

Everything you
need to know



Handy Health Cover

Policy terms
and conditions

Powered by



Employer Paid

Your HandyHealthCover starts here!

Table of cover

The table below summarises Handy Health Cover. You can claim 100% of the cost of treatment up to your cover level maximum. Please read these terms and conditions carefully for full details.

Yearly benefits	Level 1	Level 2	Level 3	Level 4	Child cover*
Everyday essentials					
Optical	£70	£100	£140	£210	✓
Dental	£70	£100	£140	£210	✓
Prescription charges, inoculations and vaccinations	£12	£15	£24	£36	—
Help to keep you ticking over					
Physiotherapy/Osteopathy/Chiropractic/Sports massage	£150	£200	£300	£450	✓
Chiropody/Podiatry	£50	£75	£100	£150	—
Acupuncture/Homeopathy/Reflexology/Earwax removal	£50	£75	£100	£150	—
Health screening†	£125	£175	£250	£375	—
Support if you need hospital treatment					
Hospital consultant fees and diagnostic tests	£125	£175	£250	£375	✓
Hospital day case admission (max 5 days)	£15 per day	£20 per day	£30 per day	£45 per day	—

GP24 service

Fast, easy access to a GP. You can speak with a GP at a time that suits you. Includes 24/7 telephone consultations, a private prescription service, online consultations and medically approved health information.

Sovereign Perks

Online access to a wide range of discounts including gym membership, cinema tickets, attractions, hotels and much more. Also includes access to a 24-hour confidential telephone helpline and digital services to support your wellbeing.

*Up to four dependent children, aged under 18, can be included at no extra cost as part of an employee's Handy Health Cover only. Dependent children are covered for specified benefits as shown in the table above. 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 Handy Health Cover for the cost of this type of health screen once in any two year period.



Welcome!

Your Handy Health Cover is there when you need to spend money on everyday health care. It gives you money back towards the cost of a new pair of glasses, contact lenses, dental check-ups and treatment, physiotherapy and much more. The table of cover on page 2 sets out what your policy covers and you have 12 months from the date of treatment to make a claim.

Once you've registered for our online service you can:

- ✓ Claim online
- ✓ View your policy, claims history and useful documents
- ✓ Update your contact details
- ✓ Access GP24 and Sovereign Perks

You will have received information on how to register for the online service in your welcome email or letter. If you need a helping hand, please contact us using the details below.

Contact us if you need a helping hand

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.

Email us

help@sovereignhealthcare.co.uk

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

Call us

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

Write to us

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

Visit us online

sovereignhealthcare.co.uk

Who we are and who regulates us

Handy Health Cover is provided by Sovereign Health Care; 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 Handy Health and your level of cover

Handy Health Cover is an employer paid health care cash plan. Before your cover 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 Handy Health Cover are shown on your policy certificate provided with your policy documents. The table of cover 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 Handy Health 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 optical, dental, physiotherapy/osteopathy/chiropractic/sports massage and hospital consultant fees and diagnostic tests. 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 Handy Health Cover 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.

To add a dependent child to your policy, please contact our customer support team on 01274 841130 or email help@sovereignhealthcare.co.uk.

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 that upgrading your cover and/or covering another adult does not create a legal contract between us and you or the other adult for cover under the agreement. Our obligations 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 Handy Health Cover 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. Any premium refunds due will be paid by your employer.

Your Handy Health Cover 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 Handy Health Cover

To ensure the ongoing sustainability of Handy Health Cover, 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 contact details we have for you on our systems, so it is important to tell us as soon as possible if your contact details change. We will not be responsible if any information we send to you does not reach you as a result of you not giving us your correct contact details.

Handy Health Cover 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.

Ending your Handy Health Cover

You or your employer can cancel your Handy Health Cover policy and that of any other adult you cover. If you want to cancel your policy and that of any other adult you cover, you must contact us and also tell your employer.

Your policy 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 policy 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 policy ends, the policy 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 leaving your employer 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 policy 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 'Your cover 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, delivery or travel 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. This list is not exhaustive. If the professional body for your practitioner is not listed in this document, please contact us or visit the 'FAQS' section in the online customer area before your treatment.

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.

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 Handy Health Cover provides immediate cover for any illnesses or injuries you had before the policy started (often referred to as 'pre-existing conditions').

