

Direct 2010

Healthcare Cash Plan



Direct Scheme Membership Plan 2010

**100% cashback for
your dental, optical,
physiotherapy and other
everyday healthcare costs**



**Doesn't that
make you feel good?**

Everyone deserves the benefit of good health

Welcome to Health Shield

Each year the cost of everyday healthcare is rising fast. Just think of the cost of dental care fees alone, and glasses or contact lenses if you wear them. Then there's the cost of physiotherapy, chiropody and other therapies with limited or no availability on the NHS. Thousands of Health Shield members receive cashback on all these bills - so why miss out?

As a Health Shield member, everyday healthcare will cost you less....

Become a member of Health Shield for as little as £9.55 a month

Single people can join Health Shield Direct for just £9.55 a month - and that also includes cover for any dependent children you may have. You and your partner can be covered for just £18.50 a month - and again that also covers dependent children. As you'll see overleaf there's a choice of five levels - and the more you choose to contribute, the more cashback you'll get. It really is that simple.

100% cashback

We refund the full amount of all your healthcare bills (up to the limit you choose and subject to annual review).

Cashback for hospital stays

Even in an NHS hospital, stays can be costly if you lose earnings and family have the expense of travelling to visit you. Health Shield members could receive a cash benefit of up to £110 per night while they, their partner or a dependant child are in hospital.

Quick cash

We aim to process claims within 48 hours, which means that your cheque or credit into your bank account will usually be with you in 5 working days. Claims for hospital benefits will take longer due to our claims checking procedures.

Customer service – claims online and direct credit notification by email

All members can use www.healthshield.co.uk to check their benefit allowances online. Simply visit the members' area of www.healthshield.co.uk and key in your Health Shield member number. This will then take you through a step by step process to enable you to create your own secure password and allow you to access and check your benefit allowances and claims information online.

Many of our members already use the direct credit facility that enables Health Shield to refund claims directly to the member's chosen bank account. We also offer direct credit notification by email. All you need to do is register for direct credit and make sure that we have your current email address. This helps improve communications with members and also helps towards environmental considerations.



DIRECT HEALTHCARE MEMBERSHIP PLAN - TABLE OF CONTRIBUTIONS AND BENEFITS 2010

LEVEL OF COVER	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	PRESTIGE LEVEL
MONTHLY PAYMENTS FOR YOU (Includes benefits for dependent children)	£9.55	£19.65	£31.75	£39.85	£57.10
MONTHLY PAYMENTS FOR YOU AND YOUR PARTNER (Includes benefits for dependent children)	£18.50	£38.70	£62.90	£79.30	£113.65
ALL CONTRIBUTIONS AND BENEFITS ARE SUBJECT TO AN ANNUAL REVIEW					
DENTAL maximum for each person 100% cashback refund	£60	£120	£160	£205	£270
DENTAL ACCIDENT maximum for each person 100% cashback refund	£200	£400	£600	£800	£1000
OPTICAL maximum for each person 100% cashback refund	£60	£120	£160	£205	£270
HOSPITAL BENEFITS: ADULT & CHILD RATES - HOSPITAL INPATIENT (PER NIGHT) - HOSPITAL DAY-CASE (PER DAY) up to a maximum of 25 nights/days per year, plus any additional costs for completion of claim forms are covered	£20	£45	£65	£85	£110
PARENTAL HOSPITAL STAY up to a maximum of 25 nights per year, plus any additional costs for completion of claim forms are covered	£20	£45	£65	£85	£110
MATERNITY - ANTENATAL APPOINTMENT a single payment	£150	£300	£560	£695	£900
PHYSIOTHERAPY, CHIROPRACTIC, OSTEOPATHY, ACUPUNCTURE AND HOMOEOPATHY maximum for each person 100% cashback refund	£120	£280	£370	£500	£640
SPECIALIST CONSULTATION, ECG, X-RAY, AND PATHOLOGY FEES maximum for each person 100% cashback refund	£120	£210	£315	£420	£520
CHIROPODY maximum for each person 100% cashback refund	£60	£120	£160	£205	£270
HEALTH & WELLBEING maximum for each person 100% cashback refund	£60	£120	£160	£205	£270
HEALTH SCREENING maximum for each person 100% cashback refund	£60	£120	£160	£205	£270
PERSONAL ACCIDENT PROTECTION	£5000	£10000	£15000	£20000	£25000
PRESCRIPTIONS - PER ITEM maximum for each adult	1	2	3	4	5
FITNESS BENEFIT	ACCESS TO SPECIAL RATES				PLUS £100
WORLDWIDE COVER	HEALTH SHIELD COVERS YOU FOR ALL BENEFITS ANYWHERE IN THE WORLD				
24-HOUR FREEPHONE HELPLINE counselling & lifestyle, health & medical and legal advice	24 HOURS A DAY, 7 DAYS A WEEK ACCESS TO TELEPHONE HELPLINES FOR ALL MEMBERS				
FAMILY PLANNING maximum for each adult 100% cashback refund	EXTRA BENEFITS EXCLUSIVE TO PRESTIGE LEVEL MEMBERS				£500
CRITICAL ILLNESS COVER maximum for each person					£2000
SICKNESS AND ACCIDENT PROTECTION					<small>CONTRIBUTION PROTECTION FOR SICKNESS & ACCIDENT</small>

The above benefits are the maximum levels which apply for 2010. For later years, both the type of benefit, benefit levels and contribution rates may change in future. (Please see your membership plan for more details).

