health shield

The best of health

Corporate Health Cash Plan Policy Document

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The Health Shield Corporate 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, prescriptions 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

- You can choose from a range of benefit levels
- Must be resident in the UK and be between the age of 16 and 70 when you apply to join
- Provide cover for your partner (at an additional cost) and dependent children up to the age of 21 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) and separate annual benefit allowances for dependent children
- Benefit limits are refreshed at the beginning of each benefit year with the exception of family planning and critical illness benefits which are lifetime allowances which can only be claimed once. 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 except for hospital benefits

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
- From the date you make your first contribution you will be covered for the following benefits only:
  - Overnight admissions to hospital as a result of an accident
  - Personal accident protection
  - Services available on MyWellness, see page 28 for more details on MyWellness.
- Qualifying periods for some benefits apply when you apply to join the plan, or if you are an existing member applying to increase your level of cover. This means that you will have to wait until the applicable qualifying period has expired before you can claim those benefits at the higher level. The qualifying periods are as follows:
  - 40 weeks after your first or increased contribution for maternity and adoption benefit and all benefits connected with maternity; and
  - 13 weeks after your first or increased contribution for all other claims
- If you apply to join the plan or you are an existing member applying to increase your level of cover, you will not be entitled to receive benefit for any pre-existing condition(s). Once notified we will write to you separately if any exclusions apply to your membership. Exclusions for pre-existing conditions apply to the following benefits:
  - Hospital inpatient
  - Hospital day surgery
  - Parental hospital stay
  - Combined physiotherapy
  - Specialist consultation, ECG, x-ray, pathology fees and MRI Scans
  - Critical illness cover
  - Sickness and accident protection cover
- 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 ad-vantage of higher benefit levels at limited additional cost in membership contributions). Please see 'Ending your membership' section on page 8
- If you opt to be covered on the Prestige level, the following apply to the additional benefits:
  - Critical illness cover is payable up to the age of 65 and payable only once during the lifetime of the 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
  - Certain prestige level benefits are not available for dependent children
- Should you leave the company that offers this Corporate 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 pay for your Health Shield membership via payroll deduction, 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 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 Corporate Health Cash Plan

These are the terms and conditions for the Corporate 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 21 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 Corporate 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 Corporate Health Cash Plan (the plan) you must be resident in the UK and be aged between 16 and 70 when you apply. You must also be permanently employed and receiving a regular wage from a UK-based company that offers the plan.

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 21 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 you are a member, you can remain on the plan until:

- you decide to leave your employer; or
- your employer no longer offers the plan.

Pre-existing conditions

If you apply to join the plan you will not be entitled to receive benefit for any pre-existing condition. 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.

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

Contributions and benefits

Your contributions and benefits 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. This does not include the family planning and critical illness benefits 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 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 21 who are living at home and studying full-time are covered at no extra cost. Each registered dependent child has their own separate allowance to use, on the same level of cover and benefit year as you. Please see the benefit table in the membership plan for details of what benefits dependent children can claim for.

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

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
- Services available in MyWellness. See page 28 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 or after the date you increase your level of cover for the maternity or adoption benefit; and
- 13 weeks after your start date for all other benefits.

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 for Prestige-level members)
- 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
- 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

The benefit year runs from 1 January to 31 December each year. 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
- Family planning (Prestige level only)
- Fitness (Prestige level only)

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

What benefits are not covered

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

Also see the 'Exclusions' section on page 11.

Benefit terms

Please read the 'How to claim' section on page 12 before going for treatment or sending us a claim. We will only assess claims for treatments and purchases that are listed in 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
- Tooth-whitening treatment provided by the dentist
- X-rays

What is not covered

- Missed appointments or administration charges
- Purchased items (for example, toothbrushes, mouthwash, dental floss)
- Gumshields or other dental items which you have bought independently
- Dental insurance premiums
- Dental prescription charges (we cover these charges under the prescriptions benefit)
- 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 22)

Also see the 'Exclusions' section on page 11.

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
- 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 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

Also see the ‘Exclusions’ section on page 11.

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 (we cover these charges under the prescriptions benefit)
- Pedicures as part of beauty treatments

Also see the 'Exclusions' section on page 11.

Prescriptions (for each item)

We will pay benefit at the appropriate rate and 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 the NHS cash equivalent for private prescription charges
- An NHS prepayment certificate up to the appropriate maximum of individual prescription items
- Dental, combined physiotherapy and chiropody prescription charges

What is not covered

- Charges above the current rate set out in the NHS prescription pricing structure

Also see the 'Exclusions' section on page 11.

