claim will be paid during the first year of a new or upgraded Plan in respect of any health condition, or related health condition, which existed or was being investigated before cover commenced. We may wish to verify medical information to support a hospital in-patient or day surgery claim.

When You submit a claim, we may ask for information from Your GP to confirm any details regarding pre-existing medical conditions, for example:

• were You taking any prescribed medication, or had taken prescribed medication in the 12 months before the application;

• had You consulted a GP or Consultant Physician/Consultant, Surgeon or other medical professional during the 12 months before the application;

• had You received advice or treatment from a qualified practitioner or therapist i.e. Physiotherapist, Acupuncturist, Chiropractor, Homeopath, Osteopath, Chiropodist, Podiatrist or any other complementary medicine practitioner, during the 12 months before the application;

• had You attended a hospital/treatment centre during the 12 months before the application;

• at the point of application were You awaiting any medical tests, investigations or treatment, or awaiting the results of any medical tests or investigations, whether or not the condition had been diagnosed;

• had You attended Your GP, Consultant Physician/Consultant Surgeon or hospital for monitoring or check-ups;

• do You have an illness, injury or condition that is permanent, or has ever previously recurred or that is likely to recur

The application form, together with any information that You give, forms part of the contract of insurance. If You are not sure whether a medical condition needs to be declared You should tell us so that we can decide whether it is relevant or not.

If You declare a pre-existing medical condition, we may agree to continue Your Plan and provide You with the rest of the benefits, on condition that the pre-existing medical condition is not covered on Your Plan.

If we discover that we have paid any claims which relate to a pre-existing medical condition, we may terminate Your Plan and seek to recover from You any monies paid to You in addition to any costs incurred.

## 5. BENEFIT INCLUSIONS AND EXCLUSIONS

**Set out below are the qualifying periods for each benefit, what is COVERED and what is NOT COVERED by each benefit and the eligibility for children for each benefit.**

**DENTAL**

In any one benefit year, we will pay 100% of the payment made by You for dental examination, dental treatment and dentures provided by a qualified dental practitioner who is on the Register of the General Dental Council, up to the maximum annual benefit shown in the Dental benefit for the level of cover purchased.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Dental benefit covers:**

- dental check-ups
- treatment provided by a dentist, periodontist or orthodontist
- endodontic (root canal) treatment
- hygienists' fees
- local anaesthetic fees and intravenous sedation
- dental brace or gum-shield provided by a dentist or orthodontist
- dental crowns, bridges and fillings
- dentures
- laboratory fees and dental technician fees when referred by a dentist or orthodontist
- dental X-rays
- denture repairs or replacements by a dental technician

We will refund the full amount paid by You to a qualified NHS or private dental practitioner up to the maximum in each benefit claiming year.

The maximum benefit payable is determined by Your level of cover.

✗ **The Dental benefit DOES NOT cover**

- dental prescription charges
- missed appointment charges
- dental consumables, for example toothbrushes, mouthwash and dental floss
- dental implants and bone augmentation procedures, for example sinus lift or bone graft
- cosmetic procedures, for example dental veneers, tooth whitening or the replacement of silver coloured fillings with white fillings, gum-shields used for sporting activities
- laboratory fees not connected to dental treatment or performed by a dentist
- dental membership schemes

**DENTAL ACCIDENT**

In any one benefit year, we will pay 100% of the payment made by You for dental treatment directly related to a blow to the head such as a fall which causes an accidental injury to Your teeth and includes anaesthetic fees, dental crowns, bridges, white fillings, dental veneers and replacement dentures or repairs, up to the maximum annual benefit shown in the Dental Accident benefit for the level of cover purchased. Your dental treatment must be provided by a qualified dental practitioner who is on the Register of the General Dental Council

You must provide full details of the accident. We will only cover dental accident claims and pay up to the maximum benefit in respect of such an accident in a benefit year according to the date the accident happened.

It is a condition of this Plan that the dentist must confirm on each receipt that the treatment is only to repair the accidental damage to the Covered Person's teeth as a direct result from a blow to the head.

The benefit will only be paid in respect of treatment the Insured Person receives within 3 months of the date of the Accident.