The Health Shield Direct Scheme Membership Plan (“the plan”)

The plan is a healthcare cash plan provided by Health Shield Friendly Society Limited (“Health Shield”).

This policy summary highlights some of the key aspects of Health Shield membership. For full details please refer to the terms and conditions.

Key features and benefits

- The plan pays for a range of everyday healthcare and wellbeing related benefits.
- You can choose from a range of benefit levels, and provide cover for your partner and dependent children where applicable.
- Claim limits are refreshed at the beginning of each benefit year. Your benefit year runs from 1 January to 31 December.
- Members must be at least 16 years of age to join in their own right.
- Dependent children are covered up to their 18th birthday.
- We will write to you separately if we need more details of any pre-existing medical conditions you may have. Until we receive this information we will be unable to accept claims for benefits which may potentially be excluded as a result of your health. When we have received this information from you we will tell you if your cover is affected.
- You can apply to change your level of cover at any time, but we will not pay out more than the applicable annual benefit limit for each claim. Claims already paid to you within the benefit year will be taken into account when determining the maximum amount available to claim at your new level.
- Cover will start from the date you make your first contribution.

Prestige level only

- Certain benefits are not available for dependent children.
- Critical illness cover is payable only once during the lifetime of the person entitled to benefit.
- Sickness and accident protection cover is payable only up to the age of 65 (or your retirement age, if earlier). An exclusion period of 30 days applies to all sickness and accident claims.

Can I change my mind?

You can cancel your Health Shield membership at any time by letting us know in writing or by telephone.

If you tell us that you do not wish to proceed with the plan, within 30 days of the commencement date, we will return all contributions you have made but you must also return any claims we have paid to you. If you wish to cancel after 30 days have passed, we will not return any contributions.

Existing members

- This plan completely replaces the terms and conditions of any existing plan you have.
- If you join this scheme from any other Health Shield scheme, any pre-existing medical conditions you have may not be waived (even if they were covered before). Your previous plan's benefit year may be different to this plan. Claims paid under your previous plan may be taken into account if they were paid in the current benefit year of the new plan.
- If you are changing to this plan from a similar scheme provided by a different cash plan provider, you should be aware that we may not offer cover for some pre-existing medical conditions provided by your previous arrangement.
- There may be benefits available under your existing plan that are not available under this plan.
- Members of this plan who reach the plan's upper age limit can continue their Health Shield membership by converting to our Direct Plus plan. If you convert from this plan to the Direct Plus plan, you will not have to serve any qualifying periods, and any medical conditions you have will continue to be either covered or excluded as they are in this plan.

How do I make a claim?

Complete the claim form included with your welcome pack and send it to us with any supporting documents (receipts, etc.) as required. You should send your claims directly to our Head Office address, not via your adviser, therapist or anyone else.

Claim forms are available to download from our website, or you can call us on 01270 588555 to request one.

Who regulates us?

Health Shield Friendly Society Limited is authorised and regulated by the Financial Services Authority. Our FSA Register number is 205304.

You can check this on the FSA Register by visiting the FSA's website www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

How can I make a complaint?

If you wish to make a complaint, please contact us:

- in writing – write to The Chief Executive, Health Shield Friendly Society Limited, Electra Way, Crewe Business Park, Crewe, Cheshire CW1 6HS
- by phone – telephone 01270 588555

You may also complain in person to any member of Health Shield staff, by email, or via our website.

We have our own internal complaints and appeals processes but if you cannot settle your complaint with us, you may be entitled to refer it to the Financial Ombudsman Service.

Financial Services Compensation Scheme

We are members of the Financial Services Compensation Scheme (FSCS). If we are unable to meet our obligations you may be entitled to compensation from the FSCS.

Other important information

Health Shield Friendly Society Limited is registered in the United Kingdom and its products are only available within the UK.

Health Shield has chosen English Law as the law applicable to the contract. The language used in all documents and communications, whether verbal or written, will be English.

All regular membership contributions are inclusive of insurance premium tax. This contract has no fixed term.

Treating Customers Fairly

We are firmly committed to the Financial Services Authority's "Treating Customers Fairly" initiative. We have developed 10 Conduct of Business Principles to ensure that our members are treated fairly. We will:

1. put you first in everything we do
2. strive to identify your needs
3. devise products that meet these needs
4. not provide staff with incentives that may risk your being sold an unsuitable product
5. be open and clear in all our dealings with you and will not hide behind small print
6. be courteous, responsive and consistent
7. listen to what you have to say
8. keep you informed of any product changes
9. deal with any complaint promptly and impartially
10. treat you as we would want to be treated ourselves

You should review your level of cover regularly to ensure that it continues to meet your needs.

Terms and conditions for the Health Shield Direct Scheme membership plan

Age limits and changing your level of cover

If you want to join the Health Shield Direct Scheme membership plan ('the plan') or increase your level of cover, you must be between 16 and 64 (that is, not yet 65) when you apply.

When you change your level of cover, we will take account of previous claims you have made when we work out your maximum entitlement for the benefit year.

Members who reach the age of 65 must convert to the Health Shield Direct Plus Scheme.

Definitions

'You' – you, as well as any partner and dependent children who are covered in this membership plan.

'Claims experience' – the number and cost of claims we paid for any one calendar year (that is, January to December).

'Dependent children' – your or your partner's children or legally adopted children who are under the age of 18, in full-time education and living at home.

