

**FLEX EXTRA HEALTHCARE MEMBERSHIP PLAN - TABLE OF CONTRIBUTIONS AND BENEFITS 2009 - 2010**

LEVEL OF COVER	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	PRESTIGE LEVEL
MONTHLY PAYMENTS FOR YOU (Includes benefits for dependent children)	£8.00	£16.25	£26.25	£32.95	£47.25
MONTHLY PAYMENTS FOR YOU AND YOUR PARTNER (Includes benefits for dependent children)	£15.40	£32.10	£52.00	£65.65	£94.05
ALL CONTRIBUTIONS AND BENEFITS ARE SUBJECT TO AN ANNUAL REVIEW					
DENTAL MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£60	£120	£160	£205	£270
DENTAL ACCIDENT MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£200	£400	£600	£800	£1000
OPTICAL MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£60	£120	£160	£205	£270
HOSPITAL BENEFITS: ADULT & CHILD RATES - HOSPITAL INPATIENT (PER NIGHT) - HOSPITAL DAY-CASE (PER DAY) UP TO A MAXIMUM OF 25 NIGHTS/DAYS PER YEAR, PLUS ANY ADDITIONAL COSTS FOR COMPLETION OF CLAIM FORMS ARE COVERED	£20	£45	£65	£85	£110
PARENTAL HOSPITAL STAY UP TO A MAXIMUM OF 25 NIGHTS PER YEAR, PLUS ANY ADDITIONAL COSTS FOR COMPLETION OF CLAIM FORMS ARE COVERED	£20	£45	£65	£85	£110
MATERNITY - ANTENATAL APPOINTMENT A SINGLE SUM PAYMENT	£150	£300	£560	£695	£900
PHYSIOTHERAPY, CHIROPRACTIC, OSTEOPATHY, ACUPUNCTURE AND HOMOEOPATHY MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£120	£280	£370	£500	£640
SPECIALIST CONSULTATION, ECG, X-RAY, AND PATHOLOGY FEES MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£120	£210	£315	£420	£520
CHIROPODY MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£60	£120	£160	£205	£270
HEALTH & WELLBEING: COMPLEMENTARY THERAPIES FOR ALLERGY TESTING, STRESS RELIEF, WEIGHT MANAGEMENT AND STOP SMOKING MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£60	£120	£160	£205	£270
HEALTH SCREENING MAXIMUM FOR EACH PERSON 100% CASHBACK REFUND	£60	£120	£160	£205	£270
PERSONAL ACCIDENT PROTECTION	£5000	£10000	£15000	£20000	£25000
PRESCRIPTIONS - PER ITEM MAXIMUM FOR EACH ADULT	1	2	3	4	5
FITNESS BENEFIT	ACCESS TO SPECIAL RATES				PLUS £100
WORLDWIDE COVER	HEALTH SHIELD COVERS YOU FOR ALL BENEFITS ANYWHERE IN THE WORLD				
24 HOUR FREEPHONE TELEPHONE HELPLINE - COUNSELLING & LIFESTYLE, HEALTH & MEDICAL AND LEGAL ADVICE	24 HOURS A DAY, 7 DAYS A WEEK ACCESS TO TELEPHONE HELPLINES FOR ALL MEMBERS				
FAMILY PLANNING MAXIMUM FOR EACH ADULT 100% CASHBACK REFUND	<b>EXTRA BENEFITS EXCLUSIVE TO PRESTIGE LEVEL MEMBERS</b>				£500
CRITICAL ILLNESS COVER MAXIMUM FOR EACH PERSON					£2000
SICKNESS AND ACCIDENT PROTECTION					CONTRIBUTION PROTECTION FOR SICKNESS & ACCIDENT
The above benefits are the maximum levels which apply for 2009 - 2010. For later years, both the type of benefit, benefit levels and contribution rates may change in future. (Please see your membership plan for more details).					

## Immediate benefit\*

### For all NEW members and members who increase their level of cover

Each year the cost of basic healthcare is rising fast. Just think of the cost of dental care fees alone, and glasses or contact lenses if you wear them. Then there's the cost of physiotherapy, chiropody and other therapies with limited or no availability on the NHS. Thousands of Health Shield members receive cashback on all these bills - so why miss out?

