HEALTHSHIELD
WE'VE GOT YOU COVERED

Corporate
Health Cash Plan

About your plan

- Claim 100% of your money back on healthcare bills, subject to annual review
- Dependent children covered up to the age of 21 and in full-time education at no additional cost
- No GP referral required before having treatment
- Worldwide cover available for selected benefits

Log-on to our Members' Area **www.healthshield.co.uk/members** where you can:

- Update your personal details and check your benefit balance
- Claim online and receive fast payment direct to your account
- Visit **mywellness** to access a range of additional services that help you manage your health and wellbeing needs

Your Weekly Payments

Level of cover and costs	Child cover	Level of money back	Access Level	Level 1	Level 2	Level 3	Level 4	Prestige Level
Weekly Payments for You (Includes benefits for dependent children)			£1.25	£2.40	£5.48	£8.22	£11.54	£17.54
Weekly Payments for You and Your Partner (Includes benefits for dependent children)			£2.50	£4.80	£10.96	£16.44	£23.08	£35.08

Summary of benefits included

Healthy & Happy								
Dental	✔	100%	£45	£75	£135	£185	£240	£315
Optical	✔	100%	£45	£75	£135	£185	£240	£315
Chiropody	✔	100%	£45	£75	£135	£185	£240	£315
Prescriptions		Per item	1	2	3	4	5	6
Health & Wellbeing	✔	100%	£45	£75	£135	£185	£240	£315
Health Screening	✔	100%	£45	£75	£135	£185	£240	£315
Combined Physiotherapy	✔	100%	£75	£140	£315	£420	£585	£740
Feel Better								
Hospital Benefits ▸ Hospital Inpatient (per night) ▸ Hospital Day Surgery (per day)	✔	Up to a maximum of 25 nights/days per year	£10	£20	£45	£65	£85	£110
Parental Hospital Stay		Up to a maximum of 25 nights per year	£5	£10	£25	£35	£45	£55
Specialist Consultation, ECG, X-ray, Pathology Fees and MRI Scans	✔	100%	£75	£150	£250	£390	£525	£675
Peace of Mind								
Dental Accident	✔	100%	£100	£200	£400	£600	£800	£1000
Maternity - Antenatal Appointment and Adoption		A single payment	£75	£150	£300	£560	£695	£900
Personal Accident Protection	✔	A single payment	£2500	£5000	£10000	£15000	£20000	£25000

My Wellness

mywellness

mywellness provides you with online tools and information to help you to proactively manage your health and wellbeing. Included within your membership plan is access to the following services: GP Anytime including Private Prescriptions, 24/7 Counselling and Support Helpline, Online Health Assessments, Cancer Screening, On-Demand Physio and Home Assistance Cover. You can also access PERKS, our rewards website which offers exclusive discounts and money back on shopping, travel and entertainment and much more. If you are a Prestige Level member, we will contribute up to £100 towards the cost of your yearly gym membership, swimming sessions, exercise classes or personal trainer. For all mywellness services, simply log on at **www.healthshield.co.uk/members** to find out more.*

Benefits for Prestige Level Members

Family Planning		**Extra Benefits Exclusive to Prestige Level Members**	£500
Critical Illness	✔		£2000
Sickness and Accident Protection			Contribution protection for sickness & accident

The above benefits and allowances are the maximum levels that apply to your plan. The costs, benefits and the benefit level are subject to an annual review and so may change in the future.
*Services may vary.

Terms and conditions for the Health Shield Corporate Scheme membership plan

GENERAL TERMS AND CONDITIONS

These are the standard terms and conditions and you should read them with the policy summary document. These terms set out the benefits and level of cover available to you. For more information on how your membership fits into our organisation as a whole, please read our memorandum and rules. These are available on our website, or you can ask us for a copy.

You should read and understand these terms. If you don't understand any part then please contact us before going for treatment or sending us a claim.

Who can join?

If you want to join the Health Shield Corporate Scheme membership plan ('the plan') or increase your level of cover, you must be between 16 and 70 when you apply and be employed by a company that offers the Health Shield Corporate Scheme.

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

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

- Hospital inpatient;
- Hospital day surgery;
- Parental hospital stay;
- Combined physiotherapy;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Critical illness cover;
- Sickness and accident protection 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

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.

You, the member, must 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 retain them as part of our investigation.

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 verify with the practitioner concerned.