'Membership plan' ('the plan') – the Health Shield Direct Scheme membership plan, and the long-term insurance cash benefit plan described in these terms and conditions. The plan is registered in a single name only (that is, your name), although cover may also be provided for your partner and dependent children, if this applies.

'Pandemic' – a disease that is widespread throughout an entire country, continent, or the whole world.

'Partner' – your husband, wife or any other person who lives with you as if you are married, no matter whether they are male or female.

'Pre-existing condition' – any disease, illness or injury that you have received medication, advice or treatment and experienced symptoms for, no matter whether the condition has been diagnosed before the start of your cover.

'Registered treatment centre' – a centre that is registered with the Department of Health and appears on the National Administrative Code Service Register.

'Surplus' – any money left over after meeting claims and expenses during the financial year.

'We', 'our', 'us' – Health Shield Friendly Society Limited, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.

Qualifying periods

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 contribution.

From the date you make your first contribution, you will be covered for the following benefits only.

- Overnight admissions to hospital as a result of an accident
- Personal accident protection
- 24-hour Freephone helpline
- Fitness benefit (this does not include the £100 benefit for Prestige-level members)

Your membership

The terms of your new plan, including the benefit and contribution levels, completely replace those of any previous Health Shield membership.

If you apply to join the plan, or if you are an existing member applying to increase your level of cover, you will not be entitled to receive benefit for any pre-existing condition. We will tell you about any conditions that are not covered.

Exclusions for pre-existing conditions may apply to the following benefits only.

- Hospital inpatient
- Hospital day-case admission
- Parental hospital stay
- Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy
- Specialist consultation fees, electrocardiogram (ECG), X-ray and pathology fees
- Critical illness cover
- Sickness and accident protection cover

You will be entitled to receive the maximum benefit if your contributions are up to date and you do not have a pre-existing condition that we cannot cover.

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 (if they are covered) and dependent children. You, and your partner and dependent children (if this applies), may only be covered or included in one membership plan.

We will write to you to tell you about any changes to the terms and conditions of your membership plan. You should read the membership plan with the rule book. You can get a copy of the rule book from our Chief Executive or from the members' area of our website at www.healthshield.co.uk. To make sure that we can provide high levels of customer service, we may monitor or record phone calls.

Contributions and benefits – yearly review

The maximum benefits are shown in the table on pages 3 and 4.

For 2010, we will refund 100% of each valid claim up to your yearly benefit limit. This is also our aim for future years, although this will depend on our performance and claims experience in the future.

As a result, we will review all benefits and contributions each year and we may make changes to them. If this leads to a reduction in the benefits we pay you in the future, we will tell you, but the percentage of each claim we refund is guaranteed to be 70% of the rates published for the relevant year. We will also apply this percentage reduction to the maximum amount shown in the benefit table.

During the lifetime of this contract, it is important you understand that if our overall claims experience, position in the marketplace or surplus are worse than expected, we may increase your contribution rates, or reduce, change or remove any benefit.

However, if our overall claims experience, position in the marketplace or surplus are better than expected, we may be able to improve your terms.

Terms and conditions for the Health Shield Direct Scheme membership plan

General exclusions

We cannot pay benefit for any claims directly related to the following.

- GP fees for private treatment
- Drugs, medicines and vaccinations
- Vasectomies, sterilisation, IVF, fertility treatment and examinations (not including the Family Planning benefit for Prestige-level members)
- Pregnancy terminations, contraceptives, sex-change operations or cosmetic surgery
- Medical examinations, consultations or reports for employment, emigration, legal or insurance reasons
- Treatment provided to you by a member of your family or a work colleague

We cannot pay benefit for claims you make as a result of the following.

- A pandemic disease
- Radioactive contamination
- Attempted suicide
- You deliberately injuring yourself
- War, hostilities, invasion or civil war, and full-time active military service
- Drug, alcohol or solvent abuse, or taking drugs (unless you have been told to by a registered medical practitioner)

If you live in the Republic of Ireland, we do not cover the first €5 a year for receipt-based claims. We can only pay claims for these benefits once a year.

Claims

We will deal with claims on the day we receive them, but we cannot accept photocopied or faxed receipts and claim forms. You should include the following details on the original receipts.

- The date you received treatment
- The full name and title (Mr, Mrs, Ms or Miss) of the person who has received the treatment
- The official stamp and qualifications of the dentist, optician, chiroprapist, physiotherapist, consultant and so on

We cannot accept receipts which have been altered. The receipts must only apply to the amount paid for the person who received treatment. We need separate receipts for each person covered. We will only pay claims to you direct, not to the healthcare practitioner who provides the receipts.

As a member, you will not receive more than the maximum benefit amount under any of the benefit rules for yourself, your partner (if they are covered) or dependent children in each case for any one calendar year (that is, January to December). We treat claims in a calendar year according to the dates you (or your partner or dependent child) were admitted to hospital or received treatment, whichever applies.

If you have been covered before as a dependent child or registered partner under someone else's Health Shield membership, we will take account of any claims you have made during your new plan's calendar year.

As a member, you agree to us processing personal and sensitive information about you. The member must also sign all claim forms to declare that the details you have provided on the forms are true, and to allow us to get independent confirmation of the details from the healthcare provider the claim relates to.

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

Benefit rules

Dental

We will pay benefit for dental treatment, at the appropriate rate and up to the appropriate maximum in any one calendar year.

When you send the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment.

