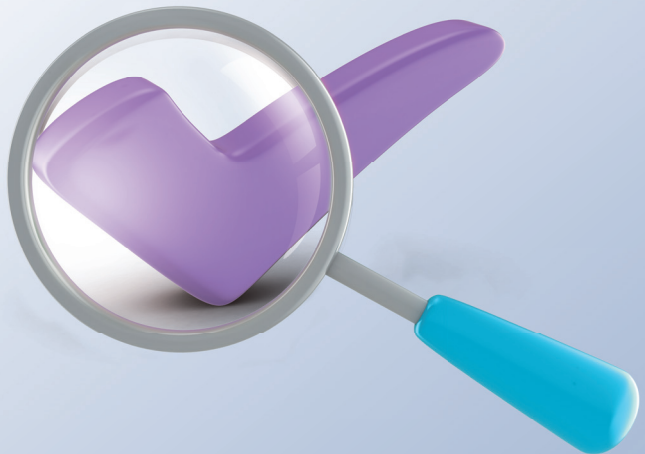


Policy terms and conditions

THE GOOD ALL ROUND CASH PLAN
EXPLAINED IN FULL



Your Good All Round cash plan

...here's what you can claim for in more detail

The table below details the health care benefits you can claim for each year with your Good All Round cash plan. Each benefit has its own claiming year, which is 12 months from the date of the first treatment you receive or hospital stay you claim for. Please read these terms and conditions for full details and benefit explanations. Premiums include Insurance Premium Tax (IPT).

Levels of cover		Level 1	Level 2	Level 3	Level 4	Level 5
Monthly premium (per person)		£9.62	£14.43	£19.24	£24.05	£28.86
Weekly premium (per person)		£2.22	£3.33	£4.44	£5.55	£6.66
Everyday essentials		Payback				
Dental including treatment, check-ups, x-rays and full or partial dentures	100%	up to £60	up to £90	up to £120	up to £150	up to £180
Optical including glasses, contact lenses and eye tests 12 month qualifying period for all types of eye surgery	100%	up to £60	up to £90	up to £120	up to £150	up to £180
Prescription charges, inoculations and vaccinations	50%	up to £16	up to £24	up to £32	up to £40	up to £48
Help to keep you ticking over						
Physiotherapy/Osteopathy/Chiropractic/Sports massage 6 month qualifying period for pre-existing conditions	50%	up to £200	up to £300	up to £400	up to £500	up to £600
Chiropody/Podiatry	50%	up to £50	up to £75	up to £100	up to £125	up to £150
Acupuncture/Homeopathy/Reflexology	50%	up to £70	up to £105	up to £140	up to £175	up to £210
Health screening including well man, well woman, osteoporosis and mammogram screening	50%	up to £70	up to £105	up to £140	up to £175	up to £210
Support if you need NHS or private hospital treatment						
Hospital in-patient and day case admission 6 month qualifying period for pre-existing conditions	Max 7 days/nights	£20 per day/night	£30 per day/night	£40 per day/night	£50 per day/night	£60 per day/night
Hospital consultant fees and diagnostic tests 6 month qualifying period for pre-existing conditions	50%	up to £150	up to £225	up to £300	up to £375	up to £450
Support when you need a helping hand						
Birth/adoption of a child 6 month qualifying period	Fixed amount	£100 per child	£150 per child	£200 per child	£250 per child	£300 per child
24-hour telephone helpline provided by a specialist third party. Available 24 hours a day, 365 days a year. Includes medical information, telephone counselling, specialist legal, financial and consumer information as well as online support on a wide range of life issues.						

Free cover for dependent children up to the age of 18

Dependent children up to the age of 18 are covered at the same level as the policyholder for all benefits excluding birth/adoption. Cover provides separate annual maximums for the policyholder and each of their dependent children.

General conditions


Welcome to Sovereign Health Care

Please read these terms and conditions and your policy documents carefully as they will help you make the most of your policy.

Your Good All Round cash plan is designed to be used. Please keep your policy documents in a safe place and don't forget to claim!

How to contact us


If you have any questions please don't hesitate to contact us using the details below. Please remember to quote your policy number(s) when you contact us.

 If you have a query please call our customer relations team on **01274 841130**


Our customer relations team are usually available Monday to Thursday between 9am to 5pm and Friday between 9am to 4pm (our **"office hours"**).

 Email **cr@sovereignhealthcare.co.uk**

You can email us at anytime and we will respond to you during office hours. Please quote your policy number and name in your email.

 Visit **www.sovereignhealthcare.co.uk**

You can claim online and get more information by visiting our website.

 You can write to us at Customer Relations, Sovereign Health Care, Royal Standard House, 26 Manningham Lane, Bradford BD1 3DN.

The purpose of these terms and conditions

These terms and conditions set out the legal terms and conditions which govern your policy. They apply to your policy whether or not you signed the application form. For the purposes of our contract you will be classed as a 'consumer', otherwise known as a retail client.

Policy start date and renewal

Your policy starts on the date specified on your policy certificate (your **"start date"**) and will renew automatically each month until it is cancelled or you allow it to lapse.

Are you eligible to join?

