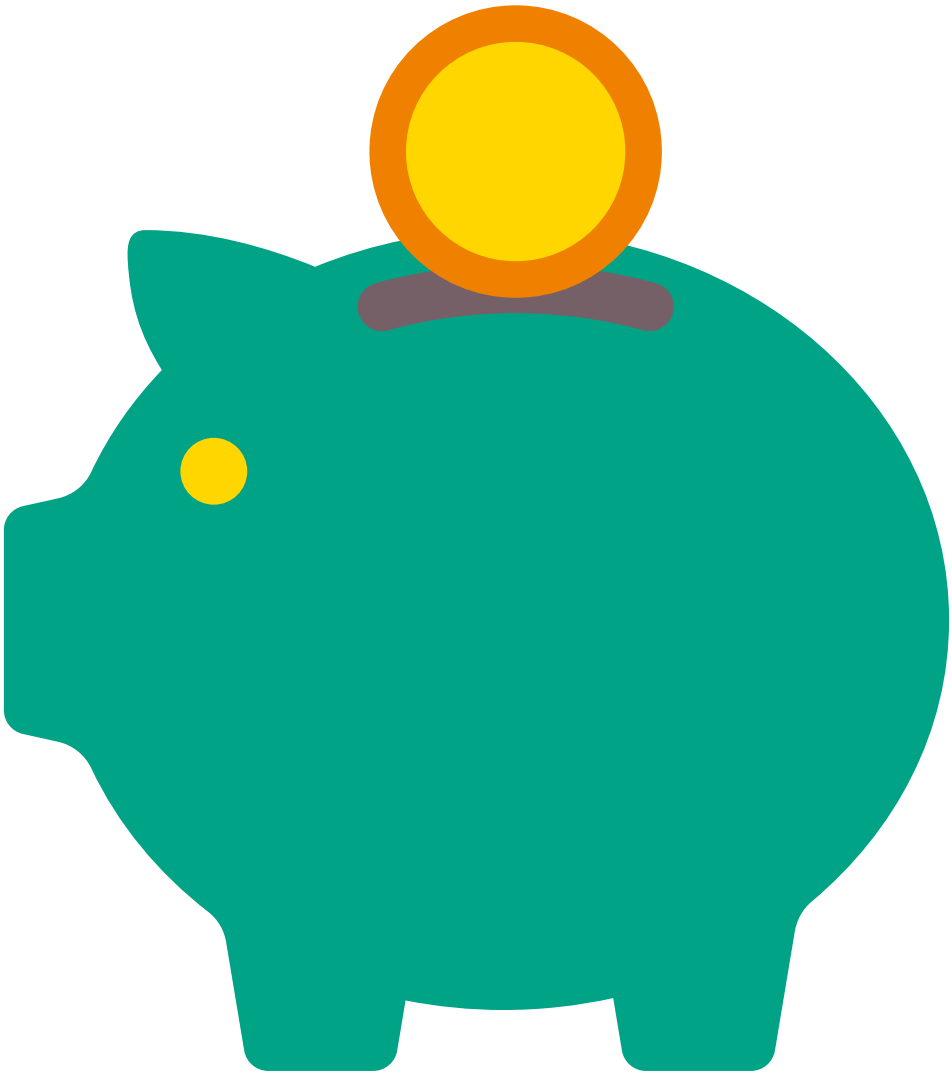
One Fund – Your Plan Explained

Corporate Health Cash Plan - Company paid

For Employees



The Exeter

Protect tomorrow today.

Contents

This document, along with your plan schedule, will provide you with the information you need on your One Fund plan. If you would like a copy of the full Terms and Conditions then please contact us or your company representative.

November 2015

Introducing One Fund

Welcome to your One Fund Corporate Health Cash Plan from The Exeter.

Your employer has chosen to offer you One Fund, at no cost to you. The plan gives you access to one annual pot of money giving you cashback for some common healthcare treatments.

