



YOUR PLAN

Terms and Conditions Document

Important Membership Information.

Please keep safe with your Schedule
of Membership

April 2008

+ medicash

A **positive** approach to health

Welcome your life your Medicash

Welcome to Medicash, one of the UK's oldest and largest providers of healthcare cash plans.

We at Medicash are passionate about promoting a positive approach to the life and health of our members. Each year the cost of healthcare treatments continue to rise, but with Medicash you can claim money back towards your optical and dental bills, plus physiotherapy, chiropractic care and many other treatments and consultations.

As an organisation with no shareholders, Medicash operates solely in the interests of our members, so please take some time to look through this booklet together with your Schedule of Membership to see how Medicash works for you.

Inside you'll find all the information that you need to know about your plan, including useful information about your cover, details of what to do when you want to make a claim and essential telephone numbers.

Please refer to your Schedule of Membership which shows:

- the date your benefit year starts
- your premiums
- the persons covered by the plan and which benefits they are entitled to claim
- how much you can claim on an annual basis for each benefit listed.

If you have any questions relating to your policy or any aspect of these terms and conditions, simply call our Customer Service Team on:

0151 702 0265

Telephone lines are open: Monday to Thursday, 8.45am until 5pm and Friday, 8.45am until 4pm (except Bank Holidays). Calls may be recorded for training and monitoring purposes.

Terms and Conditions

You need to read these Terms and Conditions along with the Schedule of Membership and the Benefit Table which together make up the Policy between you, the Member, and us.



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1 | Definitions

Benefit Date

The date shown in your Schedule of Membership, which is the first date from which you are eligible to make a claim.

Benefit Table

The table contained in the Schedule of Membership that shows the benefits applicable to each of the premium levels current at the date of Treatment or cost incurred.

Benefit Year

The annual period commencing on your Benefit Date, as shown within your Schedule of Membership. In each Benefit Year you can claim up to the yearly maximum, as shown in the Benefit Table.

Child(ren)

Born to you or your Partner, or legally adopted by you, and under the age of 16 years or 19 if in full-time education.

Cosmetic Treatment

Treatment received to change appearance and not to cure or alleviate a medical condition.

Daycase

Admission to a hospital for Treatment. You must have been allocated a bed but not be staying overnight. This benefit does not include Outpatient or Inpatient treatment, or other hospital attendances.

Hazardous Pursuits and Sports

Hazardous pursuits or sports include canyoning, gorge walking, hang-gliding, high diving, horse jumping, microlighting, mountain boarding, parasailing and rock climbing.

Inpatient Stay

When a patient is hospitalised overnight for medical Treatment, or because of a continuation of medical care.

Our/Us/We

Medicash Health Benefits Ltd, Merchants Court, 2-12 Lord Street, Liverpool L2 1TS. Medicash is a company limited by guarantee, is registered in England (number 258025), and is authorised and regulated by the Financial Services Authority.

Parental Stay

Where a member covered by the policy stays in hospital overnight to accompany a Child under the age of twelve who has been admitted as an inpatient. In the case of a dual policy we will only cover one member.

Partner

A spouse or named person who lives with you on a permanent basis, as if your legal spouse, regardless of gender.

Policy

Our contract of insurance with the Policyholder, providing the cover as detailed in the Schedule of Membership, the Benefit Table (as amended from time to time), and this Membership Policy Document.

Policyholder

The first named person in the Schedule of Membership. This person is responsible for premiums due, and is the usual recipient of benefits paid.

Pre-Existing Condition

Any disease, illness or injury for which you have experienced symptoms, or sought or received medical attention in the 12 month period before the start of your policy, or increase in the premium level of your policy.

Qualifying Period

The period between the Policy joining date and the Benefit Date, as shown in your Schedule of Membership. Premiums must be continuously paid but you cannot make a claim during this period.

Schedule of Membership

The document issued to you with this Membership Policy Document when you join or amend your cover. It shows the Policy joining date, the premiums due, the Benefit Table, the level of cover chosen, and those persons covered under the Policy.

Serious Medical Condition

Medical illnesses, injuries or disabilities that have life changing or limiting impacts.

Specialist Consultant

Registered with the General Medical Council on their Specialist Register.

Treatment

Medical or surgical management of a patient. Where a series of treatments are given, we define this to be a course of treatment, which concludes on the date that the final treatment given. In the case of an Inpatient stay the course of treatment is from the date of admission to the date of discharge.

United Kingdom

England, Wales, Scotland, Northern Ireland, the Channel Islands, the Isle of Man and British Forces Personnel posted overseas (BFPO).

You/Your

The Policyholder and/or their Partner and/or Children who are covered for benefit under the Policy.