*Qualifying Period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓**The Dental Accident benefit covers:**

• dental treatment provided by a dentist, periodontist or orthodontist directly related to a blow to the head and including any of the following:

o anaesthetic fees

o repairs or replacement of dental crowns, bridges, fillings and veneers

o repairs or replacements of dentures

o dental X-rays

✗ **The Dental Accident benefit DOES NOT cover**

• dental injury caused by eating, drinking or playing a sport or activity

• any treatment an Insured Person receives 3 months or more after the date of the accident

• dental prescription charges

• missed appointment charges

• dental consumables, for example toothbrushes, mouthwash and dental floss

• dental implants and bone augmentation procedures, for example sinus lift, bone graft

• cosmetic procedures, for example dental veneers, tooth whitening, the replacement of silver coloured fillings with white fillings

• laboratory fees not connected to dental treatment or performed by a dentist

• damage to dentures when not being worn

• dental treatment an Insured Person receives for an accident which happened before joining the Plan

**General Exclusions to the Dental Accident benefit:**

No Benefits will be payable:

1. If the Dental Injury is caused by: war or any act of war; the Insured Person serving full-time in the armed forces of any country or international organisation;
2. If the injury is due to attempted suicide or deliberate self-inflicted injury by the Insured Person (even if they are suffering with a mental illness);
3. If the Insured Person has taken part in any sport or air travel, unless as a passenger;
4. If the injury is due to a sickness or disease;
5. Repetitive Stress (Strain) Injury or Syndrome or any other condition or injury which develops over a period of time.
6. For any disabilities caused by or arising from Post-Traumatic Stress Disorder or related syndromes or any psychological or psychiatric condition.

**OPTICAL**

In any one benefit year, we will pay 100% of the payment made by You for optical treatment up to the maximum annual benefit shown in the Optical benefit for the level of cover purchased. The optician must be suitably qualified and registered with the General Optical Council.

Sundry items purchased at an optician's premises such as solutions, cleaners and contact lens removers are not covered. Additionally, prescription charges for any kind of medication are not covered under this category.

If You have bought Your contact lenses or glasses online, You must send us the receipt together with a copy of the optician's prescription showing Your name.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Optical benefit covers:**

• sight-test fees, scans or photos for an eye test and fitting fees
• prescribed lenses and accompanying frames for:
  o glasses
  o sunglasses
  o safety glasses
  o swimming goggles
• adding new prescribed lenses to existing frames
• contact lenses (including contact lenses paid for by instalment)
• lens replacement surgery or cataract surgery after 12 months of Plan start date
• repairs to glasses

Claims cannot be accepted for the purchase of spectacles or contact lenses supplied without prescription.

✗ **The Optical benefit DOES NOT cover:**

• laser eye surgery
• consultation charges prior, during and after eye surgery
• optical consumables such as contact lens cases, glasses cases and glasses chains/cords
• magnifying glasses
• ready-made glasses and coloured lenses eyewear that does not have prescription lenses
• Ophthalmic Consultant's charges or tests related to an ophthalmic consultation and conditions treated by an ophthalmologist dealing with the diagnosis, treatment and prevention of diseases of the eye and visual system with the exception of lens replacement surgery and cataract surgery
• cleaning solutions and sundries
• glasses or lenses purchased under an optical care contract scheme
• sunglasses other than prescription sunglasses
• protective eyewear and goggles/glasses used for engaging in sporting activities
• insurance premiums for glasses or contact lenses cover
• missed appointment charges

**CHIROPODY/PODIATRY**

In any one benefit year, we will pay 75% of the payment made by You for chiropody/podiatry treatment from a practitioner who is a member of an approved Professional Organisation, up to the maximum annual benefit shown in the Chiropody/Podiatry benefit for the level of cover purchased.

**Important:** In order to be able to practise in the United Kingdom, chiropodists and podiatrists must be registered with the Health and Care Professions Council (HCPC). We will not pay for treatment by someone who is not registered with the HCPC.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Chiropody/Podiatry benefit covers:**

• treatment supplied by a chiropodist or podiatrist
• assessments performed by a chiropodist or podiatrist
• consumables prescribed by and bought from the chiropodist or podiatrist at the time of treatment such as orthoses and dressings

✗ **The Chiropody/Podiatry benefit DOES NOT cover:**

• any treatment supplied by a practitioner not qualified and registered with the HCPC
• cosmetic procedures and pedicures
• X-rays and scans
• consumables such as corn plasters, arch supports, orthotics or insoles, when not prescribed and supplied by the chiropodist or

podiatrist at the time of the treatment
• surgical footwear such as corrective footwear prescribed and supplied as part of the treatment
• missed appointment charges

**PRESCRIPTIONS**

In any one benefit year, we will pay benefit up to the number of individual prescribed medication items shown in the Prescription benefit for the level of cover purchased.

