chasetempleton
the personal approach to health insurance

Everyday Healthcare Plan

Underwritten by Health Shield

- ✓ 100% refund on healthcare bills, subject to annual review
- ✓ 4 levels of cover to choose from
- ✓ Fast payment of claims by direct credit
- ✓ Dependent children covered FREE up to the age of 24 in full-time education
- ✓ No medical required to join and no GP referral required before having treatment
- ✓ Pre-existing conditions covered at the company sponsored level
- ✓ Pre-existing conditions covered at the higher level as long as you increase within 30 days
- ✓ Members' Area – check benefit allowance, amend personal details and download claim forms all online

TAILORED HEALTHCARE MEMBERSHIP PLAN — TABLE OF CONTRIBUTIONS AND ANNUAL BENEFITS

LEVEL OF COVER		CASHBACK LEVEL	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
COMPANY SPONSORED LEVEL FOR YOU (Includes benefits for all dependent children)			FOR YOU	FOR YOU	FOR YOU	FOR YOU
COMPANY SPONSORED LEVEL FOR YOU AND YOUR PARTNER (Includes benefits for all dependent children)			FOR YOU AND YOUR PARTNER	FOR YOU AND YOUR PARTNER	FOR YOU AND YOUR PARTNER	FOR YOU AND YOUR PARTNER
ALL CONTRIBUTIONS AND BENEFITS ARE SUBJECT TO AN ANNUAL REVIEW						
TO MAKE YOU FEEL BETTER						
HOSPITAL BENEFITS - HOSPITAL INPATIENT (PER NIGHT) - HOSPITAL DAY SURGERY (PER DAY)	per adult	UP TO A MAXIMUM OF 25 NIGHTS/DAYS PER YEAR	£10	£20	£30	£40
	per child		£5	£10	£15	£20
SPECIALIST CONSULTATION, ECG, X-RAY, PATHOLOGY FEES AND MRI SCANS	per adult	100%	£250	£300	£375	£500
	per child	100%	£250	£300	£375	£500
PHYSIOTHERAPY, CHIROPRACTIC, OSTEOPATHY, ACUPUNCTURE AND HOMOEOPATHY	per adult	100%	£180	£320	£430	£575
	per child	100%	£90	£160	£215	£290
CHIROPODY	per adult	100%	£50	£115	£165	£215
	per child	100%	£25	£60	£85	£110
DENTAL ACCIDENT	per adult	100%	£200	£450	£700	£900
	per child	100%	£100	£225	£350	£450
PRESCRIPTIONS	per adult	PER ITEM	1	2	3	4
HOME ASSISTANCE COVER		UP TO 14 HOURS HOME CARE ASSISTANCE AFTER A PRE-PLANNED HOSPITAL STAY OF 2 NIGHTS OR MORE				
KEEPING YOU FIT AND HEALTHY						
DENTAL	per adult	100%	£70	£125	£180	£230
	per child	100%	£35	£65	£90	£115
OPTICAL (2 YEAR BENEFIT PERIOD)	per adult	100%	£70	£125	£180	£230
	per child	100%	£35	£65	£90	£115
HEALTH & WELLBEING	per adult	100%	£80	£140	£180	£230
	per child	100%	£40	£70	£90	£115
HEALTH SCREENING (2 YEAR BENEFIT PERIOD)	per adult	100%	£110	£140	£160	£210
	per child	100%	£55	£70	£80	£105
FITNESS BENEFIT		ACCESS TO SPECIAL RATES				
ONLINE HEALTH RISK ASSESSMENT		INSTANT ACCESS TO A RANGE OF HEALTH RISK ASSESSMENTS				
WHEN YOU JUST NEED TO TALK TO SOMEONE						
24-HOUR HELPLINE		24/7 COUNSELLING & LIFESTYLE, HEALTH & MEDICAL AND LEGAL INFORMATION				
24/7 GP TELEPHONE CONSULTATIONS		SPEAK TO A GP AT A TIME THAT SUITS YOU				

WORLDWIDE COVER FOR MANY BENEFITS

The above table lists all the benefits available to you on your plan. You must refer to these before submitting a claim.

The above benefits are the maximum levels which apply. The type of benefit, benefit levels and contribution rates may change in future.