You must be age 18 or over and under the age of 66 to apply to join the policy. If you are between the ages of 16 and 18 and in full time employment, we may consider your application on an exceptional basis. You must also be a permanent United Kingdom (UK) resident for tax purposes with an address in the UK. Subject to these terms and conditions you can continue to hold a policy for as long as you wish.

Your application to join, renew a policy or change cover level is subject to acceptance by Sovereign Health Care and we reserve the right to refuse your application for any reason without providing an explanation.

Any information you provide to us about yourself and anyone else you are paying for must be accurate, true and complete to the best of your knowledge. If you fail to comply with this condition, we reserve the right to cancel your policy and any other policies you pay for at any time. See the section titled 'Ending your policy' for more details.

No medical is necessary

You do not need to undergo a medical to join Sovereign Health Care.

You can claim straightaway except for benefits with a qualifying period

When you join you can claim straightaway for treatment received on or after your start date, except for benefits with a qualifying period, for which you will not be covered until the qualifying period has expired (regardless of when you claim). We recommend that you read this section along with the sections titled 'Qualifying periods', 'Pre-existing conditions' and 'Benefits explained' before undergoing any treatment for which you intend to claim under your policy.

For benefits with a qualifying period, you must have completed the relevant qualifying period before you can claim.

If you have joined the Good All Round cash plan after holding a different type of cash plan policy with us, qualifying periods will **not** apply where your cover with us is continuous and you have already completed any relevant qualifying periods.

If you have joined the Good All Round cash plan **and** you also hold a different type of cash plan policy with us, new qualifying periods **will** apply to your Good All Round cash plan.

Qualifying periods

For laser eye surgery or refractive eye surgery (within the optical benefit) there is a 12 month qualifying period. This means we will not accept claims for laser eye surgery or refractive eye surgery received within the first 12 months of the policy.

For the birth/adoption benefit there is a 6 month qualifying period. This means we will not accept claims where the birth/adoption occurred within the first 6 months of the policy.

Where you have a pre-existing condition, a 6 month qualifying period applies for certain benefits. See the section below titled 'Pre-existing conditions' for more information.

A new qualifying period will apply if you increase your level of cover, regardless of how long you have held your policy for. See the section titled 'Changing your level of cover' for more information.

Pre-existing conditions

In this section the words, **"pre-existing condition"** mean a condition which affects you on your policy start date, or the date you upgraded your policy, and which you intend to claim for under the following benefits:

- Physiotherapy/Osteopathy/Chiropractic/Sports massage
- Hospital in-patient and day case admission
- Hospital consultant fees and diagnostic tests

You can still join if you are affected by a pre-existing condition, but your policy will not cover you for the above benefits where treatment is for a pre-existing condition until the conclusion of the 6 month qualifying period.

We will accept claims for treatment for pre-existing conditions provided the treatment is received not less than 6 months from the start date of your policy.

Where you increase your level of cover, in relation to pre-existing conditions your level of cover will only increase after 6 months of the date of the increase. See the section titled 'Changing your level of cover' for more information.

Need clarification about whether you can claim?

If you need to clarify whether or not your policy entitles you to claim for treatment, please call us on 01274 841130.

Your level of cover

Your level of cover is specified on your policy certificate which is part of your policy welcome pack. The benefits payable at each level of cover are detailed in the table of benefits on page 2. This shows your maximum entitlements per benefit claiming year, not per claim.

Changing your level of cover

You can apply to increase or decrease your level of cover at any time but you must remain at your new level of cover for 12 months before you can change again. You can change your level of cover by completing and submitting the appropriate application form to Sovereign Health Care.

Applications to change your level of cover are subject to acceptance by Sovereign Health Care and we reserve the right to refuse your application.

If you increase your level of cover you are automatically covered at the higher level of cover for all benefits from the effective date of your upgrade except where there is a qualifying period for a benefit or where you have a pre-existing condition. In these cases you must pay the premiums for your new higher level of cover for the relevant qualifying period before you can claim for these benefits at your new higher level of cover.

However you will be covered for these benefits up to your previous level of cover provided your policy has been in place for the relevant qualifying period and your premium payments are up to date. See the sections titled 'You can claim straightaway except for benefits with a qualifying period', 'Qualifying periods' and 'Pre-existing conditions' for more information.

If you apply to decrease your level of cover, your entitlement to claim for benefits at the previous higher level of cover ceases immediately from the date we accept your application.

In all cases, the benefit payable will be determined by the level of cover in force on the date of treatment and not the date the claim is submitted.

If you change your level of cover, your claiming year for each benefit will remain unchanged and any claims that we have already paid to you will count towards the maximum entitlement under your new level of cover.

Partner/Family member cover

When you join the policy you also have the option of paying for your partner and/or a family member either when you submit your own application or at a later date. If you decide to do this, your partner/family member will have their own policy in their own name however your partner's/family member's policy will be paid for by you and by the same payment method as your own policy.

Where you pay for your partner's/family member's policy and we make changes to the policy, we will write to you and your partner/family member separately to inform you both of the changes.

Where you pay for your partner's/family member's policy, we can discuss payment of their policy premiums with you but not any other part of their

policy unless your partner/family member has given us their express permission for us to do so. To do this your partner/family member must complete a 'Third party authorisation form' or call us to give us their authorisation instruction over the telephone. See the section titled 'Third party authorisation'.