Benefit will only be paid for current NHS prescription charges on the production of a receipt supplied by a Pharmacy or Dispensing Chemist, indicating that a prescription supplied by a General Practitioner has been dispensed.

To make a valid claim for prescriptions charges, You must obtain an original, named receipt from a registered pharmacist on the day You pay for Your prescription. When You send us Your claim form, You must also send us this receipt.

*This benefit is not available for Silver members.*

*This benefit is not available for Insured Children.*

*Qualifying period – 13 weeks from the Plan start date.*

✓ **The Prescription benefit covers:**

• NHS prescription charges including items obtained using NHS prepayment certificate
• for private prescriptions the amount reimbursed is the equivalent cost of an NHS prescription item in England

✗ **The Prescription benefit DOES NOT cover:**

• charges above the current rate set out in the NHS Prescription Charges
• total cost of NHS prepayment certificate
• any charges for prescriptions from outside of the United Kingdom
• prescriptions for sexual or contraceptive aids
• prescriptions for lifestyle conditions such as to help stop smoking, drinking alcohol or to lose weight

**HEALTH SCREENING**

In any one benefit year, we will pay 50% of the payment made by You for a health screen carried out by medically qualified staff at a hospital or health-screening clinic to prevent an illness, up to the maximum annual benefit shown in the Health Screening benefit for the Platinum level of cover purchased.

*This beenfit is not available for Silver and Gold members.*

*Insured Children will share the maximum annual benefit amount.*

*Qualifying period – 13 weeks from the Plan start date.*

✓ **The Health Screening benefit covers:**

• a FULL Health screen, including breast screening, heart disease screening and bone density screening

✗ **The Health Screening benefit DOES NOT cover:**

• any screening other than as stated above
• any screening carried out at a retail outlet, health club, fitness centre etc.
• any screening, checks or tests carried out in the workplace or in respect of pension, insurance, emigration, employment, legal or industrial actions
• any home testing kits
• missed appointment charges

**THERAPY TREATMENTS**

In any one benefit year, we will pay 75% of the payment made by You for therapy treatment received from a practitioner who is a member of an approved Professional Organisation, up to the maximum annual benefit shown in the Therapy Treatments benefit for the level of cover purchased. The five Therapy Treatments covered are listed below. The maximum payable between all insured named persons on the Plan is also between each of the five listed Therapy Treatments. It is NOT for each of the five Therapy Treatments - it is a total amount which can be used against one, or a combination, of the Therapy Treatments listed below.

You should only consult professionally qualified practitioners who are registered with that profession's governing body as claims for treatments provided by non-members of those professional bodies will NOT be covered.

***Claims will only be accepted with receipts from professionally qualified practitioners of the five professions registered with the Professional Organisations listed below:***

**Physiotherapy**
Health & Care Professions Council

**Acupuncture**
Acupuncture Association of Chartered Physiotherapists
British Academy of Western Medical Acupuncture
British Acupuncture Council
British Medical Acupuncture Society
Chinese Medical Institute and Register

**Chiropractic**
General Chiropractic Council

**Osteopathy**
General Osteopathic Council

**Homeopathy**
Alliance of Registered Homeopaths
Faculty of Homeopathy
Homeopathic Medical Association
Society of Homeopaths
The claim form must include the original receipt, reasons for the treatment and the type of treatment provided.

If You would like further information about finding a registered practitioner, You may wish to contact one of the organisations listed above.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Therapy Treatments benefit covers:**

- physiotherapy
- acupuncture
- chiropractic
- osteopathy
- homeopathy and homeopathic medicines prescribed by and bought directly from a homeopath
- this benefit also covers charges for X-rays and scans carried out at clinics on the recommendation of the practitioner as part of the treatment

✗ **The Therapy Treatments benefit DOES NOT cover:**

- any treatment supplied by a practitioner who is not qualified and registered with the appropriate professional body as listed above
- any other treatment that is not physiotherapy, acupuncture, chiropractic, osteopathy or homeopathy. Examples of treatments that we do not cover are aromatherapy, herbal therapies, Indian head massage, Reiki, Alexander Technique, Bowen Therapy, craniosacral therapy and cupping. This list is not exhaustive.