### Pre-existing conditions waived - no health declaration required\*\*

Your Flex Extra Scheme membership will cover pre-existing conditions. Existing members must renew their membership under the flexible benefits scheme terms and conditions to take advantage of this offer.

### We believe that Health Shield offers an excellent package of benefits, take a look at what we can offer:

- '100% refund' towards dental, dental accident, optical, physiotherapy, specialist consultation and chiropody treatment costs – subject to an annual review and up to your chosen limits
- Cash maximums that are refreshed every year
- Physiotherapy benefit also covers Acupuncture, Chiropractic, Osteopathy and Homoeopathy
- Health & Wellbeing benefit also covers Acupressure, Allergy testing, Aromatherapy, Bowen/Alexander technique, Chair massage, Colonic hydrotherapy, Hopi ear candles, Hypnotherapy, Indian head massage, Kinesiology, Naturopathy, Nutritional therapy, Reflexology, Reiki, Remedial massage, Shiatsu and Sports massage
- Cover available for you or you and your partner
- Cover provides separate annual maximums for yourself, your partner (if covered) and all dependent children up to the age of 18
- Quick payment of claims – by cheque or direct credit
- Personal Accident Protection included
- Worldwide Cover
- 24 hour FREEPHONE telephone helpline – Counselling & Lifestyle, Health & Medical and Legal Advice available
- Access to preferential corporate rates for a network of health clubs
- Dependent children covered on both Cover for You and Cover for You and Your Partner
- Authorised and regulated by the Financial Services Authority

Telephone 01270 588555  
www.healthshield.co.uk

\*Offer excludes maternity - antenatal appointment and all benefits connected with maternity.

\*\*Offer excludes critical illness and sickness and accident protection cover.

# Flex Extra 2009

## Terms and conditions for the Health Shield Flex Extra Scheme membership plan

### Age limits and changing your level of cover

If you want to join the Health Shield Flex Extra Scheme membership plan ('the plan') or increase your level of cover, you must be between 16 and 64 (that is, not yet 65) when you apply and be employed by a company that offers the Health Shield Flex Extra Scheme.

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

### Definitions

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

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

'Dependent children' – your or your partner's children or legally adopted children who are under the age of 18, in full-time education and living at home.

'Membership plan' ('the plan') – the Health Shield Flex Extra Scheme membership plan, and the long-term insurance cash benefit plan described in these terms and conditions. The plan is registered in a single name only (that is, your name), although cover may also be provided for your partner and dependent children, if this applies.

'Partner' – your husband, wife or any other person who lives with you as if you are married, no matter whether they are male or female.

'Pre-existing condition' – any disease, illness or injury that you have received medication, advice or treatment and experienced symptoms for, no matter whether the condition has been diagnosed before the start of your cover.

'Surplus' – any money left over after meeting claims and expenses during the financial year.

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

### Qualifying periods

You will receive a special immediate benefit cover concession. Normal qualifying periods will be waived allowing you and your partner (if covered) instant access to benefits with the exception of maternity - antenatal appointment benefit and all benefits connected with maternity, which has a 13-week qualifying period.

### Your membership

The terms of your new plan, including the benefit and contribution levels, completely replace those of any previous Health Shield membership.

If you apply to join the plan, or you are an existing member applying to increase your level of cover, and you have a pre-existing condition, you will be entitled to receive benefit for that condition except for critical illness and sickness and accident protection cover.

You will be entitled to receive the maximum benefit if your contributions are up to date.

To make claims for a partner, you must be contributing to the plan at the rate that covers you and your partner. You must have filled in the appropriate forms so we can officially register your partner (if they are covered) and dependent children. You, and your partner and dependent children (if this applies), may only be covered or included in one membership plan.

We will write to you to tell you about any changes to the terms and conditions of your membership plan. You can get a copy of the rule book from our Chief Executive or from the members' area of our website at [www.healthshield.co.uk](http://www.healthshield.co.uk). To make sure that we can provide high levels of customer service, we may monitor or record phone calls.

### Contributions and benefits – yearly review

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

For your flexible benefits scheme year agreed within 2009 - 2010, we will refund 100% of each valid claim up to your yearly benefit limit. This is also our aim for future years, although this will depend on our performance and claims experience in the future.

