Voluntary Paid Health Cash Plan **Terms and Conditions**

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Your Health Cash Plan Summary

This Health Shield Membership Plan ("the plan") is a Health Cash Plan provided by Health Shield Friendly Society Limited ("Health Shield"). This Plan is governed by English law and shall have jurisdiction in any legal proceedings in the English Court.

Health Cash Plans provide cover for everyday healthcare needs allowing Members to claim money back for benefits, up to an annual limit. The benefits within your plan could include dental check-ups, fillings, physiotherapy, eye tests, prescriptions and much more.

This Policy Summary does not contain the full terms and conditions of your plan; you can find these below. Please make sure you read this document carefully as it contains key information about your cover.

Key Features

- If you wish to join the plan you must be resident in the United Kingdom and be at least 16 years of age when you apply. There is a maximum age at which you can join the plan, please refer to your membership plan for details.
- You can choose from a range of benefit levels, with the option to add cover for your partner where applicable – you should refer to the benefit table and terms and conditions to see what your plan allows.
- Separate annual benefit allowances for you and your partner (if covered) and separate annual benefit allowances for all registered dependent children.
- Dependent children who are living at home in full time education are covered at no extra cost. Please refer to your membership plan for the maximum age for dependent children under your plan.
- Benefit limits are refreshed at the beginning of each benefit year. This is detailed in the welcome pack we send you when you join.
- 100% of the value of claims for receipt-based claims will be paid up to the appropriate benefit maximum – you should refer to the benefit table and terms and conditions to see what your plan allows.
- No GP referral required before having treatment except for hospital benefits.

You should review your level of cover regularly to ensure it continues to meet your needs.

Key Limitations and Exclusions

- Dependent children must be registered to your membership before you can claim for them.
- If you apply to join the plan you will not be entitled to receive benefit for any pre-existing conditions.
- Qualifying periods for some benefits apply when you apply to join the plan. This means that you will have to wait until the applicable qualifying period has expired before you can claim those benefits.
- If you wish to change your level of cover, claims that have already been paid to you within the benefit year will be deducted when determining the maximum amount available to claim at your new level.
- We may decline any application to join or to change your level of cover if we believe that the change goes against the spirit of Friendly Society membership and may cause detriment to the Society (for example, if you increase and decrease your level of cover over a short period of time with the intention of taking advantage of higher benefit levels at limited additional cost in membership contributions). Please see 'Ending your membership' section of your terms and conditions.
- If they are included on your plan, the following apply to these benefits:
    - Critical illness cover is payable up to the age of 65 and payable only once during the lifetime of each person entitled to benefit;
    - Sickness and accident protection cover is payable only up to the age of 70. An exclusion period of 30 days applies to all sickness and accident claims; and
    - Family planning cover and Sickness and accident protection cover do not apply to dependent children.

Duration of cover

Although claim limits are refreshed each year, your membership has no fixed term and will typically continue from one benefit year to the next unless you decide to leave the plan.

If this plan is arranged for you via an employer, then your membership of the plan will continue from one benefit year to the next unless:

- You decide to leave your employer;
- Your employer no longer offers the plan; or
- You cease to pay your contributions.

You should review your level of cover regularly to ensure it continues to meet your needs.

Premiums and Benefits

All premiums include Insurance Premium Tax (IPT). Health Shield reviews its pricing and benefits annually and will tell you beforehand if a review will lead to a change in the benefits or contributions paid in the future.

What if I change my mind?

You can cancel your Health Shield membership at any time by letting us know in writing or by telephone.

If you tell us that you do not wish to proceed with the plan within 30 days of the commencement date, we will return all contributions you have made, but you must also return any claims we have paid to you.

If you pay for your Health Shield membership via a payroll deduction arrangement, then we will return your contributions to your employer who will then manage the refund in line with their scheme rules.

If you wish to cancel after 30 days have passed, we will not return any contributions.

How to make a claim

Simply submit your receipt-based claim online via the Health Shield Members' Area or complete a paper claim form and post back to us at Health Shield Friendly Society, Electra Way, Crewe, CW1 6HS.

We aim to process your claim within two working days and, if accepted, we aim to credit your bank account within a further five working days. If you are claiming for an excess payment in connection to private medical insurance your claim procedure may be different. Please call us if you are unsure of how to proceed.

Making a complaint

We always try our best for our members, however, if you are unhappy with any aspect of our service, please contact us or speak to a member of the Health Shield team.

For general enquiries regarding your plan, please contact us on 01270 588555, or submit a query via www.healthshield.co.uk/contact-us/

If you want to raise a complaint about your plan, please either call on 01270 588555 or email us at complaints@healthshield.co.uk

If we are unable to resolve your complaint to your satisfaction, you are entitled to refer your case onto the Financial Ombudsman Service.

The Financial Ombudsman Service,
Exchange Tower
London E14 9SR
0800 0234567
Email:
complaint.info@financial-ombudsman.org.uk
Visit their website at:
www.financial-ombudsman.org.uk

Financial Services Compensation Scheme

We are members of the Financial Services Compensation Scheme (FSCS). If we are unable to meet our obligations, you may be entitled to compensation from the FSCS. Further information is available from the Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London, EC3A 7QU.



You should review your level of cover regularly to ensure it continues to meet your needs.

General Terms and Conditions

Where words or phrases appear in **bold type** they have a specific meaning for the purposes of this plan as detailed in the Definitions section.

These are the terms and conditions for **your** Health Cash Plan. **You** should read them with the **membership plan**. The **membership plan** set out the benefits and level of cover available to **you**. For more information on **your** membership, please see **our** Memorandum and Rules. **You** can ask **us** for a copy of these or find them on **our** website or **our** Members' Area.

Please make sure that **you** have read and understood **your membership plan** and these terms and conditions before going for **treatment** or submitting a claim.

If **you** need any further guidance or support, please visit www.healthshield.co.uk/contact-us/. You can find **our** FAQs at www.healthshield.co.uk/customers/faqs/ or contact **our** friendly customer care team on 01270 588555.

Definitions

'Accepted accreditations and qualifications' – **our** list of professional organisations and accepted qualifications that **we** recognise. The **practitioner**'s qualifications, registration or membership must be relevant to the **treatment** they are providing. **We** review this list every year.
'Accident' – a sudden, unexpected and identifiable event causing injury or illness.
'Any job' – any work of any kind, regardless of the insured person's age, education, training or experience.
'Benefit year' – the 12 month period in which **you** can claim up to the maximum allowance for each separate benefit as shown in the benefit table in **your membership plan**. The benefit year is confirmed on the policy schedule included in **your** welcome pack.
'Business days' – **our** business days are Monday to Friday (not including bank holidays).
'Claims experience' – factors relating to claims that help **us** to calculate future contributions.
'Dental accident' - an injury to **your** teeth or gums caused by a direct external impact to the head or face.
'Dependent children' – **your** or **your partner**'s children or legally adopted children who are living at home and studying full-time. The maximum age that **we** will cover a dependent child to will depend on **your** plan and **you** should consult **your membership plan** for this.
'Epidemic' – a rapid spread of an infectious disease that has affected a large number of people in a given population in a short time.
'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 having a physical examination, tests, laboratory tests, scans or x-rays and giving details of **your** and **your** family's medical history.