Free cover for dependent children

In these terms and conditions, the words "**dependent child**" mean a natural or legally adopted dependent of you or your partner who permanently resides with you, is below the age of 18 and who is not a policyholder in their own right. The words "**dependent children**" shall be construed accordingly.

The policy covers dependent children for free at the same level of cover as the policyholder for all benefits excluding birth/adoption as detailed in the table of benefits on page 2. The policy covers each named dependent child up to the same maximum entitlements as the policyholder and is subject to the same benefit rules as applied to the adult policyholder unless detailed otherwise.

Where both parents/guardians are policyholders, claims for dependent children can be made against either parent's/guardian's policy but not both. Before your policy starts you must decide which parent's/guardian's policy to add your dependent children to.

To cover your dependent children you can either include them on your original application form or you can notify us on the claim form when you submit their first claim.

If your dependent child is born in hospital you can only claim for that child from the date he or she is discharged from hospital.

When a dependent child reaches their 18th birthday they will cease to be a dependent child for the purposes of your policy and will therefore no longer be covered. If they would like to join the Good All Round cash plan in their own right and they advise us within 13 weeks of their 18th birthday, they will receive complete continuation of cover provided premium payments are up to date.

Cooling off period – your right to change your mind

If you decide your policy does not meet your requirements for any reason, you may cancel it within 14 days of the start date or from the day on which you received your policy documents (whichever is the later) by advising us of your decision in writing or by telephoning our customer relations team on 01274 841130 (the "**cancellation period**").

Any premiums paid during the cancellation period will be refunded. Premiums will not be refunded if a claim has been made within the cancellation period or after the cancellation period has expired.

If you cancel your policy, it is your responsibility to inform your employer, bank or building society to stop deducting premium payments from your salary, pension or bank/building society account.

Premium payments and frequency

Payments will be collected by Sovereign Health and Insurance Services Limited, a wholly owned subsidiary of Sovereign Health Care. The premiums stated include Insurance Premium Tax (IPT) at the current rate.

Payment of premiums is the responsibility of the policyholder, regardless of whether a third party (such as your partner) pays the policy premiums on your behalf.

Premiums are due on a continuous basis in advance in accordance with the payment method (Direct Debit or payroll deduction) and the payment frequency agreed at the outset of the policy. Premiums are not refundable. Where you have made an advance payment for whatever reason, the amount refunded will be limited to a maximum period of two years. Any advance payments do not extend the length of your rolling contracts with us beyond one calendar month.

Where you pay by payroll deduction and you leave your employer, it is your responsibility to notify us and set up a new payment method to continue cover with us.

When you take out a policy, or increase your cover, we will notify you when your first payment will be collected. To ensure your premiums are up to date, it may be necessary to take payment for 2 or more months' premiums at the first collection.

We will not process any claims until we have received a payment that covers the date for which you are claiming.

Premiums must be fully up to date at the time of claiming or we will be entitled to suspend your cover and claims may not be paid. A policyholder whose premiums fall into arrears ceases to be entitled to claim. If premiums remain unpaid for 13 consecutive weeks, your policy will be cancelled and you will not be able to claim or receive a refund of any premiums paid.

When new premium rates are introduced they are payable from the date the change is made, unless we advise you otherwise.

If you want to change your level of cover and a third party pays for your policy on your behalf, we will assume that you have the permission of the third party premium payer to change the premium payments for your policy.

Our right to vary your policy

From time to time it may be necessary for us to vary your policy, including, for example, the amount that you pay us in relation to it, the benefits available to you under it and the rules relating to it. If we notify you that we have varied your policy and we do not hear from you, we will assume that your continued payment of your policy premiums is your consent to the variation. However, if you let us know in writing that you do not consent to the variation your policy will automatically be cancelled from the next automatic renewal date.

If we make a material change to the policy we will endeavour to give you not less than 30 days notice in writing to the last correspondence address that we have for you. It is essential that you inform us of any change of correspondence address as we cannot be responsible for correspondence not reaching you.

If we are ever required to change the policy on less notice due to, for example, a change in any relevant regulation or legislation, we will advise you at the earliest opportunity.

Ending your policy

You can end your policy at any time by giving us not less than 30 days notice. We will not refund any premiums you have already paid. You can end your policy by either writing to us or calling us - please see the section titled 'How to contact us'.

If you end your policy and then decide to reapply for cover with us, your application is subject to acceptance by Sovereign Health Care and we reserve the right to refuse your application. If we accept your application

to rejoin, you will be subject to the same qualifying periods as a new applicant. Any claims that we have already paid to you may be taken into account and count towards the maximum entitlement under your new policy.

If you end your policy, it is your responsibility to inform your employer, bank or building society to stop deducting premium payments from your salary, pension or bank/building society account. We will not refund any premiums paid during your notice period. We reserve the right to end your policy at any time. Normally we will give you at least 30 days written notice of this. However, we may end your policy immediately if:

- your policy premiums remain unpaid for 13 consecutive weeks; or
- there is reasonable evidence that you misled us or attempted to do so; or
- you commit a serious breach of these terms and conditions; or
- during your dealings with Sovereign Health Care, your behaviour is unacceptably abusive or threatening towards a Sovereign Health Care employee or one of our suppliers.