• appliances, consumable items and supporting materials including but not limited to lumbar roll, spinal pillows/cushions, flexi band, tape, corn plasters, dressings, ice packs, surgical footwear, arch supports, orthotic insoles, books/literature etc.
• herbal remedies, supplements or vitamins
• medical reports
• cosmetic procedures
• X-rays
• missed appointment charges

**SPECIALIST CONSULTATION**

In any one benefit year, we will pay 75% of the payment made by You for medical specialists' consultation fees, allergy testing, vaccination, pathology tests, X-rays, scans, electrocardiograms and other investigations listed below, all undertaken on an out-patient basis, up to the maximum annual benefit shown in the Specialist Consultation for the level of cover purchased in any one benefit year.
Claims must be for consultations in a hospital or clinic on an out-patient basis only and carried out by a doctor of Consultant status.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Specialist Consultation benefit covers:**

• the fees for a Specialist Consultation that You have as an out-patient, including diagnostic consultations to help find the cause of Your symptom(s) such as:
o hearing aids and audiology tests when referred by a Specialist Consultant
o hearing-aid repairs
o investigative procedures such as colonoscopy, laparoscopy, colposcopy and sigmoidoscopy
o medical tests, including ECG, EEG and lung-function tests
o pathology and biopsy fees
o physicians' or surgeons' operation fees
o speech therapy, dyslexia and dyspraxia treatment provided by a registered medical practitioner
o X-ray, including mammograms, CT scans, ultrasounds, MRI scans and screenings
• the consultation must be with a medical professional who is a Consultant in an NHS hospital
• in addition, the Consultant must hold a current licence to practise and also be included on the General Medical Council's Specialist Register – www.gmc-uk.org or the General Dental Council Dentist's Register – www.gdc-uk.org
• blood tests or visual field tests directly connected to a diagnostic consultation
• allergy tests performed by a GP or consultant
• minor invasive investigations carried out at the same time as an out-patient consultation, and not requiring the use of a separate treatment room, are also insured

✗ **The Specialist Consultation benefit DOES NOT cover:**

• charges made by a hospital/clinic for use of their facilities such as theatre, dressings and equipment
• ambulance or taxi charges
• consultation and diagnostic tests as a result of a lifestyle choice such as vasectomy, sterilisation, cosmetic surgery and in relation to emigration, medical, insurance, employment or legal related reports
• consultation and diagnostic tests related to fertility or assisted conception
• dietician/nutritional services
• termination of pregnancy
• referrals to a hospital Consultant for pre-existing medical conditions in the first 12 months from the date of joining or upgrading a Plan or chronic conditions and ongoing treatment
• anaesthetists' fees
• psychiatric or psychological consultations or assessments including but not limited to referrals

such as for neurological or neuropsychological assessments, therapy or counselling fees
• private antenatal scans and any maternity-related appointments, consultations and care even when the appointment is with a Specialist Consultant
• missed appointment charges

**HOSPITAL IN-PATIENT**

In any one benefit year, we will pay a specified rate per night of Your hospital in-patient stay up to a maximum annual benefit of 25 nights in total as shown in the hospital in-patient benefit for the level of cover purchased. Please note that the maximum of 25 nights is a total amount to be shared across hospital in-patient, hospital day surgery and treatment and parental hospital stay within one benefit year.

Hospital in-patient means admission to a ward (but not Accident and Emergency) to receive treatment as an in-patient. In-patient stay is classed as a full night only if You are admitted as an in-patient before 12 midnight.

The admission and discharge must be from an NHS or registered private hospital in the United Kingdom, described as such by the Care Quality Commission.

We will pay benefit at the appropriate nightly rate for the period a person entitled to benefit is admitted for in-patient treatment.

If You are admitted as a day patient and then subsequently stay overnight, we will pay one night's hospital cover (not one day and one night).
The hospital's name and admission and discharge dates should be clearly stated on the claim form. The amount payable is the stated benefit and no direct costs such as Consultants' fees, room charges, medication or dressings involved with the hospital admission are covered.

*The benefit is for each Insured Person on the Plan for up to 25 nights and to be shared with Insured Children.*

In accordance with the usual practice, the date of admission is counted as the first night but the date of discharge is not counted. Time spent within an Accident and Emergency Department (A&E) is not considered as part of an admission unless the hospital declares it to be so in accordance with their records.

