HEALTHSHIELD
WE'VE GOT YOU COVERED

Corporate
Health Cash Plan

About your plan

- Claim 100% refund on healthcare bills, subject to annual review
- Dependent children covered for FREE up to the age of 21 in full-time education
- No GP referral required before having treatment

Members' Area

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

Table of contributions and benefits

Your Weekly Payments

Level of Cover	Child cover	Cashback level	Access Level	Level 1	Level 2	Level 3	Level 4	Prestige Level
Weekly Payments for You (Includes benefits for dependent children)			£1.20	£2.30	£5.20	£7.80	£10.80	£16.35
Weekly Payments for You and Your Partner (Includes benefits for dependent children)			£2.40	£4.60	£10.40	£15.60	£21.60	£32.70

Summary of benefits that can be claimed

Healthy & Happy								
Dental	✔	100%	£40	£75	£135	£185	£240	£315
Optical	✔	100%	£40	£75	£135	£185	£240	£315
Chiropody	✔	100%	£40	£75	£135	£185	£240	£315
Prescriptions		Per item	1	2	3	4	5	6
Health & wellbeing	✔	100%	£40	£75	£135	£185	£240	£315
Health screening	✔	100%	£40	£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 are services such as a virtual GP surgery, private prescriptions, 24/7 counselling and support helpline, online health assessments, cancer screening and physio triage. You can also access healthy discounts on shopping, days out 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.*
Services and information available on mywellness can change without notice.

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 are the maximum levels which apply. The type of benefit, benefit levels and contribution rates may change in future. All contributions and benefits are subject to an annual review. There is worldwide cover for many benefits. *Services may vary. Please log on at **www.healthshield.co.uk/members** to find out which services are applicable to your plan.

Terms and conditions for the Health Shield Corporate Scheme membership plan

GENERAL TERMS AND CONDITIONS

These are standard terms and conditions and should be read with the Key Facts document.

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

Who can join?

If you want to join the Health Shield Corporate Scheme membership plan ('the plan') or increase your level of cover, you must be between 16 and 64 (that is, not yet 65) 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 beforehand if a review will lead to a change in the benefits or contributions paid in the future.

As a member, you agree to us processing personal and sensitive information about you. You, the member, must also sign all claim forms to declare that the details you have provided on the forms are true, and to allow us to get independent verification of the details from the healthcare provider the claim relates to. If we believe that any documents you send us are not genuine, we may keep them.

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

Contributions

You will be entitled to receive the maximum benefit if your contributions are up to date and you do not have a pre-existing condition that we cannot cover.

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

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

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

Qualifying period

If you apply to join the plan, or if you are an existing member applying to increase your level of cover, you will 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; and
- 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 if these apply

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 re-assignment or cosmetic reasons
- Any health-screening checks, medical examinations, consultations or reports for employment, emigration, legal or insurance reasons
- Treatment provided to you by a member of your family or a work colleague
- Postage and packing costs
- Internet, telephone and group consultations
- Treatment charges covered by private medical insurance other than any excess (Excess fees are covered under the Specialist Consultation allowance.)

We cannot pay benefit for claims you make as a result of the following:

- A pandemic disease
- Radioactive contamination
- Suicide or deliberate self-inflicted injury
- War, hostilities, invasion or civil war and full-time active military service
- Nuclear, chemical or biological terrorism
- Drug, alcohol or solvent abuse, or taking drugs (unless you have been told to by a registered medical practitioner)
- Taking part in professional sports or flying as a pilot or crew member (that is, aircraft, gliders, hang-gliders, microlights, parachuting, paragliding and ballooning)

Please also see what is not covered under each section of cover.

Benefit period

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

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.

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

When you change your level of cover, we will take account of previous claims you have made when we work out your maximum entitlement for the calendar year.

How to claim

We will deal with claims on the day we receive them and make payment within a reasonable time. We cannot accept photocopied, faxed or scanned receipts and claim forms (unless you are sending us a claim via the Health Shield website). We also cannot accept credit- or debit-card receipts. You should include the following details on the original receipts:

- The date you received treatment (we cannot pay for anything you have paid for in advance and not yet received)
- The full name and title (Mr, Mrs, Ms or Miss) of the person who has received the treatment
- The official stamp and qualifications of the dentist, optician, chiropodist, physiotherapist, consultant and so on
- The type of treatment received
- The receipt clearly shows the payment amount and that it has been paid in full

We cannot accept receipts which have been altered. The receipts must only apply to the amount paid for the person who received treatment. We need separate receipts for each person covered. We will only pay claims to you direct, not to the healthcare practitioner who provides the receipts.