Your policy will automatically end if you die.

If we end your policy for any of the above reasons, we will be under no obligation to repay to you any premiums that you have already paid to us. We will pay you for any claims that we agreed we would settle before your policy ended but we may seek to recover any sums paid to you that were not due under the terms of the policy.

If we make a commercial decision to stop providing the policy, we will give you 30 days written notice. Any outstanding claims will be settled in accordance with these terms and conditions.

We will notify you in writing of our reason for ending your policy and you have the right to appeal to us through our complaints procedure. See the section titled 'Complaints procedure – your right to complain'.

If you have made payments for premiums in advance, we may refund premiums paid beyond the date for which you have had the benefit of the policy. However we retain the right to withhold such premiums if you owe us money.

Nothing in these terms and conditions affects your statutory rights.

This policy is only available to UK residents

The policy is only available to persons who for UK tax purposes are resident in the UK and have a permanent residence in the UK.

If you permanently reside outside of the UK you are not eligible to be covered by the policy.

If you are an existing customer of Sovereign Health Care and you temporarily reside outside of the UK, you can continue with your policy provided your permanent residence address is in the UK.

Claims – general rules

See the 'Benefits explained' section for specific details about what we **will** and **will not** pay for under each benefit.

You can have more than one type of Sovereign Health Care cash plan policy however you can only claim for treatment once. If you have more than one type of cash plan policy with us, you can claim against each policy but we will not pay more than you have paid for your treatment.

We do not cover premiums you may pay for other types of insurance policies including but not limited to private medical insurance (PMI) and dental maintenance schemes such as Denplan.

We take pride in paying our customers claims promptly. We process all claims as quickly as possible, but we rely on you submitting a fully completed claim form along with the relevant, valid documentation.

Once we have all the information we need, your claim will be processed promptly. The date you receive your money will then depend on your preferred method of payment of your claims.

You can choose to have your claims paid by direct credit into a bank account or by cheque. If you would like to have your claims paid into a bank account please complete the relevant section on the claim form, return a 'Direct Credit' form to us or call us on 01274 841130 to set this up.

You must submit a claim within 12 months of the date any treatment was received or the completion date of any hospital treatment. If you fail to do so, you will have waived your right to be paid/reimbursed for that claim.

Where you have paid for treatment in advance of receiving the treatment, we will only settle claims once you have received the treatment and we have had confirmation that all treatment paid for has been received.

If you pay for treatment using NHS vouchers, we will not accept the claim or reimburse you.

We will only consider claims for payment once we have received a fully completed claim form accompanied by original, valid receipts where required.

When submitting a claim, please be aware that we do not accept the following:

- receipts that have been altered, photocopied or faxed
- joint named receipts
- till roll receipts
- credit or debit card slips
- invoices not marked as 'paid'
- bank statements or photocopies of any accounts
- receipts where only a part payment or deposit has been paid, including receipts showing a balance outstanding for payment.

You must ensure that all receipts identify the name of the person who received the treatment, the name of the practitioner, details of the treatment and the date it took place.

We do **not** return any receipts or invoices. If you require a copy for your records please arrange this before you submit your claim.

For the birth/adoption benefit, we require a photocopy of the relevant original full birth or adoption certificate/document.

Where a claim or premium refund request has been submitted and the policyholder has subsequently died, we require a photocopy of the relevant original death certificate/document.

Please note that we do not request sight of original birth, adoption or death certificates/documents. We take no responsibility for the loss of these documents in the event that the original is sent to us.

All treatment must be provided by a suitably qualified practitioner and, where applicable, they must be registered with an appropriate professional body recognised by us.

Under no circumstances can claims be accepted where the health care provider/practitioner is you, your partner or a member of your family.

When you submit a claim, if we are in any doubt regarding the treatment, the person that has received the treatment or the person that has provided the treatment, we reserve the right to contact the health care provider/practitioner for further information.

Occasionally we may request a medical report from you, your GP or health care provider/practitioner to verify a claim. If we make such a request, checks will be carried out in accordance with the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal data. If we do seek additional information and/or if your GP or health care provider/practitioner makes a charge for completing your claim form, we will not pay for any amount you may be charged by them for doing this. These charges will be your responsibility.

Claims will not be paid if you are in breach of any of these terms and conditions.

Each benefit has its own individual claiming year

Each benefit has its own individual claiming year (not to be confused with a calendar year i.e. 1 January to 31 December, or the policy start date), which is 12 months from:

1. The date of the first treatment for the relevant benefit, as shown on the receipt you submit with your completed claim form, or
2. The date of first admission for hospital in-patient or day case treatment.

The maximum amount you can claim up to for an individual benefit in a claiming year is dependent upon your level of cover. Your level of cover is detailed on your policy certificate. The maximum entitlements for each level of cover for each benefit are detailed in the table of benefits on page 2.

After each benefit's claiming year has expired, you can claim again up to your policy limit. The new claiming year for the relevant benefit starts from the date of the next treatment or hospital admission as defined above.

An example of a claiming year

You take out a policy which covers you for dental treatment. You undergo, complete and pay for that dental treatment on 1 July 2018. Your claiming year for the dental benefit would therefore run from 1 July 2018 until 30 June 2019 and you could claim up to your policy limit within this time. This example is for illustrative purposes only and should you need clarification about the start or end date of the claiming

year for any benefit, please call our customer relations team on 01274 841130.