Ending your membership

At any time, our Board of Management can end your membership if they think:

- You have broken our rules;
- Your continued membership may have a negative impact on the interest of our members generally;
- You have repeatedly made claims which threaten our financial wellbeing;
- You have deliberately provided misleading or false information (or not revealed every significant circumstance we ought to know about);
- You have behaved in a threatening or abusive manner towards any member of staff;
- You have made a claim that is fraudulent or that we believe to be deliberately false, misleading or exaggerated.

We will write to you with our reason for cancelling your cover and you have the right to appeal to us.

If we end your membership for one of the reasons given above, we will not accept any future applications you make for Health Shield membership, or accept you as a partner or dependant registered to the membership of another person.

If we receive your membership contributions from your employer, or your employer pays all or part of your membership contributions, we may have to tell them the reasons why we have ended your membership.

We may also aim to recover from you any money that we have paid to you that you were not entitled to under the terms and conditions of this plan. If you do not repay us, we will take legal action as a civil matter. Once we have given notice to our lawyers, you will no longer have the option to communicate directly with us.

We are committed to preventing financial crime and we may report instances of fraud or attempted fraud to the police. Our procedures for dealing with fraudulent activity adhere to the Insurance Act 2015.

Existing members

If you are an existing member of Health Shield, please note the following:

- This plan completely replaces the terms and conditions of any existing plan;
- The benefits we will pay under this plan may be different to those of your previous plan;
- The benefit year of your previous plan may be different. We may take account of claims paid under your previous plan if we paid them in the current benefit year of the new plan.

How we use your personal data

We collect personal data from you to set up and deal with your Health Cash Plan. We handle this information in line with data-protection law. For more information on how we use your personal data, please read our privacy policy which is available at www.healthshield.co.uk/privacy/ or email our head office on info@healthshield.co.uk to ask for a paper copy.

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 become eligible to make claims:

- 40 weeks after your first or increased contribution for maternity-antenatal appointment and adoption benefit and all benefits connected with maternity;
- 13 weeks after your first or increased contribution for all other claims.

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

- Overnight admissions to hospital as a result of an accident;
- Personal accident protection;
- Services available on mywellness.

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, gender reassignment 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, partner or a work colleague;
- Postage and packaging costs;
- Internet, telephone and group consultations;
- 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 benefit year of your membership is confirmed in your policy schedule, welcome pack or within the Health Shield Members' Area.

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

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

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 calendar year.

Dependent children

The maximum benefit (as shown in the benefit table) is available over a one-year benefit period and is a separate allowance between all your registered dependent children.

Percentage return

We will refund 100% of each valid claim (as shown in the benefit table) up to your yearly benefit limit for the following benefits.

- Dental;
- Optical;
- Chiropody;
- Health and wellbeing;
- Health screening;
- Combined physiotherapy;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Dental accident.

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. The following details should be included 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 full name, official stamp, qualifications and contact details of the practitioner carrying out the treatment;
- A full description of the treatment received;
- The receipt clearly shows the payment amount and that it has been paid in full.

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 pay claims based on the relevant claims year that the treatment or purchase takes place. We will not accept applications for benefit that are more than 12 months old at the time we receive them.

You can send us your claim online via the Health Shield Members' area or fill in a paper claim form and post it back to us. We aim to process your claim within our agreed service levels as stated in the claims section within the Health Shield Members' Area. If we accept it, we will credit your bank account usually within two working days of us processing your claim.

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;
- Family planning (Prestige-level only).

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 calling 01270 588555 or emailing info@healthshield.co.uk. We review this list every year.

Why and how we verify claims to prevent fraud

We may need to ask you for more information before we can process a claim. You must provide this as soon as possible and pay any costs involved. We may also need to contact the practitioner for confirmation. While we're waiting for information, claims will stay on hold. We carry out routine checks to make sure that we're paying claims correctly. It doesn't mean that we think you're being dishonest. It is your responsibility to make sure that all of the information that you give us to support your claim is truthful and complete.