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

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

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

- Chiropody
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Health and wellbeing
- Combined physiotherapy
- Family planning (Prestige-level only)

Worldwide cover

Some benefits apply during business visits and holidays abroad that last up to 28 days. The terms and conditions (including what is and what is not covered) will apply to the claims you send in, and you must send the details translated into English, if necessary. We will convert the amount of your claim into pounds sterling using the currency exchange sell rate on the date we process your claim.

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

What benefits are covered:

- Dental
- Optical
- 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

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

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

'Claims experience' – the number and cost of claims we paid for any one 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.

'We', 'our', 'us' – Health Shield Friendly Society Limited, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.

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

BENEFIT TERMS

HEALTHY & 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 this page 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 this page.

Optical

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

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

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

What is covered:

- Contact lenses (permanent or disposable)
- Contact lens check-ups
- Contact lens cleaning solutions (including if you buy these separately)
- Eye laser surgery to correct long- and short-sightedness paid according to the date of treatment and not when payments are made
- Eyesight tests
- Lenses you buy separately to fit to existing frames
- Lenses supplied under an optical insurance plan
- 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 or the NHS form as proof of your or your partner's name, together with your receipt.

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)
- Hopi ear candles
- Hot-stone massage
- Hypnotherapy
- Indian head massage
- Kinesiology
- Manual lymphatic drainage
- Naturopathy
- Nutritional therapy
- Reflexology
- Reiki
- Shiatsu
- Sports and remedial massages including therapies
- Swedish massage

What is not covered:

- Beauty treatments (including facials)
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment
- Vega testing
- Laboratory testing not referred for by a doctor
- Hair analysis
- Home testing kits
- Any treatment, provided by a practitioner recognised by us, which is not listed above
- Appliances (for example, lumbar rolls and back supports), even if they have been supplied as part of your treatment
- Smoking cessation patches, gum, electronic cigarettes and other remedies
- Weight-management programmes
- Relationship counselling

Also see the 'Exclusions' section on page 2.

Health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any 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

What is not covered:

- Home testing kits
- Tests not included within the full health screen (for example, X-rays and blood tests)
- Any other screening check or test not carried out as part of one of those listed above
- Health screens carried out in the workplace or arranged through your employer
- Health screens carried out in mobile facilities

Also see the 'Exclusions' section on page 2.

Combined physiotherapy

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one 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, from one to 25 nights, for a medical condition to be treated or investigated
- Being admitted to the ward, from the accident and emergency department, before midnight
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim 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, from one to 25 days, to have a medical condition investigated under anaesthetic or sedation using theatre facilities, or to have a medical condition treated under anaesthetic or sedation using theatre facilities
- Operations which are cancelled after you have been admitted to hospital
- Colonoscopy, laparoscopy, colposcopy and sigmoidoscopy procedures, as long as an anaesthetic or sedation was needed and the procedure was carried out in theatre
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim 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, from one to 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 does not have to be a consultant in a hospital but must be listed on the General Medical Council's Specialist Register or be a member, fellow or licentiate of one of the Royal Colleges.

This benefit also refunds costs you would have to pay for an ECG, X-ray, pathology fees and MRI scans charged to you at the appropriate department of a hospital or as part of a consultation.

Please see the 'How to claim' section on page 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
- Pathology and biopsy fees
- Physicians' or surgeons' operation fees
- Speech therapy, dyslexia and dyspraxia treatment provided by a registered medical practitioner

- X-ray, including mammograms, CT scans, ultrasounds, MRI scans and screenings
- If a claim has been settled by a provider of private medical insurance, we can only pay benefit (up to the appropriate maximum) for any remaining excess if you send us your statement from the provider of private medical insurance. Please make sure that the statement clearly shows how much excess is left to pay

What is not covered

- Anaesthetists' fees
- Counselling fees (we cover these fees under the health and wellbeing benefit)
- Private antenatal scans
- Private hospital charges (for example, theatre and room fees)
- Pre-existing conditions
- ECG, X-ray, pathology fees and MRI scans charged to you other than when they form part of a hospital stay or a consultation

Also see the 'Exclusions' section on page 2.

PEACE OF MIND

Dental accident

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one 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 calendar year, for an NHS or private antenatal scan carried out by a sonographer.

For any scan which has taken place within 26 weeks of you becoming pregnant, we will only pay benefit if you have been covered by the scheme for at least 40 weeks.

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 claims@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.

The services available on mywellness may differ according to the type of plan. 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 does not have to be a consultant in a hospital but must be listed on the General Medical Council's Specialist Register or be a member, fellow or licentiate of one of the Royal Colleges.

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 claims@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 claims@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 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 64;
- are not aware of any medical treatment or advice you are due to receive; and
- 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 65 (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.

Exclusions to sickness and accident protection cover

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.