How to claim

Your Good All Round cash plan is designed to be used so please remember to claim.

Claiming is simple, all you need to do is:

1. For receipt based claims, remember to get an itemised receipt when you pay for treatment - this should include the name of the person who received the treatment, the name of the practitioner, details of the treatment and the date it took place. If you are claiming for the hospital benefit (in-patient or day case admission) you will need to ask the hospital or medical centre where you were treated to complete the relevant section on the claim form with their details and the details of the procedure. They should also sign and stamp the form.
2. Complete a claim form – you can do this online by registering for our secure customer area, or by post using the claim form enclosed in your policy welcome pack or by downloading one from our website. Then submit your completed claim form to us with the original named receipt(s). Remember you need to claim within 12 months of the date of treatment.
3. We will then pay the money into your bank account or send you a cheque if you prefer.

Claims for treatment abroad

You can claim for treatment received anywhere in the world from a qualified practitioner (provided that he/she is not a member of your family - see the section titled 'Claims – general rules'). For example if you buy your glasses whilst you are abroad, you can claim for these under your policy. If we accept a claim for treatment received outside the UK, it will be paid in pounds sterling at the prevailing exchange rate published by Oanda (www.oanda.com) for the relevant currency on the date we settle your claim. Please ensure you submit a valid receipt. If the receipt is not in English, it would be helpful if you could attach a covering letter in English stating the treatment you have received.

Fraudulent claims and misuse of the policy

The Good All Round cash plan has been designed to allow customers the opportunity to claim cash back towards the costs of everyday health care. In the event of a fraudulent claim we reserve the right to cancel or suspend your policy and commence legal action. We always seek to recover the costs of all fraudulent claims.

We are members of the Health Insurance Counter Fraud Group (HICFG) and will share information about suspected fraudulent activity with HICFG.

If you display blatant misuse of the policy such as providing false information, making claims under more than one insurance policy in order to receive a sum greater than the cost of treatment (this is called 'betterment'), claiming for treatment where the provider/practitioner is you, your partner or a member of your family, it is likely to lead to your policy being cancelled and premiums will not be refunded. These examples are not exhaustive and we will always act to serve the best interests of all our customers.

We will not pay claims where treatment was received as a result of intentional self injury/illness or your own negligence.

Overpayment of claims

If we make an overpayment to you on a claim, we reserve the right to offset the overpaid amount against any future claims or to recover such overpayment from you directly. In the event that your policy is cancelled any overpayment must be re-paid by you to us immediately.

Governing law and communications

The Law of England and Wales applies to the contract. All communications will be in English.

Complaints procedure – your right to complain

We pride ourselves on our customer service standards however we recognise that occasionally you may be unhappy with us. If you are not satisfied with any aspect of the service you have received from us please contact our Customer Relations Manager detailing the nature of your complaint by either:

Writing to: Customer Relations Manager, Sovereign Health Care, Royal Standard House, 26 Manningham Lane, Bradford BD1 3DN.

Telephoning: 01274 841130. Lines are open Monday to Thursday 9am to 5pm and Friday 9am to 4pm.

To help us deal with your complaint quickly, please quote your policy number and your policyholder/insured name.

If you are unhappy with the response you receive from us, you have the right to refer your complaint to the Financial Ombudsman Service, Exchange Tower, London E14 9SR. The Ombudsman will only consider your complaint after you have written confirmation from us that our internal complaints procedure has been applied in full.

How we use your personal information

Sovereign Health Care and its group companies comply with the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal information ('Data Protection Legislation') and we will store and process any personal information collected by us in our systems in accordance with Data Protection Legislation. We are committed to keeping your personal information secure, including sensitive personal information relating to health or medical conditions.

When you and/or your employer submit personal information to us, you consent to us using and sharing it in the ways described here. By providing personal information about another person (for example your partner), you confirm that you have that person's permission to provide the information to us, and for it to be used and shared by us in the same way as your own.

We will use your personal information to provide the services set out under the terms and conditions of this policy, including claims assessment and processing, as well as to prevent crime (including fraud and money laundering) and to comply with any legal requirement on us. We may also share your information with approved business partners, organisations and your employer if applicable, for the purposes of administering your policy. Information about claims may be put on a register of claims and shared with other companies, including insurers, for fraud prevention. Whenever we transfer or share information we ensure that it is protected.

Where we have your consent to do so, we may use your personal information to contact you by post, telephone, text or email about special offers, products and services which may be of interest to you. You may exercise your right to withdraw your consent and opt-out of receiving any of our marketing information by emailing us at cr@sovereignhealthcare.co.uk, quoting your policy number, or by calling 01274 841130. You can unsubscribe from any electronic marketing communications by clicking the unsubscribe link within a communication.

For further details on how your personal information is used, including disclosure to third parties, how we maintain security of your information and your rights in relation to the information we hold about you, please see our privacy policy available on our website or contact us if you require a hard copy.

Any telephone calls may be recorded and monitored for training and quality purposes.