TABLE OF ADDITIONAL WEEKLY CONTRIBUTIONS FOR TOP UPS FROM COMPANY SPONSORED LEVELS

LEVEL OF COVER	LEVEL 1 YOU	LEVEL 2 YOU	LEVEL 3 YOU	LEVEL 4 YOU
FROM COMPANY SPONSORED LEVEL 1 YOU		£2.75	£5.25	£8.00
FROM COMPANY SPONSORED LEVEL 2 YOU			£3.75	£6.50
FROM COMPANY SPONSORED LEVEL 3 YOU				£5.00

LEVEL OF COVER	LEVEL 1 YOU AND YOUR PARTNER	LEVEL 2 YOU AND YOUR PARTNER	LEVEL 3 YOU AND YOUR PARTNER	LEVEL 4 YOU AND YOUR PARTNER
FROM COMPANY SPONSORED LEVEL 1 YOU	£2.40	£7.00	£12.00	£17.50
FROM COMPANY SPONSORED LEVEL 2 YOU		£5.50	£10.50	£16.00
FROM COMPANY SPONSORED LEVEL 3 YOU			£9.00	£14.50
FROM COMPANY SPONSORED LEVEL 4 YOU				£13.00

LEVEL OF COVER	LEVEL 1 YOU AND YOUR PARTNER	LEVEL 2 YOU AND YOUR PARTNER	LEVEL 3 YOU AND YOUR PARTNER	LEVEL 4 YOU AND YOUR PARTNER
FROM COMPANY SPONSORED LEVEL 1 YOU AND YOUR PARTNER		£5.50	£10.50	£16.00
FROM COMPANY SPONSORED LEVEL 2 YOU AND YOUR PARTNER			£7.50	£13.00
FROM COMPANY SPONSORED LEVEL 3 YOU AND YOUR PARTNER				£10.00

Terms and conditions

GENERAL TERMS AND CONDITIONS

These are the Everyday Healthcare Plan terms and conditions and should be read with the Key Facts document. The scheme is underwritten and administered by Health Shield Friendly Society Limited.

Who can join?

If you want to join the Everyday Healthcare Plan 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 pay a 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.

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

If you are a new member 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 increase 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 covered. We will tell you about any conditions that are not covered.

Exclusions for pre-existing conditions may apply to the following benefits only.
- Home assistance cover
- Hospital inpatient
- Hospital day surgery
- Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans

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

We have the right to turn down any application to join the scheme or increase your level of cover, if we think that this would have a negative effect on our members.

If you retire or leave a company that offers the Everyday Healthcare Plan, and you are not yet 65, you can convert to the Health Shield Connect Scheme. If you are 65 or over, you can convert to the Health Shield Connect Plus Scheme.

Your membership

This membership plan is a long-term insurance contract with a maximum term of five years from the date the plan begins. We will renew your policy automatically every five years unless you cancel your cover or you allow it to lapse (you stop paying premiums).

We will refund the appropriate percentage of each valid claim (as shown in the benefit table) up to your yearly benefit limit. However, 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. As a result, we will review all benefits and contributions each year and will tell you in advance if a review will lead to a change in the benefits or contributions paid in the future.

As a member, you agree to us processing personal and sensitive information about you. 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. If we believe that any documents you send us are not genuine, we may keep them.

Our board of management may end your membership if they think:

- you have broken our rules;
- your continued membership may have a negative effect on the interest of the members generally;
- you have failed to act with utmost good faith which includes:
  - repeatedly making claims which threaten our financial wellbeing;
  - deliberately providing misleading or false information (or not providing information which we have specifically asked for);
  - behaving in a threatening or abusive way towards any member of our staff; or
  - making a claim that is fraudulent or that we believe to be deliberately false, misleading or exaggerated.

We are committed to preventing financial crime and we will report to the police all instances of fraud or attempted fraud.

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

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.

If you make a claim and your contributions are not paid up to date for any reason, we will not be able to process your claim.

We will put a hold on your claims until your contributions cover the dates that you are claiming for.

If you decide to end your membership, all benefits will stop after the date you have paid up to.

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 receive a special immediate benefit concession. This means we will overlook the normal qualifying periods, allowing you, and your partner and dependent children (if this applies) to claim benefits straight away.

