



Classic Health Cash Plan Policy Document



The Health Shield Classic Membership Plan (“the plan”) is a Health Cash Plan provided by Health Shield Friendly Society Limited (“Health Shield”). By selecting and maintaining this Health Cash Plan, you automatically become a member of Health Shield Friendly Society Limited whose Memorandum and Rules are available for review on the Members’ Area of the Health Shield website at www.healthshield.co.uk. Copies available on request. This Policy 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 dental check-ups, fillings, physiotherapy, eye tests and much more up to an annual benefit limit.

This Policy Summary does not contain the full terms and conditions of your plan; you can find these from page 5 within this document. Please make sure you read this document carefully as it contains key information about your cover.

If you need any further guidance or support please visit www.healthshield.co.uk/contact-us/ or contact our friendly customer care team on 01270 588555.

Key Features

- If you wish to join the Health Shield Classic Scheme or increase your level of cover, you must be resident in the UK and between the age of 16 and 70 when you apply to join and be employed by a UK-based company that agrees to pay a contribution on your behalf
- Your employer will have chosen a level of cover which they have agreed to pay on your behalf. Should you wish to increase your level of cover, you can choose from a range of benefit levels, with the option to add cover for your partner and dependent children where applicable
- Dependent children up to the age of 18 who are living at home and studying full-time are covered at no extra cost
- Separate annual benefit allowances for you and your partner (if covered). Shared annual benefit allowances for dependent children except for specialist consultation and personal accident protection
- Benefit limits are refreshed at the beginning of each benefit year. This is confirmed in the welcome pack we send to you when you join. You can also view all membership details by visiting the Members’ Area of the Health Shield website
- 100% of the value of claims for receipt-based claims will be paid up to the appropriate benefit maximum
- No GP referral required before having treatment

Key limitations and exclusions

- Members must be resident in the UK and at least 16 years of age to join in their own right and we cannot accept your application if you are aged 70 or over when you apply. Please see the 'Who can join' section of your terms and conditions for more information
- Dependent children must be registered to your membership before you can claim for them
- If you wish to increase your level of cover, claims that have already been paid to you within the benefit year will be taken into account when determining the maximum amount available to claim at your new level
- If you apply to join the plan, or if you are an existing member applying to increase your level of cover, you will receive a special immediate benefit concession. This means we will overlook the normal qualifying periods, allowing you, and your partner and dependent children (if this applies) to claim benefits straight away as soon as your first contribution is received
- If you are a new member who has a pre-existing condition, you will be entitled to receive benefit for that condition. Pre-existing conditions will not affect any voluntary increases in your level of cover, as long as you voluntarily increase your level of cover within 30 days of your company-sponsored scheme beginning. If you want to voluntarily increase your level of cover after the first 30 days, pre-existing conditions will not be covered and we will ask you to fill in a health declaration form. We will then tell you about any conditions that are not covered at the higher level. Exclusions for pre-existing conditions may apply to the following benefits only:
 - Combined physiotherapy
 - Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- 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 our 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 on page 8
- Should you leave the company that offers this Classic Plan you will no longer be eligible for the scheme however, we do have other schemes which may be beneficial to yourself

Duration of cover

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

Contributions and benefits

All contributions 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 contacting us.

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 have increased your level of cover and you pay the additional amount via payroll deduction, 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 may 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 valid, we will credit your bank account usually within three working days of us processing your claim.

If you are claiming for an excess payment in connection to private medical insurance your claim procedure will be different. Please contact 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.

We have our own internal complaints procedure but if you can't settle your complaint with us you may be entitled to refer it to the Financial Ombudsman Service. You can write to them at Financial Ombudsman Service, Exchange Tower, London, E14 9SR or call them on 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.

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

General Terms and Conditions for the Health Shield Classic Health Cash Plan

These are the terms and conditions for the Classic Health Cash Plan. You should read them with the policy summary, which you can find at the start of this document. These terms 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.

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

If you need any further guidance or support, please visit www.healthshield.co.uk/contact-us/ or contact our friendly customer care team on 01270 588555.

Definitions

Some of the words we use within this document have a specific meaning. This section will help you to understand what we mean when we use these terms.

'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 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 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 under the age of 18 and are living at home and studying full-time.

'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 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 tests.