Third party authorisation

Sovereign Health Care and its group companies comply with the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal data. We are committed to keeping your personal information secure, including sensitive personal information relating to your health or medical conditions. We are not allowed to discuss your policy(ies) with your partner, a relative or any other third party, unless you give us permission to do so. You can give us your permission by completing a 'Third party authorisation form' or by calling us to give us your authorisation instruction over the telephone. To do this call our customer relations team on 01274 841130, please note both the policyholder and the person to be authorised must be available to confirm the instruction over the telephone.

Financial Services Compensation Scheme (FSCS)

We are covered by the Financial Services Compensation Scheme (FSCS). In the unlikely event of us being unable to meet our financial obligations you may be entitled to claim compensation from the scheme. Further information about compensation scheme arrangements is available at www.fscs.org.uk or by calling 0800 678 1100.

Benefits explained

This section explains in more detail what we **will** and **will not** pay you for with regards to the individual benefits within your policy. Your level of cover and start date are detailed on your policy certificate enclosed within your welcome pack.

You are required to pay for the cost of any treatment first, for which you should obtain a detailed, named receipt. Once you have completed your treatment and paid for it in full, you can then claim the costs of the treatment back from us at the relevant percentage payback, up to your cover level maximum. A detailed original receipt should endorse your claim where relevant. For more information about claiming see pages 6 and 7.

Everyday essentials

Dental

We will refund the **full** amount paid by you to a qualified NHS or private dental practitioner up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover.

We **will** pay you for:

1. Dental treatment including check ups and hygienist fees
2. Full or partial dentures
3. X-rays

We **will not** pay you for:

1. Cosmetic dentistry
2. Dental implants
3. Non prescribed items or consumables
e.g. mouthwash, dental floss, toothbrushes
4. Registration/administration fees
5. Dental maintenance or dental membership schemes
e.g. Denplan premiums
6. Missed appointment charges

Optical

We will refund the **full** amount paid by you to a qualified optical practitioner up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover.

We **will** pay you for:

1. Sight tests
2. Prescribed spectacles including frames, prescribed sunglasses and prescribed contact lenses
3. Spectacle repairs
4. Laser eye surgery or refractive eye surgery performed by a recognised hospital or laser eye clinic. This excludes consultation at any time and any treatment received within the first 12 months of the policy

We **will not** pay you for:

1. Non prescription spectacles/sunglasses/contact lenses
2. Optical sundry items or consumables e.g. any type of solutions, spectacle cases, cleaning materials
3. Spectacle/contact lens insurance premiums
4. Receipts where only a part payment or deposit has been paid, including receipts showing a balance outstanding for payment
5. Laser eye surgery or refractive eye surgery consultations at any time
6. Laser eye surgery or refractive eye surgery received within the first 12 months of the policy
7. Missed appointment charges

Prescription charges, inoculations and vaccinations

We will refund **half** the amount paid by you for NHS or private prescription charges and/or charges for inoculations or vaccinations from a qualified medical professional up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover.

To make a valid claim for prescription charges, you must obtain an original, named receipt from a registered pharmacist on the day you pay for your prescription. When you send us your claim form, you must also send us this receipt. If you are claiming for

an NHS prepayment certificate, a photocopy of your prepayment certificate card, clearly showing your name and the valid from date, must accompany your completed claim form.

To make a valid claim for inoculations or vaccinations, you must obtain an original, named receipt from a registered pharmacist or medical practitioner on the day you pay for your inoculation or vaccination.

We will pay you for:

1. NHS prescription charges
2. Private prescription charges
3. An NHS prepayment certificate where multiple NHS prescriptions are needed
4. Prescriptions and/or other charges arising from the administration of an inoculation or vaccination

We will not pay you for:

1. Prescriptions for sexual/contraceptive aids
2. Prescriptions for lifestyle conditions i.e. to help stop smoking, drinking alcohol, weight loss etc
3. Inoculations or vaccinations provided by the NHS free of charge
4. Inoculations or vaccinations for anyone other than you or your dependent children

Help to keep you ticking over

Physiotherapy/Osteopathy/Chiropractic/ Sports massage

We will refund **half** the amount paid by you to a qualified and registered physiotherapist, osteopath, chiropractor or sports massage therapist up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover. The amount covered is not per therapy. It is a total amount which can be used against one, or a combination, of the therapy treatments detailed up to your cover level maximum.

We will pay you for:

1. Physiotherapy, osteopathy or chiropractic treatment supplied by a practitioner who is qualified and registered with an appropriate professional body recognised by Sovereign Health Care, these include:
 - Physiotherapists registered with the Health & Care Professions Council (HCPC)
 - Osteopaths registered with the General Osteopathic Council (GOsC)
 - Chiropractors registered with the General Chiropractic Council (GCC)
2. Sports massage treatment supplied by a therapist recognised by Sovereign Health Care
3. A Private Medical Insurance (PMI) excess that has been paid by you to your PMI provider in order to access physiotherapy, osteopathy, chiropractic or sports massage treatment

We will not pay you for:

1. Any treatment supplied by a practitioner who is not qualified and registered with an appropriate professional body recognised by Sovereign Health Care
2. Any other treatment that is not physiotherapy, osteopathy, chiropractic or sports massage.
Examples of treatments that we do not cover are aromatherapy, herbal therapies, Indian head

massage, Reiki, Alexander Technique, Bowen Therapy and cranial sacro therapy. This list is not exhaustive

3. Appliances and supporting materials including but not limited to lumber roll, spinal pillows/cushions, flexiband, tape, ice packs, books/literature etc
4. Medical reports
5. Treatment received for pre-existing conditions in the first 6 months from the date of joining or upgrading a policy
6. Missed appointment charges

Chiropody/Podiatry

We will refund **half** the amount paid by you to a qualified and registered chiropodist or podiatrist up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover. The amount covered is not per therapy. It is a total amount which can be used against one, or a combination, of the therapy treatments detailed up to your cover level maximum.