Exclusions

We cannot pay benefit for any claims directly related to the following.
- GP fees for private treatment
- Drugs, medicines and vaccinations (including medicines relating to homoeopathic treatment and travel-related vaccines, for example anti-malarial tablets)
- 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
- Postage and packing costs
- Internet, telephone and group consultations
- Treatments carried out in the workplace or arranged through your employer
- Treatment charges covered by private medical insurance other than any excess. (Excess fees are covered under the Specialist Consultation allowance.)

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
- Nuclear, chemical or biological terrorism
- Drug, alcohol or solvent abuse, or taking drugs (unless you have been told to by a registered medical practitioner)
- Please also see what is not covered under each section of cover

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

Benefit period

The maximum benefits are shown in the table on page 1.

The benefit year of your membership is 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 except for optical and health-screening benefits which we will pay over a two-year benefit period. We treat claims in a benefit year according to the dates you (or your partner or dependent child) received treatment.

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

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.

How to claim

We will deal with claims on the day we receive them, but we cannot accept photocopied, faxed or scanned receipts and claim forms. We also cannot accept credit- or debit-card receipts. You should include the following details on the original receipts.
- The date you received treatment (we cannot pay for anything you have paid for in advance and not yet received)
- 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
- The type of treatment received

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.

We will not pay for any part of your receipt which you paid for by using gift cards or vouchers, including vouchers from third-party discount sites, or loyalty and reward points.

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

Worldwide cover

Some 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 the 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.

Before we can pay your claim, we may ask for a copy of your travel documents.

What benefits are covered
- Dental
- Optical
- Hospital inpatient
- Hospital day surgery
- Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy (the qualification or accreditation of the practitioner may be an international equivalent)

What benefits are not covered
- Dental accident
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Chiropody
- Health and wellbeing
- Health screening
- Prescriptions

Also see the 'Exclusions' section on this page.

This cover does not replace travel insurance.

Terms and conditions

DEFINITIONS

'Accepted qualifications' – a list of approved professional organisations and accepted qualifications that we recognise. We review this list every year. The practitioner's qualifications, registration or membership must be relevant to the treatment that they are providing.

'Accident' – a sudden, unexpected and identifiable event causing injury or illness.

'Care and support assessment' – a telephone-based assessment carried out by our medically-qualified staff to cover the following areas you may need help with.
- Personal hygiene and grooming
- Dressing and undressing
- Feeding yourself
- Moving around (getting into and out of bed or a wheelchair, getting onto or off the toilet and so on)
- Bowel and bladder management
- Walking with or without an assistance device for example, walker, cane, or crutches or using a wheelchair.

'Claims experience' – the number and cost of claims we paid for any one benefit year which is confirmed in your welcome letter.

'Dependent children' – your or your partner's children or legally adopted children who are under the age of 21 and living at home, or under the age of 24 in full-time education.

'Excess' – the first part of any eligible treatment costs, that would otherwise be paid by a private medical insurer, which you have chosen to pay yourself.

'Full health screen' – a full medical check-up that may involve giving details of your and your family's medical history and having a physical examination, tests, laboratory tests, scans or X-rays, and may be followed by counselling, education, referral to hospital or further treatments, or further tests.

'Home' – where you permanently live. For Home Assistance claims, your home must be in the United Kingdom and cannot be a nursing, rest, retirement or convalescent home or similar establishment.

'Hospital' – an institute which has permanent facilities for caring for patients, has facilities for diagnosing and treating injured or sick people and provides nursing services supervised by registered general nurses. If you are admitted to a hospital it should be following a referral by a GP, consultant or through the accident and emergency (A&E) department.

'Membership plan' ('the plan') – the Everyday Healthcare 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' – an infectious 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.

'Practice-plan premiums' – payments made to a scheme provided by your dentist.

'Pre-existing condition' – any disease, illness or injury that you have received medication, advice or treatment for, and experienced symptoms of, 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.

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

BENEFIT TERMS

TO MAKE YOU FEEL BETTER

Hospital benefits

We combine hospital inpatient and hospital day-surgery 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 (after being referred by a GP or consultant or being admitted by A&E) for inpatient treatment in a recognised hospital or hospice.

You must fill in your claim form yourself confirming the medical reason for the hospital treatment. The claim form must be checked and stamped with the hospital or hospice stamp, and signed by a member of their staff. Or you can send us your inpatient letter which would have been given to you when you were discharged.

Before we can pay your claim, we may ask for more information about the treatment provided by the hospital. If there is a dispute, our Board of Management will decide whether you needed to be admitted and whether a medical facility keeps to the policy definition of a hospital.

