



Connect

Health Cash Plan

About your plan

- Claim money back on your on healthcare bills, subject to annual review
- Fast payment of claims direct to your bank account
- Dependent children covered up to the age of 18 and in full-time education at no additional cost
- Separate annual benefit allowances for you and your partner (if covered). Shared annual benefit allowances for dependent children
- No GP referral required before having treatment
- Worldwide cover available for selected benefits

Log-on to our Members' Area www.healthshield.co.uk/members where you can:

- Update your personal details and check your benefit balance
- Claim online and receive fast payment direct to your account
- Visit **mywellness** to access a range of additional services that help you manage your health and wellbeing needs

Your Monthly Payments

Level of cover and costs			Access Level	Level 1	Level 2	Level 3	Level 4	Level 5
Monthly Payments for You (Includes shared benefits for all dependent children)	Child cover	Level of money back	£8.34	£13.54	£30.28	£45.98	£64.89	£93.93
Monthly Payments for You and Your Partner (Includes shared benefits for all dependent children)			£16.68	£27.08	£60.56	£91.96	£129.78	£187.86

Summary of benefits included

Healthy & Happy								
Dental	✓	100%	£30	£65	£125	£170	£220	£285
Optical	✓	100%	£30	£65	£125	£170	£220	£285
Chiropody	✓	80%	£30	£65	£125	£170	£220	£285
Prescriptions		Per item	1	1	2	3	4	5
Health & Wellbeing	✓	80%	£30	£65	£125	£170	£220	£285
Health Screening	✓	80%	£30	£65	£125	£170	£220	£285
Combined Physiotherapy	✓	80%	£60	£125	£285	£380	£515	£655

Feel Better								
Hospital Benefits ▶ Hospital Inpatient (per night) ▶ Hospital Day Surgery (per day)	✓	Up to a maximum of 25 nights/days per year	£10	£20	£45	£65	£85	£110
Parental Hospital Stay		Up to a maximum of 25 nights per year	£5	£10	£25	£35	£45	£55
Specialist Consultation, ECG, X-ray, Pathology Fees and MRI Scans	✓	80%	£60	£130	£225	£350	£460	£600

Peace of Mind								
Dental Accident	✓	100%	£100	£200	£400	£600	£800	£1000
Maternity - Antenatal Appointment and Adoption		A single payment	£75	£150	£300	£560	£695	£900
Personal Accident Protection	✓	A single payment	£2500	£5000	£10000	£15000	£20000	£25000

My Wellness	
	<p>mywellness provides you with online tools and information to help you to proactively manage your health and wellbeing. Included within your membership plan is access to the following services: GP Anytime including Private Prescriptions, 24/7 Counselling and Support helpline and Online Health Assessments. You can also access PERKS, our rewards website which offers exclusive discounts and money back on shopping, travel and entertainment and much more. For all mywellness services, simply log on at www.healthshield.co.uk/members to find out more.*</p>

The above benefits and allowances are the maximum levels that apply to your plan. The costs, benefits and the benefit level are subject to an annual review and so may change in the future.
*Services may vary.

Terms and conditions for the Health Shield Connect Scheme membership plan

GENERAL TERMS AND CONDITIONS

These are the standard terms and conditions and you should read them with the policy summary document. These terms set out the benefits and level of cover available to you. For more information on how your membership fits into our organisation as a whole, please read our memorandum and rules. These are available on our website, or you can ask for a copy.

You should read and understand these terms. If you don't understand any part then please contact us before going for treatment or sending us a claim.

Who can join?

If you want to join the Health Shield Connect 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.

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. We will tell you about any conditions that are not covered.

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

- Hospital inpatient;
- Hospital day surgery;
- Parental hospital stay;
- Combined physiotherapy;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans.

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

We allow you to change your level of cover once (either increase or reduce it) in each benefit year.

Once you reach the age of 65, you must convert to the Health Shield Connect Plus Scheme.