We take fraud prevention very seriously. False claims can cause premiums to rise, which in turn affects our whole organisation. To protect our members, we have systems and procedures in place that detect false claims and identify fraudulent behaviour. We share information and details of fraudulent claims with other cash plans, fraud-prevention agencies, the police and other enforcement agencies. You must always act honestly. For example, you, or anyone covered on your policy, must not:

- Alter or forge a receipt or claim form;
- Give us any evidence to support a claim that you know is misleading or untrue;
- Give dishonest answers to our questions;
- Refuse to provide information that we need, or withdraw a claim to avoid investigation;
- Refuse permission for us to contact a healthcare provider to confirm your claim;
- Deliberately claim for anything, or anyone, that's not covered;
- Claim a refund from more than one policy with the intention of receiving back more than you've paid out (this is called betterment);
- Fail to tell us if the claim could be covered under another policy;
- Claim for a pre-existing medical condition that isn't covered under your policy, or a medical condition that you should have told us about when you applied for cover.

If we reasonably believe that a claim is false, fraudulent or misleading, even if we haven't proved that you've acted dishonestly, we won't pay that claim. We may end your policy and all of your benefits will stop from the date your policy ends. Anyone convicted of fraud may have to declare it when they apply for any type of insurance in the future.

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 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;
- Emergency admissions only for:
  - Hospital inpatient;
  - Hospital day surgery;
  - Parental hospital stay;
- Combined physiotherapy (the qualification or accreditation of the practitioner may be an international equivalent);
- Personal accident protection.

What benefits are not covered:

- Dental accident;
- Maternity-antenatal appointment and adoption;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Chiropody;
- Health and wellbeing;
- Health screening;
- Prescriptions;
- Family planning (Prestige-level only);
- Critical illness (Prestige-level only).

Also see the 'Exclusions' section on this page.

This cover does not replace travel insurance.

DEFINITIONS

'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.

'Any job' – a job to which you are suited because of your education, training or experience.

'Benefit year' – when the maximum allowance for each separate benefit is available to claim. The benefit period is confirmed in your policy schedule or welcome pack.

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

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

'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 GP, consultant or through the accident and emergency (A&E) department.

'Membership plan' ('the plan') – the Health Shield Corporate 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.

'Treatment' – a medical procedure or intervention (including tests and purchases) received from a qualified practitioner to help cure, relieve, control or prevent an illness or injury.

'We', 'our', 'us' – Health Shield Friendly Society Ltd, 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

HEALTHY AND HAPPY

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

Please see the 'How to claim' section on page 2 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 (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 and purchases, at the appropriate rate and up to the appropriate maximum in any one calendar year.

Please see the 'How to claim' section on page 2 before attending an optical appointment, making a purchase 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. For contact lenses that you pay for monthly, we need a statement from the provider of the contact lenses showing the amount paid and the date of payment. This must match the amount you are claiming for.

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;
- Prescribed glasses;
- Prescribed 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 calendar 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 2 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 (we cover these charges under the prescriptions benefit).

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).

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

We will accept the label off the medication packaging as confirmation of who the prescription was for if their name is not shown on the receipt. If there is no confirmation of payment on the receipt, please provide the NHS form as proof of who the perscription is for and the amount paid.

We do not pay prescription benefit for dependent children.

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, combined physiotherapy and chiropody prescription charges.

What is not covered:
- Charges above the current rate set out in the NHS prescription pricing structure.

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 calendar 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 2 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;
- Chair massage;
- Cognitive behavioural therapy;
- Colonic hydrotherapy;
- Counselling fees (for example psychiatric, psychological and bereavement);
- Deep-tissue massage;
- Hopi ear candles;
- Hot-stone massage;
- Hypnotherapy;
- Indian head massage;
- Kinesiology;
- Manual lymphatic drainage;
- Naturopathy;
- Nutritional therapy;
- Pre-natal massage;
- Reflexology;
- Reiki;
- Shiatsu;
- Sports and remedial massages (for example, for muscular or soft-tissue problems or injuries);
- 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 one calendar year, 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 2 before going for treatment or sending us a claim.

What is covered:
- A full health screen (for example, a well-woman or well-man screening).

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 by 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 calendar 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 2 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:
- 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 (we cover these charges under the prescriptions benefit).

Also see the 'Exclusions' section on page 2.

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 in any one calendar year for each person who is entitled to benefit.

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 discharge letter or discharge summary 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.

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 from the accident and emergency department) for inpatient treatment in a recognised hospital or hospice.

What is covered:
- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, up to a maximum of 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 and we accept the claim itself for payment.

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;
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments;
- Overnight stays in hospital hotels before and after being admitted to hospital.

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 from the accident and emergency department) for hospital day-surgery treatment in a recognised hospital without an overnight stay.