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
- Being admitted to the ward, from the accident and emergency department, before midnight
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim
- Worldwide cover during business visits and holidays abroad

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 reported to us after the first 30 days of cover
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments

Also see the 'Exclusions' section on page 2.

Hospital day surgery

We will pay benefit at the appropriate day rate for the period a person entitled to benefit is admitted (after being referred by a GP or consultant or being admitted by A&E) for hospital day-surgery treatment in a recognised hospital without an overnight stay.

You must fill in your claim form yourself confirming the medical reason for the hospital treatment. The claim form must be checked and stamped with the hospital stamp, and signed by a member of their staff. Or you can send us your inpatient letter which would have been given to you when you were discharged.

Before we can pay your claim, we may ask for more information about the treatment provided by the hospital. If there is a dispute, our Board of Management will decide whether you needed to be admitted and whether a medical facility keeps to the policy definition of a hospital.

What is covered
- Any day-surgery 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 sedation using theatre facilities, or to have a medical condition treated under anaesthetic or sedation using theatre facilities
- 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
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim
- Outpatient treatment for chemotherapy
- Outpatient treatment for kidney dialysis
- Outpatient treatment for oncology
- Outpatient treatment for radiotherapy
- Worldwide cover during business visits and holidays abroad

What is not covered
- Attending accident and emergency
- Attending clinics, medical centres or nursing homes
- Admissions immediately before or following an overnight stay (one day either side) for which we will pay a claim under the hospital inpatient benefit
- 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 reported to us after the first 30 days of cover
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments

Also see the 'Exclusions' section on page 2.

Specialist consultation, ECG, X-ray, pathology fees and MRI scans

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit 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) or be included on the register of specialists maintained by the General Medical Council. This benefit also refunds costs you would have to pay for an ECG, X-ray, pathology fees and MRI scans charged to you at the appropriate department of a hospital or as part of a consultation.

You must send us an original receipt showing your name, dates of the consultation or treatment, the physician's or surgeon's qualifications and their official stamp.

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
- Hearing-aid repairs
- 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 carried out at a hospital or as part of a consultation
- If a claim has been settled by a provider of private medical insurance, we can only pay benefit (up to the appropriate maximum) for any remaining excess if you send us your statement from the provider of private medical insurance.

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 reported to us after the first 30 days of cover
- Worldwide cover during business visits and holidays abroad
- ECG, X-ray, pathology fees and MRI scans charged to you other than when part of a hospital stay or a consultation

Also see the 'Exclusions' section on page 2.

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 entitled to benefit receives treatment, from a practitioner who is a member of an approved professional organisation, to relieve pain or prevent an illness. 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.

There is a list of accepted accreditations and qualifications on our website at www.healthshield.co.uk. You can also ask us to send you a list by ringing 01270 588555 or emailing claims@healthshield.co.uk. We review this list every year. The practitioner's qualifications, registration or membership must be relevant to the treatment that they are providing.

When you send us the claim form, you must also send us an original receipt showing your name, dates of treatment, the type of treatment and the practitioner's official stamp.

We will only pay claims for the treatments listed below. The practitioner must have the appropriate qualifications as shown on the separate accepted qualifications list referred to above.

The claim form must include the reasons for the treatment, and the type of treatment provided.

What is covered
- Acupuncture
- Chiropractic
- Homoeopathy
- Osteopathy (including craniosacral therapy)
- Physiotherapy
- X-ray, when necessary as part of the treatment
- Worldwide cover during business visits and holidays abroad

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) even if prescribed and supplied by your practitioner as part of the treatment
- Pre-existing conditions reported to us after the first 30 days of cover
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment
- Prescription charges (we cover these charges under the prescriptions benefit)

Also see the 'Exclusions' section on page 2.

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.

There is a list of accepted accreditations and qualifications on our website at www.healthshield.co.uk. You can also ask us to send you a list by ringing 01270 588555 or emailing claims@healthshield.co.uk. We review this list every year. The practitioner's qualifications, registration or membership must be relevant to the treatment that they are providing.

When you send us the claim form, you must also send us an original receipt showing your name, dates of treatment and the chiropodist's official stamp.