2| Becoming a member or amending your cover

- 2.1 You can apply to join or amend your level of cover by completing an application form and sending it to **Medicash Health Benefits Ltd, Merchants Court, 2-12 Lord Street, Liverpool L2 1TS**. You may also join or amend your level of cover by telephoning us on **0151 702 0304** or via our website at **www.medicash.org**
- 2.2 Persons covered by the Policy must reside within the United Kingdom.
- 2.3 All information provided to Medicash must be accurate, true and complete to the best of your knowledge and belief. Failure to do so may jeopardise your claim or cover. To protect all our members we will take action against anyone who makes a dishonest or false application.
- 2.4 We reserve the right to refuse to accept any applicant as a Policyholder or impose Qualifying Periods for anyone applying to rejoin Medicash.
- 2.5 You can apply to join if you are aged 16 or over, and are less than 66 years of age at the date of application. If you are applying to join a plan that is organised and paid for by your employer, then there is no upper age limit.
- 2.6 On some plans we will automatically change your benefits when you reach the age of 66. See your Schedule of Membership for details.
- 2.7 You can apply to include your Partner on your Policy if he/she is aged 16 or over, and is less than 66 years of age at the date of application.
- 2.8 Your Partner will cease to be covered by your Policy if he or she ceases to reside permanently with you.
- 2.9 A Child is covered under your Policy:
 - a. Up to 16 years of age,
 - b. or up to their 19th birthday if in full-time education.
- 2.10 In the unfortunate event that you or your Partner dies, a Dual Policy can be amended to a Standard Policy and no Qualifying Period will be applied.
- 2.11 You will be registered as a Policyholder with effect from the date of joining, as detailed in your Schedule of Membership.
- 2.12 We will send you a new Schedule of Membership after an amendment to your cover. The effective date of any amendment will be detailed in the Schedule of Membership.
- 2.13 If you increase your level of cover, new Qualifying Periods may apply before you can claim the new level of benefit. In the meantime, where appropriate, we will pay benefit at the previous rate.
- 2.14 Pre-existing Conditions are excluded for 12 months from the date of joining or amending your level of cover.

- 2.15 If you decrease your level of cover, all benefits will be paid at the lower rate from the date of change.
- 2.16 This is a monthly renewable insurance contract that remains in force if you continue to pay your premiums when they are due. Renewal is automatic and binding and no renewal papers or other forms of notification will be issued.

3| Premiums

- 3.1 The amount that you pay is known as the premium. The level of premium you pay determines the level of benefits that you will receive. The benefits applicable to each premium level are shown in the Benefit Table.
- 3.2 You can pay by any of the following methods:
 - direct debit
 - cheque (either posted directly to us, or via a bank or building society)
 - credit card
 - another person may pay on your behalf

Or if you have a plan through your employer:

- payroll deduction
 - your company pay on your behalf
 - direct debit
- 3.3 Premiums are inclusive of Insurance Premium Tax (IPT) at the current rate. Should the rate of IPT change, Medicash reserves the right to pass this on to members, subject to prior notification of 28 days.
 - 3.4 We will not pay claims unless your premiums are paid up to date.
 - 3.5 It remains your responsibility to ensure that your premium payments are maintained, regardless of the payment method.
 - 3.6 If premiums are more than six weeks overdue, we may cancel your Policy and your cover may cease. We will not pay any claims where the date of Treatment is after the date that your policy is paid up to.
 - 3.7 If your premium payments have lapsed and we have cancelled your Policy, you will have to apply to rejoin, and the standard waiting periods for all benefits will apply.
 - 3.8 We reserve the right to deduct any premiums due to us from any benefits payable to you.



4| Refund of premiums

- 4.1 We will refund premiums only:
 - a. If you cancel within 30 days of joining and have not made a claim
 - b. If you have paid your premiums in advance and you have correctly notified us that you wish to cancel your policy
 - c. If you have overpaid us, provided you have notified us that this is the case
 - d. In the unfortunate event that you die.
- 4.2 If you have cancelled your policy with us we will refund any contributions paid in advance. We will deduct a £25.00 administration charge for this.
- 4.3 If you have overpaid us, we will advance your Policy's payment date. Alternatively, on your request, we will make a refund where the value is £25.00 or over.
- 4.4 We will not refund any premium overpayments for periods that are more than six years prior to the date of request.
- 4.5 We will only refund bank charges that you may have incurred due to our error. We will not refund any bank interest that may have been lost.

5| Claims

- 5.1 In order to receive any of the benefits you must fully complete and sign a claim form. You must use the claim form that we provide. Claim forms are available by telephoning us on **0151 702 0265**. You can also download a claim form from our website at www.medicash.org and logging in to the '**My account**' section.
- 5.2 You must provide us with the information or proof to support your claim that we require, as detailed in section 10. We will be unable to pay any claim that does not have sufficient supporting evidence. If you have any queries about a claim, including whether or not you are eligible to make a claim, please call **0151 702 0265** and we will be happy to advise you.
- 5.3 We do not pay for charges incurred for completing a claim form, or for medical information required to support your claim. These charges are your responsibility.
- 5.4 For those claims that require the evidence of a receipt, you must pay for Treatment before you can make a claim.
- 5.5 Receipts must be unaltered originals which should show the name and qualifications of the practitioner who provided the Treatment, the date of the Treatment, the name of the recipient of the Treatment, and a description of the Treatment provided. We do not accept photocopies, credit card receipts, or estimates for Treatment.
- 5.6 We do not normally return receipts. If you wish to have your receipt returned to you, you must request this in writing at the time you make your claim.

- 5.7 **Claims must be made within 26 weeks** of the date that Treatment was received or the course of Treatment was completed, or that you were discharged from hospital. You must also notify Medicash within 26 weeks of the Birth of a Child or adoption in order to claim the Birth of a Child Benefit. Medicash will not accept any liability to pay any claims outside of this time frame.
- 5.8 The date of Treatment will determine the Benefit Year in which a claim is paid.
- 5.9 We do not pay claims for any Treatment that has resulted from participation in Hazardous Pursuits and Sports, or through self-inflicted injury.
- 5.10 In the event that your claim is also covered by another insurance policy, we will not pay more than our proportionate share, which cannot exceed the total eligible cost which you have incurred. When making a claim you must disclose to us the existence of such other cover, and provide permission for us to make contact with the other company.
- 5.11 If you have more than one insurance policy with Medicash, we will not pay more than 100% of the receipted amount.
- 5.12 You can only claim once for each episode of Treatment.
- 5.13 To protect all Medicash members, we will take action against anyone who makes a dishonest or false claim. Such action includes, but is not limited to, refusal to accept liability to pay a claim, termination of your policy without refund, or legal action.
- 5.14 Where you have notified us of a possible claim, or where we have been unable to process a claim because we require further information, that claim will be held on record for one year only.