We will pay you for:

1. Chiropody or podiatry treatment supplied by a qualified practitioner registered with the Health & Care Professions Council (HCPC)

We will not pay you for:

1. Any treatment supplied by a practitioner who is not qualified and registered with the HCPC
2. Cosmetic procedures and pedicures
3. X-rays
4. Consumable items including but not limited to corn plasters and dressings
5. Surgical footwear or appliances including but not limited to arch supports and orthotic insoles
6. Missed appointment charges

Acupuncture/Homeopathy/Reflexology

We will refund **half** the amount paid by you to a qualified and registered acupuncturist, homeopath or reflexologist up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover. The amount covered is not per therapy. It is a total amount which can be used against one, or a combination, of the therapy treatments detailed up to your cover level maximum.

We will pay you for:

1. Acupuncture, homeopathy or reflexology treatment supplied by a practitioner who is qualified and registered with an appropriate professional body recognised by Sovereign Health Care, these include:

Acupuncture

- British Acupuncture Council
- British Medical Acupuncture Society (BMAS)
- The Modern Acupuncture Association
- The Association of Traditional Chinese Medicine and Acupuncture UK

Homeopathy

- The Faculty of Homeopathy
- ITEC qualified
- The Society of Homeopaths
- Alliance of Registered Homeopaths

Reflexology

- Federation of Holistic Therapists

- British Reflexology Association
- Association of Reflexologists
- International Institute of Reflexologists
- British School of Reflexology
- International Federation of Reflexologists
- Complimentary Therapists Association

We will not pay you for:

1. Any treatment supplied by a practitioner who is not qualified and registered with an appropriate professional body recognised by Sovereign Health Care
2. Homeopathic medicines purchased in isolation e.g. from a chemist, health food shop, mail order or the internet
3. Any other treatment that is not acupuncture, homeopathy or reflexology. Examples of treatments that we do not cover are aromatherapy, herbal therapies, Indian head massage, Reiki, Alexander Technique, Bowen Therapy and cranial sacro therapy. This list is not exhaustive
4. Sundry items
5. Missed appointment charges

Health screening

We will refund **half** the amount paid by you after receiving an approved health screening check, undertaken by medically qualified staff up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover.

We will pay you for:

1. Well man or well woman screening
2. Osteoporosis and mammogram screening

We will not pay you for:

1. Screening for legal, employment, insurance, emigration or similar purposes e.g. HGV/PSV
2. Home testing kits
3. Diagnostic procedures or tests
4. Missed appointment charges

Support if you need hospital treatment

Hospital in-patient and day case admission

We will pay you at the relevant fixed daily/nightly amount up to a maximum of 7 days/nights per benefit claiming year, each time you are:

- admitted for treatment as a day patient to a recognised hospital or medical centre (with surgical facilities) where the patient signs an admission form. For the purpose of clarity, day case admission is where you are admitted and discharged on the same day. If you are admitted as a day patient and then subsequently stay overnight, we will pay one night's hospital cover (not one day and one night)
- admitted to a ward (but not accident and emergency) to receive treatment as an in-patient. For the purpose of clarity an in-patient stay is classed as a full night only if you are admitted as an in-patient before 12 midnight

The amount paid is determined by your level of cover. The claim form must be completed and signed by the hospital or medical centre where you were admitted for treatment.

We will pay you for:

1. Admission as an in-patient for treatment of a medical condition or as the result of an accident. Where admission is the result of an accident, the in-patient stay begins when you are formally admitted to a ward and does not start from the time you arrived at the hospital
2. Maternity in-patient admission including caesarean section, where hospital confinement is for the insured mother only. Benefit is not payable:
 - where the mother remains in hospital to accompany her child in the post natal period until her child is discharged from hospital
 - where the mother is registered as a dependent child on an adult's policy
3. An admission to a day case ward or unit for treatment of a medical condition
4. The first 7 days/nights in each benefit claiming year

We will not pay you for:

1. In-patient admission to hospital/nursing/residential homes/sanatoriums and accommodation arranged wholly or partly for domestic or respite reasons
2. Nights when a patient is allowed out of hospital for whatever reason
3. Admissions relating to alcohol, chemical, drug dependency, self inflicted illness/injury or conditions arising as a result of such dependency or illness/injury
4. Emergency admission due to excessive intake of alcohol or alcohol poisoning or intake of any illegal substance or drugs or solvent abuse
5. Day case admission for maternity, geriatric and psychiatric treatments
6. Attending hospital as an outpatient or for accident and emergency visits
7. Nursing treatment plans, Community Matron Service or virtual ward treatment
8. Ante or post natal admission for a dependent child registered on your policy
9. Parental stay where you accompany a dependent child who is admitted as an in-patient
10. Hotel ward accommodation costs
11. Pre-admission appointments
12. Cancelled operations or procedures
13. In-patient stays or day case admissions for pre-existing conditions in the first 6 months from the date of joining or upgrading a policy
14. Day case admission immediately prior to or following an overnight stay in hospital for which a claim may be payable under hospital in-patient

Hospital consultant fees and diagnostic tests

We will refund **half** the amount paid by you to a specialist hospital consultant who is registered with the General Medical Council (GMC) up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover.

