your | HEALTH

ST CHRISTOPHER HEALTH FUND

July 2026

Guidance Note for Members Using the Fund

Cross-references to the relevant underlying Rules of the Fund are shown in bold at the beginning of each paragraph, where appropriate.

Section A: Subscription Rates and Available Benefits

1. **Rule 5 (c) -** The Fund offers three levels of monthly subscription, providing cover as follows:

Level 1	**Either** a sole member **or** the widow/widower or partner of a deceased member
Level 2	A member **plus** spouse/partner and eligible children **or** the member's approved dependent relatives
Level 3	A member **plus** spouse/partner and eligible children **plus** approved dependent relatives

2. **Rules 5 (b) and 8 (i) -** Members' subscription rates are reviewed annually by the Committee and any changes notified to the membership in accordance with the Fund's Rules. Subscription rates were amended on 1 October 2025 and are currently set at £13.50 per month for Level 1 membership, £27.00 for Level 2 membership and £40.50 for Level 3 membership. These will increase on 1 October 2026 to £14.00 for Level 1 membership, £28.00 for Level 2 membership and £42.00 for Level 3 membership.

3. **Rules 6 (e) and 8 (h) -** Generally, the Fund makes grants to members, reimbursing them with 75% of the total cost of admissible medical treatment (as defined in the Fund's Rules). An excess of £75 applies as a deduction from a member's claim; but this excess is levied only once per member within each 12-month period (on a rolling year basis). However, an overall maximum grant cap applies in respect of all claims made under any subscription in any calendar year: this is currently £5,500.

4. **Rule 6 (b) -** Where a member has applicable Private Medical Insurance (PMI), a claim must be made under that policy before an application for assistance is submitted to the Fund. In cases where PMI has covered more than 25% of the cost of an admissible course of treatment, the Fund will normally meet the full balance of the cost, subject to the limits set out in paragraph 3, above. The Fund is prepared, subject to its normal rules, to meet the costs of qualifying treatment not covered by a member's PMI, including any excess that the insurer may apply. This means, for example, that subject to meeting the standard Fund excess of the first £75 of the first course of treatment within a rolling year, members can seek reimbursement from the Fund of any excesses paid under their PMI cover.

5. **Rule 5 (a) -** New members are not able to request assistance from the Fund during their first six months of membership.

Section B: What is Covered?

6. The Fund assists members with the payment of costs of the treatment of illness and other medical conditions, including the costs of specialist consultation fees. Certain alternative treatments may also be eligible for cover by the Fund; where members are uncertain in particular cases, they should contact the Fund's administrator beforehand. At the same time, the Rules of the Fund provide for a number of specific exclusions; these are further explained and clarified in this Section.

7. **Rule 8 (k) -** As a general point, members are reminded that the Fund is a discretionary one, with the Committee always having the ability in particular circumstances to meet claims falling outside the normal scope of cover. Each year a small number of claims are given exceptional approval in this way through the Committee's exercise of its discretion. Typically, these may involve cases where the Committee judges that rigid application of the Rules would be unnecessarily harsh or cause hardship, or where alternative therapies outside the Fund's normal scope have been medically recommended. Where a member believes that a reasonable claim has been rejected through an overly rigid application of the standard policies on grants and may warrant further consideration, or where there is uncertainty over whether to submit a claim, members are again encouraged to contact the Fund's administrator to discuss the matter and, where appropriate, to seek to have a case presented exceptionally to the Committee for appraisal.

8. **Rule 7 (a) - (e) -** Standard exclusions provided in the Fund's Rules apply to:
    - expenses incurred within the first six months of registration with the Fund (other than for a new born-child, the widow/widower/civil partner/ registered partner of a deceased member who has applied to assume membership under Rule 4(i));
    - any proportion of costs already covered by medical insurance;
    - treatment provided by a practitioner who is not registered with a recognised national medical association;

- costs of private treatment given by a General Practitioner;
- costs of treatment outside the United Kingdom whilst on holiday or business; and
- other treatment considered by the Committee to be outside the scope of the Fund.

9. **Rule 7(f)** - In addition, the Rules provide routinely for the exclusion of costs relating to;
    - ante/post natal care;
    - childbirth;
    - dentistry;
    - out patient optical treatment;
    - chiropody;
    - cosmetic treatment;
    - nursing care;
    - convalescence;
    - out patient drugs, medicines and remedies;
    - medical appliances, other than in exceptional circumstances;
    - transport/private ambulances.