Your membership

This membership plan is a long-term insurance contract with a term of five years from the date the plan begins.

We will refund the appropriate percentage of each valid claim (as shown in the benefit table) up to your yearly benefit limit. However, during the lifetime of this contract, it is important you understand that if our overall claims experience, position in the marketplace or surplus are worse than expected, we may increase your contribution rates, or reduce, change or remove any benefit. However, if our overall claims experience, position in the marketplace or surplus are better than expected, we may be able to improve your terms. As a result, we will review all benefits and contributions each year and will tell you in advance if a review will lead to a change in the benefits or contributions paid in the future.

To maintain premium and benefit levels, we may transfer a member covered by these terms to a new product by cancelling their existing policy and providing them with a new policy in its place. Where we do this, the new policy will have premiums, benefits and terms and conditions that more fairly reflect the level of claims made by that member.

You, the member, must sign all claim forms to declare that the details you have provided on the forms are true, and to allow us to get independent verification of the details from the healthcare provider the claim relates to. If we believe that any documents you send us are not genuine, we may retain them as part of our investigation.

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

Ending your membership

At any time, our Board of Management can end your membership if they think:

- You have broken our rules;
- Your continued membership may have a negative impact on the interest of our members generally;
- You have repeatedly made claims which threaten our financial wellbeing;
- You have deliberately provided misleading or false information (or not revealed every significant circumstance we ought to know about);
- You have behaved in a threatening or abusive manner towards any member of staff;
- You have made a claim that is fraudulent or that we believe to be deliberately false, misleading or exaggerated.

We will write to you with our reason for cancelling your cover and you have the right to appeal to us.

If we end your membership for one of the reasons given above, we will not accept any future applications you make for Health Shield membership, 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 aim to recover from you any money that we have paid to 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 fraudulent activity adhere to the Insurance Act 2015.

Existing members

If you are an existing member of Health Shield, please note the following.

- This plan completely replaces the terms and conditions of any existing plan;
- The benefits we will pay under this plan may be different to those of your previous plan;
- The benefit year of your previous plan may be different. We may take account of claims paid under your previous plan if we paid them in the current benefit year of the new plan.

How we use your personal data

We collect personal data from you to set up and deal with your Health

Cash Plan. We handle this information in line with data-protection law. For more information on how we use your personal data, please read our privacy policy which is available at www.healthshield.co.uk/privacy/ or email our head office on info@healthshield.co.uk to ask for a paper copy.

Contributions

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

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

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

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

Qualifying period

If you apply to join the plan, or if you are an existing member applying to increase your level of cover, you will become eligible to make claims:

- 40 weeks after your first or increased contribution for maternity-antenatal appointment and adoption benefit and all benefits connected with maternity;
- 13 weeks after your first or increased contribution for all other claims.

From the date you make your first contribution you will be covered for the following benefits only:

- Overnight admissions to hospital as a result of an accident;
- Personal accident protection;
- Services available on mywellness.

Exclusions

We cannot pay benefit for any claims directly related to the following:

- GP fees for private treatment;
- Drugs, medicines and vaccinations (including medicines relating to homeopathic treatment and travel-related vaccines, for example anti-malarial tablets);
- Vasectomies, sterilisation, IVF, fertility treatment and examinations;
- Pregnancy terminations, contraceptives, gender reassignment or cosmetic reasons;
- Any health-screening checks, medical examinations, consultations or reports for employment, emigration, legal or insurance reasons;
- Treatment provided to you by a member of your family, partner or a work colleague;
- Postage and packaging costs;
- Internet, telephone and group consultations;
- Treatments carried out in the workplace or arranged through your employer;
- Treatment while abroad;
- Treatment charges covered by private medical insurance other than any excess (excess fees are covered under the Specialist Consultation allowance).

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

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

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

Benefit period

The benefit year of your membership is confirmed in your policy schedule or welcome pack, or within the Health Shield Members' Area.