What is covered

- Anaesthetic fees
- Check-up charges
- A dental brace or gum shield provided by the dentist
- Dental practice plan premiums and joining fees (for example, Denplan)
- Dental crowns, bridges and white fillings
- Dental veneers
- Dentures, or repairs to dentures at dental laboratories
- Hygienist fees
- Orthodontic and periodontic treatment
- Tooth whitening treatment provided by the dentist
- X-rays

What is not covered

- Cancellation charges made by the dentist (for example, for missed appointments)
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on)
- Dental insurance premiums
- Dental prescription charges (we cover these charges under the 'Prescriptions' benefit)

Dental accident

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, for dental treatment you need as a result of an accidental injury to your teeth. The injury must have been caused by a direct impact to the head.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment. You must also provide full details of the accident. Your dentist must fill in and sign the claim form confirming the date of the accident and that the treatment received is as a result of that accident. We treat dental accident claims in a calendar year according to the date the accident happened.

What is covered

- Dental treatment directly related to an accident (for example, a sports injury or a fall), including the following.
 - Anaesthetic fees
 - Dental crowns, bridges and white fillings
 - Dental veneers
 - Replacement dentures or repairs

What is not covered

- Cancellation charges made by the dentist (for example, for missed appointments)
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on)
- Dental prescription charges (we cover these charges under the 'Prescriptions' benefit)
- Dental insurance, practice plan premiums and joining fees
- Any treatment you receive 12 months after the date of the accident
- Dental treatment you receive for an accident which happened before you joined the plan

Terms and conditions for the Health Shield Direct Scheme membership plan

Optical treatment

We will pay benefit for optical treatment, at the appropriate rate and up to the appropriate maximum in any one calendar year.

When you send us the claim form, you must also send us an original, fully-itemised receipt.

What is covered

- Contact lenses (permanent or disposable)
- Contact lenses (permanent or disposable), when you buy them by monthly direct debit
- Contact lens check-ups
- Contact lens solutions (including if you buy these separately)
- Eye laser surgery to correct long- and short-sightedness
- Eyesight tests
- Frames you buy separately
- Lenses you buy separately to fit to existing frames
- Lenses supplied under an optical insurance plan
- Prescribed glasses
- Prescribed magnifying glasses
- Repairs to glasses
- Sunglasses, safety glasses and swimming goggles (as long as they have prescribed lenses)

What is not covered

- Insurance premiums
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses)
- Optical consumables (for example, contact lenses and glasses cases)

Hospital benefits

We combine hospital inpatient and hospital day-case benefit payments. The maximum period for receiving combined daily or nightly rates of benefit is 25 nights in any one calendar year for each person who is entitled to benefit.

Hospital inpatient

We will pay benefit at the appropriate nightly rate for the period a person entitled to benefit is admitted for inpatient treatment in a recognised hospital or hospice.

You must fill in your claim form yourself. The hospital must then check it and stamp it with its official stamp.

What is covered

- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, from one to 25 nights, for a medical condition to be treated or investigated
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim

What is not covered

- Attending accident and emergency
- Clinics, medical centres or nursing homes
- Hospital accommodation for an elderly person who is not able to live independently
- Maternity-related admissions for dependent children
- The first 10 consecutive overnight stays as a maternity inpatient, during which time the woman gives birth
- A child's first 10 consecutive overnight stays as an inpatient after being born
- Outpatient treatment
- Permanent stays in hospital
- Pre-existing conditions

See the 'General exclusions' section.

Hospital day-case admission

We will pay benefit at the appropriate day-case rate for the period a person entitled to benefit is admitted for day-case treatment in a recognised hospital without an overnight stay.

You must fill in your claim form yourself. The hospital must then check it and stamp it with its official stamp.

What is covered

- Any day-case admission in an NHS hospital, private hospital or registered treatment centre, from one to 25 days, to have a medical condition investigated under anaesthetic, or to have a medical condition treated under anaesthetic
- Operations which are cancelled after you have been admitted to hospital
- Investigative procedures (for example, colonoscopy, laparoscopy, colposcopy and sigmoidoscopy)
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim
- Outpatient treatment carried out under anaesthetic
- Outpatient treatment for chemotherapy
- Outpatient treatment for kidney dialysis
- Outpatient treatment for oncology
- Outpatient treatment for radiotherapy

What is not covered

- Attending accident and emergency
 - Clinics, medical centres or nursing homes
 - Elderly care
 - Hospice day care
 - Maternity admissions
 - Outpatient appointments or treatments that are not covered above
 - Pre-admission appointments (appointments before you are admitted to hospital)
 - Psychiatric treatment
 - Pre-existing conditions
- See the 'General exclusions' section.

Parental hospital stay

We will pay benefit at the appropriate nightly rate for one parent to stay overnight with a registered child who has been admitted for inpatient treatment in a recognised hospital or hospice.

You must fill in your claim form yourself. The hospital must then check it and stamp it with its official stamp.

What is covered

- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, from one to 25 nights, where one parent stays with their registered child and is entitled to hospital benefits
- A parent who stays with their registered child
- An adoptive parent staying with their registered child
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim

What is not covered

- Attending accident and emergency
- Clinics, medical centres or nursing homes
- More than one parent staying with their child
- All maternity-related admissions
- Outpatient treatment
- Permanent stays in hospital
- Pre-existing conditions

See the 'General exclusions' section.