'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 Health Shield Classic Scheme membership plan and the long-term insurance cash benefit plan described in these terms and conditions.

'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.

'Resident in the UK' – having your current, permanent address in the UK.

'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 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 the Health Shield Classic Scheme membership plan ('the plan') or increase your level of cover, you must be employed by a UK-based company that agrees to pay a contribution on your behalf. You must be resident in the UK and be between 16 and 70 when you apply. As long as your employer continues to sponsor you, membership can continue after your 70th birthday.

The plan allows you to cover your partner. There is an extra cost for this, as shown in the benefit table in the membership plan. Dependent children up to the age of 18 who are living at home and studying full-time are covered at no extra cost. Your partner and any dependents need to be registered at the same address as you.

To cover your partner and dependants you must fill in the relevant form in your welcome pack so that we can officially register them. You, your partner and any dependent children can only be covered or included in one Health Shield cash plan at any one time.

Once a member, you can remain on the plan until:

- You decide to leave your employer
- Your employer ceases to offer the plan

Pre-existing conditions

If you are a new member who has a pre-existing condition, you will be entitled to receive benefit for that condition. Pre-existing conditions will not affect any extra voluntary increases in your level of cover, as long as you voluntarily increase your cover within 30 days of your company-sponsored scheme beginning.

If you want to voluntarily increase your level of cover after the first 30 days, pre-existing conditions will not be covered and we will ask you to fill in a health declaration form. We will then tell you about any conditions that are not covered at the higher level.

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

- Combined physiotherapy
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans

Contributions and benefits

Your benefits and top-up contributions are set out in the benefit table in your membership plan.

We will refund the appropriate percentage of each valid claim (as shown in the benefit table) up to your annual benefit limit.

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

Ending your membership

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

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 repeatedly made claims which threaten our financial wellbeing;
- you have behaved in a threatening or abusive way towards any member of staff; or
- your continued membership may have a negative effect on other members or our organisation as a whole.

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 registered to the membership of another person.

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

We may also 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 will take legal action as a civil matter. Once we have given notice to our lawyers, you will no longer have the option to communicate directly with us.

We are committed to preventing financial crime and we may report instances of fraud or attempted fraud to the police. Our procedures for dealing with 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 and procedures 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);
- fail to tell us if the claim has been or could be covered on another Health Shield policy; or
- claim for a pre-existing medical condition that isn't covered on your policy, or a medical condition that you should have told us about when you applied for cover.

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.

If we end your membership due to fraud, you may have to declare it when you apply for any other type of insurance in the future.

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).
- 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 up to the age of 18 who are living at home and studying full-time are covered at no extra cost. The maximum benefit (as shown in the benefit table) is available over a one-year benefit period and is shared between all your registered dependent children except for the following benefits:

- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Personal Accident Protection.

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 your annual benefit allowances.

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 order 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 your final contribution covers you for. For clarification of this date please contact us.

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 receive a special immediate benefit concession. This means we will overlook the normal qualifying periods, 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
- Vasectomies, sterilisation, IVF, fertility treatment and examinations
- 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
- Internet, telephone, couples' or group consultations
- Treatments carried out in the workplace or arranged through your employer
- Any costs covered by private medical insurance other than any excess. This is covered under the specialist consultation benefits up to your available allowance.

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 sports 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 your welcome pack. You must be an active member to claim and your membership will end once your contributions stop.

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 send us 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 lost in the post.

You should make sure that the provider of the service or treatment includes the following details on the original receipts or documents.

- 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
- 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 signing the claim form, you declare that the details you have provided on it 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 keep them.

We aim to process your claim within **two business days**. If we accept your claim, we will credit your bank account usually within **three business days** of us processing your claim. 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

We recommend you 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. You can also ask us to send you a list by calling 01270 588555. 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.

- Chiropody
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Health and wellbeing
- Combined physiotherapy

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 send in, 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:

- Dental
- Optical
- Combined physiotherapy (the qualification or accreditation of the practitioner may be an international equivalent)
- Personal accident protection

What benefits are not covered:

- Chiropractic
- Health and wellbeing and health screening
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans
- Dental accident

Also see the 'Exclusions' section on page 10.

Benefit Terms

Please review the 'How to claim' section on page 11 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.

