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

<table>
<thead>
<tr>
<th>Level of cover and costs</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Prestige Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Payments for You</td>
<td>£1.25</td>
<td>£2.40</td>
<td>£5.48</td>
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<td>(includes benefits for dependent children)</td>
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<td></td>
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<tr>
<td>Weekly Payments for You and Your Partner</td>
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<td>(includes benefits for dependent children)</td>
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<td></td>
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<td></td>
<td>£35.08</td>
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</tbody>
</table>

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 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 | £500 |
| Critical Illness | £2000 |
| Sickness and Accident Protection | Extra Benefits Exclusive to Prestige Level Members |

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.

Telephone 01270 588555 Find us on www.healthshield.co.uk
GENERAL TERMS AND CONDITIONS

These are the standard terms and conditions and you should read them before purchasing any membership. These terms set out the benefits and level of cover available to you. For more information on how we use your personal information, please read our memorandum and rules. These are available on our website, or by calling us on 01270 588555.

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, you must be employed by a company that has agreed to offer the Health Shield Corporate Scheme to its employees.
If you apply to join the plan, or if you are an existing member applying to increase your level of cover, we will check whether you have any pre-existing medical condition.
Exclusions for pre-existing medical conditions may apply to the following benefits:
Hospital inpatient; Parental hospital stay; Combined physiotherapy; Specialist consultation, ECO, X-ray, pathology fees and MRI scans; Cancer; Dental; Dental accident.

To increase your level of cover, you will become eligible to make claims:
• 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:
Overnight admissions to hospital as a result of an accident; Personal accident; Services available on membership.

Exclusions
We cannot pay benefit for any claim directly related to the following:
• GP fees for private treatment;
• Drugs, medicine or vaccinations (including medicines relating to homoeopathic treatment and travel-related vaccines, for example)
• Vacuostomies, sterilisation, IVF, fertility treatment and examinations (excluding the family planning benefit for Prestige-level members);
• Prepayment cards;
• Postage and packaging costs;
• Internet, telephone and group consultations;
• Treatment charges for the purchase of private medical insurance other than any excess (excess fees are covered under the Specialist Consultation allowance).

We cannot pay any claims you make as a result of the following:
• A pandemic disease;
• Radioactive contamination;
• Suicide or self-inflicted injury;
• War, hostilities, invasion or civil war and full-time active military service;
• Nuclear, chemical or biological terrorism;
• Drugs, medicine or vaccinations, except those prescribed by a registered medical practitioner;
• Taking part in a sport, hobby or work related to a sport (other than a dependent member that is either a professional or a member of a family, partner or a work colleague);

If you have been told to by a registered medical practitioner; the practitioner carrying out the treatment;
- the first part of any eligible treatment costs that would otherwise be paid by a private medical insurer, which you have chosen to pay for.
- 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, laboratory tests, X-rays, MRIs or PET scans.
- hospice – an institution which has permanent facilities for caring for the terminally sick.
- home care – in-home care that provides nursing services supervised by registered general nurses, on a short-term or long-term basis.

You may need to ask 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 our internal audit procedure at least once a year. 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 a claim is truthful.

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:
- notify us of a receipt or claim form;
- give us any evidence to support a claim that you know is misleading or false;
- let unauthorised persons handle your claims;
- refuse to answer our questions; and
- refuse to provide information, or withdraw or claim to avoid investigation.

If we suspect that you are making a fraudulent claim, we will inform the relevant agency.

Why and how we verify claims to prevent fraud
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- give us any evidence to support a claim that you know is misleading or false;
- let unauthorised persons handle your claims;
- refuse to answer our questions; and
- refuse to provide information, or withdraw or claim to avoid investigation.

If we suspect that you are making a fraudulent claim, we will inform the relevant agency.
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 not covered:

• Hygienist fees;
• Contact lenses;
• Dental prescription charges (we cover these charges under the ‘What is covered’ section below);
• Dental treatment charges resulting from a dental accident (or for those under the dental accident cover benefit).

See also the ‘Exclusions’ 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 on optical treatment.

What is covered:

• Contact lenses (permanent or disposable);
• Contact lens check-ups;
• Contact lens cleaning solutions (including if you buy these separately);
• Eye examinations to correct long- and short-sightedness paid according to the date of treatment and not when payments are made;
• Eyewear tests;
• Lenses or glasses bought to fit existing frames;
• Lenses supplied under an optical plan;
• Prescription glasses;
• Prescription contact lenses;
• Prescription contact lens cases;
• Sunglasses, safety glasses and swimming goggles (as long as they are prescribed);

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.

See also the ‘Exclusions’ on page 2.

Chirotherapy

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, for chirotherapy 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);
• Chirotherapy treatment;
• Podiatry treatment.

What is not covered:

• A diagnosis (for example, arm supports, orthotics or insoles) even when prescribed and supplied by the chiropodist or podiatrist who is a member of an approved professional organisation;
• Surgical footware (for example, corrective shoes prescribed and supplied by chiropodists);
• X-rays;
• Chirotherapy prescription charges (we cover these charges under the provisions benefit).

