Sovereign Health Care

ASSET

Your Asset cash plan explained in full

Policy terms and conditions

Looking after your everyday wellbeing starts here!

Table of benefits – what your Asset cash plan covers

The table below summarises the cover provided by the Asset cash plan. Please read these terms and conditions carefully for full details. The Personal Accident cover provided within your Asset policy is governed by a separate Personal Accident Insurance Policy Document included with your policy documents.

Asset yearly benefits	Level 1	Level 2	Level 3	Payback
Everyday essentials				
Dental*	up to **£80**	up to **£160**	up to **£240**	**100%**
Optical*	up to **£60**	up to **£120**	up to **£180**	**100%**
Help to keep you ticking over				
Physiotherapy/Osteopathy/Chiropractic/ Sports massage	up to **£150**	up to **£300**	up to **£450**	**100%**
Chiropody/Podiatry	up to **£50**	up to **£100**	up to **£150**	**100%**
Acupuncture/Homeopathy/Reflexology/ Earwax removal	up to **£50**	up to **£100**	up to **£150**	**100%**
Health screening†	up to **£125**	up to **£250**	up to **£375**	**100%**
Support if you need hospital treatment				
Hospital consultant fees and diagnostic tests	up to **£125**	up to **£250**	up to **£375**	**100%**
Hospital day case admission	**£30** per day	**£60** per day	**£90** per day	**Max 5 days**

Supporting benefits - helping you deal with life's challenges

Employee Assistance Programme (EAP) provided by a specialist third party

Through the EAP, you can access 24-hour confidential support and counselling on a range of life issues from marriage to divorce, birth to bereavement, legal issues to debt management. You can also access up to 8 in-person, phone or online counselling sessions where clinically appropriate.

See the separate leaflet included with your policy documents for details about how to access the service.

Personal Accident cover underwritten by American International Group UK Limited

Up to £20,000 for permanent disablement and £10,000 for accidental death should the unthinkable happen.

See the separate terms and conditions included with your policy documents for full details.

Member benefits - accessed via the online customer area

- **GP24 service** - convenient access to a practising NHS GP wherever you are in the world
- **Sovereign Perks** - access a wide range of exclusive online and high street discounts

* Up to four dependent children, aged under 18, can be included at no extra cost as part of an employee's Asset cover only. Dependent children are covered for dental and optical benefits. Cover provides separate yearly maximum amounts for the employee and each of their covered dependent children. Where an employee covers another adult, the additional adult policy does not include cover for dependent children.

† If your employer provides you with direct access to a health screen through a third party practitioner, you will only be entitled to claim through your Asset cash plan for the cost of this type of health screen once in any two year period.

Welcome to Sovereign Health Care!

Thank you for joining Sovereign Health Care. Your Asset cash plan is there to be used and will give you tax free cash back when you spend money on everyday health care, such as a new pair of glasses, contact lenses, visiting the dentist, physiotherapy and much more. The table of benefits opposite sets out what your plan covers. You have 12 months from the date of your treatment to make a claim, so please don't forget to claim!

Next steps

1. Please read these terms and conditions as they will help you to make the most of your Asset cash plan
2. If you haven't already done so, **please register for our online customer area**.
   To do this, visit our website at sovereignhealthcare.co.uk and click 'LOGIN' on the top right-hand corner of the page, then on the next page click 'REGISTER NOW'

You will need the following to register for our online customer area:

- A valid, personal email address which is unique to you (that is, one you do not share with someone else and which hasn't already been used on a different Sovereign Health Care policy)
- Your policy number (this is shown on your policy documents)
- The surname and date of birth used to set up your policy

Once you've registered for our online service you can do the following:

- Claim online
- View your cash plan information, claims history and useful documents
- Update your contact details
- **Access exclusive member benefits**

  GP24 – through our GP24 service you have convenient access to a practising NHS GP at a time that suits you

  Sovereign Perks – access a range of online and high street discounts, including cinema tickets, gym membership, car insurance, breakdown cover, mobile phones, package holidays and much more

How to contact us

If you have any questions, simply contact our customer support team using the details below. Please remember to quote your policy number when you contact us.

Call **01274 841130**. Our team is usually available Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm (our "**office hours**").

Email **help@sovereignhealthcare.co.uk** You can email us at any time and we will respond to you during office hours. Please quote your policy number and name in your email.