Dental

We will pay benefit, at the appropriate rate and 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 white fillings
- Dental veneers
- Dentures or repairs to dentures at dental laboratories
- Hygienist fees
- Orthodontic and periodontal treatment
- X-rays

What is not covered

- Missed appointments or administration charges
- Teeth-whitening
- Purchased items (for example, toothbrushes, mouthwash, dental floss)
- Gumshields or other dental items which you have bought independently
- Dental insurance premiums
- Dental prescription charges
- At-home impression kits for teeth-straightening or dental braces
- Dental check-up and treatment charges resulting from a dental accident (we cover these charges under the dental accident benefit, please see page 19)

Also see the 'Exclusions' section on page 10.

Optical

We will pay benefit, at the appropriate rate and 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 payment.

If you have bought contact lenses or glasses, you must provide proof of purchase showing that these are prescription items. For online purchases, as well as providing proof of purchase as above you must also send 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 contact lenses
- Contact lens check-ups
- Contact lens cleaning solutions to be used with your prescribed contact lenses
- Eyesight tests or scans provided at an opticians
- Prescribed lenses you buy separately to fit to existing frames
- Prescribed glasses including sunglasses, safety glasses or swimming goggles
- Prescribed magnifying glasses
- Repairs to prescribed glasses

What is not covered

- Insurance premiums
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses)
- Glasses and contact lenses you have bought independently
- Other purchased items (for example, glasses cases and eye drops)

- Frames you buy separately, unless prescribed lenses are fitted at an opticians
- Laser-eye surgery

Also see the 'Exclusions' section on page 10.

Chiropody

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person entitled to benefit receives one of the covered treatments 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
- 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
- Pedicures as part of beauty treatments

Also see the 'Exclusions' section on page 10.

Health and wellbeing and health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person entitled to benefit receives one of the covered treatments 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 11 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 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
- 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
- Vega testing
- 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
- Internet, telephone, couples' or group consultations

Also see the 'Exclusions' section on page 10.

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

We will also pay benefit at the appropriate rate and 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 permanent health-screening clinic 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 through your employer
- Health screens carried out for employment, emigration, legal or insurance reasons
- Health screens carried out in a mobile or non-permanent facility (for example, a hotel, hired venue or vehicle)

Also see the 'Exclusions' section on page 10.

Combined physiotherapy

We will pay benefit, at the appropriate rate and 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 form 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 11 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
- 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
- Pre-existing conditions
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment
- Prescription charges
- Private medical insurance excess (this may be covered under the specialist consultation benefit)
- Group sessions or classes (for example, Pilates)

Also see the 'Exclusions' section on page 10.

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 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 at the appropriate rate and 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, pathology fees, MRI scans, Mammograms, CT scans and ultrasounds carried out in an appropriate department of a hospital or as part of the consultation.

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

On the claim form, 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 and ultrasounds carried out in an appropriate department of a hospital or as part of the consultation.
- Radiologist reports
- Biopsy fees
- 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 registered medical practitioner
- Private medical insurance (PMI) excess. If a claim has been settled by a PMI provider, we can only pay benefit (up to the appropriate maximum) for any remaining excess if you have the PMI excess bolt-on. 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 (we cover these under the health and wellbeing benefit)
- Fees for private antenatal scans
- Private hospital charges (for example, theatre and room fees)
- Pre-existing conditions
- 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 as part of the consultation
- Consultations for cosmetic procedures for non-medical reasons
- Batteries for hearing aids
- Contract schemes for hearing aids
- Purchased items and consumables
- Dental check-ups, orthodontic and periodontal treatment (these are covered under the dental benefit)

Also see the 'Exclusions' section on page 10.

Dental accident

We will pay benefit, at the appropriate rate and 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. 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 white fillings
 - Dental veneers
 - 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
- Dental insurance premiums
- Joining fees and practice-plan premiums
- Dental treatment you receive for an accident which happened before you joined the plan
- Dental accident and related treatment that has taken place outside the UK

Also see the 'Exclusions' section on page 10.

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 (except air travel)
- Carrying out duties in one of the armed forces, including the Army Reserve

Also see the 'Exclusions' section on page 10.

MyWellness

Health Shield membership allows you exclusive access to a list of extra services. These services include a 24/7 counselling and support Helpline, GP anytime, online health assessments 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 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.

This is a Financial Promotion



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To ensure we're doing a good job, we may monitor or record calls.

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