What is covered:
- Any day-surgery admission in an NHS hospital, private hospital or registered treatment centre, up to a maximum of 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 and we accept the claim itself for payment;
- Outpatient treatment for chemotherapy, kidney dialysis, oncology and radiotherapy.

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;
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments;
- Overnight stays in hospital hotels before and after being admitted to hospital.

Also see the 'Exclusions' section on page 2.

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

You must fill in your claim form yourself confirming the medical reason for your registered child being admitted. 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 registered child's discharge letter or discharge summary which would have been given to you when they were discharged.

What is covered:
- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, up to a maximum of 25 nights, where one parent stays with their registered child and is entitled to hospital benefits;
- Your registered child being admitted to the ward, from the accident and emergency department, before midnight;
- A parent who stays with their registered child;
- An adoptive parent staying with their registered child;
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim and we accept the claim itself for payment.

What is not covered:
- Attending accident and emergency;
- Clinics, medical centres or nursing homes;
- More than one parent staying with their child;
- A child's first 10 consecutive overnight stays as an inpatient after

being born;
- Outpatient treatment;
- Permanent stays in hospital;
- Pre-existing conditions;
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments;
- Overnight stays in hospital hotels before and after being admitted to hospital.

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 calendar year, when a person entitled to benefit has a specialist consultation or treatment from a medically qualified person who specialises in a field of medicine.

The specialist 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 2 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;
- Radiologist reports;
- 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;
- Consultations regarding cosmetic procedures.

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 calendar year, for dental treatment you need as a result of an accidental injury to your teeth.

The injury must have been caused by a direct blow to the head.

Please see the 'How to claim' section on page 2 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 calendar year according to the date the accident happened.

We will only pay one maximum for all treatment that lasts from one calendar 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;
- 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.

Maternity – antenatal appointments and adoption

We will make a single payment for each pregnancy, up to the appropriate maximum in any one benefit year. Payment can only be made if you have been covered by the scheme for at least 40 weeks and the pregnancy has been confirmed by a NHS or private antenatal scan carried out by a sonographer within the first 26 weeks of conception.

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

What is covered:
- An NHS or private antenatal scan carried out by a sonographer which takes place within 26 weeks of you becoming pregnant;
- Fees for filling in claim forms or certificates, as long as you provide an official receipt with your claim;
- If it is a registered partner having the scan.

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

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

We will also make a single payment, up to the appropriate maximum in any one calendar year, if you adopt a child aged 16 or younger (as long as you have been covered by the scheme for at least 40 weeks). You must send us a copy of the adoption order with your claim form.

Personal accident protection

Please call 01270 588555 or email info@healthshield.co.uk for a separate personal accident claim form. Under the following conditions, we will only consider the amount of benefit we will pay under this section if a bodily injury results in death or permanent total disability (permanent disability that prevents you from doing any job – which is not limited to your occupation at the time of the accident) within one year of the accident. We will pay the sum insured in line with the level of contribution you have paid. Protection will end on your 70th birthday. You must write to us within six months of an accident to let us know about it.

To support your claim, you will need to provide medical evidence from a registered medical practitioner. You must pay any costs involved in providing this evidence.

We will not pay more than your benefit maximum per person as a result of any one accident.

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

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

Personal accident protection does not cover death or permanent total disability caused by the following:
- Motorcycling (rider or passenger);
- Diving (including scuba);
- Mountaineering;
- Rock climbing;
- Potholing;
- Parachuting;
- Boxing;
- Racing (other than on foot);
- Time trials or sprints;
- Flying (except air travel);
- Carrying out duties in one of the armed forces including the Army Reserve.

Also see the 'Exclusions' section on page 2.

mywellness

Health Shield membership allows you exclusive access to a list of extra services. These services include face-to-face counselling, gym discounts, online health-risk assessments, exclusive member discounts and much more.

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.

Services and information available on mywellness can change without notice.

EXTRA BENEFITS EXCLUSIVE TO PRESTIGE-LEVEL MEMBERS

Family planning (Prestige-level only)

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

The specialist must be listed on the General Medical Council's Specialist Register or be a member, fellow or licentiate of one of the Royal Colleges.

Please see the 'How to claim' section on page 2 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:
- Private family planning clinics;
- Private fertility treatment and examinations;
- Private IVF treatment;
- Private sterilisation fees;
- Private vasectomy fees.

What is not covered:
- Family planning benefit for dependent children;
- Contraceptives.