See also the ‘Exclusions’ on page 2.

Pre-existing conditions

We do not pay prescription benefit for dependent children.

What is not covered:

• NHS prescription charges or the NHS cash equivalent for private prescriptions (except as described below);
• An NHS prepayment certificate up to the appropriate maximum of individual prescription items in any one calendar year, for NHS prescription benefits;
• Dental, combined physiotherapy and chiropody prescription charges.

What is not covered:

• Charges above the current rate set out in the NHS prescription charge list.

See also the ‘Exclusions’ on page 2.

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:

• Acupuncture;
• Chiropody;
• Homeopathy;
• Osteopathy (including craniosacral therapy);
• Psychotherapy;
• 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 support), even if they have been supplied as part of your treatment;
• Smoking cessation products, electronic cigarettes and other remedies;
• Weight management programmes;
• Relationship counselling.

See also the ‘Exclusions’ 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 or injury.

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 these listed activities;
• Health screens carried out in the workplace or arranged through your employer;
• Health screens carried out by mobile facilities.

See also the ‘Exclusions’ on page 2.

Combined physiotherapy and chiropody

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one calendar year, for combined physiotherapy and chiropody treatment 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 qualifications and qualifications referred to above.

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

See also the ‘Exclusions’ section on page 2.

Terms and conditions for the Health Shield Corporate Scheme membership plan

We will pay benefit for NHS prescription charges or the NHS cash equivalent for private prescriptions (except as described below).

An NHS prepayment certificate up to the appropriate maximum of individual prescription items in any one calendar year, for NHS prescription benefits;

Dental, combined physiotherapy and chiropody prescription charges.

What is not covered:

• Charges above the current rate set out in the NHS prescription charge list.

See also the ‘Exclusions’ on page 2.

Feel better

Better health

We do not pay prescription benefit for dependent children.

What is not covered:

• 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 ‘What is covered’ section below);
• Self-medication.

See also the ‘Exclusions’ on page 2.

Better health

We will pay benefit, hospital inpatient and hospital day-surgery benefit payments. The maximum period for receiving combined daily or nightly rates is limited to 25 days in any one calendar year for each person who is entitled to benefit.

You must fill in your claim form yourself confirming the medical treatment carried out at a hospital and skyped or stamped with the hospital or hospice stamp, and signed by a member of their staff. The claim form must be signed and approved and the 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 Directors will decide whether you are entitled to be admitted and whether a medical facility keeps to the policy definition of a hospital.

Hospital inpatient

Hospital inpatient benefit is paid at the appropriate rate for the period a person is entitled to benefit is admitted (after being referred by a GP or consultant or by treatment from the accident and emergency department) for hospital 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 recognised 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 individual who is not able to live independently;
• Maternity-related admissions for dependent children;
• The first 10 consecutive overnight stays as a maternity patient, during which period you are entitled to benefit;
• A child’s first 10 consecutive overnight stays as an inpatient after being born;
• Outpatient treatment;
• Permanent stays in hospital;  
• Pre-existing conditions;
• Voluntary stays in medical spas and spa hospitals for non-essential treatments;
• Overnight stays in hospital hotels before and after being admitted to hospital.

See also the ‘Exclusions’ on page 2.

Hospital day surgery

We will pay benefit at the appropriate rate for the period a person is entitled to benefit is admitted (after being referred by a GP or consultant or by treatment 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 recognised treatment centre, up to a maximum of 25 days, to have a medical condition to be treated or investigated;
• Hospital inpatient benefit;
• Operations which are cancelled after you have been admitted to hospital;
• Coloscopy, laparoscopy, colposcopy and sigmoidoscopy procedures where the treated individual was referred 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.

See also the ‘Exclusions’ on page 2.

Outpatient treatment for chemotherapy, kidney dialysis, oncology and radiotherapy.

What is not covered:

• Attending accident and emergency;
• Handicapped transport, clinics, medical centres or nursing homes;
• Admissions immediately before or following an overnight stay (day or night) for which we will pay a claim under the hospital inpatient benefit;
• Elderly care;
• Hospice day care;
• Maternity admissions;
• Outpatient treatments or treatments that are not covered above;
• Pre-admission arrangements (appointments before you are admitted to hospital);
• Illegal, drug-related or immoral treatments;
• 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.

See also the ‘Exclusions’ on page 2.

Parental hospital stay

We will pay benefit at the appropriate rate for any period of stay overnight with a registered child who has been admitted for inpatient treatment for that period.

You must fill in your claim form yourself confirming the medical reason for your registered child being admitted. The claim form must be countersigned 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 you were discharged.

What is covered:

• Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a treatment centre, up to a maximum of 25 nights, where one parent stays with their registered child and is entitled to benefit;
• The 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 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 due to the financial year.

Treatment – a medical procedure or intervention (including tests and purchases) received from a qualified practitioner to help cure, relieve, control or correct a complaint.

We’ll, ‘we’, ‘us’ – Health Shield Friendly Society Ltd, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 5HS.