Terms and conditions for the Health Shield Direct Scheme membership plan

Maternity – antenatal appointments

We will make a single payment for each pregnancy, up to the appropriate maximum in any one calendar year, for an NHS or private antenatal scan carried out by medically qualified staff at a hospital, GP surgery, registered clinic or medical centre.

You must fill in the claim form yourself. The hospital or surgery must then check it and stamp it with its official stamp.

What is covered

- An NHS or private antenatal scan carried out by medically qualified staff at a hospital, GP surgery, registered clinic or medical centre
- Fees for filling in claim forms or certificates, as long as you provide an official receipt with your claim
- A registered partner who has the scan

We will only make a single payment for a pregnancy that lasts from one calendar year to another.

What is not covered

- Attending accident and emergency
- Antenatal appointments for dependent children
- A partner who is not registered with us, unless you have confirmed that they live with you

Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, when a person entitled to benefit receives treatment to relieve and prevent an illness or pain, from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of the treatment. The claim form must include the reasons for the treatment, and the type of treatment provided.

What is covered

- Acupuncture
- Appliances (for example, lumbar rolls and back supports) prescribed and supplied by your practitioner as part of the treatment
- Chiropractic
- Homoeopathy
- Osteopathy (including craniosacral therapy)
- Physiotherapy
- X-ray, when necessary as part of the treatment

What is not covered

- Any treatment, provided by a practitioner who is recognised by us, which is not listed above
- Appliances (for example, lumbar rolls and back supports) not prescribed and supplied by your practitioner as part of the treatment
- Pre-existing conditions
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment

Specialist consultation fees, electrocardiogram (ECG), X-ray, and pathology fees

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, when a person entitled to benefit has a specialist consultation or treatment from a medically qualified person who specialises in a field of medicine. The specialist does not have to hold a consultant position in a hospital, but must be a member, fellow or licentiate (licence-holder) of one of the Royal Colleges (or their international equivalent). This benefit also refunds costs you would have to pay for an ECG or X-ray, and pathology fees charged to you at the appropriate department of a hospital or as part of a consultation.

You must send us an original receipt, showing the qualifications of the physician or surgeon. On the claim form, you must fill in the reason for the consultation, treatment or tests.

What is covered

- Hearing aids and audiology tests provided by a registered hearing-aid supplier
- Investigative procedures (for example, colonoscopy, laparoscopy, colposcopy and sigmoidoscopy)
- Medical tests, including ECG, EEC and lung function tests
- Pathology and biopsy fees
- Physicians' or surgeons' operation fees
- Speech therapy, dyslexia and dyspraxia treatment provided by a registered medical practitioner
- X-ray, including mammograms, CT scans, ultrasounds, MRI scans and screenings
- Any amount left after a claim has been settled by a provider of private medical insurance, as long as you send us your statement

What is not covered

- Anaesthetists' fees
 - Counselling fees (we cover these fees under the health and wellbeing benefit)
 - Private antenatal scans
 - Private hospital charges (for example, theatre and room fees)
 - Pre-existing conditions
- See the 'General exclusions' section.

Chiropody

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, for chiropody treatment from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment.

What is covered

- Assessments (for example, gait analysis, which is an analysis of how you walk)
- Chiropody treatment
- Consumables prescribed and supplied by the chiropodist or podiatrist at the time of the treatment (for example, arch supports, orthotics or insoles)
- Podiatry treatment
- Surgical footwear (for example, corrective shoes prescribed and supplied as a part of the treatment)

What is not covered

- Consumables that are not prescribed and supplied by the chiropodist or podiatrist at the time of the treatment (for example, arch supports, orthotics or insoles)
- X-rays

Health and wellbeing (including complementary therapies for allergy testing, stress relief, weight management and treatment to stop smoking)

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, when a person receives treatment related to their health and wellbeing, or treatment to relieve and prevent an illness or pain, from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of the treatment. The claim form must include the reasons for the treatment, and the type of treatment provided.

Terms and conditions for the Health Shield Direct Scheme membership plan

What is covered

- Acupressure
- Allergy testing, including food intolerance and nutrition tests
- Aromatherapy
- Bowen and Alexander techniques
- Chair massage
- Colonic hydrotherapy
- Counselling fees (for example psychiatric, psychological and bereavement)
- Hopi ear candles
- Hypnotherapy
- Indian head massage
- Kinesiology
- Naturopathy
- Nutritional therapy
- Reflexology
- Reiki
- Shiatsu
- Sports and remedial massages

What is not covered

- Beauty treatments (including facials)
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment
- Vega testing
- Laboratory testing not referred by a doctor
- Hair analysis
- Home testing kits
- Any treatment, provided by a practitioner recognised by us, which is not listed above
- Appliances (for example, lumbar rolls and back supports), even if they have been supplied as part of your treatment
- Stop-smoking patches, gum and so on
- Weight management programmes (for example, Weight Watchers, Slimming World or LighterLife)
- Marriage guidance counselling (for example, Relate)
- Internet, telephone and group consultations

Health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, for a health screen carried out by medically qualified staff at a hospital, registered health screening clinic or service. The health screen must be used to help prevent an illness.

When you send us the claim form, you must also send us an original, dated and fully-itemised receipt.