Visit **sovereignhealthcare.co.uk** for more information and to register for our online service.

Write to us at: Customer Support, Sovereign Health Care, 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ.

Who we are and who regulates us

Sovereign Health Care is an insurance provider and a not for profit company limited by guarantee. We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our Financial Services Register number is 202818, and you can use this number to search the Financial Services Register if you need more information. We are authorised to provide non-investment insurance contracts, and we only offer services related to our own products. We do not provide advice or make any recommendations about our insurance products, however we will provide the information you need to make your own decision. Our registered office is 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ.

General conditions

Joining Asset and your level of cover

Asset is an employer paid health care cash plan. Before your plan started, your employer gave us your details and told us the level of cover they will pay for.

If your employer allows, you can upgrade to a higher level of cover and/or cover another adult. For more details, see the section 'Upgrading and covering another adult'.

Your level of cover and the start date of your Asset cash plan are shown on your policy certificate provided with your policy documents. The table of benefits on page 2 shows the yearly benefits we will pay for the different levels of cover. The amounts shown are the maximum amounts we will pay each year, not per claim.

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

Cover for dependent children

Up to four dependent children can be included at no extra cost as part of an employee's Asset cover only. For the purposes of these terms and conditions, the words "**dependent child**" mean your child (biological or legally adopted) who permanently lives with you and is aged under 18. The words "**dependent children**" shall be construed accordingly. Dependent children are covered for dental and optical benefits. Cover provides separate yearly maximum amounts for the employee and each of their covered dependent children.

Where an employee covers another adult, the additional adult policy does not include cover for dependent children.

If both parents or guardians have the Asset cash plan provided by their employer, cover for dependent children is only provided once. So, before you make your first claim for a dependent child, you must decide which parent's or guardian's policy to add them to.

You can add a dependent child to your policy when you submit their first claim. To make a claim for treatment received by a dependent child, simply fill in a claim form providing all the information we ask for about them.

When a dependent child reaches their 18th birthday, their cover will end as they will no longer be a dependent child for the purposes of your policy.

Upgrading and covering another adult

If your employer allows, you can apply to upgrade to a higher level of cover and/or cover another adult. To do this you must fill in the relevant application form and return it to your employer.

All applications will be subject to our acceptance.

If you apply to cover another adult, the person must be under the age of 75 to be eligible for cover. You can only cover one additional adult.

Please note, if you upgrade your cover or cover another adult we will only be acting upon your instruction. Our obligations under this contract are to your employer as explained in the section 'The agreement between your employer and us'.

Cooling off period – your right to change your mind

Your Asset policy has been put in place by your employer. If you want to leave the scheme, you must contact them and they will tell us.

If you have upgraded your level of cover and/or covered another adult and you decide the extra cover does not meet your needs for any reason, you can cancel within 14 days of the cover starting or from the day you received your policy documents, whichever is later. This is known as the "**cancellation period**". To cancel during the cancellation period, you must tell us and your employer in writing.

We will not refund any premiums if you have made a claim during the cancellation period or if the cancellation period has ended before you cancel. If any premium refunds are due to you where you have upgraded your level of cover and/or covered another adult, we will refund the premium to your employer. Your employer is then responsible for passing the refund on to you.

Your Asset premiums

Your employer is responsible for paying the premiums for your cover to us. Premiums are due on an agreed date each month and are not refundable. Each payment pays for the cover provided in the month that has just passed.

If the premiums are not kept up to date, we will be entitled to suspend your cover under the terms of the agreement and may not pay any claims made. If the premiums are still not paid after three months, your policy will be considered cancelled and all cover provided under it will end.

If you choose to upgrade your policy and/or cover another adult, your employer will deduct the additional monthly premiums for this from your salary and pay them to us each month. Please make sure the correct amount is deducted from your regular salary.

Our right to make changes to the Asset cash plan

To ensure the ongoing sustainability of the Asset cash plan, we will regularly review the performance of the scheme. If we decide to make any changes to the policy premiums, benefits or rules, we will give your employer at least 30 days' written notice.

If you are paying to upgrade your policy and/or cover another adult, we will give you 30 days' written notice if we make any changes. We will send the notice to the address we have for you on our systems, so it is important to tell us as soon as possible if you change address. We will not be responsible if any documents we send to you do not reach you as a result of you not giving us your correct address.