Claiming year

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 Handy Health Cover starts on 1 November 2025, your claiming year is 1 November 2025 to 31 October 2026. Your new claiming year will then start on 1 November 2026 and end on 31 October 2027, 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 cover 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 a claim form which you can download from the 'Useful documents' section of the secure customer area. 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 haven't provided your bank account details.

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

Handy Health Cover is designed to allow you to claim cash back towards the costs of your 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 will lead to your policy being cancelled. We will not refund any premiums if this happens, and you may be asked to repay any claims paid. 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 aim to act in the best interests of all of 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

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 841 130. 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.

Our full complaints procedure can be found in the 'Useful documents' section on our website (or contact us if you would like us to send you a copy).

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, telephone, 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 Handy Health Cover policy 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.

Your cover explained

This section explains in more detail what we will and will not pay you for with regards to the individual benefits of Handy Health Cover. 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 cover 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.

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, although you may be able to claim for these under the 'prescription charges, inoculations and vaccinations' benefit
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. Laser eye surgery or refractive eye surgery consultations
5. Missed appointment charges

Prescription charges, inoculations and vaccinations

We will refund the amount you have paid for NHS or private prescription charges, and charges for inoculations or vaccinations from a qualified medical professional, up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

To make a valid claim for prescription charges, you must get a named receipt from a registered pharmacist on the day you pay for your prescription. When you send us your claim, you must also send us this receipt. If you are claiming for an NHS prepayment certificate, you must send us a copy of your prepayment certificate, clearly showing your name and the 'valid from' date, with your claim.

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

What is covered

1. NHS prescription charges
2. Private prescription charges
3. An NHS prepayment certificate
4. Prescription and other charges arising from having an inoculation or vaccination

What is not covered

1. Prescriptions for sexual aids or contraceptives
2. Prescriptions for lifestyle conditions (for example, to help you give up smoking, stop drinking alcohol or lose weight)
3. Inoculations or vaccinations provided free of charge by the NHS
4. Inoculations or vaccinations for anyone other than you
5. Any postage, packing and delivery costs

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 who is qualified and registered with an appropriate professional body recognised by us, including:
 - Sports Therapy Association (STA)
 - Federation of Holistic Therapists (FHT)
 - The Association of Soft Tissue Therapists/ Sports Massage Association (SMA)
 - Sports Therapy Organisation (STO)
- This list is not exhaustive. If the professional body for your practitioner is not listed here, please contact us or visit the 'FAQS' section in the online customer area **before** your treatment.
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
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)
2. Gait analysis or biomechanical assessment

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)

This list is not exhaustive. If the professional body for your practitioner is not listed here, please contact us or visit the 'FAQS' section in the online customer area **before** your 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. 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

Health screening (also known as a 'health check', 'health assessment' and 'health MOT'), is a proactive approach to health where individuals choose to undergo a range of tests to assess their overall health and identify potential problems. We will refund the amount you have paid after receiving an approved health screening up to your cover level maximum in each claiming year.

Health screening providers, such as Bupa, Nuffield Health, Bluecrest Wellness, and some private hospitals, have a range of health assessment packages which we will cover subject to them meeting the requirements outlined here. Please note, this is a non-exhaustive list and not a recommendation; there are other providers available. If you are in any doubt as to whether we will cover the screening you are interested in, please contact us **before** you arrange and pay for your assessment.

What is covered

We cover a health screening you choose to undergo that includes a range of tests which:

1. Are carried out in-person by medically qualified staff, and
2. Are designed to evaluate your general health

What is not covered

1. Health screening conducted at home or remotely
2. Screening for legal, employment, insurance, emigration or similar purposes (for example, compulsory health screening for HGV/PSV)
3. Diagnostic procedures or tests
4. Missed appointment charges
5. Standalone screening for specific conditions
6. Any tests you choose to add on or purchase in addition to the health screening package you are claiming for

Restriction on cover

If your employer provides you with direct access to a health screening, we will only pay for this type of health screen once in any two year period. For this type of health screen to be covered, 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.

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 provide a copy of your formal referral letter 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. Pregnancy related scans
6. Dietician or nutritional services

7. Termination of pregnancy

8. 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, and cosmetic procedures
3. Appointments before you are admitted
4. Cancelled operations or procedures
5. If your treatment means that you have to stay in hospital overnight

GP24 and Sovereign Perks

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

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
- medically approved health information
- fit notes if clinically appropriate
- consultant or specialist referrals

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.

Sovereign Perks also provides access to a 24-hour confidential telephone helpline and digital services to support your wellbeing.

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.

HandyHealthCover

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