To make a claim for hospital in-patient benefit You will need to provide us with a copy of Your hospital discharge letter as evidence of Your admission and discharge. If You do not have Your discharge letter, You will need to get written confirmation of Your hospital stay such as a letter on headed paper from the hospital. Weekend leave or longer periods of home leave do not count as a discharge, although no amounts will be paid for nights not spent at hospital.

Adults staying with their children at the hospital are not entitled to Hospital benefit and nor are children staying with their parents at the hospital.

Transfers from one hospital to another without a period at home in between are counted as a continuous period in hospital.

In cases of long stay admissions a claim may be submitted after 20 nights and an amount will be paid up to the number of nights due within the rules. Gold and Platinum members will be eligible for convalescence benefit for a stay in a registered convalescent home following 10 consecutive nights stay in hospital.

A maximum of 25 nights benefit may be claimed in each Benefit Year per Insured Person.

If the maximum annual benefit has been paid for an Insured Person in a Benefit Year, a new claim may be made for payment from the day a consecutive Benefit Year commences.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Hospital In-Patient benefit covers:**

• an overnight stay in a hospital as an in-patient for a medical condition to be treated or investigated
• an in-patient is a patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons
• where You are required to sign a consent form and are allocated a bed – the use of which is normally for a period of supervised recovery
• out-patient cancer treatment, for example chemotherapy or radiotherapy (when required to stay overnight)

✗ **The Hospital In-Patient Benefit DOES NOT cover:**

• hospital stays caused by a Pandemic, as defined by the Department of Health, such as, but not limited to Influenza, Avian Flu, SARS, Zika Virus etc.
• attending a hospital Accident and Emergency Department
• attendance for kidney dialysis
• attendance or treatment not in a hospital, for example operations carried out in a GP's surgery/practice or dental clinic
• pregnancy termination
• cancelled operations or procedures
• cosmetic surgery
• sterilisation
• vasectomy
• fertility treatment
• laser eye surgery
• pregnancy, maternity or childbirth related admissions for a mother or child insured by this Plan
• hospital stays during which a birth occurs or which immediately follows a birth
• maternity in-patient admission:
  • Where the mother remains in hospital to accompany her child in the post-natal period until her child is discharged from hospital
OR
  • Where the mother is registered as an Insured Child on an adult's Plan
• maternity-related admissions for Insured Children in respect of treatment that does not include admission to a ward
• attendance at clinics, medical centres or nursing homes
• hospital accommodation or similar institution, for an elderly person who is not able to live independently
• overnight stays in hospital hotels before and after being admitted to hospital
• admissions relating to alcohol, chemical, drug dependency, self-inflicted illness/injury or conditions arising as a result of such dependency or illness/injury
• out-patient attendance or treatment, including procedures carried out in an out-patient setting such as: tests or investigations, biopsies and endoscopies carried out for investigative purposes as a day patient
• permanent stays in hospital
• any voluntary admissions to medical spas and spa hospitals for non-essential treatments
• attendance at hospital for treatment and/or pain relief administered by injection as a day patient
• admissions for rehabilitation, domestic reasons or respite care
• if You had a day surgery procedure and are admitted as an in-patient on the same day this counts as one event not two so only one day/night can be claimed.
• pre-existing medical condition - any disease, illness or injury that You have received medication, advice or treatment for, or

experienced symptoms of, no matter whether the condition has been diagnosed in the last 12 months before cover commenced
• condition for which You:
o have been referred to a Consultant or hospital for either tests or treatment before the date that You joined the policy
OR
o reasonably believe that You would be referred to a Consultant or hospital for tests or treatment within 12 months of joining the policy

We may ask for evidence that Your condition is not pre-existing if You claim for this benefit during the first 12 months of cover.

**HOSPITAL DAY SURGERY AND TREATMENT**
Hospital Day Surgery and treatment means admission to and discharge on the same day, from an NHS or registered private hospital in the United Kingdom, described as such by the Care Quality Commission.

The hospital must be in the United Kingdom and its name and admission and discharge dates should be clearly stated on the claim form. The amount payable is the stated benefit and no direct costs such as Consultants' fees, room charges, medication or dressings involved with the hospital admission are covered.

A day-patient does not occupy a bed overnight. If You are admitted as a day-patient and then stay overnight, we will only pay one night's hospital benefit cover – NOT one day and one night.