'Hospice' – an institution that provides inpatient palliative care for patients with a life-limiting or terminal illness.
'Hospital' – an institution which has permanent inpatient 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 or a consultant, or through the accident and emergency department.
'Membership plan' - (the plan) – the document containing the benefit table and the list of benefits available to **you** under **your** plan and the prices for additional cover.
'Member' – the plan is registered in **your** name as **you** are the member. Cover may also be provided for **your partner** and **dependent children**. **We** will send all communications to **you** as the member. **You** are also responsible for the contributions that are due and **you** will usually receive any benefit **we** pay.
'Pandemic' – an **epidemic** that is widespread throughout an entire country, continent, or the whole world. This would be declared by the World Health Organization.
'Partner' – anyone who permanently lives with **you** in a relationship. This could be **your** husband, wife, civil partner or unmarried partner, regardless of gender.
'Practice-plan premiums' – payments made to a scheme provided by **your** dentist.
'Practitioner' – a skilled medical or health professional who has received the appropriate training and qualifications for the **treatment** they are providing.
'Pre-existing condition' – any disease, illness or injury that **you** or anyone who is covered on the policy has 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.
'Specialist' - a specialist consultant who is a member or fellow of one of the Royal Colleges or listed as a specialist on the General Medical Council register. **We** do not cover members or fellows of the Royal College of General Practitioners.
'Start date' – the date **your** plan starts. **You** can find more information on this in the policy schedule included in **your** welcome pack.
'Surplus' – any money left over after meeting claims and expenses during the financial year.
'Treatment' – a medical or surgical procedure or intervention (including tests and purchases) or alternative health and wellbeing treatments received from a qualified **practitioner** to help cure, relieve, control or prevent an illness or injury.
'United Kingdom' – England, Wales, Scotland and Northern Ireland.
'We', 'our', 'us' – Health Shield Friendly Society Limited, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS. **We** are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Authority registration number 205304.
'You' and **'your'**– you, the **member** of this plan.

Who can join?

If **you** want to join this Health Cash Plan ('the plan') you must be resident in the **United Kingdom** and be at least 16 when you apply. There is a maximum age at which **you** can join the plan, please refer to **your membership plan** for the maximum age applicable to **your** plan.

If this plan is arranged for you via an employer, then you must be employed by a UK-based company that offers this plan.

For Direct Plus plan members only

The Health Shield Direct Plus Health Cash Plan ('the plan') is for members who are resident in the **United Kingdom** and who have reached the age of 65. Membership is restricted to the appropriate level of cover that **you** were paying for at the age of 64 within **your** previous Health Shield scheme. **You** cannot increase **your** level of cover but **you** can reduce it.

The plan may allow **you** to cover **your partner**. There may be an extra cost for this, as shown on **your membership plan**. **Dependent children** who are living at home and studying full-time are covered at no extra cost. Please see the **membership plan** for the maximum age applicable to **dependent children** for **your** plan. **Your partner** and any dependents need to be living at the same address as **you**.

To cover **your partner you** must fill in the application form provided in **your** welcome pack. **Dependent children** can be registered via the online Members' Area. **You**, **your partner** and any **dependent children** can only be covered or included in one Health Shield cash plan at any one time.

Once **you** are a **member**, **you** can remain on the plan until you decide to leave the plan. If **your** plan is arranged for **you** via an employer, **you** will remain as a **member** on the plan until:

- **You** decide to leave **your** employer;
- **Your** employer no longer offers the plan; or
- **You** cease to pay **your** contributions.

For Direct plan members only

Your membership will be transferred automatically to Health Shield's Direct Plus scheme at the start of **your** next **benefit year** after **your** 65th birthday.

For Flexible plan members only

Once **you** are a **member**, **you** can remain on the plan for 12 months, after which **you** will be able to cancel, change or renew **your** cover.

Pre-existing conditions

If **you** apply to join the plan **you** will not be entitled to receive benefit for any **pre-existing condition** on the benefits listed below. If **you** have told **us** that **you** have a **pre-existing condition**, **we** will ask **you** to fill in a health declaration form and will tell **you** about any conditions that are not covered. Any registered exclusions will also be listed in the cover and claims section of the Health Shield's Members' Area.

Exclusions for pre-existing conditions apply to the following benefits only (where appropriate):

- Combined physiotherapy;

- Critical illness cover;
- Hospital day surgery;
- Hospital inpatient;
- MRI, CT and PET scans;
- Parental hospital stay;
- Sickness and accident protection cover;
- Specialist consultation; and
- Specialist consultation and scanning.

For Flex plan members only
You do not need a medical examination to be accepted as a member of this plan. **We** will cover **you**, **your partner** and any **dependent children** on this plan for **pre-existing conditions**, subject to the terms and conditions and benefit rules of this plan.

Contributions and benefits

Your benefits and contributions are set out in **your membership plan**.

We will refund valid claims (as shown in the benefit table) up to **your** annual benefit limit. This does not include the family planning and critical illness benefits (if these are included in **your** plan) as these are lifetime allowances which can only be claimed once.

During the lifetime of this contract it is important to 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 they are better than expected, **we** may be able to improve **your** terms.

We will tell **you** beforehand if there is a change to benefits or contributions paid in the future.

Ending your membership

If **you** apply to join the plan, upgrade **your** level of cover or to add a **partner** to the plan, **your** plan contains a 30-day cooling off period. If **you** decide to change **your** mind during this period, **you** should tell **us**. **We** will refund the contributions **you** have paid to **us**, providing that no claims have been made by **you**, **your partner** or **your dependent children**.

If after 30 days have passed, **you** wish to cancel **your** cover **we** will not return **your** contributions.

If **you** decide that this **plan** no longer meets **your** needs, **you** can cancel it at any time by contacting **us**.

For Flexible plan members only
If **you** decide to join the plan, **your** cover will typically continue for 12 months after which **you** will be able to cancel, change or renew **your** cover.

Our board of management can end **your** membership at any time if they think:

- **you** have deliberately provided misleading or false information (or not told **us** about every significant circumstance **we** need to be aware of);
- **you** have made a claim that is fraudulent or that **we** believe to be deliberately false, misleading or exaggerated;
- **you** have behaved in a threatening or abusive way towards any member of staff;
- **your** continued membership may have a detrimental or prejudicial effect on other **members** or **our** organisation as a whole; or
- **You** have been in breach of any of our rules or any of the plan terms and conditions applicable to you.

We will tell **you** in writing **our** reason for cancelling **your** cover. **You** have the right to appeal against this decision.

If **we** end **your** membership for one of the reasons given above, **we** will not accept any future applications from **you** for a cash plan or accept **you** as a **partner** or **dependant child** registered to the membership of another person.