Unlike other health cash plans that have a limit on every benefit type, One Fund is unique in giving you more flexibility in how you choose to use the fund.

It also gives you the flexibility to use the annual fund in a way you feel you will benefit from most without the limitations of some other plans.

Six key benefits (benefit limits apply)

1. Consultation and diagnostics

- Including investigative tests and diagnostic scans.

2. Counselling and advice helpline

- Confidential service, 24 hour access to fully trained telephone counsellors
- Telephone counselling is free of charge to you and does not impact on your benefit limit
- Face-to-face counselling sessions can be arranged
- Access to free, qualified legal and financial advice over the telephone, covering debt, taxation and many aspects of law.

3. Dental

- Including NHS and private dentistry
- Cash towards most non cosmetic dental treatment.

4. Complementary therapies

- Physiotherapy
- Osteopathy
- Chiropractic
- Acupuncture
- Homeopathy.

5. Optical

- Including cashback on eye tests, prescription glasses and contact lenses.

6. Health screening

- Because prevention is better than cure.

You can find full details of what is and isn't covered on pages 8-13.

How your plan works

Your employer will pay a monthly premium on your behalf, as stated in your plan schedule. This entitles you to a maximum annual allowance which you can look up on page 7 'One Fund cover levels'.

When you need treatment you simply pay for it as normal, keep the receipts and then claim cashback. For guidance, please see page 14.

The overall benefit limit is an annual one. You can claim up to the overall limit in one benefit, or across two or more benefits. You can only claim specified capped amounts within your overall limit in any plan year for optical benefit (glasses, contact lenses etc), dental benefit, or for health screenings.

The other benefits can be claimed up to the full annual limit. But the maximum we will pay in any plan year is limited by your overall maximum.

You can claim back 100% of whatever you spend, up to your annual limit, except for optical and dental benefits. An excess applies to these two benefits and this is explained on page 6.

Every claim you make will reduce the overall amount left available for you to claim across all benefits in that plan year. The start of your plan year is stated in your plan schedule. At the start of the following plan year, the amount you can claim returns to the overall maximum.

If your employer chose to provide a separate plan for your partner, your partner will have access to their own annual allowance each year.

You may have chosen to share either your allowance or your partner's allowance with a child(ren), and if so this will be stated on the plan schedule. Any claim made on behalf of the child will reduce the maximum available to claim on that plan. A child, must be under 18 years old (or 21 years if in full-time education). Children aren't able to claim on health screening or counselling benefits.

Below is an example of how the plan works. It is used for illustrative purposes only and isn't a real case.

Claim example:

Jenny, Personal Assistant (PA)

Jenny's employer has awarded her a £16 per month One Fund Corporate Health Cash Plan as part of her benefits package. This gives her an annual fund of £830 to claim from.

Jenny suffers an injury to her back so she goes to see a physiotherapist. A course of ten sessions is recommended to try and ease the pain. Jenny has all ten sessions and feels much better. She pays £50 for each session and keeps all her receipts.

She now fills out a claims form and sends it into The Exeter, together with her receipts. There is no excess to pay on physiotherapy so £500 is paid straight into her bank account.

This is the first time Jenny has made a claim this plan year so £500 is deducted from her total fund of £830.

How the excess works

When claiming for optical or dental treatment, there is a £50 excess per benefit, per plan year (excluding eye tests)

This means the first £50 of treatments costs in each of these benefit categories cannot be reclaimed.

Any amount above this will be paid by us, up to your maximum limit in any plan year. If you make another claim for the same benefit in the same plan year, you will not have to pay another excess in that plan year – we will cover the full amount, up to your remaining level of cover.

A new excess will also be payable (for dental and optical benefits only) from the date of your plan anniversary.

Below is an example of how the plan works. It is used for illustrative purposes only and isn't a real case.