The Asset cash plan premiums include insurance premium tax (IPT) at the current rate. We may change the premiums following changes to the rate of IPT or to any legislation or regulations that apply.

Leaving Asset

You or your employer can cancel your membership of the Asset scheme and that of any other adult you cover. If you want to cancel your membership and that of any other adult you cover, you must contact us and also tell your employer.

Your membership and that of any other adult you cover will automatically end if:

- our agreement with your employer is cancelled

- you leave your employer; or
- you die.

We may cancel your membership and that of any other adult you cover if:

- your employer does not pay premiums or any other payments that are due under the agreement; or
- there is reasonable evidence that you or any other adult you cover misled us or attempted to do so.

If your membership ends, the membership of any other adult you cover will also end.

If you leave your employer, we may invite you to join a different Sovereign Health Care cash plan. If you apply within 30 days of your policy ending and we accept your application, you will receive continuous cover and we will provide cover for any conditions that you had before cover under the new plan starts.

If you have upgraded your level of cover and/or have covered another adult and would like to cancel this arrangement, you must tell your employer to stop collecting premiums from your salary and let us know. As premiums are paid for the month that has just passed, any premiums you have already paid will not be refunded.

This policy is only available to UK residents

The policy is only available to people who, for UK tax purposes, are resident and have a permanent home in the UK. The policy must be paid for by a UK source.

Claims - general rules

See the 'Benefits explained' section for specific details about what is and is not covered under each benefit.

You can have more than one Sovereign Health Care policy, but you can only claim for each treatment once. If you have more than one policy, you can claim against both policies but we will not pay more than you have paid for your treatment.

We do not cover premiums you pay for other types of insurance policies, including (but not limited to) Private Medical Insurance (PMI) and dental schemes, such as Denplan.

We process all claims as quickly as possible, but we rely on you sending us a fully filled-in claim form, either online or by post, along with all the documents we ask for. Claims may be delayed if you do not send us complete or valid documents.

You can choose to have your claims paid by direct credit into a bank account or by cheque. To register for direct credit, simply contact our customer support team or register online in the secure customer area – see page 3 for our contact details.

We will only accept claims made within 12 months of the date any treatment was received. We will not accept claims made after this.

If you have paid for treatment before you receive it, we will only settle claims once we have had confirmation that all the treatment you have paid for has been received.

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

We will only consider paying claims once we have received, either online or by post, a fully filled-in claim form and valid receipts where required.

We will not pay for any postage, packing and delivery costs.

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

- receipts that have been altered
- receipts showing joint names
- till roll receipts
- credit or debit card slips
- invoices not marked as 'paid'
- bank statements or copies of any accounts

- receipts where only a part payment or deposit has been paid, including receipts showing a balance outstanding.

You must make sure that all receipts include:

- the name of the person who received the treatment;
- the name of the practitioner and, if it applies, the professional body they are registered with;
- details of the treatment; and
- the date treatment took place.

We do not return any receipts or invoices. If you need a copy for your records, please make sure you have this before making your claim.

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

We never accept claims where the provider or practitioner is you, your partner, another adult you cover, a member of your family or your employer.

When you make a claim, if we are in any doubt about the treatment, the person who received the treatment or the provider of the treatment, we may contact the health care provider or practitioner for more information.

Occasionally we may ask you, your GP or health care provider or practitioner for a medical report to confirm the details of a claim. If we do this, we will carry out checks in line 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. You must pay any fee your GP or health care provider or practitioner charges for filling in your claim form or providing any further information we ask for.

We will not pay claims if you break these terms and conditions.

Claims – Personal Accident cover

The Personal Accident cover provided by your Asset policy is underwritten by American International Group UK Limited. AIG Direct manages all aspects of customer service and claims on behalf of American International Group UK Limited. The terms and conditions that apply to the Personal Accident cover are set out in the separate Personal Accident Insurance Policy Document included with your policy documents. Should you need to make a claim on your policy, please notify AIG Direct.

Write to: Claims Manager, Personal Accident Customer Service Centre, American International Group UK Limited, The AIG Building, 2-8 Altyre Road, Croydon, CR9 2LG.

Phone: 0800 731 6396

Email: aigdirect.claims@aig.com

You can claim straightaway

You can claim immediately for treatment received on or after the cover start date shown on your policy certificate.