If **your** plan is arranged for **you** via an employer, **we** may tell **your** employer that **we** have ended **your** membership.

We may also try to recover from **you** any money **we** have paid **you** that **you** were not entitled to under the terms and conditions of this plan. If **you** do not repay **us**, **we** may 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 fraud keep to the Insurance Act 2015.

Why and how we check claims to prevent fraud

We take fraud prevention very seriously. False claims may cause contributions to rise, which in turn could affect **our** organisation. To protect **our** members, **we** have systems in place that detect false claims and identify fraudulent behaviour. **We** share information and details of fraudulent claims with other cash plan providers, fraud prevention agencies, the police and other enforcement agencies. It is **your** responsibility to make sure that all the information **you** give **us** to support a claim is truthful and complete. **You** must always act honestly. For example, **you**, or anyone covered on **your** policy, must not:

- alter or forge any documents **you** give **us**, for example application forms, claim forms or receipts;
- provide **us** with 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 any information **you** give **us**;

- deliberately claim for anything, or anyone, that's not covered under **your** membership;
- claim a refund from more than one insurance provider with the intention of receiving back more than **you**'ve paid out (this is called betterment); or
- fail to tell **us** if the claim has been or could be covered on another Health Shield policy.

As well as checking claims for fraud, **we** also carry out routine checks to make sure that **we**'re paying claims correctly. **We** do this to protect **our** interests – it does not mean that **we** think **you**'re being dishonest.

We may need to ask **you** for further information before **we** can assess a claim. **You** must provide this information within a reasonable time and at **your** own expense. **We** may also need to contact the **practitioner** for confirmation. While **we**'re waiting for information, all claims relating to **your** membership will remain on hold.

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.

Following an investigation where **we** have identified false, fraudulent or misleading claims, **we** may end **your** policy. All of **your** benefits will stop from the date **we** end **your** policy.

Existing and previous members

If **you** are an existing or previous health cash plan **member**, please note the following:

- These terms and conditions completely replace those of any previous plan;
- The benefits **we** will pay may be different to those of any previous plan;
- The **benefit year** of **your** previous plan may be different (**you** can find this in the policy schedule in **your** welcome pack); and
- **We** will take any claims **we** have previously paid off the new available allowances if they were paid in the current **benefit year** of this plan.

Dependent children

Dependent children who are living at home and studying full-time are covered at no extra cost. **You** can register **your** children through the Health Shield Members' Area.

There is a maximum age for **dependent children** to be included on **your** plan. Please refer to **your membership plan** for details of the maximum age applicable to **your** plan.

Each registered **dependent child** has their own separate annual benefit allowance to use.

Please refer to the benefit table within the **membership plan** for details of what benefits **dependent children** are eligible to claim for and their benefit allowances.

Percentage return

We will pay **you** 100% of the total cost of a valid claim up to the appropriate maximum amount **you** are entitled to in the **benefit year** for **your** chosen level of cover.

Please see the benefit table in the **membership plan** for the annual benefit allowances **you** are able to claim back for each level of cover.

How we use your personal information

We collect personal information from **you** in order to set up and manage **your** plan. **We** will handle this information in line with current data protection legislation. For more information on how **we** use **your** personal information, please see **our** privacy policy at www.healthshield.co.uk/privacy-policy/ or contact **us** to ask for a copy.

Contributions

Your contributions must be paid in full for **us** to assess any claims. If **you** miss a payment, **we** will put any claims on hold until **your** contributions are up to date.

If **you** decide to end **your** membership, all benefits will stop after the period which the final contribution covers **you** for. For clarification of this date please contact **us**.

Qualifying period

From the date **your** membership starts, **you** will be covered for the following benefits only:
- Overnight admissions to hospital as a result of an accident;
- Personal accident protection; and
- Services available in MyWellness. See page 36 for more details on MyWellness.

When **you** join the plan, or if you are an existing member when you increase your level of cover, you will be able to make a claim:
- 40 weeks after **your** start date for the maternity or adoption benefit; and
- 13 weeks after **your** start date for all other benefits.

For Direct Plus plan members only

You will become eligible to make claims for **treatment** that **you** receive after **we** have received **your** first contribution.

For Flex plan members only

If **you** apply to join the plan, or if **you** are an existing **member** applying to increase **your** level of cover **you** will receive immediate benefit, allowing **you**, your **partner** and **dependent children** (if this applies) to claim benefits as soon as **your** first contribution is received.

Exclusions

Please also see 'What is not covered' under each benefit section.

We cannot pay benefit for any claims directly related to the following:
- GP fees for private **treatment**;
- Prescription fees and medication (except under the prescriptions benefit if this applies);
- Vasectomies, sterilisation, IVF, fertility **treatment** and examinations (not including the family planning benefit);

- Pregnancy terminations and contraceptives
- Cosmetic consultations and procedures for non-medical reasons (except under the dental benefit if this applies);
- Any health checks, **treatments**, medical examinations, consultations or reports for employment, emigration, legal or insurance reasons;
- **Treatment** provided by a family member, **partner** or work colleague;
- Postage and packing costs or administrative charges;
- Travel costs;
- Couples', or group consultations;
- **Treatments** carried out in the workplace or arranged, facilitated or promoted through **your** employer; or
- Any costs covered by private medical insurance other than any **excess**. This is covered under the specialist consultation benefit, if this is included in **your** Plan.

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

- A **pandemic** or **epidemic**;
- Radioactive contamination;
- Suicide or deliberate self-inflicted injury;
- War, hostilities, invasion or civil war and military service;
- Acts of terrorism;
- Alcohol or solvent use;
- Taking drugs, unless they have been prescribed to **you** by a registered medical **practitioner**;
- Taking part in professional sport; or
- Flying as a pilot or crew member (that is, in an aircraft, glider, hang-glider, microlight or hot-air balloon, or while parachuting or paragliding).

Benefit period

We will confirm **your start date** within the policy schedule in **your** welcome pack. **You** must be a current **member** to claim and **your** membership will end once **your** contributions stop. **You** cannot claim benefit for any **treatments**, consultations or purchases made or received prior to **your start date**.

Entitlements

The maximum amounts **you** are entitled to are shown in the benefit table on **your membership plan** and in the Members' Area on **our** website. **We** will not pay more than the maximum benefit amount for **you**, **your partner** or **dependent children** (if they are covered) within each **benefit year**. What **you** are entitled to depends on **your** level of cover at the time of **your treatment** or when making a purchase.

How to claim

You can submit **your** claim online through the Health Shield Members' Area or fill in a paper claim form and post it back to **us**. **We** cannot accept claims sent by email.

When **you** make a claim by post **you** must send **us** the original receipts and documents. Online claims must be supported by a good-quality image of the original receipts or documents.

We recommend that **you** keep **your** original receipt if **you** are making **your** claim online or take a copy of it if **you** are sending **your** claim by post. **We** cannot be held responsible for any documents not received by **us**.