As a result, we will review all benefits and contributions each year and we may make changes to them. If this leads to a reduction in the benefits we pay you in the future, we will tell you, but the percentage of each claim we refund is guaranteed to be 70% of the rates published for the relevant year. We will also apply this percentage reduction to the maximum amount shown in the benefit table.

During the lifetime of this contract, it is important you understand that if our overall claims experience, position in the marketplace or surplus are worse than expected, we may increase your contribution rates, or reduce, change or remove any benefit.

However, if our overall claims experience, position in the marketplace or surplus are better than expected, we may be able to improve your terms.

### General exclusions

We cannot pay benefit for any claims directly related to:

- emigration, legal, insurance or similar matters;
- GP fees for private treatment;
- examinations at medical centres;
- drugs and medicines;
- vasectomies, sterilisation, IVF, fertility treatment and examinations (not including the Family Planning benefit for Prestige-level members); and
- pregnancy terminations, contraceptives, sex-change operations or cosmetic surgery.

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

- drug, alcohol or solvent abuse; or
- taking drugs (unless you have been told to by a registered medical practitioner).

If you live in the Republic of Ireland, we do not cover the first £5 a year for receipt-based claims. We can only pay claims for these benefits once a year.

### Claims

We will deal with claims on the day we receive them, but we cannot accept photocopied or faxed receipts and claim forms. You should include the following details on the original receipts.

- The date you received treatment
- The full name and title (Mr, Mrs, Ms or Miss) of the person who has received the treatment
- The official stamp and qualifications of the dentist, optician, chiropodist, physiotherapist, consultant and so on

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

The benefit year of your membership plan will be confirmed in your welcome letter. As a member, you will not receive more than the maximum benefit amount under any of the benefit rules for yourself, your partner (if they are covered) or dependent children in each case for any one benefit year. We treat claims in a benefit year according to the dates you (or your partner or dependent child) were admitted to hospital or received treatment, whichever applies.

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

As a member, you agree to us processing personal and sensitive information about you. The member must also sign all claim forms to declare that the details you have provided on the forms are true, and to allow us to get independent confirmation of the details from the healthcare provider the claim relates to.

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

### Benefit rules

#### Dental

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

When you send the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment.

What is covered

- Anaesthetic fees
- Check-up charges
- A dental brace or gum shield provided by the dentist
- Dental practice plan premiums and joining fees (for example, Denplan)
- Dental crowns, bridges and white fillings
- Dental veneers
- Dentures, or repairs to dentures at dental laboratories
- Hygienist fees
- Orthodontic and periodontic treatment
- Tooth whitening treatment provided by the dentist
- X-rays

What is not covered

- Cancellation charges made by the dentist (for example, for missed appointments)
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on)
- Dental prescription charges. We cover these charges under the 'Prescriptions' benefit.

#### Dental accident

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, for dental treatment you need as a result of an accidental injury to your teeth. The injury must have been caused by a direct impact to the head.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment. You must also provide full details of the accident. Your dentist must fill in and sign the claim form confirming the date of the accident and that the treatment received is as a result of that accident. We treat dental accident claims in a benefit year according to the date of accident.

What is covered

Dental treatment directly related to an accident (for example, a sports injury or a fall), including the following.

- Anaesthetic fees
- Dental crowns, bridges and white fillings
- Dental veneers
- Replacement dentures or repairs

What is not covered

- Cancellation charges made by the dentist (for example, for missed appointments)
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on)
- Dental prescription charges. We cover these charges under the 'Prescriptions' benefit.
- Dental practice plan premiums and joining fees (for example, Denplan)
- Any treatment you receive 12 months after the date of the accident
- Dental treatment you receive for an accident which happened before you joined the plan

#### Optical treatment

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

When you send us the claim form, you must also send us an original, fully-itemised receipt.