Claim example:

Paul, Deputy Manager

Paul's employer provides him with the £14 per month One Fund Corporate Health Cash Plan. In January Paul goes to the dentist for his regular routine check-up and the bill is £50.

Paul knows that there is a £50 excess on dental treatment with his One Fund Health Cash Plan so he pays the bill as normal and keeps his receipt.

On Paul's next visit to the dentist in June he needs a crown fitted which will cost £300. This time after he pays the bill he submits a claim form and receipts to The Exeter for both the £50 check-up and £300 crown.

The claims team validate the claim and then pay £300 (£350 less the £50 excess) straight into Paul's bank account.

Paul has not made another claim this plan year so £300 is deducted from his total annual fund of £730, leaving him £430 to claim in that plan year. £65 of this can be used for dental which has an annual cap of £365.

One Fund cover levels

The table below shows the different cover levels available. Your plan schedule will confirm which level you are entitled to.

Pay	**£10** p/m	**£12** p/m	**£14** p/m	**£16** p/m	**£18** p/m	**£20** p/m	**£25** p/m
For a total annual fund of	**£520**	**£625**	**£730**	**£830**	**£935**	**£1,040**	**£1,600**
Consultation & diagnostics **No excess**	✓	✓	✓	✓	✓	✓	✓
Counselling & advice helpline **No excess**	✓	✓	✓	✓	✓	✓	✓
Complementary therapies† **No excess**	✓	✓	✓	✓	✓	✓	✓
Dental **£50 excess**	£260 per year	£315 per year	£365 per year	£415 per year	£470 per year	£520 per year	£800 per year
Optical **£50 excess (excludes eye tests)**	£120 per year	£140 per year	£165 per year	£200 per year	£235 per year	£260 per year	£350 per year
Health screening **No excess**	£120 per year	£140 per year	£165 per year	£200 per year	£235 per year	£260 per year	£350 per year

†Complementary therapies (Physiotherapy, Osteopathy, Chiropractic, Acupuncture, Homeopathy)

Important:

- Any claim is subject to the amount of total Annual Fund remaining after payment of any other claim(s)
- The benefit limits for Dental, Optical and Health Screening are included in the total annual fund and are not in addition to it
- Children will share the allowance of the adult on whose plan they are named
- Children are not entitled to money towards health screening or the counselling and advice helpline
- Partners can also be covered for an extra premium at the discretion of your employer.

A guide to claiming

Here's a list of what we do and don't pay for under this plan for each type of claim.

Partners can be provided with a separate plan at an equivalent premium with benefits that mirror yours. Children can share the cover limits available to their named adult where applicable. See our general exclusions on page 13.

Dental cover

What's covered under the plan?

Plan holders can claim for the following up to the annual dental benefit limit for their premium:

- Check-ups
- Dental x-rays
- Hygienist fees
- Extractions
- Fillings
- Dentures, whether partial, or complete, plus denture repairs
- Dental operations including anaesthetic
- Crowns, bridges or inlays
- Dental braces for adults

All treatments to be carried out by a member of the General Dental Council. Each claim is paid subject to the claimant having paid the first £50 under this benefit in each plan year.

What's NOT covered?

Any other dental treatment or expense not listed in 'what's covered' above, including but not limited to:

- Teeth whitening or any other cosmetic treatment
- Dental veneers
- Dental braces for children
- Dental implants (however attachments to implants such as a crown or bridge may be covered)
- Treatments for gum disease
- Prescription charges or anything which does not constitute treatment, such as missed appointment fees
- Dental consumables such as toothbrushes, mouthwash and dental floss
- Dental treatment where you cannot provide evidence of being clinically necessary.

Optical cover

What's covered under the plan?

Plan holders can claim for the following up to the annual optical benefit limit for their premium:

- Prescription glasses
- Prescription contact lenses, including monthly prescribed
- Repairs to, or replacement of, frames or prescription lenses
- Sunglasses or goggles issued under prescription
- Eye tests*
- Laser eye treatment – subject to the employee's plan being held and paid for 2 years minimum
- Other eye operations to improve eyesight, e.g. cataracts, stigmatisms

All treatments to be carried out by, and all purchases made through, a member of the General Optical Council.