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

As a member, you will not receive more than the maximum benefit amount under any of the benefit rules for yourself, your partner (if they are covered) or dependent children in each case for any one 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.

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.

Dependent children

The maximum benefit (as shown in the benefit table) is available over a one-year benefit period and is shared between all your registered dependent children.

Percentage return

We will refund up to 100% of each valid claim (as shown in the benefit table) up to your yearly benefit limit for the following benefits.

- Dental;
- Optical;
- Chiroprody;
- Health and wellbeing;
- Health screening;
- Combined physiotherapy;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Dental accident.

How to claim

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

- The date you received treatment (we cannot pay for anything you have paid for in advance and not yet received);
- The full name and title (Mr, Mrs, Ms or Miss) of the person who has received the treatment;
- The full name, official stamp, qualifications and contact details of the practitioner carrying out the treatment;
- A full description of the treatment received;
- The receipt clearly shows the payment amount and that it has been paid in full.

The receipts must only apply to the amount paid for the person who

received treatment. We need separate receipts for each person covered. We will only pay claims to you direct, not to the healthcare practitioner who provides the receipts.

We pay claims based on the relevant claims year that the treatment or purchase takes place. We will not accept applications for benefit that are more than 12 months old at the time we receive them.

You can send us your claim online via the Health Shield Members' Area or fill in a paper claim form and post it back to us. We aim to process your claim within our agreed service levels as stated in the claims section within the Health Shield Members' Area. If we accept it, we will credit your bank account usually within two working days of processing your claim.

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

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

There is a list of accepted accreditations and qualifications on our website at www.healthshield.co.uk. You can also ask us to send you a list by calling 01270 588555 or emailing info@healthshield.co.uk. We review this list every year.

Why and how we verify claims to prevent fraud

We may need to ask you for more information before we can process a claim. You must provide this as soon as possible and pay any costs involved. We may also need to contact the practitioner for confirmation. While we're waiting for information, claims will stay on hold. We carry out routine checks to make sure that we're paying claims correctly. It doesn't mean that we think you're being dishonest. It is your responsibility to make sure that all of the information you give us to support your claim is truthful and complete.

We take fraud prevention very seriously. False claims can cause premiums to rise, which in turn affects our whole 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 plans, fraud-prevention agencies, the police and other enforcement agencies. You must always act honestly. For example, you, or anyone covered on your policy, must not:

- Alter or forge a receipt or claim form;
- Give us 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 your claim;
- Deliberately claim for anything, or anyone, that's not covered;
- Claim a refund from more than one policy with the intention of receiving back more than you've paid out (this is called betterment);
- Fail to tell us if the claim could be covered under another policy;
- Claim for a pre-existing medical condition that isn't covered under your policy, or a medical condition that you should have told us about when you applied for cover.

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. We may end your policy and all of your benefits will stop from the date your policy ends. Anyone convicted of fraud may have to declare it when they apply for any type of insurance in the future.

Worldwide cover

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

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

What benefits are covered:

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

What benefits are not covered:

- Dental accident;
- Specialist consultation, ECG, X-ray, pathology fees and MRI scans;
- Health and wellbeing;
- Chiroprody;
- Health screening.

Also see the 'Exclusions' section on this page.

This cover does not replace travel insurance.

DEFINITIONS

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

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

'Any job' – a job to which you are suited because of your education, training or experience.

'Benefit year' – when the maximum allowance for each separate benefit is available to claim. The 12-month period is confirmed in your policy schedule or welcome pack.

'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.

'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

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details of your and your family's medical history and having a physical examination, tests, laboratory tests, scans or X-rays, and may be followed by counselling, education, referral to hospital or further treatments, or further tests.

'Hospice' – an institution that provides palliative care for the terminally ill.

'Hospital' – an institution which has permanent facilities for caring for patients, has facilities for diagnosing and treating injured or sick people and provides nursing services supervised by registered general nurses. If you are admitted to a hospital, it should be following a referral by a GP, consultant or through the accident and emergency (A&E) department.