There are no qualifying periods, and the Asset cash plan provides immediate cover for any illnesses or injuries you had before the policy started (often referred to as 'pre-existing conditions') for the main cash plan benefits. However, cover for pre-existing conditions **does not** necessarily apply to the Personal Accident cover which has separate terms and conditions.

Claiming year explained

For the purposes of these terms and conditions, 'claiming year' means the 12 month period from your cover start date until its anniversary, and each subsequent 12 month period. For example, if your Asset cash plan starts on 1 November 2024, your claiming year is 1 November 2024 to 31 October 2025. Your new claiming year will then start on 1 November 2025 and end on 31 October 2026, and so on.

Your level of cover limits the amount you can claim for each benefit in each claiming year.

You can make more than one claim against a particular benefit but you cannot go over the relevant maximum claim amount.

The table of benefits on page 2 sets out the benefits we will pay. The maximum claim amount shown is the most we will pay in each claiming year, not per claim.

How to claim

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 and, if it applies, the professional body they are registered with, details of the treatment and the date it took place.

   If you are claiming for the hospital day case admission benefit, you can either provide a copy of your hospital discharge summary with your claim or ask the hospital or medical centre to fill in the relevant section of the claim form with their details and the details of the procedure (they should also sign and stamp the form). If you provide a copy of your hospital discharge summary, this must include the date and reason you were admitted.

2. Fill in a claim form. You can do this online by registering for our secure customer area, or by post using the claim form provided with your policy documents or by downloading one from our website. Send the filled-in claim form to us with the named receipt(s). Remember you need to claim within 12 months of the date of treatment.

3. Once we accept your claim, we will 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 provided by a suitably qualified practitioner and, where this applies, they must be registered with an appropriate professional body recognised by us. We never accept claims where the provider or practitioner is you, your partner, another adult you cover, a member of your family or your employer. For example, if you buy your glasses while 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 at the exchange rate published by Oanda (www.oanda.com) for the relevant currency on the date we settle your claim. Please make sure you send a valid receipt with your claim. If the receipt is not in English, please attach a covering letter in English giving details of the treatment you have received.

Fraudulent claims and misuse of the policy

The Asset cash plan is designed to allow customers to claim cash back towards the costs of their everyday health care. If you make a fraudulent claim, we may cancel or suspend your policy and commence legal action. We always try to recover the costs of fraudulent claims. We are members of the Insurance Fraud Investigators Group (IFIG) and will share information about suspected fraudulent claims with other members of IFIG.

If you deliberately misuse the policy this is likely to lead to your policy being cancelled. We will not refund any premiums if this happens. Examples of misusing the policy include (but are not limited to):

- providing false information
- making claims under more than one insurance policy in order to receive more than the cost of treatment (this is called 'betterment'); or
- claiming for treatment where the provider or practitioner is you, your partner, another adult you cover, a member of your family or your employer.

We will always act in the best interests of all our customers.

We will not pay claims for treatment received because of intentional self-injury or illness, or your own negligence.

Overpayment of claims

If we pay you too much for a claim, we have the right to recover the overpayment from any future claims you make or from you direct. If the policy is cancelled, you must repay any overpayment immediately.

Governing law and communications

The Law of England and Wales applies to these terms and conditions. All communications will be in English.

Complaints procedure – your right to complain

We pride ourselves on our customer service. However, we know that occasionally you may be unhappy with the service you receive from us. If you are not satisfied with any part of our service, please contact our Customer Support Manager with details of your complaint.

Phone: 01274 841130. Lines are open Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm.

Email: help@sovereignhealthcare.co.uk

Write to: Customer Support Manager, Sovereign Health Care, 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ

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

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

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 personal information collected by us in our systems in line 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 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 or another adult), you confirm that you have that person's permission to give us their information, and for us to use and share it in the same way as we use and share your information.

We will use your personal information to provide the services set out in the terms and conditions of this policy, including to assess and process claims, prevent crime (including fraud and money laundering) and to comply with any legal requirements that apply.

We may also share your information with approved business partners, organisations and your employer for the purposes of administering your policy. We may put information about claims on a register of claims and share it with other companies, including insurers, to help prevent fraud. Whenever we transfer or share information we make sure it is protected.