Each claim is paid subject to the claimant having paid the first £50 under this benefit in each plan year, *with exception of eye tests where no excess applies.

What's NOT covered?

Any other optical treatment or expense not listed above, including but not limited to:

- Any cosmetic eye treatment or operation
- Non-prescription glasses, sunglasses, contact lenses or goggles
- Charges for anything which does not directly improve eyesight, such as missed appointment fees
- Optical consumables, such as contact lens/glasses cases, lens solutions or other cleaning agents.

Health screening

What's covered under the plan?

Plan holders can claim 100% of the receipt up to the maximum annual health screening benefit limits for their premium for the following:

- A full health screen, well man or well woman screen with no requirement for a GP recommendation
- Heart, breast and bone density screening recommended by a GP as part of a general health check
- These should be carried out by medically qualified staff at a recognised hospital or clinic
- If the plan holder is unsure what qualifies as a health screen they can contact us in advance of their appointment.

What's NOT covered?

Any treatment or expense not listed above including but not limited to:

Any other screenings for specific complaints, e.g. genetic disorders

Any supplementary charges not directly linked to improved health, such as missed appointment fees

Tests not included in a full screen, such as blood tests, although these may be covered under the separate consultations allowance

Routine screenings requested by outside sources such as the employer, the courts or an insurance company

Children are not covered for this benefit.

Consultations & diagnostics

What's covered under the plan?

Plan holders can claim 100% of the receipt up to the maximum annual fund limits for their premium for the following:

Any fee for a diagnostic consultation with a Specialist Consultant, Consultant Physician or Surgeon which is referred by a GP

Medical tests, such as ECG, EEC and lung function tests undertaken as part of Consultant's diagnosis

Investigative tests, such as needle biopsies, audiograms and patch tests undertaken as part of the consultant's diagnosis

Blood tests undertaken as part of the Consultant's diagnosis

X-rays and diagnostic scans, such as mammograms, CT scans, ultrasounds, MRI scans undertaken as part of the Consultant's diagnosis

The excess paid if a Private Medical Insurance provider has settled a consultation or diagnostic bill. We can only pay the benefit (up to the appropriate maximum) if we receive a statement from the Private Medical Insurance provider.

What's NOT covered?

Consultations not directly linked to improved general health such as, but not limited to:

Consultations or treatments for obesity or eating disorders

Health screening – covered under separate allowance

Speech therapy and dyslexia services

Cosmetic treatments, surgery or advice other than in respect of problems which started after joining e.g. as a result of an accident

Vasectomy, sterilisation or other fertility/infertility treatments or family planning

Invasive investigative procedures such as colonoscopy or endoscopy

Costs associated with medical reports for work

Other charges for anything which does not directly improve the claimant's health, such as missed appointment fees or sundry fees for staffing or room hire passed on by a consultant

The excess paid if a Private Medical Insurance provider has settled any other medical bill other than for consultations or diagnostics.

Complementary therapies – physiotherapy, osteopathy, chiropractic, acupuncture and homeopathy

What's covered under the plan?

Plan holders can claim 100% of the receipt up to the maximum annual fund limits for their premium for the following:

Rehabilitation treatment paid for and received from registered practitioners of Physiotherapy, Osteopathy or Chiropractic. See Glossary for definitions of practitioners on pages 18 & 19

Treatments paid for and received from registered practitioners of Acupuncture and Homeopathy

Homeopathic medicines prescribed by a registered homeopath and purchased through him or her

All treatment paid up to the annual limit upon proof of purchase in the form of a receipted account. Appointments include initial assessment appointments and all treatments must be carried out by qualified practitioners.

What's NOT covered?