What is covered

- Contact lenses (permanent or disposable)
- Contact lenses (permanent or disposable), when you buy them by monthly direct debit
- Contact lens check-ups
- Contact lens solutions (including if you buy these separately)
- Eye laser surgery to correct long- and short-sightedness
- Eyesight tests
- Frames you buy separately
- Lenses you buy separately to fit to existing frames
- Lenses supplied under an optical insurance plan
- Prescribed glasses
- Prescribed magnifying glasses
- Repairs to glasses
- Sunglasses, safety glasses and swimming goggles (as long as they have prescribed lenses)

What is not covered

- Insurance premiums
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses)
- Optical consumables (for example, contact lens and glasses cases)

#### Hospital benefits

We combine hospital inpatient and hospital day-case benefit payments. The maximum period for receiving combined daily or nightly rates of benefit is 25 nights in any one benefit year for each person.

#### 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 or hospice.

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

**What is covered**

- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, from one to 25 nights, for a medical condition to be treated or investigated
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim

**What is not covered**

- Attending accident and emergency
- Child inpatient benefit for the first 10 nights after the birth
- Clinics, medical centres or nursing homes
- Hospital accommodation for an elderly person who is not able to live independently
- Maternity cases – we will only pay benefit after the first 10 overnight stays as an inpatient
- Maternity-related admissions for dependent children
- Outpatient treatment
- Permanent stays in hospital

**Hospital day-case admission**

We will pay benefit at the appropriate day-case rate for the period a person is admitted for day-case treatment in a recognised hospital without an overnight stay.

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

**What is covered**

- Any day-case admission in an NHS hospital, private hospital or registered treatment centre, from one to 25 days, to have a medical condition treated or investigated under anaesthetic
- Operations which are cancelled after you have been admitted to hospital
- Invasive investigative procedures (for example, a colonoscopy)
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim
- Outpatient treatment carried out under anaesthetic
- Outpatient treatment for chemotherapy
- Outpatient treatment for kidney dialysis
- Outpatient treatment for oncology
- Outpatient treatment for radiotherapy

**What is not covered**

- Attending accident and emergency
- Clinics
- Elderly care
- Hospice day care
- Maternity admissions
- Outpatient appointments or treatments that are not covered above
- Pre-admission appointments (appointments before you are admitted to hospital)
- Medical centres
- Nursing homes
- Psychiatric treatment

**Parental hospital stay**

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

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

**What is covered**

- Any period of overnight stay in a hospice, an NHS hospital, a private hospital or a registered treatment centre, from one to 25 nights, where one parent stays with their registered child
- An adoptive parent staying with their registered child
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim

**What is not covered**

- Attending accident and emergency
- Clinics, medical centres or nursing homes
- More than one parent staying with their child
- All maternity-related admissions
- Outpatient treatment
- Permanent stays in hospital

**Maternity – antenatal appointments**

We will make a one-off payment, up to the appropriate maximum in any one benefit year, for an NHS or private antenatal scan carried out by medically qualified staff at a hospital, GP surgery, registered clinic or service.

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

**What is covered**

- An NHS or private antenatal scan carried out by medically qualified staff at a hospital, GP surgery, registered clinic or service

- Fees for filling in claim forms or certificates, as long as you provide an official receipt with your claim

We will only make one payment in any one benefit year.

**What is not covered**

- Attending accident and emergency
- Antenatal appointments for dependent children
- Medical centres
- Nursing homes
- A partner who is not registered with us

**Physiotherapy, chiropractic, osteopathy, acupuncture and homoeopathy**

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person receives treatment to relieve and prevent an illness or pain, from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of the treatment. The claim form must include the reasons for the treatment, and the type of treatment provided.

**What is covered**

- Acupuncture
- Appliances (for example, lumbar rolls and back supports) prescribed and supplied by your practitioner as part of the treatment
- Chiropractic
- Homoeopathy
- Osteopathy
- Physiotherapy
- X-ray, when necessary as part of the treatment

**What is not covered**

- Any treatment, provided by a practitioner who is recognised by us, which is not listed above
- Appliances (for example, lumbar rolls and back supports) not prescribed and supplied by your practitioner as part of the treatment

**Specialist consultation fees, electrocardiogram (ECG), X-ray, and pathology fees**

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person has a specialist consultation or treatment from a medically qualified person who specialises in a field of medicine. The specialist does not have to hold a consultant position in a hospital, but must be a member, fellow or licentiate (licence-holder) of one of the Royal Colleges (or their international equivalent). This benefit also refunds costs you would have to pay for an ECG or X-ray, and pathology fees charged to you at the appropriate department of a hospital or as part of a consultation.