If we have your consent to do so, we may use your personal information to contact you by post, phone, text or email about special offers, products and services which may be of interest to you. You can withdraw your consent and opt-out of receiving marketing information by emailing us at help@sovereignhealthcare.co.uk or calling 01274 841130. Please give us your policy number when you contact us. You can unsubscribe from any electronic marketing communications by clicking the unsubscribe

link within a communication, or you can do this online by updating your marketing contact preferences in our secure customer area.

For more details on how we use your personal information, including sharing it with third parties, how we keep your information secure, and your rights relating to the information we hold about you, please see our privacy policy on our website (or contact us if you would like us to send you a copy).

We may record and monitor phone calls for training and quality purposes.

Third party authorisation

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 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 filling in a 'Third party authorisation form' or by calling us on 01274 841130. To give authorisation over the phone, both you and the person you want to authorise must be available to confirm the instruction over the phone.

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 to you, you may be entitled to claim compensation from the scheme. More information about compensation scheme arrangements is available at www.fscs.org.uk or by calling 0800 678 1100.

The agreement between your employer and us

Your Asset cash plan is provided through a formal agreement between your employer and Sovereign Health Care (the "**agreement**"). These terms and conditions explain what benefits you can claim for, the general rules that apply to the policy and how to make a complaint. It also gives information about our regulator. There is no legal contract between you and us for cover under the agreement.

Benefits explained

This section explains in more detail what we will and will not pay you for with regards to the individual benefits of the Asset cash plan. Your level of cover is shown on your policy certificate, which is included with your policy documents. For all benefits, we will pay you up to the yearly maximum amount for your level of cover, as shown in the table of benefits on page 2.

You must pay for any treatment first and get a detailed, named receipt. Once you have completed your treatment and paid for it in full, you can claim the costs of the treatment back from us, up to your yearly maximum amount, which will depend on your level of cover. You must send the detailed receipt with your claim. For more information on how to claim, see page 8.

The Personal Accident cover provided within your Asset policy is governed by a separate Personal Accident Insurance Policy Document included with your policy documents.

Everyday essentials

Dental

We will refund the amount you have paid to a qualified NHS or private dental practitioner up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

What is covered

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

What is not covered

1. Cosmetic dentistry
2. Dental implants
3. Dental prescription charges
4. Non-prescribed items (such as mouthwash, dental floss and toothbrushes)
5. Missed appointment charges
6. Registration and administration fees
7. Premiums for dental maintenance or dental membership schemes (such as Denplan)

Optical

We will refund the amount you have paid to a qualified optical practitioner up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

What is covered

1. Sight tests
2. Prescription eyewear
3. Glasses repairs
4. Laser eye surgery or refractive eye surgery performed by a recognised hospital or laser eye clinic, but not the consultation fee

What is not covered

1. Non-prescription eyewear
2. Miscellaneous items (such as any type of solutions, glasses cases and cleaning materials)
3. Premiums for eyewear insurance
4. Receipts where you have only made a part payment or paid a deposit, including receipts showing a balance outstanding
5. Laser eye surgery or refractive eye surgery consultations
6. Missed appointment charges

Help to keep you ticking over

Physiotherapy/Osteopathy/ Chiropractic/Sports massage

We will refund the amount you have paid to a qualified and registered physiotherapist, osteopath, chiropractor or sports massage therapist up to the appropriate maximum amount in each claiming year. This maximum amount depends on 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 covered, up to the yearly maximum amount for your level of cover.

What is covered

1. Physiotherapy, osteopathy or chiropractic treatment provided by a practitioner who is qualified and registered with an appropriate professional body recognised by us, including:
   - physiotherapists registered with the Health & Care Professions Council (HCPC);
   - osteopaths registered with the General Osteopathic Council (GOsC); and
   - chiropractors registered with the General Chiropractic Council (GCC)
2. Sport massage treatment provided by a therapist recognised by us
3. A Private Medical Insurance (PMI) excess that you have paid to your PMI provider in order to access physiotherapy, osteopathy, chiropractic or sports massage treatment

What is not covered

1. Any treatment provided by a practitioner who is not qualified and registered with an appropriate professional body recognised by us
2. Any other treatment that is not physiotherapy, osteopathy,

chiropractic or sports massage (including, but not limited to, aromatherapy, herbal therapies, Indian head massage, Reiki, Alexander Technique, Bowen Therapy and craniosacral therapy)

3. X-rays and scans
4. Appliances and supporting materials (including, but not limited to, lumber rolls, spinal pillows or cushions, flexibands, tape, ice packs and books)
5. Missed appointment charges

Chiropody/Podiatry

We will refund the amount you have paid to a qualified and registered chiropodist or podiatrist up to the appropriate maximum amount in each claiming year. This maximum amount depends on 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 covered, up to the yearly maximum amount for your level of cover.

