

ESSENTIALS PLUS HEALTHCARE MEMBERSHIP PLAN - TABLE OF CONTRIBUTIONS AND BENEFITS

LEVEL OF COVER	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
WEEKLY PAYMENTS FOR YOU (Includes benefits for dependent children)	£1.00	£2.00	£3.50	£5.00
WEEKLY PAYMENTS FOR YOU AND YOUR PARTNER (Includes benefits for dependent children)	£1.65	£3.65	£6.65	£9.65
ALL CONTRIBUTIONS AND BENEFITS ARE SUBJECT TO AN ANNUAL REVIEW				
DENTAL MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£50	£100	£150	£200
DENTAL ACCIDENT MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£165	£400	£600	£800
OPTICAL MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£50	£100	£150	£200
PHYSIOTHERAPY, CHIROPRACTIC, OSTEOPATHY, ACUPUNCTURE AND HOMOEOPATHY MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£150	£280	£370	£500
SPECIALIST CONSULTATION, ECG, X-RAY, AND PATHOLOGY FEES MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£200	£260	£300	£400
CHIROPODY MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£50	£100	£150	£200
HEALTH & WELLBEING: COMPLEMENTARY THERAPIES FOR ALLERGY TESTING, STRESS RELIEF, WEIGHT MANAGEMENT AND STOP SMOKING MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£70	£120	£160	£205
HEALTH SCREENING MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£100	£130	£150	£200
FITNESS BENEFIT	ACCESS TO SPECIAL RATES			
WORLDWIDE COVER	HEALTH SHIELD COVERS YOU FOR ALL BENEFITS ANYWHERE IN THE WORLD			
EMPLOYEE ASSISTANCE PROGRAMME & 24 HOUR FREEPHONE HELPLINE - COUNSELLING & LIFESTYLE, HEALTH, MEDICAL AND LEGAL ADVICE PLUS UP TO 6 FACE TO FACE SESSIONS	24 HOURS A DAY, 7 DAYS A WEEK ACCESS TO TELEPHONE HELPLINES PLUS UP TO 6 FACE TO FACE COUNSELLING SESSIONS FOR ALL MEMBERS			
The above benefits are the maximum levels which apply. For later years, both the type of benefit, benefit levels and contribution rates may change in future.				

Pre-existing conditions waived

Your Essentials Plus Scheme membership will cover pre-existing conditions. This offer also applies to any increase in cover made within 30 days of your company sponsored scheme beginning.

Immediate benefit - For all NEW members and members who increase their level of cover

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 annually, in line with your company benefit year
- Physiotherapy benefit also covers Acupuncture, Chiropractic, Osteopathy and Homoeopathy
- Health & Wellbeing benefit also 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
- Dependent children covered on both Cover for You and Cover for 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
- Worldwide Cover
- Employee Assistance Programme and 24 hour FREEPHONE telephone helpline – Counselling & Lifestyle, Health & Medical and Legal Advice plus up to 6 face to face sessions
- Access to preferential corporate rates for a network of health clubs
- Authorised and regulated by the Financial Services Authority



Essentials Plus

Company Sponsored

Healthcare Cash Plan - Essentials Plus Scheme Membership Plan

Age limits and changing your level of cover

If you want to join the Health Shield Essentials Plus Scheme membership plan ('the plan') or increase your level of cover, you must be between 16 and 69 (that is, not yet 70) when you apply and be employed by a company that agrees to make a company-sponsored contribution on your behalf. As long as your employer continues to sponsor you, membership will end at age 70 under the terms of the plan. You will not be able to continue in this scheme after your 70th birthday.

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.

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 benefit year.

'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 Essentials Plus 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.

'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.

'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

As a member of the Essentials Plus Scheme, you will become eligible to make claims for treatment that you receive after we have received your first contribution from your employer.

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 are a new contributor who has a pre-existing condition, you will be entitled to receive benefit for that condition. Pre-existing conditions will not affect any extra voluntary paid increases in your level of cover, as long as you voluntarily increase your cover within 30 days of your company-sponsored scheme beginning.