Any treatment or expense not listed above including but not limited to:

Any medical appliances or pharmacy items, other than those prescribed by a homeopath

Scans or x-rays (these may be available under Consultations allowance)

Other charges for anything which does not directly improve the claimant's health, such as missed appointment fees or sundry fees for staffing or room hire passed on by the treatment provider

Spa treatments

Treatment which falls outside of the named categories even if they are of a similar nature

Treatment administered by members not affiliated to bodies recognised by us as specified in the Glossary, starting on page 18

Maintenance or Preventative Treatment paid for and received from registered practitioners of Physiotherapy, Osteopathy or Chiropractic. See Glossary on pages 18 & 19 for definitions of registered practitioners.

Counselling & advice helpline

What's covered under the plan?

Plan holders can claim 100% of the amount paid up to the annual fund limit for telephone and face to face counselling. All treatment is to be provided by our selected partner.

- 24 hour access to fully trained providers of telephone counselling. This is provided free of charge and will not reduce the overall benefit pot
- Access to fully trained providers of face-to-face counselling sessions, covered up to the annual limit for the premium that is being paid.
- 24 hour telephone access to qualified advice on legal and financial matters. This is provided free of charge and will not reduce the overall benefit pot.
- There is a limit of five calls per benefit year for this service
- To access these services, please firstly contact us on **0300 123 3256** so we can authorise your claim.

What's NOT covered?

Any treatment not listed above.

Children are not covered for this benefit.

General exclusions

- We won't pay a claim for treatment administered, or for items purchased, outside of the United Kingdom
- We won't pay a claim if you arrange treatment before the start of the policy
- We won't pay a claim if the treatment was undertaken before the start date of the policy
- We won't pay a claim if treatment is needed as a result of abuse of, or dependency upon, drugs, alcohol, solvents or other addictive substances
- We won't pay a claim for injuries sustained as a result of reckless endangerment either through participation in dangerous sports, professional sports (in which the claimant is being paid or compensated for playing) or through their involvement in criminal activity in which they are not an innocent victim
- We won't pay a claim if we don't receive the information we ask for
- We won't pay a claim if plan holder ceases to be a UK resident. We won't pay a claim until after the first payment has been received for your plan or if the company has unpaid premiums outstanding
- We won't pay any amounts which have already been claimed from another source such as another insurance plan, a dental/optical cover scheme or dental practice premiums.

Making a claim

Three simple steps to making a claim

Step 1

Pay for your treatment and keep your receipt(s).

Step 2

Send your completed claim form and original receipt(s) to:

The Exeter, Jewry House, Jewry Street, Winchester, Hampshire, SO23 8RZ

To save on postage you may wish to hold on to receipts that are equal to or below the excess amount on optical and dental. You can send these with your next claim. All claims should be submitted within three months of the treatment date.

Step 3

The money will be paid directly into your bank account (less any applicable excess), usually within three days of the claim being received.

Sample receipt

	Physiotherapy Clinic
Name, address and qualifications of practitioner	HPC REGISTERED 7 ANY PLACE AVENUE, ANYTOWN AN1 2BG
Details of recipient of treatment	MR JOHN SMITH, 11 HIGH STREET, ANYTOWN, A1 2MS
Details of treatment including date, description of treatment and cost	03/04/15 FULL DESCRIPTION £18.00 12/04/15 FULL DESCRIPTION £18.00 19/04/15 FULL DESCRIPTION £18.00
Confirmation that the practitioner has been paid for the treatment	RECEIPT PAID IN FULL 19/04/15

Where to find a claim form

Call **0300 123 3256**.

Lines open: Monday to Friday
9am to 5pm.