*Qualifying period – 13 weeks from the Plan start date.*

*Insured Children will share the maximum annual benefit amount.*

✓ **The Hospital Day Surgery and Treatment benefit covers:**
• day surgery includes a surgical procedure involving the use of theatre facilities when You are admitted as a day patient and You have a local or general anaesthetic
• the surgical procedure is one that aims to treat a disease, injury or abnormality by operating directly on or removing the affected body part, or removing a foreign body
• operations which are cancelled after You have been admitted to hospital
• colonoscopy, laparoscopy, colposcopy and sigmoidoscopy procedures, as long as an anaesthetic or sedation was needed and the procedure was carried out in theatre
• out-patient treatment for chemotherapy, kidney dialysis, oncology and radiotherapy

✗ **The Hospital Day Surgery and Treatment benefit DOES NOT cover:**
• attending hospital as an out-patient or for accident and emergency visits
• nursing treatment Plans, Community Matron Service or virtual ward treatment
• day case admission for maternity, geriatric, psychiatric or psychological treatments
• ante or post-natal admission for an Insured Child registered on Your Plan
• parental stay where You accompany an Insured Child who is admitted as an in-patient
• hotel ward accommodation costs
• pre-admission appointments
• in-patient stays or day case admissions for pre-existing medical conditions in the first 12 months from the date of joining or upgrading a Plan
• day case admission immediately prior to or following an overnight stay in hospital for which a claim may be payable under hospital in-patient

**PARENTAL HOSPITAL STAY**

This benefit is payable at the appropriate nightly rate according to the benefit schedule if You or Your insured Partner accompany an Insured Child for one or more overnight admissions in an NHS or registered private hospital or treatment centre, described as such by the Care Quality Commission.

A maximum of 25 nights benefit may be claimed in each Benefit Year.

You must fill in Your claim form confirming the medical reason for Your Insured Child being admitted and send that to us with the Insured Child's discharge letter or discharge summary which would have been given to You when they were discharged. The discharge letter or summary must state that You or Your insured Partner stayed in hospital overnight with an Insured Child.

*This benefit is not available for Silver members.*

*This benefit is not available for Insured Children.*

*Qualifying period – 13 weeks from the Plan start date.*

✓ **The Parental Hospital Stay benefit covers:**

• any period of overnight stay in an NHS hospital, a private hospital or a registered treatment centre, where one parent stays with their Insured Child and is entitled to hospital benefits

• an adoptive parent staying with their Insured Child

✗ **The Parental Hospital Stay benefit DOES NOT cover:**

• a parental stay with a child in hospital because of a pregnancy or any condition associated with pregnancy

• stays of the mother following her previous discharge in respect of the birth of a child who remains in hospital and for whom benefit is payable under "hospital in-patient" benefit

• attending Accident and Emergency Department

• attending clinics, medical centres or nursing homes

• more than one parent staying with their child

• a child's first 10 consecutive overnight stays as an in-patient after being born

• out-patient treatment

• permanent stays in hospital

• the child's Pre-existing medical conditions in the first 12 months from the date of joining or upgrading a Plan

• any voluntary admissions to medical spas and spa hospitals for non-essential treatments

• overnight stays in hospital hotels before and after being admitted to hospital

**BIRTH OR ADOPTION OF A CHILD**

We will pay a fixed benefit for the birth or adoption of ONE child in each benefit claiming year, providing that premiums have been paid at the relevant rate for the previous 10 month qualifying period. There is no additional benefit for multiple births.

Benefit is payable according to the benefit schedule once in each Benefit Year on the birth or adoption of Your child. The benefit according to the benefit schedule is only payable to one parent, whether they are the mother or father, where both parents are insured under this Plan. A copy of the birth certificate or the legal adoption papers must be attached to the claim form. For the Adoption of a child benefit the benefit is only payable for the registered adoption of a child up to the age of 10.

The Birth benefit is also paid for a stillbirth of Your child after 24 weeks of pregnancy (if the expected due date was after 10 months of the Plan start date) if an official certificate is submitted.

Adoption of a child benefit is included in this cover, however, a claim under this benefit may not be submitted until the Plan has been in place and premiums received for at least 10 months.

The adoption certificate should be dated after the end of this qualifying period and before the child's 10th birthday. The child must be living at the same address as You.

We only make one payment for each child no matter how many Plans You or Your Partner are insured on. If You have more than one Plan You will have to choose which Plan to claim on.