You should make sure that the provider of the service or **treatment** follows our receipt requirements on the original receipts or documents. It is **your** responsibility to obtain this information prior to making **your** claim:

- The date **you** received **treatment** or bought the item;
- The first name, surname and title of the person who has received the **treatment** or item;
- Contact details for the provider on letter-headed paper, including the company logo or official stamp;
- The full name and qualifications for the professional providing the **treatment** (if this applies – see the 'Qualification and accreditations' section);
- Confirmation of the type of item **you** bought or **treatment** received. This must be listed within the 'What is covered' section under each benefit; and
- A clear breakdown of costs for the **treatment** or item which shows that it has been paid in full.

We cannot accept credit- or debit-card receipts alone as they do not include the full details **we** need. **We** also will not pay for anything **you** have paid for in advance and not yet received.

If more than one person covered on the plan has received **treatment**, the receipt must clearly show the name and cost paid per person.

We will only pay claims to **you** direct, not to the provider of the **treatment** or the place **you** made **your** purchase. This does not apply to private medical insurance **excess** claims.

Claims are paid based on the date that the **treatment** or purchase takes place. **We** then deduct them from the relevant **benefit year** allowance.

You should make **your** claim within 12 months after the date of **treatment** or purchase. Claims **we** receive after this period may be harder to confirm and so may affect **our** ability to assess **your** claim. If **you** are sending **us** a claim that is more than 12 months old, **you** will need to do this by post.

By submitting the claim, **you** declare that the details **you** have provided are true, and also allow **us** to get independent confirmation 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 not return them.

We aim to process **your** claim within two **business days** and, if accepted, **we** aim to credit **your** bank account within a further five **business days**. All claims paid will be in British pounds sterling.

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

We have the right to recover funds from **you** for any payments made incorrectly, no matter who is at fault. **You** can repay **us** by a direct payment, or **we** can adjust any future benefit payments **we** make to **you**.

Please see each benefit section for further information we may need to support your claim.

Qualifications and accreditations

To ensure a successful claim, please check **our** list of **accepted accreditations and qualifications** before receiving **treatment**.

You can find the list on **our** website at www.healthshield.co.uk/customers/how-to-claim/ or within the Health Shield Members' Area. **We** review this list every year.

For the following benefits, the **practitioner**'s qualifications, registration or membership must be on **our** accepted list and relevant to the **treatment** that they are providing:

- Combined physiotherapy;
- Chiropody;
- Family planning;
- Fitness;
- Health and wellbeing;
- MRI, CT and PET scans;
- Specialist consultation; and
- Specialist consultation and scanning.

Worldwide cover

This cover is not travel insurance.

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

In order for **us** to complete **our** assessment of **your** claim, **we** may ask for a copy of **your** travel documents to confirm that **you** have not been outside of the **United Kingdom** for more than 28 days.

What benefits are covered:

- Combined physiotherapy (the qualification or accreditation of the **practitioner** may be an international equivalent);
- Dental;
- Emergency admissions only for:
    - hospital inpatient;
    - hospital day surgery; and
    - parental hospital stay;

- Optical; and
- Personal accident protection.

What benefits are not covered:
- Chiropody;
- Critical illness;
- Dental accident;
- Family planning;
- Fitness;
- Health and wellbeing;
- Health screening;
- Home help and home nursing;
- Maternity-antenatal appointment and adoption;
- MRI, CT and PET scans
- Prescriptions;
- Specialist consultation;
- Specialist consultation and scanning; and
- Vaccinations and inoculations.

Also see the 'Exclusions' section on page 12.

Making a complaint

We always try **our** best for **our members**, however, if **you** are unhappy with any aspect of **our** service, please contact us on 01270 588555, or submit a query via www.healthshield.co.uk/contact-us/

If you want to raise a complaint about your plan, please either call 01270 588555 or email us at complaints@healthshield.co.uk

We have **our** own internal complaints procedure but if **we** can't settle **your** complaint with **us**, **you** are entitled to refer it to the Financial Ombudsman Service. **You** can contact them at Financial Ombudsman Service, Exchange Tower, London, E14 9SR, Email: complaint.info@financial-ombudsman.org.uk, or telephone 0800 0234567.

Financial Services Compensation Scheme

We are members of the Financial Services Compensation Scheme (FSCS). If **we** are unable to meet **our** obligations, **you** may be entitled to compensation from the FSCS. Further information is available from the Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London, EC3A 7QU.

Benefit terms

Please note that not all of the following benefits may be applicable to **your** plan. **You** should review the benefit table within **your membership plan** to confirm which benefits apply to **your** plan.

Please review the 'How to claim' section on page 13 before going for **treatment** or sending **us** a claim. **We** will only assess claims for **treatments**/ purchases that are listed within the 'what is covered' section of each benefit.

Chiropody

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives one of the **treatments** covered below. The **treatment** must be provided by a **practitioner** who holds one of **our accepted qualifications and accreditations** relevant to the **treatment** provided.

What is covered:
- Assessments (for example, gait analysis or biomechanical assessments);
- Chiropody **treatment**; and
- Podiatry **treatment**.

What is not covered:
- Purchased items and 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 (these are covered under the prescriptions benefit, if applicable to your plan); and
- Pedicures as part of beauty **treatments**.

Also see the 'Exclusions' section on page 12.

Combined physiotherapy

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives one of the covered **treatments** below for a medical reason. This benefit also covers charges for x-rays and scans recommended by a **practitioner**, carried out as part of the **treatment** or at a clinic following a referral.

The **treatment** or referral must be provided by a **practitioner** who holds one of **our accepted qualifications and accreditations** relevant to the **treatment** provided.

The claim must include the medical reason for **treatment**, and the receipt must show which of the covered **treatments** was received.

Please see 'How to claim' on page 13 for full details of what the receipt must show.

What is covered:
- Acupuncture;
- Chiropractic **treatment** (including adjustments and report of findings);
- Homeopathy;
- Osteopathy (including craniosacral therapy);
- Physiotherapy; and
- X-rays and scans as part of the **treatment**. If following a referral this is carried out at a clinic, **we** will need proof of the referral.

What is not covered:
- Any **treatments** not shown in the 'What is covered' section;
- Purchased items and consumables (for example, lumbar rolls and back supports) even if prescribed or supplied by **your practitioner** as part of the **treatment**;
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of **your treatment**;
- Prescription charges (these are covered under the prescriptions benefit, if applicable to your plan);
- Private medical insurance **excess** (this is covered under the specialist consultation benefit, if applicable to your plan); and
- Group sessions or classes (for example, pilates).

Also see the 'Exclusions' section on page 12.

Critical illness

We will pay critical illness benefit if critical illness is diagnosed. **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 and **you** must make the claim within 12 months of the critical illness being diagnosed.

Please call 01270 588555 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; and
  - 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; and
  - The diagnosis must be confirmed by diagnostic techniques that are widely used at the time **you** make **your** claim; and
- 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 commencement date of this plan;
- If **you** die within 28 days of being diagnosed with a critical illness or having surgery; and
- **We** will not pay critical illness benefit for claims caused directly or indirectly by **you** being infected by, or treated for HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS).