Name and qualifications of practitioner → **+ medicash Physiotherapy Clinic**
HPC REGISTERED
MERCHANTS COURT, 2-12 LORD STREET,
LIVERPOOL L2 1TS.
TEL: 0151 702 0265 WWW.MEDICASH.ORG

Details of recipient of treatment → **MR AN OTHER, 11 HIGH ST,
ANYTOWN, A1 2MS.**

Details of treatment including date, description of treatment and cost → **03/01/08 TREATMENT £18.00
10/01/08 TREATMENT £18.00
17/01/08 TREATMENT £18.00**

**RECEIPT PAID IN FULL
17/01/08**

6| Benefit payments

- 6.1 The type of cover that we provide and the amount that we will pay you for each type of cover are known as benefits and are detailed in the Benefit Table.
- 6.2 The amounts shown in the Benefit Table are the maximum amounts that you can claim for each benefit in any one Benefit Year.
- 6.3 Benefits are paid to the Policyholder in British Pounds Sterling by direct credit to a UK bank or building society, or by cheque to the policyholder's home address. If you wish to arrange payment to another person you will have to apply in writing to us at the time of making your claim.
- 6.4 Benefits will not be paid:
 - a. If treatment is received during any applicable Qualifying Period
 - b. Until we have successfully received your first premium
 - c. If your premiums are not paid up to date.
- 6.5 We reserve the right to recover any overpayments made to you either directly, or by adjusting any future benefit payments made to you.

7| Cancellation and terminations

- 7.1 If you decide that this policy is not suitable or does not meet your needs, let us know and we will cancel your Policy. If you cancel within 30 days of joining or amending your plan, and providing you have not made a claim we will refund all or the amended portion of the premiums that you have paid.
- 7.2 You may cancel your Policy at any time. You must give us notification in writing or by telephone on **0151 702 0265**. We will cancel your Policy with effect from the date you notify us.
- 7.3 We reserve the right to cancel your Policy at any time. We will give you not less than 28 days written notice of this.
- 7.4 All the cover and benefits of your Policy will cease automatically:
 - a. If you cancel your Policy
 - b. If we cancel your Policy
 - c. In the unfortunate event that you die
 - d. If premiums are more than six weeks overdue. We may cancel your Policy and your cover may cease. We will not pay any claims we receive where the date of Treatment is after the date that your Policy is paid up to.
- 7.5 We will not accept claims for any Treatment after your policy has been terminated.

8| Your Rights – Data Protection, complaints and compensation rights

- 8.1 For the purposes of the Data Protection Act 1998 we are the Data Controller in relation to any personal data you provide to us. Under the principles of the Data Protection Act 1998 we will endeavour to ensure that your personal information held by us is:
- Processed fairly and lawfully
 - Processed for limited purposes
 - Adequate, relevant and not excessive
 - Accurate
 - Kept for no longer than is necessary
 - Processed in accordance with the right of data subjects under the Act
 - Kept secure
 - Not transferred to other countries without adequate protection.
- 8.2 We will treat all sensitive and medical information we receive with the strictest confidence.
- 8.3 Under the Data Protection Act 1998 you may write to us and request a copy of the information we hold about you. If these details are inaccurate you can ask us to amend them. We reserve the right to charge the maximum fee payable for a subject access request under the terms of the Data Protection Act 1998.
- 8.4 If you are not happy with any aspect of our service, send the full details of your complaint to the **Head of Customer Operations, Medicash, Merchants Court, 2-12 Lord Street, Liverpool L2 1TS**. We will respond to you within five working days and send you a copy of our complaints procedure.
- 8.5 If you are not satisfied with our response you can refer your complaint to the **British Healthcare Association, 26-28 Headlands, Kettering, Northamptonshire NN15 7HP** or to the **Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR**.
- 8.6 In the unlikely event that Medicash Health Benefits Limited becomes insolvent and is unable to pay the benefits provided under the plan, you are protected by the Financial Services Compensation Scheme (FSCS). Under this scheme the first £2,000 of a claim or policy is protected in full. Above this threshold, 90% of the rest of the claim or value of unused premiums may be met. Further information can be found at **www.fscs.org.uk/consumer**.



9| Our Rights: How we protect our members

- 9.1 You must satisfy yourself that the Policy and level of cover you have chosen are right for you. We will not provide any personal advice in respect of the suitability of either the Policy or the level of cover chosen but will provide information to assist your decision or understanding.
- 9.2 The terms of this Policy are governed by English Law and all communications will be made in English. We can provide communications in alternative formats upon request.
- 9.3 We reserve the right to periodically make premium and/or benefit changes in line with our claims experience and market position. If we make such changes we will write to you giving you at least 28 days notice and detailing how this will affect your Policy.
- 9.4 We will notify you of any changes in writing to your home address as last notified to us. We will not be responsible if the notification, for any reason, fails to come to your attention. If you are not happy with the changes we have made you may cancel your Policy.

