# Terms and conditions for the Health Shield Premier Scheme membership plan

## GENERAL TERMS AND CONDITIONS

**These are the Health Shield Premier Scheme terms and conditions and should be read with the Key Facts document.**

**Please make sure that you have read and understood both documents before going for treatment or sending us a claim.**

### Who can join?

If you want to join the Health Shield Premier 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 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.

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:

- Combined physiotherapy
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Home assistance 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 and dependent children. You, and your partner and dependent children (if this applies), may only be covered or included in one membership plan.

### 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 beforehand 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 verification 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.

We can refuse claims if we reasonably believe that the treatment has not taken place or that you have not paid for an item. This includes rejecting receipts from certain practitioners and claims that we cannot check with the practitioner concerned.

### 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 and medicines (including medicines relating to homoeopathic treatment)
- Vasectomies, sterilisation, IVF, fertility treatment and examinations
- Pregnancy terminations, contraceptives, gender re-assignment or cosmetic reasons
- Any health-screening checks, 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
- Suicide or deliberate self-inflicted injury
- War, hostilities, invasion or civil war and full-time active military service
- Nuclear, chemical or biological terrorism
- Drug, alcohol or solvent abuse, or taking drugs (unless you have been told to by a registered medical practitioner)
- Taking part in professional sports or flying as a pilot or crew member (that is, aircraft, gliders, hang-gliders, microlights, parachuting, paragliding and ballooning)
- Please also see what is not covered under each section of cover.

### Benefit period

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

**The benefit year of your membership is confirmed in your welcome letter or email.** 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) were admitted to hospital or received treatment, whichever applies.

If you have been covered before as a member or 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 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.

Your maximum benefit allowance (as shown in the benefit table) is available over a one-year benefit period except for the following benefits.

- Optical
- Health screening

### How to claim

We will deal with claims on the day we receive them and make payment within a reasonable time. We cannot accept photocopied, faxed or scanned receipts and claim forms (unless you are sending us a claim via the Health Shield website). 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
- The receipt clearly shows the payment amount and that it has been paid in full

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 accept applications for benefit that are more than 12 months old at the time we receive them.

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.

Before receiving treatment for one of the benefits listed below please make sure that you have checked our list of accepted accreditations and qualifications to see whether the person or organisation treating you has the accreditations and qualifications we accept:

- Chiropody
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Health and wellbeing
- Combined physiotherapy

### 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 on the date we process your claim.

Before we can pay your claim, we may ask for a copy of your travel documents which confirms that you have not been outside of the United Kingdom for more than 28 days.

What benefits are covered:

- Dental
- Optical
- Combined physiotherapy (the qualification or accreditation of the practitioner may be an international equivalent)

# Terms and conditions for the Health Shield Premier Scheme membership plan

What benefits are not covered:

- Dental accident
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Chiropody
- Health and wellbeing
- Health screening
- Flu jabs

Also see the 'Exclusions' section on page 2.

This cover does not replace travel insurance.

## DEFINITI NS

'**List of accepted accreditations and 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.

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

'**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 25 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.

'**Hospice**' – an institution that provides palliative care for the terminally ill.

'**Hospital**' – an institution 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 G , consultant or through the accident and emergency (A&E) department.

'**embership plan**' ('the plan') – the Health Shield remier 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.

'**Palliative care**' – an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.

'**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 at the same address 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 Ltd, Electra Way, Crewe Business ark, 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

## HEALTHY & HAPPY

### Dental

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

lease see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

What is covered:

- Anaesthetic fees
- Check-up charges
- A dental brace or gum shield provided by the dentist
- Joining fees and practice-plan premiums
- 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
- 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.

### ptical

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

lease see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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

What is covered:

- Contact lenses (permanent or disposable)
- Contact lens check-ups
- Contact lens cleaning solutions (including if you buy these separately)
- Eye laser surgery to correct long- and short-sightedness paid according to the 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
- rescribed glasses
- rescribed magnifying glasses
- Repairs to prescribed 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, glasses cases)
- Frames you buy separately

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.

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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
- Chiropody prescription charges

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

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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

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 carried out by a qualified practitioner
- Aromatherapy massages
- Bowen and Alexander techniques
- hair massage
- ognitive behavioural therapy
- olonic hydrotherapy
- ounselling fees (for example psychiatric, psychological and bereavement)
- Hopi ear candles
- Hot-stone massage
- Hypnotherapy
- Indian head massage
- Kinesiology
- Manual lymphatic drainage
- Naturopathy
- Nutritional therapy
- Reflexology
- Reiki
- Shiatsu
- Sports and remedial massages including therapies
- Swedish massage

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
- Smoking cessation patches, gum, electronic cigarettes and other remedies
- Weight-management programmes
- Relationship counselling

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.

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

What is covered:

- 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 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
- Health screens carried out in mobile facilities

Also see the 'Exclusions' section on page 2.

### Combined physiotherapy

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

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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

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

# Terms and conditions for the Health Shield Premier Scheme membership plan

What is covered:
- Acupuncture
- Chiropractic
- Homoeopathy
- Osteopathy (including craniosacral therapy)
- Physiotherapy
- X-rays and scans, 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) even if 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
- Prescription charges

Also see the 'Exclusions' section on page 2.

### Flu jabs

We will pay benefit to you and your partner (if they are covered), at the appropriate rate and up to the appropriate maximum in any one benefit year, for flu (influenza) vaccinations.

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

We do not pay for flu jabs for dependent children.

What is covered:
- Flu (influenza) vaccination from a GP or nurse, for example in a GP's surgery or a pharmacy

What is not covered:
- Any tests, treatment or other services provided by the above
- Inoculations or vaccinations that are not for flu (influenza)
- Vaccinations carried out in the workplace or arranged through your employer

Also see the 'Exclusions' section on page 2.

## FEEL BETTER

### 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 be a consultant in a hospital but must be listed on the General Medical Council's Specialist Register or be a member, fellow or licentiate of one of the Royal Colleges.

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.

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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, EEG 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
- 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. Please make sure that the statement clearly shows how much excess is left to pay

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
- ECG, X-ray, pathology fees and MRI scans charged to you other than when they form part of a hospital stay or a consultation

Also see the 'Exclusions' section on page 2.

## PEACE OF MIND

### 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.

Please see the 'How to claim' section on page 3 before going for treatment or sending us a claim.

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. 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
- Dental insurance premiums
- Joining fees and practice-plan premiums
- 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

Also see the 'Exclusions' section on page 2.

### mywellness

Health Shield membership allows you exclusive access to a list of extra services. mywellness brings these services together in one place and they can be easily accessed online, on any device, through the mywellness tab on our Members' Area.

To take advantage of the services, you will first need to register on to Health Shield's Members' Area at www/healthshield.co.uk/members where you will be asked to confirm your Health Shield member number.

Once registered, please log in and select the 'mywellness' tab where you'll be able to access all the extra services which are available to you.

The services available on mywellness may differ according to the type of plan. Services and information available on mywellness can change without notice.

**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 20893 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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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.

INVESTORS IN PEOPLE

PREMIERMP/APRIL2017