Download from
www.the-exeter.com

Email **cashplan@the-exeter.com**

When we receive a claim

When we receive a claim, we check that:

- The receipt tells us everything we need to know to pay the claim, this includes:
  - Full details (name, address and qualifications) of the treatment provider, so we can contact them
  - The name of the person who received treatment
  - A receipt should be itemised, or if this is not possible, a separate breakdown should be provided by the practitioner
  - The treatment is covered under the plan
  - You have not exceeded your annual limit for this type of claim
  - The appropriate excess has been paid
  - We are not paying any amounts which have already been claimed from another source such as another insurance or optical/dental care scheme.

We will keep hold of any receipts. So you should take a copy if, for any reason, you need a record of the details. We will never pay a treatment provider directly. We will only reimburse a paid receipt.

We will be unable to pay any claim which does not have sufficient supporting evidence, as listed above.

All receipts must be original, we will not accept amended receipts, photocopies, credit or debit card receipts or estimated bills.

Receipts in respect of claims should be submitted within three months of the treatment being administered.

Receipts relating to payment of the excess only can be submitted to support a claim at any time during the plan year – you may wish to hold on to these receipts until you make a claim, to save postage.

The date treatment was received will determine which plan year we use to calculate the benefit allowance to pay the claim.

You will need to complete your bank details so we can pay money straight into your account, which will remove any need for you to bank a cheque. This will ensure that money reaches your account much quicker, usually within three working days of us paying it.

If you have any queries about how to make a claim, please call 0300 123 3256

We will pay claims in accordance with the terms outlined in this document.

We regret we cannot pay for charges incurred in claiming.

When we won't pay

We will not pay a claim when:

- The treatment claimed for is not covered under the terms outlined in this document
- The cost of the claim falls within the excess
- The amount claimed causes you to exceed the annual limit of your plan. In this case we would reimburse you up to your annual limit.

Integrity

We trust that you will operate within the spirit of the plan and will make claims for genuine dental, optical and medical benefits. Should we discover, upon checking with treatment providers, that you have made a claim which is fraudulent or otherwise lacks integrity, we reserve the right not only to decline the claim, but also to cancel the plan.

Other information

If you leave the company

If the leave the company your cover and the cover of a child or partner will cease.

If you wish to complain

If you wish to make a complaint then please contact us in writing:

The Exeter
Jewry House
Jewry Street
Winchester
Hampshire
SO23 8RZ

If you cannot settle your complaint with us, you may be entitled to refer it to the Financial Ombudsman Service.

Additional protection

We are covered by the Financial Services Compensation Scheme (FSCS). You may be entitled to compensation from the scheme if we cannot meet your obligations. This depends on the type of business and the circumstances of the claim. For claims in respect of death or incapacity due to injury, sickness or infirmity the level of cover is 100% of the claim and in all other cases the level of cover is 90% of the claim.

You can get further information on the scheme by calling us on **0300 123 3256** or you can request it from the Financial Services Compensation Scheme at fscs. org.uk or by calling **0800 678 1100** or writing to 10th Floor, Beaufort House, 15 St Botolph Street, London EC3A 7QU.

Glossary words and phrases explained

Acupuncture/chiropractic homeopathy/osteopathy/physiotherapy
Treatment given by a **Practitioner** who is qualified, and registered with an approved professional organisation recognised by **Us** in the appropriate field.

Acupuncturist
A doctor who is also a Medical Member or an Accredited Member of the British Medical Acupuncturist Society and recognised by us as being fit to carry out such **Treatment**.

Annual entitlement/claims entitlement/annual limit/annual allowance
The maximum amount which can be claimed on a One Fund Plan in a **Corporate Plan Year**.

Chiropractor
A practitioner on the Register of Chiropractors kept by the General Chiropractic Council as required as part of the Chiropractors Act 1994, and recognised and agreed by **Us**.

Company
The organisation which pays the premiums for the **Corporate Plan**.

Company representative
The person within the **Company** responsible for signing the application form on behalf of the **Company**, and acting as the named contact for the **Company's Corporate Plan**.

Consultation
A meeting with a medical **Specialist** to find out more about a medical condition and decide how to treat it.