You must send us an original receipt, showing the qualifications of the physician or surgeon. On the claim form, you must fill in the reason for the consultation, treatment or tests.

**What is covered**

- Counselling fees
- Hearing aids provided by a registered hearing-aid supplier
- Investigative procedures (for example, colonoscopy, sigmoidoscopy)
- Medical tests, including ECG, EEC and lung function tests
- Pathology and biopsy fees
- Physicians' or surgeons' operation fees
- Speech therapy, dyslexia and dyspraxia treatment
- X-ray, including mammograms, CT scans, ultrasounds and MRI scans

**What is not covered**

- Anaesthetists' fees
- Medical examinations and reports
- Private antenatal scans
- Private hospital charges (for example, theatre and room fees)

**Chiropody**

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, for chiropody treatment from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of your treatment.

**What is covered**

- Assessments (for example, gait analysis, which is an analysis of how you walk)
- Chiropody treatment
- Orthotics supplied by the chiropodist or podiatrist at the time of the treatment (for example, arch supports)
- Podiatry treatment

**What is not covered**

- Consumables (for example, corn plasters or insoles) that are not bought as part of the treatment
- Surgical footwear
- X-rays

**Health and wellbeing (including complementary therapies for allergy testing, stress relief, weight management and treatment to stop smoking)**

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person receives treatment related to their health and wellbeing, or treatment to relieve and prevent an illness or pain, from a practitioner who is a member of an approved professional organisation.

When you send us the claim form, you must also send us an original, fully-itemised receipt, showing the separate dates of the treatment. The claim form must include the reasons for the treatment, and the type of treatment provided.

**What is covered**

- Acupressure
- Allergy testing, including food intolerance and nutrition tests
- Aromatherapy
- Bowen and Alexander techniques
- Chair massage
- Colonic hydrotherapy
- Hopi ear candles
- Hypnotherapy
- Indian head massage
- Kinesiology
- Massages (for example, sports and remedial)
- Naturopathy
- Nutritional therapy
- Reflexology
- Reiki
- Shiatsu

**What is not covered**

- Vega testing
- Laboratory testing not referred by a doctor
- Hair analysis
- Home testing kits
- Any treatment, provided by a practitioner recognised by us, which is not listed above
- Appliances (for example, lumbar rolls and back supports)
- Stop-smoking patches, gum and so on
- Weight management programmes (for example, Weight Watchers)

**Health screening**

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, for a full health screen. The health screen must be used to help prevent an illness.

When you send us the claim form, you must also send us an original, dated and fully-itemised receipt.

**What is covered**

- A full health screen carried out by medically qualified staff at a hospital, registered health screening clinic or service
- Well Man and Well Woman clinics

**What is not covered**

- Home testing kits
- Screening for employment services
- Tests not included within the full health screen (for example, X-rays and blood tests)

**Personal accident protection**

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

We will not pay more than £25,000 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.

'Permanent total disablement' means a permanent disability that prevents the insured person from carrying out a job.

We will decide, based on medical advice, if we will pay benefit.

Personal accident protection does not cover death or permanent total disablement caused by:

- radioactive contamination;
- taking part in professional sports or flying as a pilot or crew member (that is, aircraft, gliders, hang-gliders, microlights, parachuting, paragliding, ballooning);
- suicide or deliberate injury;
- war, hostilities, invasion or civil war, and full-time active military service; or
- drug, alcohol or solvent abuse, or taking drugs (unless you are told to by a registered medical practitioner).

#### Prescriptions (for each item)

We will pay benefit to you and your partner (if they are covered), at the appropriate rate and up to the appropriate maximum number of items in any one benefit year, for NHS prescription charges (or the NHS cash equivalent).

When you send us your claim form, you must also send us an original, dated and fully-itemised receipt, which you can get from your chemist.

What is covered

- NHS prescription charges or the NHS cash equivalent for private prescription charges
- An NHS prepayment certificate up to the appropriate maximum
- Dental prescription charges

What is not covered

- Charges above the current rate set out in the NHS prescription pricing structure
- We do not pay prescription benefit for dependent children.