What is covered
- Assessments (for example, gait analysis, which is an analysis of how you walk)
- Chiropody treatment
- Podiatry treatment

What is not covered
- Consumables (for example, arch supports, orthotics or insoles) even when prescribed and supplied by the chiropodist or podiatrist at the time of the treatment
- Surgical footwear (for example, corrective shoes prescribed and supplied as a part of the treatment)
- X-rays
- Worldwide cover during business visits and holidays abroad
- Chiropody prescription charges (we cover these charges under the prescriptions benefit)

Also see the 'Exclusions' section on page 2.

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 blow to the head.

When you send us the claim form, you must also send us an original receipt showing your name, dates of treatment and the dentist's official stamp.

Your dentist must also confirm on the receipts that the treatment has been caused by a direct blow to the head which has resulted in accidental injury to your teeth. 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 the accident happened.

We will only pay one maximum for all treatment that lasts from one benefit year to another.

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)
- Damage to dentures when not being worn
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on)
- Dental prescription charges (we cover these charges under the prescriptions benefit)
- Dental insurance, premiums and joining fees for your practice's dental plan
- 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
- Injuries caused by eating and drinking
- Worldwide cover during business visits and holidays abroad

Also see the 'Exclusions' section on page 2.

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 individual prescription 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 of individual prescription items
- Dental prescription charges

What is not covered
- Charges above the current rate set out in the NHS prescription pricing structure
- Worldwide cover during business visits and holidays abroad

Also see the 'Exclusions' section on page 2.

We do not pay prescription benefit for dependent children.

Home Assistance Cover

Cover is provided and arranged on our behalf by Aria Assistance and underwritten by Aria Insurance Limited.

This benefit provides you and your partner (if covered) with help at home immediately after a period of at least two nights' hospital inpatient treatment. Treatment can be in a hospice, NHS hospital, private hospital or registered treatment centre. Your hospital inpatient stay must be for planned treatment only.

Before you are due to be admitted to hospital, you will need to call 0844 3385759. (This call is not free.) During this call, you will be asked to quote your scheme number which is 72010, and then a care and support assessment will be carried out. If you are eligible for assistance, we will arrange for our appointed care provider to contact you to carry out a full assessment of your needs in your home (in line with the Care Quality Commission's requirements). The care provider will also monitor your needs to make sure that the assistance provided continues to meet your needs.

We will then arrange and pay for up to 14 hours' necessary personal care or domestic assistance in your home for up to one week. If you make more than one claim for this benefit in a plan year, cover is limited to six weeks in total for the period of insurance.

What is covered
You may be able to receive the following benefits and services.
- Personal care, including help with:
  - bathing, showering and cleaning teeth;
  - support with getting up and going to bed;
  - help in using the bathroom and toilet;
  - dressing, undressing and caring for clothes;
  - preparing, and cleaning up after, meals and drinks;
  - hair care and shaving;
  - foot care; and
  - recognising and discussing health needs.
- Domestic assistance, including help with:
  - cleaning;
  - general tidying and light household duties;
  - changing bed linen;
  - ironing and laundry; and
  - dog walking and feeding your household pets.
- Wellbeing call
  - To discuss the services and benefits that you are eligible to receive under this policy and to answer any questions about your cover that you may have

What is not covered
We will not pay for any services that:
- are not arranged by us;
- follow a period of hospital inpatient treatment of less than two nights;
- are not covered under the hospital inpatient benefit of this plan;
- follow an emergency hospital admission;
- are received outside of the United Kingdom or away from your home;
- include medical treatment of any kind;
- include transportation services of any kind; or
- are related to a pregnancy.

Also see the 'Exclusions' section on page 2.

KEEPING YOU FIT AND HEALTHY

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 receipt showing your name, dates of treatment and the dentist's official stamp.

What is covered
- Anaesthetic fees
- Check-up charges
- A dental brace or gum shield provided by the dentist
- Premiums and joining fees for the practice's dental plan (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
- Worldwide cover during business visits and holidays abroad

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 treatment charges resulting from a dental accident (we cover these charges under the dental accident benefit)

Also see the 'Exclusions' section on page 2.

Optical

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

When you send us the claim form, you must also send us an original receipt showing your name, the date of treatment or payment and the optician's official stamp.