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

'Palliative care' – an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.

'Pandemic' – an infectious disease that is widespread throughout an entire country, continent, or the whole world.

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

'Practice-plan premiums' – payments made to a scheme provided by your dentist.

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

'Registered treatment centre' – a centre that is registered with the Department of Health and appears on the National Administrative Code Service Register.

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

'Treatment' – medical procedure or intervention (including tests and purchases) received by a qualified practitioner to help cure, relieve, control or prevent an illness or injury.

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

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

BENEFIT TERMS

HEALTHY AND HAPPY

Dental

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

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

Dependent children will share the maximum benefit amount.

What is covered:

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

What is not covered:

- Cancellation charges made by the dentist (for example, for missed appointments);
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on);
- Dental insurance premiums;
- Dental prescription charges (we cover these charges under the prescriptions benefit);
- Dental treatment charges resulting from a dental accident (we cover these charges under the dental accident benefit).

Also see the 'Exclusions' section on page 2.

Optical

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

Please see the 'How to claim' section on page 2 before attending an optical appointment, making a purchase or sending us a claim.

If you have bought your contact lenses or glasses online, you must send us the receipt together with a copy of the optician's prescription showing your name. For contact lenses that you pay for monthly, we need a statement from the provider of the contact lenses showing the amount paid and the date of payment. This must match the amount you are claiming for.

Dependent children will share the maximum benefit amount.

What is covered:

- Contact lenses (permanent or disposable);
- Contact lens check-ups;
- Contact lens cleaning solutions (including if you buy these separately);
- Eye laser surgery to correct long- and short-sightedness paid according to the date of treatment and not when payments are made;
- Eyesight tests;
- Lenses you buy separately to fit to existing frames;
- Lenses supplied under an optical insurance plan;
- Prescribed glasses;
- Prescribed magnifying glasses;
- Repairs to prescribed glasses;
- Sunglasses, safety glasses and swimming goggles (as long as they have prescribed lenses).

What is not covered:

- Insurance premiums;
- Non-prescribed glasses and contact lenses (for example, ready-made glasses and coloured lenses);
- Optical consumables (for example, glasses cases);
- Frames you buy separately.

Also see the 'Exclusions' section on page 2.

Chiropody

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

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

Dependent children will share the maximum benefit amount.

What is covered:

- Assessments (for example, gait analysis, which is an analysis of how you walk);
- Chiropody treatment;
- Podiatry treatment.

What is not covered:

- Consumables (for example, arch supports, orthotics or insoles) even when prescribed and supplied by the chiropodist or podiatrist at the time of the treatment;
- Surgical footwear (for example, corrective shoes prescribed and supplied as a part of the treatment);
- X-rays;
- Chiropody prescription charges (we cover these charges under the prescriptions benefit).

Also see the 'Exclusions' section on page 2.

Prescriptions (for each item)

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

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

We will accept the label off the medication packaging as confirmation of who the prescription was for, if their name is not shown on the receipt. If there is no confirmation of payment on the receipt, please provide the NHS form as proof of who the prescription is for and the amount paid.

We do not pay prescription benefit for dependent children.

What is covered:

- NHS prescription charges or the NHS cash equivalent for private prescription charges;
- An NHS prepayment certificate up to the appropriate maximum of individual prescription items;
- Dental, combined physiotherapy and chiropody prescription charges.

What is not covered:

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

Also see the 'Exclusions' section on page 2.

Health and wellbeing

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

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

We will only pay claims for the treatments listed below. The practitioner must have the appropriate qualifications as shown on the separate list of accepted accreditations and qualifications referred to above.

The claim form must include the reasons for the treatment, and the type of treatment provided.

Dependent children will share the maximum benefit amount.

What is covered:

- Acupressure;
- Allergy testing, including food intolerance and nutrition tests carried out by a qualified practitioner;
- Aromatherapy massages;
- Bowen and Alexander techniques;
- Chair massage;
- Cognitive behavioural therapy;
- Colonic hydrotherapy;
- Counselling fees (for example, psychiatric, psychological and bereavement);
- Deep-tissue 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 and remedial massages (for example, muscular or soft-tissue problems or injuries);
- Swedish massage.