10. With regard to the exclusions set out in paragraph 9 above, however, the Committee also offers the following clarifications with regard to its current policy stance:

    a) **nursing care**: while ongoing nursing care is excluded from Fund coverage, the Fund is prepared (always subject to its normal rules) to reimburse costs of specific nursing care during convalescence as well as respite and/or post-operative care, up to a maximum amount of £2,000 in a calendar year;

    b) **out patient drugs, medicines and remedies:** while these are generally excluded, the Fund is prepared to give reimbursement, in accordance with its normal rules, for drugs and dressings required on discharge from an in-patient stay (commonly referred to as TTOs – 'To Take Out'). Thus, for example, members discharged from a private hospital with TTO items under private prescriptions will be able to submit claims to the Fund for these items in the normal way.

    c) **vaccinations**[1]**:** the Fund is prepared to provide reimbursement (subject to its normal rules) for certain vaccinations given to particular categories of patients for whom they would not normally be made available on the National Health Service:
        - Meningitis B, for children born before 1 May 2015 (currently, NHS provides to babies born after that date);
        - HPV 'Gardasil', for boys aged 12-13 years (currently NHS provides to girls aged 12-13);
        - Shingles, for adults aged 50-70 and over 78 years (currently NHS makes available to patients aged 70-78).

[1] Please note that members interested in receiving the following vaccinations should always first discuss the benefits and advisability with their own medical practitioners before proceeding.

d) **in vitro fertilisation (IVF) treatment:** as previously notified to members, certain restrictions apply to Fund cover for these treatments. In order to be eligible, members must have subscribed to the Fund for at least 6 months. The claim must be for treatment on or after the 6 months qualifying period as one cannot claim in retrospect. Members are then eligible for a single cycle of IVF treatment, subject to the Fund's normal Rules. In all cases, however, members are reminded that they must consult the Fund's administrator before going ahead with treatment.

11. In any case in which a member has ongoing long term (more than 2 years) medical treatment, the Committee reserves the right to review periodically the continued payment of costs.

Section C: How to Make a Claim

12. **Rule 6** - When considering or making an application to the Fund for assistance, members are asked to bear in mind the following points:
    - applicants are asked to approach the Fund's administrator, either by letter, telephone or e-mail, before expenses are incurred;
    - where applicable, claims must be made under private medical insurance (PMI) before an application for assistance is made to the Fund. If part of the costs incurred is covered by PMI, evidence for this amount must be provided;
    - if a claim is successful, the level of benefit payable shall be that applying on the date on which treatment took place;
    - claims are subject to a rolling year limit as set out in paragraph 3 above;
    -
    - claims must be supported by invoices. These should be on the headed notepaper of the practitioner, and receipted by the practitioner. They should clearly state the medical condition and the treatment provided (e.g. consultation, surgery), the cost of the treatment, the date of treatment and name of member receiving the treatment. **Please note that credit card receipts alone are not acceptable**;
    - invoices must be less than six months old. Subject to this time limit, and wherever possible, members should submit all invoices relating to a particular course of treatment at the same time;
    - claims should include original documentation from hospital or consultant;
    - claims can be submitted via email (and scanned copies of documentation) or hard copy;
    - if submitting via hard copy, documentation should be accompanied by a covering letter which must specify the claimant's contact details including telephone number and/or email address so that any queries can be resolved quickly. Please specify in the covering letter if you want the original documentation from the hospital or consultant returned to you;
    - if the claim relates to a medical insurance shortfall, all relevant documentation (originals) must be provided so that the amount payable by the Fund can be calculated;

- ensure that the Fund Administrator has your bank account details (sort code and account number) otherwise the processing of your claim may be delayed;
- if a payment is made to a bank account outside the UK, a charge will be applied which must be met by the member. As of October 2023 this is £15, but may change at any time as advised by the Fund's bank.

13. The attached Appendix to this Guidance Note sets out a number of worked examples of claims in order to illustrate for members how grants are calculated in different scenarios.

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Appendix: Examples of How to Calculate Your Claim

75% Claim	
Total cost of treatment (no medical insurance contribution)	£300
Fund excess	-£75
	£225
75% of claim paid	x 75%
Member receives	£168.75

AXA Shortfall/Excess	
Example 1 - Total cost of treatment	£645
Cost met by AXA	£445
Shortfall (ie amount not met by AXA)	£200
As AXA have paid more than 25% of total cost of treatment, the Fund will reimburse the entire shortfall less the £75 excess, as follows	
Fund excess	-£75
Member receives	£125
Example 2 - Total cost of treatment	£1,250
Cost met by AXA	£400
Shortfall (ie amount not met by AXA)	£850
As AXA have paid more than 25% of total cost of treatment, the Fund will reimburse the entire shortfall less the £75 excess, as follows	
Fund excess	-£75
Member receives	£775
Example 3 - Total cost of treatment	£200
Cost met by AXA	£50
Shortfall (ie amount not paid by AXA)	£150
As AXA has only paid 25% of the total cost the Fund will reimburse the entire shortfall, less the £75 excess, as follows	
Fund Excess	-£75
Member receives	£75
Example 4 - Total cost of treatment	£160
Cost met by AXA	-£10
Shortfall (ie amount not paid by AXA	£150
As AXA has paid less than 25% of the total cost the Fund will reimburse 75% of the claim, less the excess	
Fund excess	-£75
	£75
75% of claim to be paid	x 75%
Member receives	£63.75