If you want to voluntarily increase your level of cover after the first 30 days, pre-existing conditions will not be overlooked, depending on the details shown above. We will tell you about any conditions that are not covered at the higher level.

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 be included in one membership plan.

We will write to you to tell you about any changes to your membership plan terms and conditions. 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 page 1.

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 100% of the rates published for the relevant year.

This membership plan is a long-term insurance contract with a maximum term of five years from the date the plan begins.

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.

General exclusions

We cannot pay benefit for any claims directly related to:

- emigration, legal, insurance or similar matters;
- GP fees for private treatment;
- examinations at medical centres;
- drugs and medicines;
- vasectomies, sterilisation, IVF, fertility treatment and examinations; and
- pregnancy terminations, contraceptives, sex-change operations or cosmetic surgery.

We cannot pay benefit for claims you make as a result of:

- 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, chiropodist, 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.

The benefit year of your membership plan will be confirmed in your welcome letter. 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 benefit year. We treat claims in a benefit year according to the dates you (or your partner or dependent child) received treatment, whichever applies.

Terms and conditions for the Health Shield Essentials Plus Scheme membership plan

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 claims you have made during your new plan's benefit 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 benefit 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 prescription charges.

Dental accident

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit 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 benefit year according to the date of accident.

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.
- Dental practice plan premiums and joining fees (for example, Denplan)
- 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

Optical treatment

We will pay benefit for optical treatment, at the appropriate rate and up to the appropriate maximum in any one benefit 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 lens and glasses cases)

Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person 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
- 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
- Having a pre-existing medical condition treated or investigated

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 benefit year, when a person 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.

Terms and conditions for the Health Shield Essentials Plus Scheme membership plan

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

- Counselling fees
- Hearing aids provided by a registered hearing-aid supplier
- Investigative procedures (for example, colonoscopy, 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
- X-ray, including mammograms, CT scans, ultrasounds and MRI scans

What is not covered

- Anaesthetists' fees
- Medical examinations and reports
- Private antenatal scans
- Private hospital charges (for example, theatre and room fees)
- Having a pre-existing medical condition treated or investigated

Chiropody

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit 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
- Orthotics supplied by the chiropodist or podiatrist at the time of the treatment (for example, arch supports)
- Podiatry treatment

What is not covered

- Consumables (for example, corn plasters or insoles) that are not bought as part of the treatment
- Surgical footwear
- 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 benefit 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.

What is covered

- Acupuncture
- Allergy testing, including food intolerance and nutrition tests
- Aromatherapy
- Bowen and Alexander techniques
- Chair massage
- Colonic hydrotherapy
- Hopi ear candles
- Hypnotherapy
- Indian head massage
- Kinesiology
- Massages (for example, sports and remedial)
- Naturopathy
- Nutritional therapy
- Reflexology
- Reiki
- Shiatsu

What is not covered

- 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)
- Stop-smoking patches, gum and so on
- Weight management programmes (for example, Weight Watchers)

Health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, for a full health screen. 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 full health screen carried out by medically qualified staff at a hospital, registered health screening clinic or service
- Well Man and Well Woman clinics

What is not covered

- Home testing kits
- Screening for employment services
- Tests not included within the full health screen (for example, X-rays and blood tests)

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).

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.

Employee Assistance Programme (including family care counselling helpline)

We will give you and your family access to a professional telephone service, 24 hours a day, seven days a week. This provides counselling, support and guidance on a whole range of lifestyle, health, medical and legal problems. Advice and counselling is available from specialist teams of counsellors, lawyers and medical staff. [This service is provided on behalf of Health Shield by FirstAssist Services Ltd.]

If you want to speak to a family care counsellor, lawyer or medical advisor, call Freephone 0800 1079042 and quote scheme number 72008. [This call is free.]

If the telephone counsellor thinks you would benefit from face-to-face counselling, they will arrange the first of up to six sessions for you. These sessions will take place close to your home or place of work. The cost of these sessions will automatically be covered by your plan. Face-to-face counselling can be provided for you only, and is not available for your family.



The Crystal Mark is only applicable to the Terms and conditions and does not apply to the design and layout of this leaflet.



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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.