What is not covered:

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

- Weight-management programmes;
- Relationship counselling.

Also see the 'Exclusions' section on page 2.

Health screening

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, for a health screen carried out by medically qualified staff at a hospital or health-screening clinic to prevent an illness.

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

Dependent children will share the maximum benefit amount.

What is covered:

- A full health screen (for example, a well-woman or well-man screening).

What is not covered:

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

Also see the 'Exclusions' section on page 2.

Combined physiotherapy

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person entitled to benefit receives treatment to relieve pain or prevent an illness, from a practitioner who is a member of an approved professional organisation. This benefit also covers charges for X-rays and scans carried out at clinics on the recommendation of the practitioner as part of the treatment.

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

We will only pay claims for the treatments listed below. The practitioner must have the appropriate qualifications as shown on the separate list of accepted accreditations and qualifications referred to above.

The claim form must include the reasons for the treatment, and the type of treatment provided.

Dependent children will share the maximum benefit amount.

What is covered:

- Acupuncture;
- Chiropractic;
- Homoeopathy;
- Osteopathy (including craniosacral therapy);
- Physiotherapy;
- X-rays and scans, when necessary as part of the treatment.

What is not covered:

- Any treatment, provided by a practitioner who is recognised by us, which is not listed above;
- Appliances (for example, lumbar rolls and back supports) even if prescribed and supplied by your practitioner as part of the treatment;
- Pre-existing conditions;
- Herbs, herbal remedies, supplements or vitamins, even if they have been supplied as part of your treatment;
- Prescription charges (we cover these charges under the prescriptions benefit).

Also see the 'Exclusions' section on page 2.

FEEL BETTER

Hospital benefits

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

You must fill in your claim form yourself confirming the medical reason for the hospital treatment. The claim form must be checked and stamped with the hospital or hospice stamp, and signed by a member of their staff. Or you can send us your discharge letter or discharge summary which would have been given to you when you were discharged.

Before we can pay your claim, we may ask for more information about the treatment provided by the hospital. If there is a dispute, our Board of Management will decide whether you needed to be admitted and whether a medical facility keeps to the policy definition of a hospital.

Hospital inpatient

We will pay benefit at the appropriate nightly rate for the period a person entitled to benefit is admitted (after being referred by a GP or consultant or being admitted from the accident and emergency department) for inpatient treatment in a recognised hospital or hospice.

Dependent children will share the maximum benefit amount.

What is covered:

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

What is not covered:

- Attending accident and emergency;
- Clinics, medical centres or nursing homes;
- Hospital accommodation for an elderly person who is not able to live independently;
- Maternity-related admissions for dependent children;
- The first 10 consecutive overnight stays as a maternity inpatient, during which time the woman gives birth;
- A child's first 10 consecutive overnight stays as an inpatient after being born;
- Outpatient treatment;
- Permanent stays in hospital;
- Pre-existing conditions;
- Any voluntary admissions to medical spas and spa hospitals for

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non-essential treatments;

- Overnight stays in hospital hotels before and after being admitted to hospital.

Also see the 'Exclusions' section on page 2.

Hospital day surgery

We will pay benefit at the appropriate day rate for the period a person entitled to benefit is admitted (after being referred by a GP or consultant or being admitted from the accident and emergency department) for hospital day-surgery treatment in a recognised hospital without an overnight stay.

Dependent children will share the maximum benefit amount.