What is covered

1. Chiropody or podiatry treatment provided by a qualified practitioner registered with the Health & Care Professions Council (HCPC) or the Register for Foot Health Practitioners (RFHP)

What is not covered

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

Acupuncture/Homeopathy/ Reflexology/Earwax removal

We will refund the amount you have paid to a qualified and registered acupuncturist, homeopath, reflexologist or hearing care professional up to the appropriate maximum amount in each claiming year. This maximum amount depends on 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 treatments covered, up to the yearly maximum amount for your level of cover.

What is covered

1. Acupuncture, homeopathy, reflexology or earwax removal treatment provided by a practitioner who is qualified and registered with an appropriate professional body recognised by us. Recognised professional bodies include the following:

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

Earwax removal

- Care Quality Commission (CQC)
- Health & Care Professions Council (HCPC)
- British Society of Hearing Aid Audiologists (BSHAA)

What is not covered

1. Any treatment provided by a practitioner who is not qualified and registered with an appropriate professional body recognised by us
2. Homeopathic medicines bought in isolation (for example, from a chemist or health food shop, by mail order or online)
3. Any other treatment that is not acupuncture, homeopathy, reflexology or earwax removal (including, but not limited to, aromatherapy, ear candling, herbal therapies, Indian head massage, Reiki, Alexander Technique, Bowen Therapy and craniosacral therapy)
4. Hearing tests and consultations
5. Miscellaneous items (including products and equipment to soften, remove or prevent a build-up of earwax)
6. Missed appointment charges

Health screening

We will refund the amount you have paid after receiving an approved health screening check, carried out by medically qualified staff, up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

If your employer provides you with direct access to a health screen through a third party practitioner, we will only pay for this type of health screen once in any two year period. Also, for this type of health screen to be covered under the Asset cash plan, you must choose to have the health screen (we will not cover screening that you must have under the terms of your employment), and you must pay for the health screen yourself.

What is covered

1. Well person screening (including ECGs and screening to test for high cholesterol, kidney function, diabetes, thyroid problems, liver function, and female and male specific cancers)
2. Osteoporosis screening

What is not covered

1. Screening for legal, employment, insurance, emigration or similar purposes (for example, compulsory health screening for HGV/PSV)
2. Home testing kits
3. Diagnostic procedures or tests
4. Missed appointment charges

Support if you need hospital treatment

Hospital consultant fees and diagnostic tests

We will refund the amount you have paid to a specialist hospital consultant who is registered with the General Medical Council (GMC) up to the appropriate maximum amount in each claiming year. This maximum amount depends on 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 help diagnose an illness or condition. The GP or health care practitioner making the referral should not be linked to the hospital consultant in a way which could create a conflict of interest.

What is covered

1. An appointment with a specialist hospital consultant
2. Treatment from a specialist hospital consultant
3. X-rays and diagnostic tests, investigations and scans ordered

by a specialist hospital consultant to help with a diagnosis

4. A Private Medical Insurance (PMI) excess that you have paid to your PMI provider in order to be seen and treated by a specialist hospital consultant

What is not covered

1. Charges made by a hospital or clinic for using their facilities (for example, operating theatres, dressings and equipment)
2. Ambulance or taxi charges
3. Consultations and diagnostic tests that are needed as a result of a lifestyle choice (such as a vasectomy, sterilisation, cosmetic surgery and emigration) or for medical and/or insurance related reports
4. Consultation and diagnostic tests related to fertility or assisted conception
5. Dietician or nutritional services
6. Termination of pregnancy
7. Missed appointment charges

Hospital day case admission

We will pay you, at the relevant fixed daily amount, for up to a maximum of five days per claiming year, each time you are treated in a recognised hospital or medical centre (with surgical facilities) where you must sign an admission form. For clarity, day case admission is where you are admitted and discharged on the same day. The amount we will pay depends on your level of cover. To claim, you can either provide a copy of your hospital discharge summary with your claim or ask the hospital or medical centre to fill in the relevant section of the claim form with their details and the details of the procedure (they should also sign and stamp the form). If you provide a copy of your hospital discharge summary, this must include the date and reason you were admitted.