Also see the 'Exclusions' section on page 12.

Dental

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives one of the **treatments** below.

What is covered:
- Check-up charges;
- Anaesthetic fees for dental **treatment**;
- A dental brace or gumshield provided by the dentist or orthodontist;
- Joining fees and **practice-plan premiums**;
- Dental crowns, bridges and fillings;
- Dental veneers;
- Dentures or repairs to dentures at dental laboratories;
- Hygienist fees;
- Orthodontic and periodontal **treatment**;
- X-rays; and
- Teeth-whitening **treatment** provided by the dentist.

What is not covered:
- Missed appointments or administration charges;
- Teeth-whitening not provided by a dentist e.g. home-whitening kits;
- Purchased items and consumables (for example, toothbrushes, mouthwash, dental floss);
- Gumshields or other dental items which **you** have bought independently;
- Dental insurance premiums;
- Dental prescription charges (these are covered under the prescriptions benefit, if applicable to your plan);
- At-home impression kits for teeth-straightening or dental braces; and
- Dental check-up and **treatment** charges resulting from a **dental accident** (these are covered under the **dental accident** benefit, if applicable to your plan).

Also see the 'Exclusions' section on page 12.

Dental accident

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives dental **treatment** as a result of an accidental injury to their teeth or gums. The injury must have been caused by a direct external impact to the head or face.

You can only claim this benefit if **you** have had a dental emergency appointment within 30 days of the **accident** or injury. **Your** dentist must confirm on all receipts that the **treatment** has been caused by a direct external impact to the head or face which has resulted in accidental injury to **your** teeth. **You** must also provide full details of the **accident**, including the date it happened.

Any future claims for **treatment** relating to the **accident** will be taken from the allowance of the **benefit year** that the **accident** happened, up to the appropriate maximum.

What is covered:
- Dental check-up and **treatment** charges resulting from a **dental accident** (for example, a sports injury or a fall), including the following:
  - Anaesthetic fees;
  - Dental crowns, bridges and fillings;
  - Dental veneers; and
  - Replacement dentures or repairs.

What is not covered:
- Injury caused other than by a direct external impact to the head or face;
- Injuries caused by eating and drinking;
- Missed appointment or administration charges made by the dentist;
- Damage to dentures when not being worn;
- Purchased items and consumables (for example, toothbrushes, mouthwash and dental floss);
- Dental prescription charges (these are covered under the prescriptions benefit, if applicable to your plan);
- Dental insurance premiums;

- Joining fees and **practice-plan premiums** (these are covered under the dental benefit, if applicable to your plan);
- Dental **treatment you** receive for an **accident** which happened before **you** joined the plan; and
- **Dental accident** and related **treatment** that has taken place outside the UK.

Also see the 'Exclusions' section on page 12.

Family planning

We will pay benefit to **you** and **your partner** (if they are covered) up to the appropriate maximum, when a person entitled to benefit has a **specialist** consultation, **treatment** or tests with a family planning **practitioner** who is a member or fellow of one of the Royal Colleges or listed as a **specialist** on the General Medical Council register (please see www.gmc-uk.org).

This is not a yearly benefit – the allowance is the total maximum **you** or **your partner** (if covered) can claim during **your** lifetime.

We do not cover consultations, **treatments**, tests, scans or x-rays provided by private doctors or members or fellows of the Royal College of General Practitioners.

On the claim, **you** must provide the medical reason for the consultation, **treatment**, test, scan or x-ray.

What is covered:
- Private family planning clinics;
- Private fertility **treatment** and examinations;
- Private IVF **treatment**;
- Private sterilisation fees; and
- Private vasectomy fees.

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

Also see the 'Exclusions' section on page 12.

Fitness and exercise

You, **your partner** and **dependent children** (if covered) have access to a contribution towards a gym membership, swimming sessions, exercise classes (for example, yoga, pilates and aerobics) or a personal trainer. The personal trainer must be accredited by the Register of Exercise Professionals (REPS) or the British Association of Sports Rehabilitators and Trainers (BASRaT).

What is not covered:
- Skill-based sports classes and training, for example football, basketball, tennis and badminton; and
- Club or association membership fees.

Health and wellbeing

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives one of the **treatments** covered below. The **treatment** must be provided by a **practitioner** who holds one of **our accepted qualifications and accreditations** relevant to the **treatment** provided.

The receipt must show which of the covered **treatments** was received.

Please see page 13 under 'How to claim' for full details of what the receipt must show.

What is covered:
- Acupressure;
- Allergy testing, including food intolerance and nutrition tests;
- Aromatherapy massages;
- Bowen and Alexander techniques;
- Chair massage;
- Cognitive behavioural therapy;
- Colonic hydrotherapy;
- Counselling fees for individuals (for example, anxiety, stress or bereavement);
- Deep tissue and remedial 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 massage and sports therapy; and
- Swedish massage.

What is not covered:
- Any **treatments** not shown in the 'What is covered' section;
- Home testing kits;
- Beauty **treatments** (including facials);
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of **your treatment**;
- Laboratory testing;
- Hair analysis;
- Purchased items and consumables (for example, lumbar rolls and back supports), even if they have been supplied as part of **your treatment**;
- Patches, gum, electronic cigarettes and other remedies to help **you** stop smoking;
- Weight-management programmes

- Relationship counselling; and
- Couples' or group consultations.

Also see the 'Exclusions' section on page 12.

Always get the advice of your practitioner about your condition before receiving treatment.

Health screening

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives a full medical check-up to detect or prevent an illness.

The health screen must include giving **your** (and **your partner**'s if they are covered) medical history and **your** family's medical history, a physical examination and investigative tests. It may also include laboratory tests, scans or x-rays. The **treatment** must be carried out at a **hospital** or a health-screening clinic (including non-permanent or mobile clinics) by an appropriate healthcare professional.

What is covered:
- A **full health screen**.

What is not covered:
- Home testing kits;
- Further tests not included in the **full health screen** (for example, x-rays and blood tests);
- Any other screening check or test not carried out as part of a **full health screen** (for example, mammograms or fitness analysis);
- Health screens carried out in the workplace or arranged, paid, facilitated or promoted through **your** employer; and
- Health screens carried out for employment, emigration, legal or insurance reasons.

Also see the 'Exclusions' section on page 12.

Hearing aids and surgical appliances

We will pay benefit, at the appropriate rate, for hearing aids and surgical appliances up to the appropriate maximum in any one **benefit year**.

What is covered:
- Hearing aid and hearing aid adjustments or repairs and audiology tests provided by a registered hearing aid dispenser. All hearing aid dispensers must be registered with the HCPC (Health and Care Professions Council) and you can check on their official website (please see www.hcpc-uk-org). Many are also members of the BSHAA (British Society of Hearing Aid Audiologists) who, again, have a list of registered dispensers on their website (please see www.bshaa.com); and
- Surgical appliances which are prescribed or supplied by your GP or healthcare practitioner.