Corporate plan
The contract of insurance with **You** to provide the **Plan** for the **Plan Holders**.

Corporate plan anniversary
The anniversary of the date on which the **Plan** started.

Corporate plan year
The annual period commencing on the start date, or the anniversary of the start date as shown on your **Employees' Plan Schedules**.

Cosmetic treatment
Treatment received to change appearance and not to cure or alleviate a medical condition.

Dangerous or hazardous sports/pursuits
Dangerous (hazardous) pursuits and sports include, but are not limited to, canyoning, gorge walking, hang-gliding, high diving, horse jumping, microlighting, mountain boarding, parasailing and rock climbing.

Dependant children
Born to **You** or your **Partner**, or legally adopted by **You** or your **Partner**, and under the age of 18 years, or 21 if in full time education and residing with **You**.

Employee(s)
Any person employed by, or working in some capacity for, the **Company** which pays the premiums for the One Fund Corporate **Plan**.

Excess(es)
A fixed contribution that must be paid by the **Plan Holder** in each **Corporate Plan Year** if a claim is made.

GP
A general medical practitioner (doctor) who has a Certificate of General Practice Training and is registered with the General Medical Council in the UK.

Homeopath
A practitioner whose name appears on the register of the Homeopathic Medical Association, The Society of Homeopathy, The Faculty of Homeopathy or The Alliance of Registered Homeopaths.

Hospital
Either a private hospital registered under the UK Care Standards Act 2000 or a hospital run by the National Health Service which provides specialist facilities for treatment.

Maintenance treatment
Treatment with the intent of stopping the original causes of an injury or illness from reoccurring. This is usually a monthly or periodic treatment.

Osteopath
A practitioner on the Register of Osteopaths kept by the General Osteopathic Council as required as part of the Osteopaths Act 1993, and recognised and agreed by **Us**.

Our/us/we
The Exeter is a trading name of The Exeter Cash Plan, which is authorised by the Prudential Regulatory Authority and regulated by the Financial Conduct Authority and the Prudential Regulatory Authority.

Partner
A person who lives with you on a permanent basis, as a domestic **Partner**.

Physiotherapist
A physiotherapist regulated by and registered as practising with the Health Professions Council and recognised by **Us**.

Plan
The benefits and **Annual Entitlement** available to a **Plan Holder**.

Plan holder(s)
The first named person on the **Plan Schedule**, who will receive benefits paid under the **Corporate Plan**.

Plan schedule
The document containing details of an individual **Plan Holder's** limits of cover at the start of their plan. If the details change or are amended, we will issue an amended schedule.

Preventative treatment
Treatment to prevent an injury or illness from occurring. This is usually a monthly or periodic treatment.

Rehabilitation treatment
Treatment to help **You** recover from an injury or illness and is usually evidenced by multiple claims over a short period of time.

Specialist
A medical practitioner, who is registered under the Medical Acts and is a specialist in the **Treatment** referred for. Registered as a specialist under the General Medical Council. They will be or will have been, a National Health Service Consultant and must be recognised as a specialist by **Our** claims team.

Treatment
Surgical or medical services (including diagnostic tests) to diagnose, relieve or cure a disease, illness or injury.

United Kingdom
This means England, Scotland, Wales, and Northern Ireland, plus the Channel Islands and the Isle of Man.

UK resident
A person who is ordinarily resident in the UK.

You
The **Plan Holder**.

- Cashback on everyday healthcare bills
- Claim for NHS and private healthcare treatment
- Add children to share your allowance at no extra cost (excluding health screening and the counselling and advice helpline)
- Flexibility to choose how to spend your annual allowance.

Contact us

The Exeter, Jewry House, Jewry Street, Winchester, Hampshire, SO23 8RZ

Members
0300 123 3256

cashplan@the-exeter.com

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0300 123 3257

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www.the-exeter.com

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