10| Benefit Rules

You need to refer to your Schedule of Membership to find out which benefits are included in your cover.

10.1 Routine Dental Treatment

Cover for routine dental treatment needed to secure and maintain oral health.

- i. We will pay the amount you have paid to a member of the General Dental Council, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table. Please refer to your Schedule of Membership and benefit table for details.
- ii. To process your claim, we require an original, dated receipt from the practitioner.
- iii. If you pay for your Treatment via a dental care plan (capitation scheme) we will pay up to the percentage shown on your Schedule of Membership for your dental benefit, for payments you have made to the plan. You must provide us with an original receipt of payments from the dental care plan provider. You will need to submit your claim within 26 weeks of the end of the period of your dental care plan.

We cover:	We do not cover:
<ul style="list-style-type: none"> • dental treatment and dental check-ups • premiums under a dental-care contract • hygienist fees • investigative dental x-rays, and laboratory fees deriving from dental treatment • the cost of anaesthetic for dental treatment • the cost of dentures and repairs to dentures • braces provided by a dentist 	<ul style="list-style-type: none"> • tooth whitening or cosmetic dentistry • non-prescribed items or consumables • charges for missed appointments • registration or joining fees for a dental care contract

10.2 Dental Accidents and Injuries

Cover for permanent dental treatment required as a result of an accident or injury. You can only claim this benefit if there has been a dental emergency appointment within 72 hours of the accident or injury.

- i. We will pay the amount you have paid to a member of the General Dental Council or Specialist Consultant, up to a maximum in any one benefit year, within your chosen premium level. Please refer to your Schedule of Membership and benefit table for details.
- ii. To process your claim, we require an original, dated receipt from the practitioner.
- iii. Medicash need the following information from your dentist in order to process the claim:
 - a. Date of the accident
 - b. Full report of the incident and all dental injuries sustained
 - c. The treatment plan (Medicash do not cover treatment that is not established clinical practice or drugs that are not licensed within the UK)
 - d. The date that the treatment or episode of treatment will start and finish
 - e. The name of the Consultant Oral/Maxillo-Facial Surgeon responsible for the treatment if applicable
 - f. Detailed treatment costs

Cover is limited to the treatment described in the treatment plan.
- iv. Medicash may ask for extra evidence to show how the injury was sustained, evidence that the injury is not as result of chronic periodontal disease, or evidence that if the injuries resulted from sporting activities that the appropriate mouth guards were worn.

We cover:	We do not cover:
<ul style="list-style-type: none"> • dental treatment relating to an accident or injury • investigative dental x-rays, and laboratory fees relating to the dental treatment • the cost of anaesthetic for dental treatment • the cost of dentures and repairs to dentures resulting from the accident or injury • replacement veneers, implants, dentures and orthodontics resulting from an accident or injury 	<ul style="list-style-type: none"> • injuries that existed before or when you took out the plan • treatment for accidents and injuries sustained whilst partaking, training for or coaching in any sport, when the appropriate mouth guards were not worn • treatment relating to periodontal disease • fees charged for preparing reports • charges for missed appointments • injuries that are self inflicted

10.3 Dental Emergencies

Cover for when immediate treatment is needed to relieve acute pain, swelling as a result of an infection or dental haemorrhaging.

- i. We will pay the percentage shown of the amount you have paid to a member of the General Dental Council or Specialist Consultant, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt from the practitioner.
- iii. Dental emergency treatment is limited to treatment that is needed immediately to relieve pain or to prevent a dental problem worsening. Any treatment needed after the emergency is covered by the Routine dental treatment or Dental accident and injury parts of this Dental Plan.

We cover:	We do not cover:
<ul style="list-style-type: none"> • dental treatment urgently needed to relieve severe acute pain, swelling due to infection or dental haemorrhaging • charges for out of hour appointments • anaesthetic fees for dental treatment 	<ul style="list-style-type: none"> • treatment relating to periodontal emergencies • treatment as a result of an accident, where cover is provided under the Accident and Injury part of this Dental Plan • injuries that are self inflicted

10.4 Oral Cancer

We will pay the maximum amount within your chosen premium level as shown in the Benefit Table, upon diagnosis for oral cancer.

- i. A diagnosis of oral cancer includes lips, tongue, major salivary glands, gums, mouth, pharynx, or oral cavity from lips to pharynx. Diagnosis must be supported by a Specialist Consultant's letter and histology.

You must be under the care of a Specialist Consultant practicing in the UK.

- ii. You must tell Medicash about an oral cancer claim within 28 days of diagnosis.
- iii. This benefit is payable only once in a lifetime.

We cover:	We do not cover:
<ul style="list-style-type: none">• oral cancer	<ul style="list-style-type: none">• oral cancer claims made within the first 12 months of taking out the plan• claims where you have a previous medical history of oral cancer or have been referred by your dentist or GP for diagnostic tests for oral cancer before taking out the plan

10.5 Optical

- i. We will pay the percentage shown of the amount you have paid, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt from the practitioner.

We cover:	We do not cover:
<ul style="list-style-type: none">• eye health tests and eyesight tests performed by a member of the General Optical Council• prescribed spectacles, prescribed sunglasses and prescribed contact lenses• safety goggles required for your employment• laser eye surgery	<ul style="list-style-type: none">• contact lens check-ups or solutions• non-prescribed spectacles or sunglasses• spectacle repairs or new or replacement frames• non-prescribed items or consumables• goggles used for leisure activities

10.6 Hearing Aids

- i. We will pay towards the cost of hearing aids you have paid to a registered hearing aid dispenser, up to the maximum in any one benefit year and at the percentage rate shown, within your chosen premium level in the Benefit Table.
- ii. To process your claim, we require an original dated receipt from the practitioner. We may require additional evidence that the practitioner is appropriately qualified and insured.