Please contact our customer care team to check what surgical appliances we cover before making a claim.

What is not covered:
- Batteries for hearing aids;
- Contract schemes for hearing aids; and
- Micro-suction earwax removal.

Also see the 'Exclusions' section on page 12.

Home help and home nursing

We will pay benefit for home help and home nursing services, up to the appropriate maximum in any one **benefit year**. Please see the 'How to claim' section on page 13 before going for **treatment** or submitting a claim.

What is covered:
- Home-help services provided by a local authority;
- Home-help services provided by an agency contracted directly by a local authority; and
- Home nursing or home-help services provided by an agency, on the recommendation of **your** GP.

What is not covered:
- Home-help services provided for maternity cases.

Also see the 'Exclusions' section on page 12.

Hospital benefits

We combine **hospital** inpatient and **hospital** day-surgery benefit payments. The maximum period for receiving this benefit is a total of 25 days or nights (or a combination of both) in any one **benefit year** for each person who is entitled to benefit.

You must fully fill in the paper claim form, confirming the medical reason for the **hospital treatment** or stay. The claim form must then be checked, signed, dated and stamped in section 6 by an appropriate member of staff at the **hospital**, **registered treatment centre** or **hospice**. Or, **you** can fill in **your** claim form and send it to **us** with the discharge letter or summary.

We may ask for more information about the **treatment** provided by the **hospital**. If there is a dispute about **your hospital** claim, **our** management team will decide whether **your** claim meets the terms and conditions and whether the medical facility falls within the definition of a **hospital**, **registered treatment centre** or **hospice**.

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 day-surgery **treatment** in a recognised **hospital** or **registered treatment centre** 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, or treated, with anaesthetic or sedation and using theatre facilities;
- Being admitted from an accident and emergency department to have a medical condition investigated or treated with anaesthetic or sedation and 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 using theatre facilities;
- Outpatient **treatment** for chemotherapy, kidney dialysis, oncology and radiotherapy; and
- Fees for filling in claim forms, as long as **you** provide an official receipt with **your** claim and **we** accept the claim.

What is not covered:

- Attending an accident and emergency department only;
- Nursing homes or **hospital** accommodation for any person who is not able to live independently;
- Any admissions to medical spas and spa **hospitals**;
- Overnight stays in **hospital** hotels;
- 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 or **hospice** day care;
- Maternity admissions;
- Outpatient appointments or **treatments** that are not covered above;
- Pre-admission appointments (appointments before **you** are admitted to **hospital**); and
- Psychiatric **treatment**.

Also see the ‘Exclusions’ section on page 12.

Hospital inpatient

We will pay benefit at the appropriate nightly rate for the period a person entitled to benefit is admitted for inpatient **treatment** in a recognised **hospital**, **registered treatment centre** or **hospice** following a referral by a GP or consultant or being admitted from the accident and emergency department.

What is covered:

- Overnight stay in an NHS **hospital**, a private **hospital**, a **registered treatment centre** or **hospice**, from one to 25 nights, for a medical condition to be treated or investigated;
- Being admitted to a ward, from the accident and emergency department, before midnight; and
- Fees for filling in claim forms, as long as **you** provide an official receipt with **your** claim and **we** accept the claim.

What is not covered:

- Attending an accident and emergency department only;
- Overnight stays at nursing homes or rehabilitation centres;
- **Hospital** accommodation for a person who is not able to live independently;
- Any admissions to medical spas and spa **hospitals**;
- Overnight stays in **hospital** hotels;
- Maternity-related admissions for **dependent children**;
- The first 10 consecutive overnight stays as a maternity inpatient, during which the child is born;
- A child's first 10 consecutive overnight stays as an inpatient after being born;
- Outpatient **treatment**; and
- Permanent stays in **hospital**.

Also see the 'Exclusions' section on page 12.

Maternity and adoption

We will make a single payment of **your** maximum allowance for a pregnancy confirmed by an NHS or private antenatal scan carried out by a sonographer within the first 26 weeks of pregnancy. **You** must fill in a paper claim form and make sure that section 7 is checked, signed, dated and stamped by an appropriate member of staff at the **hospital** or surgery. Or, fill in **your** claim form and send it to **us** with proof of the antenatal scan showing the patient's name, date and proof of how many weeks pregnant they are (for example, a copy of the scan).

For maternity claims the pregnant person must be **you**, **your** registered **partner** or a **partner** who is not registered with **us** but lives with **you** (**we** will need proof of this).

This benefit also covers **you** if **you** adopt a child aged 16 or under or **you** have parental responsibility following a surrogate birth. **You** must fill in a paper claim form and provide a copy of the adoption certificate for adopted children or parental order for children born by surrogacy.

What is covered:

- A pregnancy that has been confirmed by an NHS or private antenatal scan carried out by a sonographer which takes place within the first 26 weeks of pregnancy; and
- Fees for filling in claim forms, as long as **you** provide an official receipt with **your** claim and **we** accept the claim.

What is not covered:
- The cost of having a private antenatal scan;
- Attending an accident and emergency department;
- Antenatal appointments for **dependent children**; and
- The pregnancy of a **partner** who is not registered with **us** and does not live with **you**.

Also see the 'Exclusions' section on page 12.

You are only allowed to claim for one maximum allowance per pregnancy, adoption or parental order.

MRI, CT and PET scans

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit has an MRI, CT or PET scan following referral by a **specialist**.

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 13 before going for treatment or submitting a claim.

When **you** submit the claim, **you** must also send **us** an original receipt or invoice showing **your** name and the date of the scan. **You** should also make sure that the referral letter from **your specialist** is included.

What is covered:
- MRI, CT or PET scan carried out at the appropriate department of a **hospital** or **registered treatment centre** or referred for by a **specialist** as part of a consultation. **You** will need to provide the letter of referral from the **specialist** to evidence this referral;
- Outpatient scans;
- Inpatient scans; and
- Radiologists' reports.

What is not covered:
- Anaesthetists' fees;
- Private antenatal scans;
- Private **hospital** charges (for example, room fees);
- MRI, CT and PET scans charged to you other than when part of a hospital stay or a consultation; and
- 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 (**excess** fees are covered under the Specialist Consultation allowance, if applicable to your plan).

Also see the 'Exclusions' section on page 12.

Optical

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit receives one of the covered **treatments** below. **We** will pay benefit for optical tests, **treatments** and purchases (if covered). **We** assess claims based on the date **treatment** or tests have been carried out or, for any covered purchases, the date of purchase.

If **you** have bought contact lenses or glasses, **you** must provide proof of purchase indicating these are prescription items. For online purchases, as well as providing proof of purchase **you** must also provide a copy of the most recent optical prescription, issued by an optician, showing the name of the person **you** are claiming for.

For contact lenses that **you** pay for monthly, **we** need a statement from the provider showing the name of the person **you** are claiming for, the amount paid and the date of payment. This must match the amount **you** are claiming for.