What is covered

- A Well Man or Well Woman screen
- A full health screen

What is not covered

- Home testing kits
- Tests not included within the full health screen (for example, X-rays and blood tests)
- Any health screening checks, medical examinations, consultations or reports for the purpose of your employment, emigration, legal or insurance reasons
- Any other screening check or test not carried out as part of one of those listed above

Personal accident protection

Please call the claims department on 01270 588555 for a separate personal accident claim form. Under the following conditions, we will only consider the amount of benefit we will pay under this section if a bodily injury results in death or permanent total disablement within one year of the accident. We will pay the sum insured in line with the level of contribution you have paid. Protection will end on your 70th birthday. You must write to us within six months of an accident to let us know about it.

We will not pay more than £25,000 as a result of any one accident.

'Bodily injury' means an injury caused only by an accident and not by any sickness, disease or gradual cause. 'Bodily injury' does not cover post-traumatic stress disorder.

'Permanent total disablement' means a permanent disability that prevents the insured person from carrying out a job.

We will decide, based on medical advice, if we will pay benefit.

Personal accident protection does not cover death or permanent total disablement caused by the following.

- Radioactive contamination
- Taking part in professional sports or flying as a pilot or crew member (that is, aircraft, gliders, hang-gliders, microlights, parachuting, paragliding, ballooning)
- Suicide or deliberate injury
- War, hostilities, invasion or civil war, and full-time active military service
- Drug, alcohol or solvent abuse, or taking drugs (unless you are told to by a registered medical practitioner)

Prescriptions (for each item)

We will pay benefit to you and your partner (if they are covered), at the appropriate rate and up to the appropriate maximum number of items in any one calendar year, for NHS prescription charges (or the NHS cash equivalent).

When you send us your claim form, you must also send us an original, dated and fully-itemised receipt, which you can get from your chemist.

What is covered

- NHS prescription charges or the NHS cash equivalent for private prescription charges
- An NHS prepayment certificate up to the appropriate maximum
- Dental prescription charges

What is not covered

- Charges above the current rate set out in the NHS prescription pricing structure

We do not pay prescription benefit for dependent children

Fitness benefit

Incorpore's Corporate Fitness Network will give you and your family access to better rates for a network of health clubs and hotels. You can join a health club at the lowest corporate rate available and enjoy special discounts and take advantage of preferred rates on leisure, relaxation and 'pamper' breaks at hotels around the world.

Visit www.incorpore.co.uk or phone Incorpore's Customer Support Line on 0845 6024601 (quoting reference HEA).

Also, if you are a Prestige-level member, we will contribute up to £100 towards the cost of your yearly health club membership, swimming, exercise classes or personal trainer. You must provide an original, dated receipt when you send us your claim form.

Worldwide cover

All benefits apply during business visits and holidays abroad that last up to 28 days. The terms and conditions (including what is and what is not covered) will apply to any claims you send in, and you must send the details translated into English, if necessary. We will convert the amount of your claim into pounds sterling using the currency exchange sell rate, supplied by our bank, on the date we process your claim.

Terms and conditions for the Health Shield Direct Scheme membership plan

24-hour Freephone helpline

You and your family can use our professional telephone service, 24 hours a day, seven days a week. This service provides counselling, support and guidance on a whole range of lifestyle, health and medical and legal problems. You can get advice and counselling from specialist teams of counsellors, lawyers and medical staff. [This service is provided by First Assist Services Ltd.]

If you want to speak to a family-care counsellor, lawyer or medical advisor, call 0800 1079042 and quote scheme number 70840. [This call is free.]

Family planning (Prestige level only)

We will pay family planning benefit to you and your partner (if they are covered), at the appropriate rate and up to the agreed maximum. We will only pay family planning benefit to you and your partner (if they are covered) once during your lifetime.

You must send us an original receipt, showing the qualifications of the physician or surgeon. The physician or surgeon does not have to hold a consultant position in a hospital, but must be a member, fellow or licentiate (licence holder) of one of the Royal Colleges (or their international equivalent).

On the claim form, you must fill in the reason for the consultation, treatment or tests.

What is covered

- Private family planning clinics
- Private fertility treatment and examinations
- Private IVF treatment
- Private sterilisation fees
- Private vasectomy fees

What is not covered

- Family planning benefit for dependent children
- Pregnancy terminations
- Contraceptives

Critical illness (Prestige level only)

If you, your partner (if they are covered) or your dependent children are diagnosed with a critical illness after the end of the 13-week qualifying period, we will pay benefit at the appropriate rate. We will not pay more than £2,000 as a result of a critical illness. We will only pay critical illness benefit to any person once during their lifetime. Critical illness benefit does not apply to anyone aged 65 or over.

Please call the claims department on 01270 588555 for a separate critical illness claim form. To support your claim, you will need to provide medical evidence from a registered medical practitioner. You must pay any costs involved in providing this evidence.

What is covered

- Cancer – a malignant tumour caused by malignant cells growing and spreading uncontrollably to other tissue. The term ‘cancer’ includes leukaemia and Hodgkin’s disease, but the following are not included in the cover:
 - All tumours which are histologically described as being ‘pre-malignant’, ‘non-invasive’, or ‘cancer in situ’
 - All forms of lymphoma present in HIV
 - Kaposi’s sarcoma present in HIV
 - Any skin cancer, other than malignant melanoma
- Heart attack – when a part of the heart muscle dies as a result of not receiving enough blood. It will cause chest pain, new electrocardiograph changes and an increase in cardiac enzymes.