We cover:	We do not cover:
<ul style="list-style-type: none">• the cost of hearing aids when they are supplied by a registered hearing aid dispenser	<ul style="list-style-type: none">• consumables for hearing aids such as batteries• fitting costs or retuning costs• repairs to hearing aids

10.7 Specialist Consultation

- i. We will pay the percentage shown of the amount you have paid to a Specialist Consultant, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt from the Specialist Consultant.

We cover:	We do not cover:
<ul style="list-style-type: none">• initial consultation fees from a Specialist Consultant	<ul style="list-style-type: none">• fees for follow-up consultations• other charges that may arise from the consultation such as, but not limited to, room fees, dressings, medicines, anaesthetic fees, surgical fees• diagnostic and investigative tests and procedures (this is covered by the Diagnostic and Investigative Tests benefit where applicable)• health screening or examinations for the purpose of a medical report or medical certificate

10.8 Diagnostic and Investigative Tests

- i. We will pay the percentage shown of the amount you have paid for diagnostic and investigative tests and procedures resulting from a consultation with a GP or Specialist Consultant, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt detailing the tests carried out.

We cover:	We do not cover:
<ul style="list-style-type: none"> • diagnostic and investigative tests and procedures under the management of a Specialist Consultant or GP 	<ul style="list-style-type: none"> • Specialist Consultation fees (this is covered by the Specialist Consultation benefit) • other charges that may arise from the treatment such as, but not limited to, room fees, dressings, medicines, anaesthetic fees, surgical fees • health screening or examinations for the purpose of a medical report or medical certificate. • laboratory testing kits not referred by a Specialist Consultant or GP • home testing kits

10.9 Complementary Therapies

- i. We will pay the percentage shown of the amount you have paid to a qualified practitioner, up to a maximum in any one benefit year, within your chosen premium level as shown in the Benefit Table.
- ii. To process your claim, we require an original dated receipt from the practitioner. We may require additional evidence that the practitioner is appropriately qualified and insured.

We cover:	We do not cover:
<ul style="list-style-type: none"> • physiotherapy including sports massage • osteopathy • chiropractic assessment and treatment 	<ul style="list-style-type: none"> • Cosmetic Treatment or general physical fitness sessions • purchased items or consumables

10.10 Alternative Therapies

- i. We will pay the percentage shown of the amount you have paid to a qualified practitioner, up to a maximum in any one benefit year, within your chosen premium level in the Benefit Table.
- ii. To process your claim, we require an original dated receipt from the practitioner. We may require additional evidence that the practitioner is appropriately qualified and insured.

We cover:	We do not cover:
<ul style="list-style-type: none">• acupuncture• allergy testing including food intolerance and nutrition tests• homeopathy• Chinese medicines• reflexology• Bowen and Alexander technique• hypnotherapy as part of a treatment plan• indian head massage• reiki• stop smoking treatments	<ul style="list-style-type: none">• Cosmetic Treatments or beauty treatments or general physical fitness sessions• purchased items or consumables• homeopathic medicines purchased in isolation from the chemist, health food shop, by mail order or over the internet

Find a practitioner

Physiotherapy – www.hpc-uk.org

Chiropractic – www.gcc-uk.org

Osteopathy – www.osteopathy.org.uk

Homeopathy – www.the-hma.org, www.trusthomeopathy.org

Chiropody – www.hpc-uk.org

Reflexology – www.aor.org.uk, www.reflexology-uk.co.uk,
www.britreflex.co.uk, www.intfedreflexologists.org

Acupuncture – www.acupuncture.org.uk,
www.medical-acupuncture.co.uk

10.11 Chiropody

- i. We will pay the percentage shown of the amount you have paid to a qualified practitioner, up to a maximum in any one benefit year, within your chosen premium level in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt from the chiropodist. We may require additional evidence that the practitioner is appropriately qualified and insured.

We cover:	We do not cover:
<ul style="list-style-type: none">• chiropody assessment and treatment	<ul style="list-style-type: none">• cosmetic and beauty treatments or pedicures• purchased items or consumables• surgical footwear or appliances

10.12 Inpatient and Parental Stay

- i. We will pay the amount shown in the Benefit Table within your chosen premium level for each full night of Inpatient Stay.
- ii. We will pay the amount shown in the Benefit Table within your chosen premium level for a Parental Stay for each night accompanying a Child in hospital, providing that this benefit is included in the premium level of your plan.
- iii. To process your claim, we require a completed claim form that includes admission and discharge dates. The claim form must be stamped with the hospital or hospice stamp, and signed by a member of their staff; alternatively you can send us your MED 10 certificate.
- iv. We will pay up to the maximum number of nights shown in your Schedule of Membership in any one Benefit Year for the combined total of nights claimed for Inpatient and Parental Stay.
- v. Inpatient stays following an accident are not subject to standard Qualifying Periods.