If **you** are claiming for contact lens solution only, **you** must provide **us** with the proof of purchase and most recent contact lens prescription issued by an optician showing the name of the person the contact lenses are prescribed for.

What is covered:
- Prescribed glasses (for example sunglasses, safety glasses and swimming goggles);
- Prescribed lenses **you** buy separately to fit to existing frames;
- Prescribed contact lenses;
- Contact lens check-ups;
- Contact lens cleaning solutions to be used with **your** prescribed contact lenses;
- Eye laser surgery to correct long- and short-sightedness paid according to the date of **treatment** and not when payments are made;
- Eyesight tests or scans provided at an opticians;
- Prescribed magnifying glasses; and
- Repairs to prescribed glasses.

What is not covered:
- Insurance premiums;
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses);
- Other purchased items and consumables (for example, glasses cases and eye drops); and
- Frames **you** buy separately, unless prescribed lenses are fitted at an opticians.

Also see the 'Exclusions' section on page 12.

Parental hospital stay

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

You must fill in the paper claim form confirming the medical reason for the registered child being admitted. The claim form must then be checked, signed, dated and stamped in section 6 by an appropriate member of staff at the **hospital**, **registered treatment centre** or **hospice**. Or, **you** can fill in **your** claim form and send it to **us** with **your** registered child's discharge letter or summary.

What is covered:

- Any period of overnight stay in an NHS **hospital**, a private **hospital**, a **registered treatment centre** or **hospice**, from one to 25 nights, where one parent stays with their registered child;
- **Your** registered child being admitted to a ward, from the accident and emergency department, before midnight; and
- Fees for filling in claim forms, as long as **you** provide an official receipt with **your** claim and **we** accept the claim.

What is not covered:

- Attending an accident and emergency department only;
- Overnight stays at rehabilitation centres;
- Any admissions to medical spas and spa **hospitals**;
- Overnight stays in **hospital** hotels;
- More than one parent staying with their child;
- A child's first 10 consecutive overnight stays as an inpatient after being born;
- Outpatient **treatment**; and
- Permanent stays in **hospital**.

Also see the 'Exclusions' section on page 12.

Personal accident protection

Please call **01270 588555** 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 disablement within one year of the **accident**. Permanent total disablement is a disability that prevents **you** from doing **any job** – which is not limited to **your** occupation at the time of the **accident**.

We will pay the sum insured in line with the level of contribution **you** have paid. Cover will end on **your** 70th birthday. **You** must write to **us** within six months of an **accident** to let **us** know about it.

You will need to provide medical evidence from a registered medical **practitioner** to support **your** claim. **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-diving);
- Mountaineering;
- Rock climbing;
- Potholing;
- Parachuting;
- Boxing;
- Racing (other than on foot);
- Time trials or sprints;
- Flying as a pilot or crew (that is, in an aircraft, glider, hang-glider, microlight or hot-air balloon, or while parachuting or paragliding); or
- Carrying out duties in one of the armed forces, including the Army Reserve.

Also see the 'Exclusions' section on page 12.

Prescriptions (for each item)

We will pay benefit up to the appropriate maximum number of individual prescription items in any one **benefit year** for NHS prescription charges. **We** will also cover private prescription charges up to the standard NHS prescription costs on the date of purchase.

Please provide the original receipt showing the name of the person the prescription was for, the amount paid and the date of purchase. If there is no name on the receipt, please also provide a copy of the prescription or the pharmacy label from the medication packaging as confirmation of who the prescription was for. If **you** want to claim towards the cost of an NHS prepayment certificate, **we** will need a copy of the certificate to support **your** claim.

We do not pay prescriptions benefit for **dependent children**.

What is covered:
- NHS prescription charges or up to the NHS cash equivalent for private prescription charges;
- An NHS prepayment certificate up to the appropriate maximum of individual prescription items; and
- 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 12.

Sickness and accident protection cover

If a person entitled to benefit is continuously off work for more than 30 days due to being unfit for work following:
- Sickness; or
- Accidental injury

We will repay that person's contributions for the time that they are off work.

The cause of **your** or **your partner**'s absence must have started after the **start date** of your plan. A person entitled to benefit must be in permanent employment and aged between 16 and 70. **We** will not pay benefit for any period of absence after **you**, or **your partner**, have reached the age of 70 or **your** membership has ended.

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

You are not entitled to claim for the first 30 days of each absence.

You must fill in a claim form and send **us** a copy of the fit note confirming the medical reason and the start date of **your** absence, as provided by the GP.

We only pay this benefit for completed periods of absence. **We** will need further fit notes confirming the absence is continuing, or confirmation of the return-to-work date provided either by **your** employer or GP. Unless **you** have returned to work and provided evidence of this, **we** will only pay benefit up to the date the GP signed **your** fit note.

We will pay 1/30th of **your** monthly contribution for each consecutive day a person entitled to benefit is not fit for work, not including the first 30 days. **We** will pay the benefit every 30 days during the absence, up to a maximum of 12 monthly payments for any one claim. When **we** assess the maximum benefit period, **we** will treat periods of absence resulting from the same cause as being the same period of absence, unless separated by a minimum of three months of returning to work.

What is not covered:
- Any period of disability caused by any physical or mental disorder, any severe illness, or any recurring or continuing disease which **you** had received **treatment** or advice for before **your** cover began;

- Any period of absence that a registered medical **practitioner** has not provided medical evidence for (**you** must pay all the costs involved in getting medical evidence);
- Pregnancy, childbirth or any complication connected to these;
- A mental disorder, unless it is investigated and diagnosed by a GP; and
- HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS).

Also see the 'Exclusions' section on page 12.

Specialist consultation

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit has a specialist consultation with a **practitioner** who is a member or fellow of one of the Royal Colleges or listed as a **specialist** on the General Medical Council register (please see www.gmc-uk.org).

We will also pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit is charged for private **treatment**, medical tests, ECG, x-ray, and pathology fees carried out in an appropriate department of a **hospital** or referred for by the **specialist** as part of the consultation.

We do not cover consultations, **treatment**, medical tests or x-rays provided by private doctors or GPs (members or fellows of the Royal College of General Practitioners).

On the claim, **you** must provide the medical reason for the consultation, **treatment**, medical test or x-ray.

What is covered:
- Consultations provided by a **specialist**;
- Investigative procedures (for example, colonoscopy, laparoscopy, colposcopy and sigmoidoscopy);
- Medical tests (for example, EEG and lung-function tests);
- ECG, x-ray, and pathology fees carried out in an appropriate department of a **hospital** or referred for by a **specialist** as part of the consultation. **You** will need to provide the letter of referral from the **specialist** to evidence this referral;
- Mammograms and ultrasounds;
- Radiologist reports;
- Micro-suction earwax removal carried out by a **specialist**;
- Biopsy fees; and
- Physicians' or surgeons' operation fees.

