Dear Customer

**Important information about your cash plan**

From 1 January 2024, we are making some changes to our product benefits and policy rules which will affect your cover and the price you pay.

So that you have full information, we have provided the following in this document:

- An important information leaflet which summarises the changes
- The current policy terms and conditions and insurance product information document which apply until 31 December 2023
- The new policy terms and conditions and insurance product information document which are effective from 1 January 2024

**Please read these carefully.**

For any enquiries, our customer support team is here to help on 01274 841130 (lines are open Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm), or by emailing help@sovereignhealthcare.co.uk (please include your name and policy number in your email).

Kind regards

Russ Piper

Chief Executive

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

Morrisons

# Health care cash plan

Exclusively for Morrisons colleagues

**Important information - updates and price increase from 1 January 2024**

Provided by Sovereign Health Care

# Important information

From 1 January 2024, we are making some changes to the Morrisons health care cash plan which will affect your cover and the price you pay. We are introducing some new benefits and policy rules, summarised below, to make your cash plan more useable. The new benefits table and prices are shown opposite. Please read this leaflet along with the policy terms and conditions for full details.

# Updates to cash plan benefits

**The following new benefits will be covered:**

- Inoculations and vaccinations within the prescription charges benefit
- Sports massage within the physiotherapy/osteopathy/chiropractic benefit
- Earwax removal within the acupuncture/homeopathy/reflexology benefit

**We are also:**

- Removing the 12 month qualifying period for all types of eye surgery within the optical benefit
- Increasing the maximum adoption age from 5 to 16 within the birth/adoption of a child benefit

Please remember, treatment must be provided by a qualified health care practitioner who is registered with a professional body recognised by us.

# Updates to policy terms and conditions

**To help make the cash plan easier to understand, we are changing how your claiming year works.**
Currently each individual benefit has its own claiming year but, from 1 January 2024, your policy will have one overall claiming year for all benefits. **For existing customers**, your new claiming year will start on 1 January 2024 and run to 31 December 2024, it will then start again on 1 January 2025 and so on. **For customers joining after 1 January 2024**, your claiming year will begin on your cover start date and resets on the policy anniversary, i.e. 12 months after your cover start date.

**Cover for dependent children will be limited to a maximum of four children per adult policy.**
However, if you currently cover more than four children, this will not change, and they will continue to be covered until they are 18 years old.

# Why is the price increasing?

Since 2007 the only changes in the price of your cash plan have been due to increases in UK taxation. However, rising costs of health care now mean we have to raise prices. We are all too aware of the cost of living challenges people are facing and therefore have worked hard to continue to make your cash plan good value for money.

In these challenging times and with the changing provision of health care, we hope your cash plan will continue to meet your needs. Please remember, you have 12 months from the date of treatment to claim and, to make things even easier, you can submit adult policy claims online.

# Table of benefits and prices from 1 January 2024

Premiums include insurance premium tax (IPT) at the current rate.

| Levels of cover | | Level 2 | Level 3 | Level 4 | Level 5 | Level 6 |
|---|---|---|---|---|---|---|
| **Weekly premium** (per person) | | £1.95 | £2.94 | £3.93 | £5.07 | £6.63 |
| **Four weekly premium** (per person) | | £7.80 | £11.76 | £15.72 | £20.28 | £26.52 |
| Everyday essentials | Payback | | | | | |
| **Dental** including treatment, check-ups and x-rays | 100% | up to £70 | up to £105 | up to £140 | up to £175 | up to £210 |
| **Optical** including glasses, contact lenses and eye tests | 100% | up to £90 | up to £135 | up to £180 | up to £225 | up to £270 |
| **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 £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Chiropody/Podiatry** | 50% | up to £50 | up to £75 | up to £100 | up to £125 | up to £150 |
| **Acupuncture/Homeopathy/Reflexology/ Earwax removal** | 50% | up to £150 | up to £225 | up to £300 | up to £375 | up to £450 |
| **Health screening** including well person 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** 6 month qualifying period for pre-existing conditions | Max 30 nights | £20 per night | £30 per night | £40 per night | £50 per night | £60 per night |
| **Recuperation** 6 month qualifying period for pre-existing conditions | Fixed amount | £90 | £135 | £180 | £225 | £270 |
| **Hospital day case admission** 6 month qualifying period for pre-existing conditions | Max 10 days | £18 per day | £27 per day | £36 per day | £45 per day | £54 per day |
| **Hospital consultant fees and diagnostic tests** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| 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 |
| **Home care** for local authority or accredited agency care services such as cleaning, laundry and shopping | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Hearing aids** 6 month qualifying period for pre-existing conditions | 50% | up to £100 | up to £150 | up to £200 | up to £250 | up to £300 |
| **Specialist medical aids** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |

## Free cover for up to four dependent children aged under 18

Up to four dependent children, aged under 18, are covered at the same level as the policyholder for all benefits excluding birth/adoption, home care, hearing aids and specialist medical aids. Cover provides separate yearly maximums for the policyholder and each of their covered dependent children.