*This benefit is not available for Insured Children.*

*Qualifying period – 10 months from the Plan start date.*

✓ **The Birth or Adoption of Child benefit covers:**

• the birth of Your child whether at home or in hospital
• the legal adoption of a child under the age of 10 by You or Your Partner. However, we will not pay this benefit if that child is already related to either You or Your Partner (for example if You adopt Your Partner's child)
• the stillbirth of Your child after 24 weeks of pregnancy
• premature birth if normal birth would have been 10 months after the Plan start date

✗ **The Birth or Adoption of Child Benefit DOES NOT cover:**

• birth or adoption which occurs within 10 calendar months of the start date of this Plan
• a miscarriage in the first 24 weeks of pregnancy
• foster children
• a baby born to a child who is insured under the Plan
• pregnancy termination
• a child born or adopted before or during the 10 month qualifying period
• an adoption where the adoption process commenced prior to the plan being taken out
• premature birth if normal birth would have been within 10 months of Plan start date
• the legal adoption of a child who is already related to You or Your Partner prior to the adoption taking place
• children already insured on the Plan may not subsequently be the subject of an Adoption Grant by either parent
• claims for overseas births and adoptions are not covered

**CONVALESCENCE**

Benefit is payable according to the benefit schedule for the Gold and Platinum levels of cover only once in each Benefit Year per Insured Person.

We will not pay the Convalescence benefit in the first 12 months from the date of joining or upgrading a Plan where the in-patient stay was for a pre-existing medical condition.

The Convalescence benefit is not payable when the patient dies in hospital or before convalescence can be taken up.

*This benefit is not available for Silver members.*

*This benefit is not available for Insured Children. Qualifying period – 13 weeks from the Plan start date.*

✓ **The Convalescence benefit covers:**

• if You spend a minimum of 10 consecutive nights in hospital as an in-patient for post-operative recovery and a valid claim has been made under the hospital in-patient benefit. The Convalescence benefit must be claimed within 3 months of being discharged from hospital.
• covers a stay at a recognised convalescent home
• all claims for Convalescence benefit must be

supported by an original receipt showing details of Your stay in a registered convalescent home and the charges paid

✗ **The Convalescence benefit DOES NOT cover:**

• claims in the first 12 months from the date of joining or upgrading a Plan where the in-patient stay was for a pre-existing medical condition.
• claims from children for Convalescence benefit
• claims for Convalescence benefit when the patient dies in hospital
• does not cover convalescence at your home, a hotel or any other location which is not a recognised convalescence home
• claims for respite care, elder care or rehabilitation

**6. CLAIMS**

To make claims for a Partner, You must be contributing to the Plan at the rate that covers You and Your Partner. You must have filled in the appropriate forms so we can officially register Your Partner. You, Your Partner and up to four children permanently residing with You and under the age of 18 can be insured on a Plan.

We will refund You the appropriate percentage of each valid claim, as shown in the benefit table, up to Your yearly benefit limit.

We will deal with claims and make payment within a reasonable time.

We have the right to investigate claims. If we believe that any documents You send us in support of any claim are not genuine, we may keep the documents and refuse the claim. We can also refuse claims if we reasonably believe that the treatment has not taken place or that You have not paid for an item. This includes rejecting receipts from certain practitioners and claims that we cannot check with the practitioner concerned. If claims, in whole or in part, are found to be fraudulent, it could lead to rejection of the claim and termination of Your Plan.
We will only pay claims to You directly, not to the healthcare practitioner who provides the receipts.

We will not accept claims for benefits that are more than 12 months old at the time we receive them.

If You have more than one insurance Plan with us or another provider, You cannot claim for more than 100% of the cost of Your treatment.
During the lifetime of this contract, it is important You understand that if our overall claims experience is worse than expected, we may increase Your premiums, or reduce, change or remove any benefit. However, if our overall claims experience is better than expected, we may be able to improve Your terms.

**Qualifying period**

If You apply to join the Plan, or if You are an existing member applying to increase Your level of cover, You will become eligible to make claims:
• 13 weeks after Your first or increased premium for all benefits; and
• 40 weeks after Your first or increased premium for Birth or Adoption benefit

No benefit will be paid in respect of treatment commenced during the qualifying periods, irrespective of the future duration of that course of treatment.