What is covered:

- Any day-surgery admission in an NHS hospital, private hospital or registered treatment centre, up to a maximum of 25 days, to have a medical condition investigated under anaesthetic or sedation using theatre facilities, or to have a medical condition treated under anaesthetic or sedation using theatre facilities;
- Operations which are cancelled after you have been admitted to hospital;
- Colonoscopy, laparoscopy, colposcopy and sigmoidoscopy procedures, as long as an anaesthetic or sedation was needed and the procedure was carried out in theatre;
- Fees for filling in claim forms or certificates, as long as you provide an official hospital receipt with your claim and we accept the claim itself for payment;
- Outpatient treatment for chemotherapy, kidney dialysis, oncology and radiotherapy.

What is not covered:

- Attending accident and emergency;
- Attending clinics, medical centres or nursing homes;
- Admissions immediately before or following an overnight stay (one day either side) for which we will pay a claim under the hospital inpatient benefit;
- Elderly care;
- Hospice day care;
- Maternity admissions;
- Outpatient appointments or treatments that are not covered above;
- Pre-admission appointments (appointments before you are admitted to hospital);
- Psychiatric treatment;
- Pre-existing conditions;
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments;
- Overnight stays in hospital hotels before and after being admitted to hospital.

Also see the 'Exclusions' section on page 2.

Parental hospital stay

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

You must fill in your claim form yourself confirming the medical reason for your registered child being admitted. The claim form must be checked and stamped with the hospital or hospice stamp, and signed by a member of their staff. Or you can send us your registered child's discharge letter or discharge summary which would have been given to you when they were discharged.

What is covered:

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

What is not covered:

- Attending accident and emergency;
- Clinics, medical centres or nursing homes;
- More than one parent staying with their child;
- A child's first 10 consecutive overnight stays as an inpatient after being born;
- Outpatient treatment;
- Permanent stays in hospital;
- Pre-existing conditions;
- Any voluntary admissions to medical spas and spa hospitals for non-essential treatments;
- Overnight stays in hospital hotels before and after being admitted to hospital.

Also see the 'Exclusions' section on page 2.

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

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one benefit year, when a person entitled to benefit has a specialist consultation or treatment from a medically qualified person who specialises in a field of medicine.

The specialist must be listed on the General Medical Council's Specialist Register or be a member, fellow or licentiate of one of the Royal Colleges. This benefit also refunds costs you would have to pay for an ECG, X-ray, pathology fees and MRI scans charged to you at the appropriate department of a hospital or as part of a consultation.

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

On the claim form, you must fill in the reason for the consultation, treatment or tests.

Dependent children will share the maximum benefit amount.

What is covered:

- Hearing aids and audiology tests provided by a registered hearing aid supplier;
- Hearing-aid repairs;
- Investigative procedures (for example, colonoscopy, laparoscopy, colposcopy and sigmoidoscopy);
- Medical tests, including ECG, EEG and lung-function tests;
- Radiologist reports;
- Pathology and biopsy fees;
- Physicians' or surgeons' operation fees;
- Speech therapy, dyslexia and dyspraxia treatment provided by a registered medical practitioner;
- X-ray, including mammograms, CT scans, ultrasounds, MRI scans and screenings;
- If a claim has been settled by a provider of private medical insurance, we can only pay benefit (up to the appropriate maximum) for any remaining excess if you send us your statement from the provider of private medical insurance. Please make sure that the statement clearly shows how much excess is left to pay.

What is not covered:

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

Also see the 'Exclusions' section on page 2.

PEACE OF MIND

Dental accident

We will pay benefit, at the appropriate rate and up to the appropriate maximum in any one 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 blow to the head.

Please see the 'How to claim' section on page 2 before going for treatment or sending us a claim.

Your dentist must also confirm on the receipts that the treatment has been caused by a direct blow to the head which has resulted in accidental injury to your teeth. You must also provide full details of the accident. We treat dental accident claims in a benefit year according to the date the accident happened.

We will only pay one maximum for all treatment that lasts from one benefit year to another.

Dependent children will share the maximum benefit amount.

What is covered:

- Dental treatment directly related to an accident (for example, a sports injury or a fall), including the following:
 - Anaesthetic fees;
 - Dental crowns, bridges and white fillings;
 - Dental veneers;
 - Replacement dentures or repairs.