You – as you, as well as any partner and dependent children who are covered, if this applies, in this membership plan.
Specialist consultation, ECG, X-ray, pathology fees and MRI scans

What is covered:
• Specialist consultation, including ECG, X-ray, pathology fees and MRI scans.

We will only pay the appropriate rate and up to the appropriate maximum in any one calendar year, if 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 fee rate and up to the appropriate maximum in any one calendar year, if you have a specialist consultation or treatment from a medically qualified person who specialises in a field of medicine.

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 not covered:
• Dental accident

We will only pay one maximum for all treatment that lasts from one 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 taken place, must not result from a direct blow to the head which has resulted in accidental injury to your teeth. You must also provide full details of the accident and the dental 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 accidental injury to your teeth.

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:
• Dental treatment charges made by the dentist (for example, for missed appointments);
• Damage to dentures when not being worn;
• Damage to your example, toothbrushes, mouthwash, dental floss and so on;
• Dental coronal (crown) fees (we cover these charges under the provisions of benefit 4);
• Dental extractions;
• Joining fees and practice-plan premiums;
• Dental treatment received less than 26 weeks and the previous benefit has been confirmed by a NHS or private dental scan carried out before a similar accident.

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

Terms and conditions for the Health Shield Corporate Scheme membership plan

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

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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 membership 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 provide 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 assisted conception services;
• Private vasectomy fees.

What is not covered:
• Family planning benefit for dependent children;
• Contraceptive benefit.

Also see the ‘Exclusions’ section on page 2.

Sickness and accident protection cover (Prestige-level only)

We will provide sickness and accident protection cover for you and your partner (if they are covered) for the following:

• Heart attack – when a part of the heart muscle dies as a result of reduced blood supply;
• Kidney failure – where both kidneys fail to work and, as a result, you need a kidney transplant 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, pancreas or bone marrow, or being included on an official UK waiting list;
• Motor neuron disease – confirmation by a consultant that you have been diagnosed with motor neuron disease;
• Multiple sclerosis – a definitive 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 significantly or moderately impaired and cannot have been weakened for a continuous period of at least six months;
  • The diagnosis must be confirmed by appropriate investigative techniques that are widely used at the time you make your claim;
• Stroke – permanent brain damage resulting from a blood clot caused by an injury to a blood supply. Traumatic aseptic haemorrhagic (temporary injury) strokes or strokes due to a brain embolus or episodes resulting in temporary neurological symptoms are not included;
• Sickness;
• Accidental injury.

Sickness and accident protection cover only applies if you or your partner (if they are covered) have a claim. You must make the claim within 12 months of the critical illness being diagnosed.

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

We will not pay for any disability period that a registered medical practitioner has not provided medical evidence for. You must pay all the costs of getting medical evidence before we will consider paying for it.

We will pay for any period of disability caused by the following:
• Pregnancy, childbirth or any complication connected to these;
• A mental disorder, unless it was diagnosed before the critical illness;
• HIV (Human Immunodeficiency Virus) or any HIV-related illness, including any of the acquired immune deficiency syndrome (AIDS).

Also see the ‘Exclusions’ section on page 2.

Terms and conditions for the Health Shield Corporate Scheme membership plan

As part of our ongoing quality control programme, calls may be monitored or recorded.

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

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Family planning (Prestige-level only)

We will provide 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 assisted conception services;
• Private vasectomy fees.

What is not covered:
• Family planning benefit for dependent children;
• Contraceptive benefit.

Also see the ‘Exclusions’ section on page 2.

Sickness and accident protection cover (Prestige-level only)

We will provide sickness and accident protection cover for you and your partner (if they are covered) for the following:

• Heart attack – when a part of the heart muscle dies as a result of reduced blood supply;
• Kidney failure – where both kidneys fail to work and, as a result, you need a kidney transplant 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, pancreas or bone marrow, or being included on an official UK waiting list;
• Motor neuron disease – confirmation by a consultant that you have been diagnosed with motor neuron disease;
• Multiple sclerosis – a definitive 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 significantly or moderately impaired and cannot have been weakened for a continuous period of at least six months;
  • The diagnosis must be confirmed by appropriate investigative techniques that are widely used at the time you make your claim;
• Stroke – permanent brain damage resulting from a blood clot caused by an injury to a blood supply. Traumatic aseptic haemorrhagic (temporary injury) strokes or strokes due to a brain embolus or episodes resulting in temporary neurological symptoms are not included;
• Sickness;
• Accidental injury.

Sickness and accident protection cover only applies if you or your partner (if they are covered) have a claim. You must make the claim within 12 months of the critical illness being diagnosed.

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

We will not pay for any disability period that a registered medical practitioner has not provided medical evidence for. You must pay all the costs of getting medical evidence before we will consider paying for it.

We will pay for any period of disability caused by the following:
• Pregnancy, childbirth or any complication connected to these;
• A mental disorder, unless it was diagnosed before the critical illness;
• HIV (Human Immunodeficiency Virus) or any HIV-related illness, including any of the acquired immune deficiency syndrome (AIDS).

Also see the ‘Exclusions’ section on page 2.