- Coronary artery bypass surgery – open heart surgery, recommended by a consultant cardiologist, that uses bypass grafts to correct one or more coronary arteries that have narrowed or become blocked. Non-surgical procedures, such as balloon or stent angioplasty or laser treatments, are not included.
- Kidney failure – where both kidneys fail to work and, as a result, you begin regular kidney dialysis or have a kidney transplant. We will pay critical illness benefit if you need a kidney transplant and you have been included on an official UK waiting list.
- Major organ transplant – the transplant of a heart, liver, lung, pancreas or bone marrow, or being included on an official UK waiting list to receive an organ.
- Motor neurone disease – confirmation by a consultant that you have been diagnosed with motor neurone disease.
- Multiple sclerosis – a definite diagnosis by a consultant neurologist of multiple sclerosis that meets all the following conditions:
 - The movement of your muscles, or your physical senses, must currently be weakened, and have been weakened for a continuous period of at least six months.
 - The diagnosis must be confirmed by diagnostic techniques that are widely used at the time you make your claim.
- Stroke – permanent neurological (nerve) damage to the brain caused by an interruption to its blood supply. Transient ischaemic attacks (temporary interruptions to the brain’s blood supply) or episodes resulting in temporary neurological symptoms are not included.

What is not covered

- If you suffered from that critical illness (or a related condition) or had surgery at or before the end of the 13-week qualifying period.
- If you die within 28 days of being diagnosed with a critical illness or having surgery.
- If the critical illness or surgery is in any way caused by being exposed to chemicals or nuclear material.
- If the critical illness or surgery is in any way caused by drug, alcohol or solvent abuse, or taking drugs (unless you are told to by a registered medical practitioner).
- We will not pay critical illness benefit for claims caused directly or indirectly by you being infected by, or treated for, HIV or any HIV-related illness, including AIDS.

Sickness and accident protection cover (Prestige level only)

Please call the claims department on 01270 588555 before you make a claim. Your Prestige-level contributions are covered for up to 12 months when you or your partner (if they are covered) are continuously off work for at least 30 days due to one of the following.

- Sickness
- Accidental injury

Sickness and accident protection cover only applies if you or your partner (if they are covered):

- have completed a qualifying period of 13 weeks
- are in full-time employment and between the ages of 16 and 64
- are not aware of any medical treatment or advice you are due to receive, and
- are in good health.

If you suffer a disability, we will pay 1/30th of your monthly contribution, after the first 30 days of your disability, for each consecutive day you are disabled. We will refund benefit every 30 days during your disability, up to a maximum of 12 payments for any one claim.

By 'disability', we mean being totally prevented from carrying out your normal job or work as a result of an accidental bodily injury or sickness, as confirmed by a registered medical practitioner, that takes place after the start date. 'Normal job or work' means paid work of at least 16 hours a week that you carry out immediately before the start of your disability, and any similar job that you may reasonably be expected to carry out.

We will not pay disability benefit for any period you are disabled after you have reached the age of 65 (or your retirement date, if earlier).

When we assess the maximum benefit period, we will treat periods of disability resulting from the same cause as being the same period of disability, as long as they are not separated by at least three calendar months before you return to work.

Exclusions to sickness and accident protection cover

An exclusion period of 30 days applies to all claims.

We will not pay any amount where the disability happens within the 13-week qualifying period.

We will not pay for any period of disability caused by any physical or mental disorder, any chronic (severe) illness, or any recurring or continuing disease which you had received treatment or advice for before your cover began.

We will not pay for any period of disability that a registered medical practitioner has not provided medical evidence for. You must pay all the costs involved in getting medical evidence.

We will not pay for any period of disability caused by the following.

- War
- Attempted suicide
- You deliberately injuring yourself
- You being under the influence of alcohol or drugs (other than drugs taken under medical supervision, but not for treating a drug addiction)
- Pregnancy, childbirth or any complication connected to these
- A mental disorder, unless it is investigated and diagnosed by a consultant
- HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS)
- Cosmetic surgery
- A pandemic disease



The Crystal Mark only applies to the terms and conditions section, and does not apply to the design and layout of this leaflet.

questions and answers

Who are Health Shield?

Health Shield is a Friendly Society that has been helping its members with the cost of everyday healthcare for over 130 years.

How can Health Shield afford to make such generous cashback refunds?

We are a non-profit making Friendly Society, which means that our income is used for the benefit of our members.

Who can become a member of Health Shield?

Anyone aged between 16 and 64.

Do I need a medical?

No. Your application form simply contains a declaration of good health. If you have any existing condition (except optical or dental) then you'll be asked to complete a health declaration form.

Is the healthcare cash plan scheme the same as private medical insurance?

No. Health Shield protects members from the increasing costs of 'everyday' healthcare. It can be used on its own or as a complementary addition to PMI.

The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Health Shield will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Health Shield to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by Health Shield or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society
 - If you receive a refund you are not entitled to, you must pay it back when Health Shield asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.



HEALTH SHIELD DIRECT APPLICATION

PLEASE FILL IN AND SIGN BOTH PARTS OF THIS APPLICATION FORM

PART ONE (PLEASE USE BLOCK CAPITALS)

1 YOUR DETAILS

I WANT TO BECOME A NEW HEALTH SHIELD DIRECT MEMBER I WANT TO CHANGE MY LEVEL OF CONTRIBUTION

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

FULL POSTAL ADDRESS

POSTCODE

NATIONAL INSURANCE NUMBER (This will be your reference number for the Part Two Direct Debit Form below)

TELEPHONE NUMBER

EMAIL ADDRESS

(Only fill in section 2 if you want cover for you and your partner)

2 YOUR PARTNER'S DETAILS

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

3 DEPENDENT CHILDREN UNDER THE AGE OF 18 LIVING AT YOUR ADDRESS

SURNAME

FORENAME(S)

DATE OF BIRTH

MALE

FEMALE

SURNAME

FORENAME(S)

DATE OF BIRTH

MALE

FEMALE

SURNAME

FORENAME(S)

DATE OF BIRTH

MALE

FEMALE

SURNAME

FORENAME(S)

DATE OF BIRTH

MALE

FEMALE

PART TWO DIRECT DEBIT (PLEASE USE BLOCK CAPITALS)

INSTRUCTIONS TO YOUR BANK/BUILDING SOCIETY TO PAY BY DIRECT DEBIT.