We cover:	We do not cover:
<ul style="list-style-type: none"> • when you are hospitalised overnight for medical treatment or a continuation of medical care • when one adult covered by the plan stays with their Child when they are admitted as an Inpatient 	<ul style="list-style-type: none"> • the first night of Inpatient Stay • any period of home leave during the Inpatient stay • the first 14 nights after the birth of a child • accommodation costs or stays that are for domestic reasons, or if you are a resident • admissions due to Cosmetic Treatment • outpatient treatment • attendance at an accident and emergency unit, unless you are subsequently admitted as an Inpatient • Pre-existing Conditions

10.13 Hospital Daycase

- i. We will pay you at the appropriate daily rate shown in the Benefit Table for each admission as a Daycase to a hospital or recognised medical centre to receive a diagnosis, treatment, investigation or minor surgery. Your attendance must be pre-planned with no intended overnight stay.
- ii. We will pay up to the maximum number of days shown in your Schedule of Membership in any one Benefit Year.
- iii. To process your claim, we require a completed claim form that includes admission and discharge dates. The claim form must be stamped with the hospital or hospice stamp, and signed by a member of their staff; alternatively you can send us your MED 10 certificate.

Remember

claims must be submitted
within 26 weeks

We cover:	We do not cover:
<ul style="list-style-type: none"> any day case admission in an NHS, private hospital or treatment centre 	<ul style="list-style-type: none"> any period where Inpatient Benefit has been claimed outpatient appointments, including pre-operative checks attendance at an accident and emergency unit ante-natal or post-natal appointments Pre-existing Conditions

10.14 Birth of a Child

- i. We will pay a single amount at the appropriate rate shown in the Benefit Table, for each child that you or your partner give birth to, or adopt under the age of twelve months.
- ii. To process your claim we require the original full (not short) birth certificate or original adoption certificate and proof that the child was placed in your care before the age of twelve months.

We cover:	We do not cover:
<ul style="list-style-type: none"> the birth of a child the birth of a child that is still-born. an adoption of a child that is under the age of twelve months when placed with the adoptive parents, upon production of an adoption certificate 	<ul style="list-style-type: none"> terminations of pregnancy miscarriages prior to 24 weeks of term the fostering of a child a baby born to a Child any claim within the first 12 months of the Policy



10.15 Recuperation

- i. We will pay a single amount at the appropriate rate for your chosen premium level in any one Benefit Year, if you have been an Inpatient for a minimum of five consecutive nights.

We cover:	We do not cover:
<ul style="list-style-type: none">• 50% of the benefit shown in your Benefit Table for between 5 and 9 consecutive nights as an inpatient• 100% for 10 consecutive nights or more	<ul style="list-style-type: none">• recuperation related to pregnancy or childbirth• Daycase or Outpatient attendances

10.16 Prescription Charges

- i. We will pay towards the cost of prescription charges, including under a pre-payment scheme, up to a maximum in any one benefit year and at the percentage rate shown, within your chosen premium level in the Benefit Table.
- ii. To process your claim, we require an original, dated receipt from a registered pharmacist.

10.17 Personal Accident

10.17.1 Broken Bones

We will pay an amount at the appropriate rate shown in the Benefit Table when there has been a break or breaks of the radius, ulna, humerus, femur, tibia or fibula bone. When you notify us, we will send you a claim form that must be signed by your GP or hospital doctor. We may request access to your medical records if we require further information.

10.17.2 Other Personal Accident Benefits

Personal Accident Benefits other than for broken bones are provided through a third party arrangement as detailed on the Schedule of Membership. We reserve the right to change this arrangement subject to 28 days notice. We will pay the Benefits shown within your chosen Premium level in the Benefit Table in the event of the Member sustaining Bodily Injury or Permanent and Irrecoverable Disablement which is the sole and direct cause of Bodily Injury and will in all probability last for the remainder of your life, without reference to your occupation.

If any Member disappears and after a suitable period of time it is reasonable to believe that such Member has died as a result of Bodily Injury, the Death Benefit shall become payable subject to the Member's representative signing an undertaking that if the belief is subsequently found to be incorrect such Death Benefit shall be refunded.

Death and/or injury to a Member as a direct result of unavoidable exposure to the elements shall be deemed to have been caused by Bodily Injury.

In the event of a Member sustaining Permanent Total Disablement, Paraplegia or Quadriplegia the underwriters will pay an additional amount of 25% of the Permanent Total Disablement Benefit, subject to a maximum of £5,000, for costs necessarily incurred as a result of having to move his or her permanent residence to an alternative location or for the costs of alterations to the Members' residence, car or place of work.

Accident/Accidental means a sudden unexpected, unusual specific Event which occurs at an identifiable time and place but also includes exposure resulting from a mishap to a conveyance in which the Member is travelling.

Bodily Injury is that which is caused by an Accident and which solely and independently of any other cause results within 24 months from the date of such injury in the Member's death, dismemberment or disablement. Bodily Injury does not include sickness, disease, any naturally occurring condition, any gradually operating cause or post-traumatic stress disorder, other than as a direct result of accidental Bodily Injury caused by an Event.

Loss of Eye(s) shall include total and irrecoverable loss of sight, which is deemed to have occurred:

- i. in both eyes when the condition is shown to the satisfaction of the underwriters to be permanent and without expectation of recovery and the Member's name has been added to the Register of Blind Persons on the authority of a fully qualified ophthalmic Specialist;
- ii. in one eye when the degree of sight remaining after correction is 3/60 or less on the Snellen scale and the underwriters are satisfied that the condition is permanent and without expectation of recovery.

Total Loss of Hearing means the total, permanent and irrecoverable loss of hearing.