Health and wellbeing

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 12 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 11.

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

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 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 11.

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 12 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 (this may be covered under the prescriptions benefit)
- 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 11.

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 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 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
- 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
- Permanent stays in hospital
- Pre-existing conditions

Also see the 'Exclusions' section on page 11.

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
- 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)
- Psychiatric treatment
- Pre-existing conditions

Also see the 'Exclusions' section on page 11.

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 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
- 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
- Permanent stays in hospital
- Pre-existing conditions

Also see the 'Exclusions' section on page 11.

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. 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 (see maternity and adoption benefit)
- 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 11.

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 (we cover these charges under the prescriptions benefit)
- 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 11.

Maternity and adoption

You must have been covered by the scheme for 40 weeks before you are entitled to claim this benefit. The 40-week qualification period also applies when existing members have increased their level of cover. Please see the 'Qualifying periods' section on page 10 for more information.

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 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 claim form and provide a copy of the adoption certificate or parental order.

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
- 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
- The pregnancy of a partner who is not registered with us and does not live with you

Also see the 'Exclusions' section on page 11.

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

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 11.

Extra benefits for Prestige-level members

Family planning (Prestige level only)

We will pay benefit to you and your partner (if they are covered), at the appropriate rate and 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 form, 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
- Private vasectomy fees

What is not covered

- Family planning benefit for dependent children
- Contraceptives

Also see the 'Exclusions' section on page 11.

Critical illness (Prestige level only)

We will pay critical illness benefit at the appropriate rate if critical illness is diagnosed after the end of the 13-week qualifying period. We will not pay more than £2,000 as a result of a critical illness. We will only pay critical illness benefit to any person once during their lifetime. Critical illness benefit does not apply to anyone aged 65 or over 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
  - Any skin cancer, other than malignant melanoma
- Heart attack – when a part of the heart muscle dies as a result of not receiving enough blood. It will cause chest pain, new electrocardiograph changes and an increase in cardiac enzymes.
- Coronary artery bypass surgery – open heart surgery, recommended by a consultant cardiologist, that uses bypass grafts to correct one or more coronary arteries that have narrowed or become blocked. Non-surgical procedures, such as balloon or stent angioplasty or laser treatments, are not included.
- Kidney failure – where both kidneys fail to work and, as a result, you begin regular kidney dialysis or have a kidney transplant. We will pay critical illness benefit if you need a kidney transplant and you have been included on an official UK waiting list.
- Major organ transplant – the transplant of a heart, liver, lung, pancreas or bone marrow, or being included on an official UK waiting list to receive an organ.
- Motor neurone disease – confirmation by a consultant that you have been diagnosed with motor neurone disease.
- Multiple sclerosis – a definite diagnosis by a consultant neurologist of multiple sclerosis that meets all the following conditions.
- The movement of your muscles, or your physical senses, must currently be weakened, and have been weakened for a continuous period of at least six months.
- The diagnosis must be confirmed by diagnostic techniques that are widely used at the time you make your claim.
- Stroke – permanent neurological (nerve) damage to the brain caused by an interruption to its blood supply. Transient ischaemic attacks (temporary interruptions to the brain's blood supply) or episodes resulting in temporary neurological symptoms are not included.

What is not covered

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

Also see the 'Exclusions' section on page 11.

Sickness and accident protection cover (Prestige level only)

You or your partner (if covered) must have been covered by the scheme for 13 weeks before you are entitled to claim this benefit, and the cause of your absence must have started after this date. 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.

Your Prestige-level contributions are covered for up to 12 months when a person entitled to benefit is continuously off work for at least 30 days, due to being unfit for work following:

- sickness; or
- accidental injury.

By 'unfit for work', we mean being totally prevented from carrying out your normal job or work

as a result of an accidental bodily injury or sickness, as confirmed by a registered medical practitioner, that takes place after the start date of your plan. 'Normal job or work' means paid work of at least 16 hours a week that you carry out immediately 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
- HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS)

Also see the 'Exclusions' section on page 11.

Fitness and exercise (Prestige level only)

As a Prestige member you, your partner and dependent children (if covered) also have access to £100 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
- Club or association membership fees

MyWellness

Your 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, cancer screening, 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 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/customers** 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.

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