Please complete to instruct your branch to make payments direct from your account. Then return this form to: Health Shield Friendly Society, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS

REFERENCE NUMBER

BANK/BUILDING SOCIETY NAME

BANK/BUILDING SOCIETY ADDRESS

 POSTCODE

4 PLEASE TICK THE LEVEL YOU HAVE CHOSEN AND INDICATE WHETHER YOU REQUIRE COVER FOR YOU OR YOUR PARTNER

LEVEL 1 LEVEL 2 LEVEL 3 LEVEL 4 PRESTIGE

YOU YOU & PARTNER

5 MEDICAL HISTORY

Health Shield does not cover any pre-existing medical conditions that have arisen before the time of joining or increasing cover.

Examples of pre-existing medical conditions that may lead to the exclusion of certain benefits are as follows: diabetes, epilepsy, respiratory conditions (e.g. asthma), skin disorders (e.g. eczema, psoriasis), arthritis, heart problems (e.g. anginal), circulatory problems (e.g. thrombosis), gynaecological disorders, digestive disorders (e.g. liver, bowel or stomach), kidney disorders, cancer, back/neck/shoulder problems, or mental or physical disability.

Have you (or your partner or dependent children where applicable) ever suffered from a medical condition?

YES If you tick the 'YES' box, we will send you a health declaration form to request further information.

NO By ticking the 'NO' box, you declare that you (or your partner or dependent children where applicable) have not:

- received medication, advice or treatment
- experienced symptoms for any disease, illness or injury, whether the condition has been diagnosed or not before the start of your cover.

6 I agree to abide by Health Shield's membership and benefit regulations and accept Health Shield's right to vary them if it considers it necessary. I give my consent to all processing of personal and sensitive data. I declare that all the information included is accurate, true and complete to the best of my knowledge and belief.

SIGNATURE DATE / /

I agree that Health Shield can use my details to inform me about new products and services that are available. Please tick box if you do not require further information.

ORIGINATORS /ID NUMBER

6 | 2 | 4 | 7 | 5 | 6



2 NAME OF ACCOUNT HOLDER

3 SORT CODE NUMBER

4 ACCOUNT NUMBER

5 YOUR INSTRUCTIONS TO THE BANK/BUILDING SOCIETY AND SIGNATURE

Please pay Health Shield from the account detailed in this instruction subject to the safeguard assured by the Direct Debit Guarantee. I understand that this instruction may remain with Health Shield and, if so, details will be passed electronically to my Bank/Building Society.

BANK/BUILDING SOCIETIES MAY REFUSE TO ACCEPT INSTRUCTIONS TO PAY DIRECT DEBITS FROM SOME TYPES OF ACCOUNT.

SIGNATURE DATE / /

FOR BRANCH USE ONLY - NO ACKNOWLEDGEMENT REQUIRED

RESPONSE SERVICE
LICENCE No. NWW16574

2



Health Shield
FREEPOST - NWW 16574
CREWE
CW1 6ZZ

Increase your level of cover and get lots more cashback for a little more each month



Doesn't that make you feel even better?

We believe that Health Shield offers an excellent package of benefits.

Take a look at what we can offer:

- '100% refund' towards dental, dental accident, optical, physiotherapy, specialist consultation and chiropody treatment costs – subject to an annual review and up to your chosen limits
- Cash maximums that are refreshed every year
- Physiotherapy benefit also covers Acupuncture, Chiropractic, Osteopathy and Homoeopathy
- Health & Wellbeing benefit covers Acupressure, Allergy testing, Aromatherapy, Bowen/Alexander technique, Chair massage, Colonic hydrotherapy, Hopi ear candles, Hypnotherapy, Indian head massage, Kinesiology, Naturopathy, Nutritional therapy, Reflexology, Reiki, Remedial massage, Shiatsu and Sports massage
- Cover available for you or you and your partner
- Cover provides separate annual maximums for yourself, your partner (if covered) and all dependent children up to the age of 18
- Quick payment of claims – by cheque or direct credit
- Personal Accident Protection included
- Worldwide Cover
- 24-hour FREEPHONE helpline – Counselling & Lifestyle, Health & Medical and Legal Advice available
- Access to preferential corporate rates for a network of health clubs
- Dependent children covered on both Cover for You and Cover for You and Your Partner
- Authorised and regulated by the Financial Services Authority



Health Shield Friendly Society Ltd., Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.
Telephone: 01270 588555 Fax: 01270 251366 Opening hours: 8.00am to 6.00pm, Monday to Friday
Email: info@healthshield.co.uk Website: www.healthshield.co.uk

Established in 1877 Authorised and regulated by the Financial Services Authority.
As part of our on-going quality control programme, calls may be monitored or recorded.

The paper in this literature is made from sustainable certified forests.
DMP/JANUARY2010