To make a valid claim you must have a formal referral from your GP or qualified health care practitioner to see a specialist hospital consultant to support diagnosis of an illness/condition. The GP or health care practitioner making the referral should not be linked to the hospital consultant in a way which creates a conflict of interest.

We will pay you for:

1. An appointment with a specialist hospital consultant
2. Treatment from a specialist hospital consultant
3. X-rays and diagnostic tests, investigations and/or scans ordered by a specialist hospital consultant to aid diagnosis
4. A Private Medical Insurance (PMI) excess that has been paid by you to your PMI provider in relation to you seeing and being treated by a specialist hospital consultant

We will not pay you for:

1. Charges made by a hospital/clinic for use of their facilities such as theatre, dressings and equipment
2. Ambulance or taxi charges
3. Consultation and diagnostic tests as a result of a lifestyle choice such as vasectomy, sterilisation, cosmetic surgery, emigration, medical and/or insurance related reports
4. Consultation and diagnostic tests related to fertility or assisted conception
5. Dietician/nutritional services
6. Termination of pregnancy
7. Referrals to a hospital consultant for pre-existing conditions in the first 6 months from the date of joining or upgrading a policy
8. Missed appointment charges

Support when you need a helping hand

Birth/Adoption of a child

We will pay a fixed amount for the birth/adoption of a child or children in each benefit claiming year providing that premiums have been paid at the relevant rate for the 6 month qualifying period.

The birth/adoption benefit is only payable upon sight of a photocopy of the full birth certificate/adoption papers showing the name of the policyholder(s) and child's name. The amount payable is per child and is determined by your level of cover.

We will pay you for:

1. The birth of a child whether at home or in hospital
2. The legal adoption of a child under the age of 16
3. The birth of a child stillborn after 24 weeks gestation (upon submission of a stillbirth certificate)

We will not pay you for:

1. A miscarriage of up to 24 weeks gestation
2. Foster children
3. Pregnancy termination
4. The legal adoption of a child who is already related to you or your partner prior to the adoption taking place
5. Claims in the first 6 months from the date of joining or upgrading a policy

24-hour telephone helpline

The 24-hour telephone helpline included within your Good All Round cash plan is provided by a specialist, third party which is a separate and independent service provider to Sovereign Health Care.

Please see the separate leaflet in your policy welcome pack for details about how to access the service.

If you're going through difficult times or experiencing one of life's major events, you can call the telephone helpline and benefit from the wealth of experience, knowledge and emotional support they can offer.

Some of the services you have access to include:

- A 24-hour telephone support helpline
- Legal, financial and consumer information
- Medical information
- Online support

The services of the telephone helpline are also available to your legal partner and children aged 16-24 in full-time education residing in the same household. All counsellors providing services under the telephone helpline are bound by the confidentiality provisions of the British Association for Counselling and Psychotherapy (BACP) Code of Ethics and Practice. The code of ethics and practice of the BACP binds all therapists providing services. Any legal information provided to you is subject to the confidentiality provisions of the Law Society of England and Wales code of conduct for solicitors. The effect of these various codes is that anything you may discuss with a counsellor or legal consultant remains confidential. Neither the fact that you have used the service or the content of any contact will be divulged to anyone else outside the third party provider. The only circumstances in which information may be disclosed are:

- If you provide explicit consent
- The third party provider is ordered by a court of law to disclose information
- The nature of your problem is such that the counsellor has reasonable grounds for believing that there may be a risk of harm to yourself or someone else.

Sovereign Health Care reserves the right to change the provider of the 24-hour telephone helpline.

Sovereign Health Care does not accept responsibility for any delay or failure in the provision or content of the service which is beyond our or the third party provider's control.

If your cover through Sovereign Health Care ends you and your family will no longer be eligible to use the services of the 24-hour telephone helpline.

From top to toe, we can help with your health costs

The Good All Round cash plan gives you money back for a range of everyday health care costs whether you receive treatment privately or through the NHS. The same price applies to everyone regardless of age, medical history or how often you claim. Cash plans are designed to be used and are a practical way to budget towards your health care – cost no longer has to be a reason for delaying treatment.

www.sovereignhealthcare.co.uk

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T&CS_06/2018



IMPORTANT INFORMATION

Change of address and registered office

Sovereign Health Care relocated during autumn 2022 and our new address and registered office is:

**2nd Floor, West Wing
The Waterfront
Salts Mill Road
Shipley
Bradford
BD17 7EZ**

Any mail sent to our old address will be redirected and our telephone numbers remain the same.

Visit our dedicated web page for more information, including how to register for our online service:

sovereignhealthcare.co.uk/move

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