What is covered

1. An admission to a day case ward or unit for treatment of a medical condition
2. The first five claims for day case admission in each claiming year

What is not covered

1. Attending hospital as an outpatient or visits to an accident and emergency department
2. Day case admission related to maternity (pregnancy and childbirth), geriatric (older people), psychiatric and hospice care
3. Appointments before you are admitted
4. Cancelled operations or procedures
5. If your treatment means that you have to stay in hospital overnight

Employee Assistance Programme

The Employee Assistance Programme (EAP) within your Asset policy is provided by a specialist third party which is a separate and independent service provider to Sovereign Health Care.

Please see the separate EAP leaflet included with your policy documents for details about how to access the service.

Balancing everyday life with the requirements of work and home can create pressures for all of us. If you're going through difficult times or experiencing one of life's major events, you can call the EAP and benefit from the wealth of experience, knowledge and emotional support they can offer. Some of the services you have access to through the EAP include:

- A 24-hour telephone support helpline
- In-person, phone or online counselling
- Legal, financial and consumer information
- Medical information
- Support for managers

There's also online support with information and resources on a range of topics.

Please don't hesitate to call. The services of

the EAP are confidential and are there when you need a helping hand. The services of the EAP are also available to your partner, spouse and dependent children (aged 16-24, and in full time education).

All counsellors providing services under the EAP are bound by the confidentiality provisions of the British Association for Counselling and Psychotherapy (BACP) Code of Ethics and Practice. Anything you may discuss with a counsellor or legal consultant is confidential. Neither the fact that you have used the service or the content of any contact will be divulged to your employer or anyone else outside the third party EAP provider. The only circumstances in which information may be disclosed are:

- If you provide explicit consent
- The third party EAP 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 EAP. We do not accept responsibility for any delay or failure in the provision or content of the service which is beyond our or the third party EAP 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 EAP.

The services provided by the EAP are run in accordance with HM Revenue and Customs (HMRC) guidelines.

Member benefits

You also have access to the following member benefits through our secure online customer area. Please register and log in to the online service for details of how to access these benefits. See page 3 for how to register for the online service.

GP24

Through the GP24 service you have convenient access to a practising NHS GP at a time that suits you, wherever you are in the world. The service includes:

- GP telephone consultations available 24 hours a day, seven days a week
- a private prescription service
- webcam GP consultations, and
- medically approved health information

The GP24 service is provided by HealthHero on our behalf. By using the GP24 service, you agree to HealthHero's terms and conditions, which are available on the GP24 app.

Sovereign Perks

Through Sovereign Perks you can access a wide range of online and high street discounts on cinema tickets, gym membership, car insurance, breakdown cover, mobile phones, package holidays and much more.

The terms and conditions that apply to Sovereign Perks are available through our secure customer area. Sovereign Perks is managed and run on our behalf by Parliament Hill Ltd, using third party partners. Any purchases you make will be with the relevant third party and not us, so their terms and conditions will apply. All offers may be withdrawn or changed without notice.

We have the right to change the providers of GP24 and Sovereign Perks without telling you.

We are not responsible for any delay or failure in providing the member benefit services, or for the benefits provided, which are beyond our or the third party providers' control.

Sovereign Health Care

ASSET

Feel good about choosing Sovereign Health Care

We believe better health is for everyone!

Founded in 1873 as a local hospital fund, we've been helping to make health care more affordable for over 150 years. We exist solely for the benefit of our customers, business partners and the community. We are a not for profit company, which allows us to make a real difference to people's lives through our Community Programme.

Over the past 10 years we have donated over £7 million to good causes which improve the health and wellbeing of people who live in the communities we serve. We are a loyal supporter of the NHS and regularly support investments in groundbreaking technology which improve patient outcomes and experience.

If you have any questions about your Asset cash plan or need our help, please call or email our customer support team.

01274 841130

Lines are open Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm.

help@sovereignhealthcare.co.uk

Please include your name and policy number in your email.

sovereignhealthcare.co.uk