Loss of Limb(s) shall mean:

- i. in the case of a lower limb by permanent physical severance at or above the ankle or permanent total loss of use of an entire leg or foot;
- ii. in the case of an upper limb by permanent physical severance of the entire four fingers through or above the metacarpo phalangeal joints or permanent total loss of use of an entire arm or hand.

Paraplegia shall mean the permanent and total paralysis of the two lower limbs.

Permanent Total Disablement

- i. where the Member is gainfully employed, shall mean disablement caused other than by Loss of Limbs, Loss of Eye(s) or Total Loss of Hearing which will entirely prevent the Member from engaging in his or her usual occupation for the remainder of his/her life;
- ii. where the Member is not gainfully employed, shall mean disablement caused other than by Loss of Limb(s), Loss of Eye(s) or Total Loss of Hearing which will entirely prevent the Member from engaging in any and every occupation for the remainder of his/her life.

Quadriplegia shall mean the permanent and total paralysis of all four limbs of the body.

Exclusions

The underwriters shall not be liable in respect of Bodily Injury directly consequent upon:

- i. the Member committing or attempting to commit suicide, or intentionally inflicting self-injury;
- ii. the Member engaging in flying or any other aerial activity except as a passenger;
- iii. the Member participating in any sport as a professional;
- iv. the Member engaging in active service in any of the Armed Forces of any nation;
- v. war, meaning armed conflict between nations, including forces acting for an international authority, whether war be declared or not, invasion, civil war, military action, any attempt to usurp power, or any activity arising out of an attempt to participate in any of these actions within the Country of Nationality and Country of Domicile of the Member(s);
- vi. radioactive contamination;
- vii. the Member engaging in or taking part in rock climbing or mountaineering normally involving ropes or guides, hang-gliding, parachuting or driving or riding in any kind of race;
- viii. the Member being in a state of insanity (temporary or otherwise) or any psychiatric, mental, nervous or stress-related disorder or anxiety state;
- ix. deliberate exposure to exceptional danger (except in an attempt to save a human life), the Member's own criminal act or the Member engaging or taking part in civil commotion or riots of any kind;
- x. pregnancy or childbirth;
- xi. injuries resulting from Osteoporosis disease.

Benefits Limits

Where an accident results initially in disability and subsequently death the underwriters will pay the Death Benefit. On payment of a Benefit in respect of any of the items: Death, Permanent Total Disablement, Permanent and Incurable Paralysis of all Limbs, Paraplegia, Quadriplegia and Permanent and Incurable Insanity Personal Accident Cover will cease in respect of the Member who is the subject of the Claim.

If you have a Claim, you or your representative should let us know within 28 days of the accident. We will send you or your representative a Claim form. In respect of a Claim for Accidental Death the underwriters require a Coroner's Certificate or Report as proof of accident, a death certificate and Grant of Probate or Letters of Administration to support the Claim. In respect of a Claim for disablement the underwriters require a medical report from a Doctor or Consultant.

Payment of any Benefit under the Policy shall be subject to production of such evidence as the underwriters may require in relation to:

- i. the happening of the event upon which the Benefit is payable;
- ii. the title of the person claiming payment.

10.18 Discounted Health Club Membership

We will provide you with a voucher that on production will allow you access to health club membership at discounted rates at selected participating establishments.

Membership of any of the participating establishments is at the sole discretion of that establishment in accordance with their rules and procedures and we have no influence over these. We do not endorse any particular establishment and do not accept any liability to you as a result of any health club membership taken up under this arrangement.

10.19 Online Health Screening

You and your immediate family members living in the same household are able to complete a confidential Health Risk Assessment which will give you a personalised report in addressing potential health risks. The information given will produce a confidential Personal Health Report outlining recommendations and opportunities for change.

You can update your Health Risk Assessment as often as you wish, so that you can monitor health improvements gained from lifestyle changes.

Details of how to access the website are shown on the Schedule of Membership. This service is provided through our service partner as detailed on the Schedule of Membership.

10.20 Health Screening

We will provide you with a Health Screen Voucher which provides you with access to one free Health Screen from an assessor at selected establishments together with a report. This service is provided through a third party arrangement as detailed on the Schedule of Membership. Before the Health Screen Voucher can be used it needs to be activated, please refer to the instructions on your Schedule of Membership.

Any follow up or additional Health Screens outside of the cover available under your Policy will be at your own cost. Your Health Screen must be claimed before the expiry date recorded on the Health Screen Voucher otherwise it will be invalid. Providing that your Policy remains in force and Premium payments are up to date a new Health Screen Voucher will be issued to you every three years from your original joining date as set out in the Schedule of Membership. We do not accept any liability to you as a result of any conclusions or advice given during the health screen taken up under this arrangement.

10.21 Telephone Helplines and Online Support

These services are provided through our service partners as detailed on the Schedule of Membership. You get direct, unlimited and confidential, round the clock access to a team of highly qualified professional counsellors. You can call as often as you need to, whether it is about the same problem or other issues you find yourself having to face.

You must pay for the cost of the call to the helpline and any costs arising from the advice you receive. Medicash do not endorse any particular establishment and do not accept any liability arising to you as a result of any advice or counselling taken up under this arrangement. **Important Note:** This is not an emergency service and it will not provide a diagnosis or prescribe Treatment but be limited to the supply of advice and information only.

10.21.1 Counselling Helpline

This is an independent and confidential service providing unlimited access. A trained and experienced counsellor will respond to your call and they will help you to work through the issues and assist you in finding a way to deal with them. It provides support for personal

issues that cause anxiety such as relationship difficulties, family problems, bereavement, addictions, as well as work related issues such as pressure of work, relationships with colleagues or managers, harassment and bullying.