This benefit also covers the following up to the appropriate maximum in any one **benefit year**:

- Hearing aids and hearing aid adjustments or repairs and audiology tests provided by a registered hearing aid dispenser. All hearing aid dispensers must be registered with the HCPC (Health and Care Professions Council) and you can check this on their official website (please see www.hcpc-uk.org). Many are also members of the BSHAA (British Society of Hearing Aid Audiologists) who, again, have a list of registered dispensers on their website (please see www.bshaa.com);
- Speech therapy, dyslexia and dyspraxia **treatment** provided by a relevant registered **practitioner**;
- If a claim has been settled by an individual sponsored Private Medical Insurance (PMI) provider, **we** can only pay benefit, up to the appropriate maximum in any one **benefit year**, for any remaining **excess**. **You** must send **us** a statement from the PMI provider clearly showing the **excess** amount and date of **treatment**; and
- If company PMI excess cover is included on **your membership plan** and if a claim has been settled by a company sponsored PMI provider, we will pay benefit, up to the appropriate maximum in any one **benefit year**, for any remaining **excess**. **You** must send us a statement from the PMI provider clearly showing the **excess** amount and date of **treatment**.

What is not covered:

- Anaesthetists' fees;
- Counselling fees (these are covered under the health and wellbeing benefit, if applicable to your plan);
- Fees for private antenatal scans (these are covered under the maternity and adoption benefit, if applicable to your plan);
- Private **hospital** charges (for example, theatre and room fees);
- Medical tests, ECG, x-ray and pathology fees charged to you and not carried out in an appropriate department of a **hospital** or referred for by a **specialist** as part of the consultation;
- Consultations for cosmetic procedures for non-medical reasons;
- Batteries for hearing aids;
- Contract schemes for hearing aids;
- Micro-suction earwax removal, unless carried out by a **specialist**;
- Purchased items and consumables; and
- Dental check-ups, orthodontic and periodontal treatment (these are covered under the dental benefit, if applicable to your plan).

Also see the 'Exclusions' section on page 12.

Specialist consultation and scanning

We will pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit has a **specialist** consultation with a **practitioner** who is a

member or fellow of one of the Royal Colleges or listed as a **specialist** on the General Medical Council register (please see www.gmc-uk.org).

We will also pay benefit up to the appropriate maximum in any one **benefit year**, when a person entitled to benefit is charged for private **treatment**, medical tests, ECG, x-ray, ultrasounds, screenings, pathology fees and MRI scans carried out in an appropriate department of a **hospital** or **registered treatment centre** or referred for by the **specialist** as part of the consultation.

We do not cover consultations, **treatment**, medical tests, scans or x-rays provided by private doctors or GPs (members or fellows of the Royal College of General Practitioners).

On the claim, **you** must provide the medical reason for the consultation, **treatment**, medical test, scan or x-ray.

What is covered:

- Consultations provided by a **specialist**;
- Investigative procedures (for example, colonoscopy, laparoscopy, colposcopy and sigmoidoscopy);
- Medical tests (for example, EEG and lung-function tests);
- ECG, x-ray, pathology fees, MRI scans, mammograms, CT scans, PET scans and ultrasounds carried out in an appropriate department of a **hospital** or **registered treatment centre**, or referred for by a **specialist** as part of the consultation. **You** will need to provide the letter of referral from the **specialist** to evidence this referral;
- Radiologist reports;
- Micro-suction earwax removal carried out by a **specialist**;
- Biopsy fees; and
- Physicians' or surgeons' operation fees.

This benefit also covers the following up to the appropriate maximum in any one **benefit year**:

- Hearing aids and hearing aid adjustments or repairs and audiology tests provided by a registered hearing aid dispenser. All hearing aid dispensers must be registered with the HCPC (Health and Care Professions Council) and you can check this on their official website (please see www.hcpc-uk.org). Many are also members of the BSHAA (British Society of Hearing Aid Audiologists) who, again, have a list of registered dispensers on their website (please see www.bshaa.com);
- Speech therapy, dyslexia and dyspraxia **treatment** provided by a relevant registered **practitioner**;
- If a claim has been settled by an individual sponsored Private Medical Insurance (PMI) provider, **we** can only pay benefit, up to the appropriate maximum in any one **benefit year**, for any remaining **excess**. **You** must send **us** a statement from the PMI provider clearly showing the **excess** amount and date of **treatment**; and
- If company PMI excess cover is included on **your membership plan**, then if a claim

has been settled by a company sponsored PMI provider, we will pay benefit, up to the appropriate maximum in any one **benefit year**, for any remaining **excess**. **You** must send us a statement from the PMI provider clearly showing the **excess** amount and date of **treatment**.

What is not covered:
- Anaesthetists' fees;
- Counselling fees (these are covered under the health and wellbeing benefit, if applicable to your plan);
- Fees for private antenatal scans (these are covered under the maternity and adoption benefit, if applicable to your plan);
- Private **hospital** charges (for example, theatre and room fees);
- Medical tests, ECG, x-ray, pathology fees MRI scans, Mammograms, CT scans and ultrasounds charged to **you** and not carried out in an appropriate department of a **hospital** or referred for by a **specialist** as part of the consultation;
- Consultations for cosmetic procedures for non-medical reasons;
- Batteries for hearing aids;
- Contract schemes for hearing aids;
- Micro-suction earwax removal unless carried out by a **specialist**;
- Purchased items and consumables; and
- Dental check-ups, orthodontic and periodontal **treatment** (these are covered under the dental benefit, if applicable to your plan).

Also see the 'Exclusions' section on page 12.

Vaccinations and inoculations

We will pay benefit to **you** and **your partner** (if they are covered) for vaccinations and inoculations up to the appropriate maximum in any one **benefit year**.

Please see the 'How to claim' section on page 13 before going for **treatment** or submitting a claim.

We do not pay vaccinations and inoculations cover for **dependent children**.

What is covered:
- Vaccinations and inoculations, including flu jabs, from a GP or nurse, for example in a GP's surgery, a pharmacy or travel clinic.

What is not covered:
- Any tests, **treatment** or other services provided by the above (if **you** are given a prescription **you** may be able to claim under the prescription benefit).

Also see the 'Exclusions' section on page 12.

MyWellness

Health Shield membership allows **you** exclusive access to a list of extra services. These services may include a 24/7 counselling and support helpline, GP anytime, health assessments, on-demand physio, home assistance cover and access to PERKS, which offers exclusive **member** deals including gym discounts and much more.

MyWellness brings these services together in one place and they can be easily accessed online, on your smartphone, tablet or computer, through the MyWellness tab on **our** Members' Area.

To take advantage of these services, **you** will first need to register on to Health Shield's Members' Area at www.healthshield.co.uk/.

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 your plan. Services and information available on MyWellness can change without notice.

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breeze

Access all your Cash Plan benefits and MyWellness services, whenever you need them, through the Breeze app.

Search 'Breeze' in your app store.

Breeze: Health & Wellbeing
Health Shield

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health shield
The best of health

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