What is not covered:

- Cancellation charges made by the dentist (for example, for missed appointments);
- Damage to dentures when not being worn;
- Dental consumables (for example, toothbrushes, mouthwash, dental floss and so on);
- Dental prescription charges (we cover these charges under the prescriptions benefit);
- Dental insurance premiums;
- Joining fees and practice-plan premiums;
- Any treatment you receive 12 months after the date of the accident;
- Dental treatment you receive for an accident which happened before you joined the plan;
- Injuries caused by eating and drinking.

Also see the 'Exclusions' section on page 2.

Maternity – antenatal appointments and adoption

We will make a single payment for each pregnancy, up to the appropriate maximum in any one benefit year. Payment can only be made if you have been covered by the scheme for at least 40 weeks and the pregnancy has been confirmed by a NHS or private antenatal scan carried out by a sonographer within the first 26 weeks of conception.

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

What is covered:

- An NHS or private antenatal scan carried out by a sonographer which takes place within 26 weeks of you becoming pregnant;
- Fees for filling in claim forms or certificates, as long as you provide an official receipt with your claim;
- If it is a registered partner having the scan.

We will only make a single payment for a pregnancy that lasts from one benefit year to another.

What is not covered:

- Attending accident and emergency;
- Antenatal appointments for dependent children;
- A partner who is not registered with us, unless you have confirmed that they live with you.

We will also make a single payment, up to the appropriate maximum in any one benefit year, if you adopt a child aged 16 or younger (as long as you have been covered by the scheme for at least 40 weeks). You must send us a copy of the adoption order with your claim form.

Personal accident protection

Please call 01270 588555 or email info@healthshield.co.uk for a separate personal accident claim form. Under the following conditions, we will only consider the amount of benefit we will pay under this section if a bodily injury results in death or permanent total disability (permanent disability that prevents you from doing any job – which is not limited to your occupation at the time of the accident) within one year of the accident. We will pay the sum insured in line with the level of contribution you have paid. Protection will end on your 70th birthday. You must write to us within six months of an accident to let us know about it.

To support your claim, you will need to provide medical evidence from a registered medical practitioner. You must pay any costs involved in providing this evidence.

We will not pay more than your benefit maximum per person as a result of any one accident.

'Bodily injury' means an injury caused only by an accident and not by any sickness, disease or gradual cause. 'Bodily injury' does not cover post-traumatic stress disorder.

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

Personal accident protection does not cover death or permanent total disability caused by the following:

- Motorcycling (rider or passenger);
- Diving (including scuba);
- Mountaineering;
- Rock climbing;
- Potholing;
- Parachuting;
- Boxing;
- Racing (other than on foot);
- Time trials or sprints;
- Flying (except air travel);
- Carrying out duties in one of the armed forces including the Army Reserve.

Also see the 'Exclusions' section on page 2.

mywellness

Health Shield membership allows you exclusive access to a list of extra services. mywellness brings these services together in one place and they can be easily accessed online, on any device, through the mywellness tab on our Members' Area.

To take advantage of the services, you will first need to register on to Health Shield's Members' Area at www.healthshield.co.uk/members where you will be asked to confirm your Health Shield member number.

Once registered, please log in and select the 'mywellness' tab where you'll be able to access all the extra services which are available to you.

Services and information available on mywellness can change without notice.

The Direct Debit Guarantee - if applicable to your scheme



- The Guarantee is offered by all banks and building societies that accept instruction to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Health Shield will notify you (normally 10 working days) in advance of your account being debited or as otherwise agreed. If you request Health Shield to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Health Shield or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
 - If you receive a refund you are not entitled to, you must pay it back when Health Shield asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.



The Crystal Mark only applies to the terms and conditions section, and does not apply to the design and layout of this leaflet.

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Email: info@healthshield.co.uk Website: www.healthshield.co.uk

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As part of our on-going quality control programme, calls may be monitored or recorded.

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