What is covered
- Contact lenses (permanent or disposable)
- Contact lens check-ups
- Contact lens solutions (including if you buy these separately)
- Eye laser surgery to correct long- and short-sightedness paid according to date of treatment and not when payments are made
- Eyesight tests
- Lenses you buy separately to fit to existing frames
- Lenses supplied under an optical insurance plan
- Prescribed glasses
- Prescribed magnifying glasses
- Repairs to prescribed glasses
- Sunglasses, safety glasses and swimming goggles (as long as they have prescribed lenses)
- Worldwide cover during business visits and holidays abroad

What is not covered
- Insurance premiums
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses)
- Optical consumables (for example, glasses cases)
- Frames you buy separately

Also see the 'Exclusions' section on page 2.

Health and wellbeing

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 pain or prevent an illness or pain, from a practitioner who is a member of an approved professional organisation.

There is a list of accepted accreditations and qualifications on our website at www.healthshield.co.uk. You can also ask us to send you a list by ringing 01270 588555 or emailing claims@healthshield.co.uk. We review this list every year. The practitioner's qualifications, registration or membership must be relevant to the treatment that they are providing.

We will only pay claims for the treatments listed below. The practitioner must have the appropriate qualifications as shown on the separate accepted qualifications list referred to above.

When you send us the claim form, you must also send us an original receipt showing your name, dates of treatment and the practitioner's qualifications and official stamp.

The claim form must include the reasons for the treatment, and the type of treatment provided.

What is covered
- Acupressure
- Allergy testing, including food intolerance and nutrition tests
- Aromatherapy massages
- Bowen and Alexander techniques
- Chair massage
- Cognitive behavioural therapy
- 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 for 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)
- Relationship counselling
- Internet, telephone and group consultations
- Worldwide cover during business visits and holidays abroad

Also see the 'Exclusions' section on page 2.

Health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any two-year benefit period, for a health screen carried out by medically qualified staff at a hospital or health-screening clinic to prevent an illness.

When you send us the claim form, you must also send us an original receipt showing your name, the date of the health screen and the health-screening provider's official stamp.

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 employment, emigration, legal or insurance reasons
- Any other screening check or test not carried out as part of one of those listed above
- Health screens carried out in the workplace or arranged through your employer
- Worldwide cover during business visits and holidays abroad
- Health screens carried out in mobile facilities

Also see the 'Exclusions' section on page 2.

Fitness benefit

Membership will give you and your family access to special rates for a network of health clubs and hotels via Incorpore's Corporate Fitness Network. 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.

To search for your nearest health club which is taking part, you will need to visit www.incorpore.co.uk or phone Incorpore's Customer Support Line on 0845 6024601 (quoting reference HEA).

Online health-risk assessment

This service is provided on behalf of Health Shield by Capita and provides instant access to a range of health-risk assessments.

You will need to visit www.firstassistonline.com and quote access code 72010. Once logged in, please choose the Fitness2live section. You will then be asked to register and accept their separate terms and conditions before starting your assessment using your employer's code, which is the access code quoted above.

WHEN YOU JUST NEED TO TALK TO SOMEONE

24-hour 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 information and counselling from specialist teams of counsellors, lawyers and medical staff. (This service is provided by Capita.)

If you want to speak to a family-care counsellor, lawyer or medical advisor, call 0800 1079042 and quote scheme number 72010. (This call is free from BT landlines.)

24/7 GP telephone consultation service

You and your family can speak with a GP at a time that is convenient for you. This service allows you to talk in confidence to a qualified practising GP. Each call is confidential unless you give your permission for details to be passed on to anyone else.

The service is available 24 hours a day, every single day of the year from anywhere in the world.

Your call will be answered by a specially trained operator who will take some details and arrange for a GP to call you back at a convenient time. If the GP advises, and you agree, we will send a record of your consultation to your own doctor.

This service is not a replacement for your own doctor or the emergency services. It can give you advice and support for routine queries. For urgent medical problems, you should get advice from your own doctor or the emergency services.

There is no limit to the number of calls you can make to the service. To use the service, all you need to do is call 0845 319 6462 and quote scheme number 72010. (This call is not free.)

The GP telephone consultation service is provided on behalf of Health Shield by Medical Solutions UK Ltd.

The Direct Debit Guarantee - if applicable to your scheme

DIRECT Debit

- The Guarantee is offered by all banks and building societies that accept instruction to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Health Shield will notify you (normally 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.

Crystal Mark 20577
Clarity approved by Plain English Campaign

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

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Email: info@healthshield.co.uk Website: www.healthshield.co.uk

Established in 1877. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation 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.

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