**Exclusions**

We will not pay benefit for any claims directly related to the following:
• GP fees for private treatment

• drugs, medicines and vaccinations including but not limited to medicines relating to homoeopathic treatment (when not prescribed as part of a homeopathic consultation) and travel-related vaccines, for example anti-malarial tablets
• vasectomies, sterilisation, IVF, fertility treatment and examinations
• pregnancy terminations, contraceptives, gender reassignment or cosmetic reasons
• any health-screening checks, medical examinations, consultations or reports for employment, emigration/immigration, legal or insurance reasons
• treatment provided to You by a member of Your family or a work colleague
• postage and packing costs
• internet, telephone and group consultations
• treatments carried out in the workplace or arranged through Your employer
• treatments, goods or services provided or received outside the United Kingdom
• treatment charges covered by private medical insurance

**We will not pay benefit for claims You make as a result of the following**:
• a pandemic disease
• radioactive contamination
• suicide or deliberate self-inflicted injury
• war, hostilities, invasion or civil war and full-time active military service
• nuclear, chemical or biological terrorism
• drug, alcohol or solvent abuse
• taking part in professional sports or flying as a pilot or crew member in an aircraft, gliders, hang-gliders, microlights, parachuting, paragliding and ballooning

***Please also see what is not covered under each section of cover.***

**Benefit period**
The maximum benefits are shown in Your Plan schedule.
Each benefit has its individual benefit year which is 12 months starting from the treatment date on the first receipt you send us, along with your claim form. During this benefit year you can still claim for similar treatments, goods and services, however, we will not pay you more than the maximum annual benefit for your level of cover.

After your benefit year is over, a new benefit year will commence when you submit your next claim.

As a member, You will not receive more than the maximum annual benefit amount under any of the benefit rules for You, Your Partner (if they are insured) or Insured Children in each case for any one benefit year.

We treat claims in a benefit year according to the dates You (or Your Partner or Insured Child) were admitted to hospital or received treatment, whichever applies.

When You change Your level of cover, we will take account of all previous claims You have made when calculating Your maximum entitlement for the benefit year.

**Insured Children**
The maximum benefit (as shown in the benefit table) is available over a one-year benefit period and is shared between You and all Your Insured Children.

## 7. FRAUD

Fraud is a criminal activity that can result in a fine or a prison sentence. We would consider someone to be committing fraud by making a claim, or a statement in support of a claim or sending us a document in support of a claim knowing that it was in whole or in part, false or misleading or exaggerated in any way with the intention of deceiving us into paying them more than they are entitled to.

If we reasonably believe that a claim is false or fraudulent, even if we have not proved that You have acted dishonestly, we will not pay that claim. We may terminate Your Plan and all Your benefits will stop immediately. We will not refund any premiums for a terminated Plan. We will charge You any other costs that we have incurred and may take legal action to recover any costs that we reasonably incur as a result of the fraud, plus interest and legal costs. We may also notify Your employer.
Insurance fraud is a criminal offence. We take fraud prevention very seriously. We always pass details of suspected fraudulent claims to the police or Crown Prosecution Service for them to investigate and prosecute through the criminal courts. Anyone convicted of fraud may have to declare it when they apply for any type of insurance in the future.

**How do we check claims and prevent fraud?**

We check all claims. We may need to ask You for further proof before we can process a claim; You must provide this at Your own expense. We may also contact the practitioner for verification. If the claim is for Your dependant we may ask You for proof of Your relationship with them. While we are waiting for information we will not pay any claims on Your Plan. We do these routine checks to make sure that we are paying claims correctly; it doesn't mean that we think You are being dishonest.
It is Your responsibility to make sure that all the information that You give us with a claim is truthful and complete.

You must always act honestly. For example You, or anyone insured on Your Plan, must not:

- alter or forge a receipt/claim form
- send us any evidence with a claim that You know is misleading or untrue
- give dishonest answers to our questions
- refuse to give us any information that we need, or withdraw a claim to avoid investigation
- refuse permission for us to contact a healthcare provider
- deliberately claim for anything, or anyone, that is not insured
- fail to tell us if the claim could be covered on another Plan
- claim for a pre-existing medical condition that isn't covered on Your Plan, or a medical condition that You should have told us about when You made a claim

***For more information on changing your membership and for all other general Terms and Conditions, please refer to your General Terms and Conditions Plan document.***

transport
friendly society

# Contacting the Transport Friendly Society

## Head Office:

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tfs
Our members are going places



TFS HCP PD2 - 12.21_v2