Also see the 'Exclusions' section on page 2.

Critical illness (Prestige-level only)

We will pay critical illness benefit at the appropriate rate, if critical illness is diagnosed after the end of the 13-week qualifying period. We will not pay more than £2,000 as a result of a critical illness. We will only pay critical illness benefit to any person once during their lifetime. Critical illness benefit does not apply to anyone aged 65 or over.
You must make the claim within 12 months of the critical illness being diagnosed.

Please call 01270 588555 or email info@healthshield.co.uk for a separate critical illness claim form. To support your claim, you will need to provide medical evidence from a registered medical practitioner. You must pay any costs involved in providing this evidence.
What is covered:
- Cancer – a malignant tumour caused by malignant cells growing and spreading uncontrollably to other tissue
  The term 'cancer' includes leukaemia and Hodgkin's disease, but the following are not included in the cover:
  - All tumours which are histologically described as being 'pre-malignant', 'non-invasive', or 'cancer in situ';
  - All forms of lymphoma present in HIV;
  - Kaposi's sarcoma present in HIV;
  - Any skin cancer, other than malignant melanoma.
- Heart attack – when a part of the heart muscle dies as a result of not receiving enough blood. It will cause chest pain, new electrocardiograph changes and an increase in cardiac enzymes.
- Coronary artery bypass surgery – open heart surgery, recommended by a consultant cardiologist, that uses bypass grafts to correct one or more coronary arteries that have narrowed or become blocked. Non-surgical procedures, such as balloon or stent angioplasty or laser treatments, are not included.
- Kidney failure – where both kidneys fail to work and, as a result, you begin regular kidney dialysis or have a kidney transplant. We will pay critical illness benefit if you need a kidney transplant and you have been included on an official UK waiting list.
- Major organ transplant – the transplant of a heart, liver, lung, pancreas or bone marrow, or being included on an official UK waiting list to receive an organ.
- Motor neurone disease – confirmation by a consultant that you have been diagnosed with motor neurone disease.
- Multiple sclerosis – a definite diagnosis by a consultant neurologist of multiple sclerosis that meets all the following conditions:
  - The movement of your muscles, or your physical senses, must currently be weakened, and have been weakened for a continuous period of at least six months;
  - The diagnosis must be confirmed by diagnostic techniques that are widely used at the time you make your claim.
- Stroke – permanent neurological (nerve) damage to the brain caused by an interruption to its blood supply. Transient ischaemic attacks (temporary interruptions to the brain's blood supply) or episodes resulting in temporary neurological symptoms are not included.

What is not covered:
- If you suffered from that critical illness (or a related condition) or had surgery at or before the end of the 13-week qualifying period;
- If you die within 28 days of being diagnosed with a critical illness or having surgery;
- We will not pay critical illness benefit for claims caused directly or indirectly by you being infected by, or treated for, HIV or any HIV-related illness, including AIDS.

Also see the 'Exclusions' section on page 2.

Sickness and accident protection cover (Prestige-level only)

Please call 01270 588555 or email info@healthshield.co.uk before you make a claim. Your Prestige-level contributions are covered for up to 12 months when you or your partner (if they are covered) are continuously off work and have provided a fit note from your doctor to cover that period for at least 30 days, due to one of the following:
- Sickness;
- Accidental injury.

Sickness and accident protection cover only applies if you or your partner (if they are covered):
- Have completed a qualifying period of 13 weeks;
- Are in full-time employment and between the ages of 16 and 70;
- Are not aware of any medical treatment or advice you are due to receive;
- Are in good health.

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

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

We will not pay disability benefit for any period you are disabled after you have reached the age of 70 (or your retirement date, if earlier).

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

What is not covered:
An exclusion period of 30 days applies to all claims. This means that we will not pay any benefit for the first 30 days of your sickness or accidental injury.

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

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

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

We will not pay for any period of disability caused by the following:
- Pregnancy, childbirth or any complication connected to these;
- A mental disorder, unless it is investigated and diagnosed by a GP;
- HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS).

Also see the 'Exclusions' section on page 2.

Health Shield Friendly Society Ltd., Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.
Telephone: 01270 588555 Fax: 01270 251366 Opening hours: 8.00am to 6.00pm, Monday to Friday
Email: info@healthshield.co.uk Website: www.healthshield.co.uk
Established in 1877. Authorised 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.

CORPORATEMP/JANUARY2019