#### Fitness benefit

Incorpore's Corporate Fitness Network will give you and your family access to better rates for a network of health clubs and hotels. You can join a health club at the lowest corporate rate available and enjoy special discounts and take advantage of preferred rates on leisure, relaxation and 'pamper' breaks at hotels around the world.

Visit [www.incorpore.co.uk](http://www.incorpore.co.uk) or phone Incorpore's Customer Support Line on 0845 6024601 (quoting reference HEA).

Also, if you are a Prestige-level member, we will contribute up to £100 towards the cost of your yearly health club membership. You must provide an original, dated receipt when you send us your claim form.

#### Worldwide cover

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

#### Family care counselling helpline

You and your family can use our professional telephone service, 24 hours a day, seven days a week. This service provides counselling, support and guidance on a whole range of lifestyle, health and medical and legal problems. You can get advice and counselling from specialist teams of counsellors, lawyers and medical staff. (This service is provided by First Assist Services Ltd.)

If you want to speak to a family-care counsellor, lawyer or medical advisor, call 0800 1079042 and quote scheme number 70840. (This call is free.)

#### Family planning (Prestige level only)

We will pay family planning benefit to you and your partner (if they are covered), at the appropriate rate and up to the agreed maximum. We will only pay family planning benefit to you and your partner (if they are covered) once during your lifetime.

You must send us an original receipt, showing the qualifications of the physician or surgeon. On the claim form, you must fill in the reason for the consultation, treatment or tests.

What is covered

- Private family planning clinics
- Private fertility treatment and examinations
- Private IVF treatment
- Private sterilisation fees
- Private vasectomy fees

What is not covered

- Family planning benefit for dependent children
- Pregnancy terminations
- Contraceptives

#### Critical illness (Prestige level only)

If you, your partner (if they are covered) or your dependent children are diagnosed with a critical illness after the end of the 13-week qualifying period, we will pay benefit at the appropriate rate. 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.

Please call the claims department on 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.
- If the critical illness or surgery is in any way caused by being exposed to chemicals or nuclear material.
- If the critical illness or surgery is in any way caused by drug, alcohol or solvent abuse, or taking drugs (unless you are told to by a registered medical practitioner).
- We will not pay critical illness benefit for claims caused directly or indirectly by you being infected by, or treated for, HIV or any HIV-related illness, including AIDS.

#### Sickness and accident protection cover (Prestige level only)

Please call the claims department on 01270 588555 before you make a claim. Your Prestige-level contributions are covered for up to 12 months when you or your partner (if they are covered) are continuously off work for at least 30 days due to one of the following.

- Sickness
- Accidental injury

Sickness and accident protection cover only applies if you or your partner (if they are covered):

- have completed a qualifying period of 13 weeks;
- are in full-time employment and between the ages of 16 and 64;
- are not aware of any medical treatment or advice you are due to receive; and
- are in good health.

If you suffer a disability, we will pay 1/30th of your monthly contribution, after the first 30 days of your disability, for each consecutive day you are disabled. We will refund benefit every 30 days during your disability, up to a maximum of 12 payments for any one claim.

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

We will not pay disability benefit for any period you are disabled after you have reached the age of 65 (or your retirement date, if earlier).

When we assess the maximum benefit period, we will treat periods of disability resulting from the same cause as being the same period of disability, as long as they are not separated by at least three benefit months before you return to work.

#### Exclusions to sickness and accident protection cover

An exclusion period of 30 days applies to all claims.

We will not pay any amount where the disability happens within the 13-week qualifying period.

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

We will not pay for any period of disability that a registered medical practitioner has not provided medical evidence for. You must pay all the costs involved in getting medical evidence.

We will not pay for any period of disability caused by:

- war;
- attempted suicide;
- you deliberately injuring yourself;
- you being under the influence of alcohol or drugs (other than drugs taken under medical supervision, but not for treating a drug addiction);
- pregnancy, childbirth or any complication connected to these;
- a mental disorder, unless it is investigated and diagnosed by a consultant;
- HIV (human immunodeficiency virus) or any HIV-related illness, including acquired immune deficiency syndrome (AIDS); or
- cosmetic surgery.



The Crystal Mark is only applicable to the Terms and conditions and does not apply to the design and layout of this leaflet.



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