10.21.2 Homecall

This service gives assistance in the event of a domestic emergency to restore the main services to your home, ensuring it remains safe and secure and avoids causing further damage. Major areas of emergency assistance include: domestic plumbing and drainage systems; domestic gas and electricity supply; roofing; locks and security systems; heating systems. Arrangements will be made for an approved contractor to come to your help quickly. Close control is maintained on the prices charged by the contractor and the standard of service and response times that they maintain. Whilst you are responsible for the call-out charge and the repair cost, you will have peace of mind that you will receive prompt priority service from an approved contractor.

10.21.3 Health Advice

Health Related Helpline – Provides practical advice covering diet and lifestyle, allergies and food intolerance, infertility advice and family health. If appropriate we can give you information about professional organisations that can provide you with further specialist advice.

Medical Information – Information on how to access the length of hospital waiting lists for the major medical areas; Information and advice in respect of obtaining a second opinion on medical matters; Details of facilities available through Social Services; Details of additional sources of information and societies who specifically deal with particular disabilities or ailments.

Wellbeingworks® – This is a personal online support programme, offering 24-hour access to specialist health consultants and an interactive healthy lifestyles website. It provides a comprehensive health portal that includes regular feature articles, HealthBytes and a medical encyclopaedia. It provides essential information on topics including: Men's health, Women's health, Children's health, Pregnancy, Nutrition, Fitness & Exercise, Sexual health and Medical conditions.

10.21.4 Expert Medical Opinion

Members or eligible dependent children together with their treating doctors, can consult with some of the world's top medical experts for a diagnosed serious medical condition. These medical experts are voted by their peers as the best in their specialities of medicine and are able to provide additional insight and information to help confirm diagnosis and appropriate recommended treatment plans.

10.21.5 General Support

General Support Helpline – This service provides stress, debt, redundancy and bereavement counselling and legal information. This helpline gives advice on problems of a personal nature and practical help about how to identify and manage a problem.

LifeManagement™ Services – This service gives expert information and guidance to members, encouraging them to balance work and personal issues. This may include

answering questions about finance, legal, and consumer affairs, worries about personal problems and events such as relocation, promotion, bereavement or job loss which affect people from time to time.

FAMILYcare Services – This service is designed to provide hands-on help and support with specific issues affecting families. There are three main components; Childcare Service to advise parents with their childcare and parenting needs; Eldercare Service to support people with any questions/concerns about issues affecting an elderly relative such as their care and housing needs; and Young People/Education to provide information and guidance on issues affecting older children/young adults, for example, education options, benefit entitlement, employment rights etc.

Money Management Service – The services offered under our Money Management Services umbrella fall into two categories; Money Advice Service to help members who are in Debt and need assistance to help them deal with what may be a long-term issue; and Financial Education Service. This gives information to educate members of their options when investing money, such as taking out a mortgage, savings, investments, tax, pension options, etc. This is not a financial advisory service, we present facts so that members can make informed decisions. This service is confidential. All cases are managed by a dedicated Money Management team.

10.22 Face to Face Counselling Sessions

Where appropriate, either following your call to the Counselling Helpline or through your employer, you can see a counsellor in person. This will be arranged for you at a convenient location provided that you have been a policy holder for a minimum of six months. The maximum number of counselling sessions you are entitled to in any one Benefit Year is set out in the Benefit Table. Additional counselling sessions agreed with our service provider, that are required above your annual Medicash entitlement, will be at your own expense and subject to an individual agreement.

Medicash encourage a pragmatic approach to counselling, empowering members to take control of their situation, encouraging them to be more proactive in their own well-being.

10.22.1 Individual Trauma

This forms part of the face to face service, delivered off-site, for those individuals assessed as having suffered a trauma. You will receive immediate clinical support through this arrangement, to support you in reducing the risk of post traumatic stress disorder, allowing individuals to get on with their life and work in a timely fashion.

10.23 Worldwide Cover

Benefit cover is ordinarily only for Treatment within the United Kingdom. However you are covered for emergency Treatment that you receive anywhere in the world during overseas visits that are intended to last no more than 28 days. Receipts must be submitted to Medicash translated into English, if necessary. This cover is for emergency treatment for Dental, Optical, Inpatient and Parental Stay, and Personal Accident benefits.

Useful Numbers

claims 0151 702 0265

Increase your cover 0151 702 0304

Add your partner 0151 702 0304

Recommend a friend 0151 702 0304

customer service 0151 702 0265

Your Medicash Healthcare Plan

This insurance is provided by Medicash Health Benefits Limited, Merchants Court, 2-12 Lord Street, Liverpool L2 1TS. A company limited by guarantee, and registered in England (number: 258025).

Medicash Health Benefits Limited is authorised and regulated by the Financial Services Authority. Details of registration can be found at www.fsa.gov.uk or by calling the FSA on 0845 606 1234.

Medicash is also covered by the Financial Services Compensation Scheme and the Financial Ombudsman Service.

+ medicash

Merchants Court, 2-12 Lord Street, Liverpool L2 1TS.

Tel: 0151 702 0265 Fax: 0151 702 0250

E-mail: claims@medicash.org

Website: www.medicash.org

All Medicash telephone numbers are available from Monday to Thursday, 8.45am until 5pm and Friday, 8.45am until 4pm (except on public holidays). Telephone calls may be recorded or monitored for training purposes.