# Here to help

If you have any questions about your Morrisons health care cash plan, please call or email the Sovereign Health Care 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.

Register for the online service at:

## sovereignhealthcare.co.uk



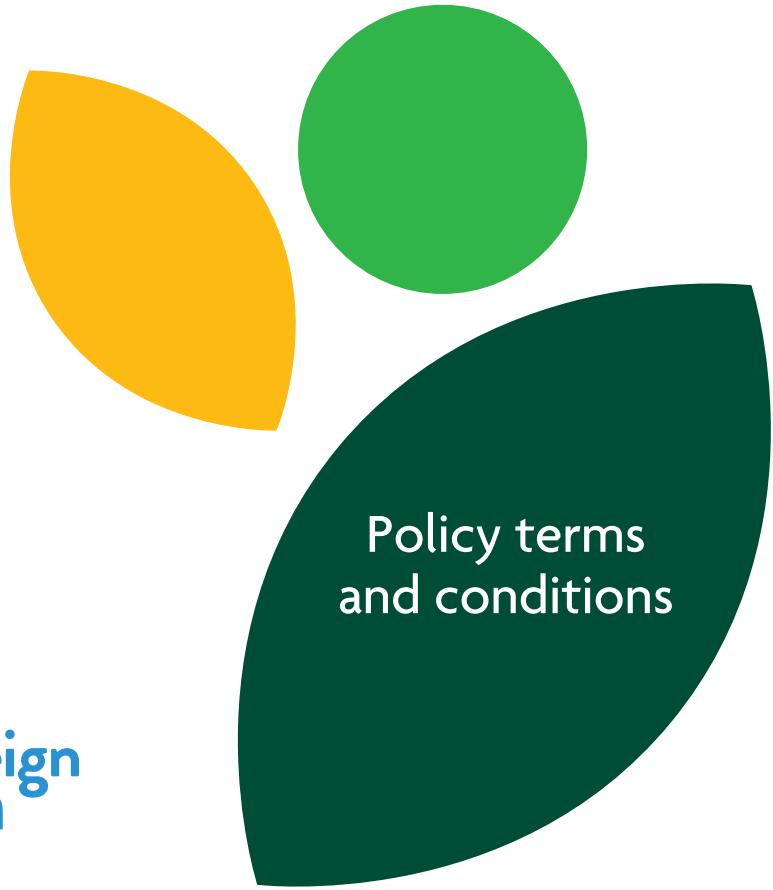
Provided by Sovereign Health Care

Morrisons

Morrisons
Since 1899

# Health care cash plan

Exclusively for Morrisons colleagues

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# What you can claim in more detail...

The table below details the health care benefits you can claim for each year. 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 explanation. Premiums include Insurance Premium Tax (IPT).

| Levels of cover | | Level 2 | Level 3 | Level 4 | Level 5 | Level 6 |
|---|---|---|---|---|---|---|
| **Weekly premium** (per person) | | £1.86 | £2.79 | £3.72 | £4.65 | £5.58 |
| **Four weekly premium** (per person) | | £7.44 | £11.16 | £14.88 | £18.60 | £22.32 |
| Everyday essentials | Payback | | | | | |
| **Dental** including treatment, check-ups, x-rays and full or partial dentures | 100% | up to £70 | up to £105 | up to £140 | up to £175 | up to £210 |
| **Optical** including glasses, contact lenses and eye tests 12 month qualifying period for all types of eye surgery | 100% | up to £90 | up to £135 | up to £180 | up to £225 | up to £270 |
| **Prescription charges** including NHS or private prescription charges and NHS prepayment certificates | 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** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Chiropody/Podiatry** | 50% | up to £50 | up to £75 | up to £100 | up to £125 | up to £150 |
| **Acupuncture/Homeopathy/Reflexology** | 50% | up to £150 | up to £225 | up to £300 | up to £375 | up to £450 |
| **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** 6 month qualifying period for pre-existing conditions | Max 30 nights | £20 per night | £30 per night | £40 per night | £50 per night | £60 per night |
| **Recuperation** 6 month qualifying period for pre-existing conditions | Fixed amount | £90 | £135 | £180 | £225 | £270 |
| **Hospital day case admission** 6 month qualifying period for pre-existing conditions | Max 10 days | £18 per day | £27 per day | £36 per day | £45 per day | £54 per day |
| **Hospital consultant fees and diagnostic tests** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| 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 |
| **Home care** for local authority or accredited agency care services such as cleaning, laundry and shopping | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Hearing aids** 6 month qualifying period for pre-existing conditions | 50% | up to £100 | up to £150 | up to £200 | up to £250 | up to £300 |
| **Specialist medical aids** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |

## 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, home care, hearing aids and specialist medical aids. Cover provides separate annual maximums for the policyholder and each of their dependent children.

# General conditions

## Welcome

The Morrisons health care cash plan is provided exclusively to colleagues by 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.

The Morrisons health care 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 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?

Any Morrisons colleague may apply to join the Morrisons health care cash plan as long as they are employed by Morrisons. Furthermore, colleagues can also pay to cover their partner and/or a family member, and/or cover their dependent children up to the age of 18 free of charge. See the sections titled 'Partner/Family member cover' and 'Free cover for dependent children' for more details.

You must also be a permanent United Kingdom (UK) resident for tax purposes with an address in the UK. Please note, this does not apply to colleagues who work at the Morrisons Gibraltar store – Morrisons Gibraltar colleagues should refer to the separate addendum to these terms and conditions which apply in Gibraltar only.

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.

Subject to these terms and conditions you can continue to hold a policy for as long as you are an employee of Morrisons. If you leave the employment of Morrisons you, your partner/family member and/or dependent children will no longer be eligible for cover under the Morrisons health care cash plan. You may be eligible to transfer to a different Sovereign Health Care cash plan. See the section titled 'Ending your policy' for more details.

## No medical is necessary

You do not need to undergo a medical to join the Morrisons health care cash plan.

## 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.

## 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
- Hospital in-patient
- Recuperation
- Hospital day case admission
- Hospital consultant fees and diagnostic tests
- Hearing aids
- Specialist medical aids

You can still join if you are affected by a pre-existing condition, but your policy will not cover you for these 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 Morrisons health care cash plan 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 and/or the premiums payable, we will write to you and your partner/family member separately to inform you 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 your partner's/family member's 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, home care, hearing aids and specialist medicals aids, 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. Dependent child claims cannot be submitted online. These should be sent to us in the post.

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 Sovereign Health Care 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 (usually payroll deduction or Direct Debit for Morrisons Gibraltar colleagues) 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.

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, it is your responsibility to inform your employer, bank or building society to stop deducting premium payments from your salary or bank/building society account. We will not refund any premiums paid during your notice period.

If you leave the employment of Morrisons you, your partner/family member and/or dependent children will no longer be eligible for cover under the Morrisons health care cash plan. You may transfer your cover to a different Sovereign Health Care cash plan with continuation of cover, subject to us being advised within 30 days of you leaving the employment of Morrisons. Please note the premiums payable and the cover provided under the policy are different to the Morrisons health care cash plan.

Morrisons Gibraltar colleagues who leave the employment of Morrisons will **not** be eligible to transfer to a different Sovereign Health Care cash plan as we do not sell our products outside of the UK. Morrisons Gibraltar colleagues should refer to the separate addendum to these terms and conditions which apply in Gibraltar only.

Where you are no longer eligible to be covered, we will write to you and inform you when your cover will end. Where your cover ends because you are no longer eligible to be covered, you will be entitled to claim for treatment received on or before the date your policy ends. Please remember you must submit a claim within 12 months of the date any treatment was received or the completion date of any hospital treatment.

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. Please note, this does not apply to colleagues who work at the Morrisons Gibraltar store – Morrisons Gibraltar colleagues should refer to the separate addendum to these terms and conditions which apply in Gibraltar only.

If you are an existing customer of the Morrisons health care cash plan 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 Sovereign Health Care policy however you can only claim for treatment once. If you have more than one, 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 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. 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. For Morrisons Gibraltar colleagues, claims can **only** be paid by direct credit – Morrisons Gibraltar colleagues should refer to the separate addendum to these terms and conditions which apply in Gibraltar only.

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.

We will not pay for any postage, packaging and/or delivery costs.

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 a 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 November 2019. Your claiming year for the dental benefit would therefore run from 1 November 2019 until 31 October 2020 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

The Morrisons health care 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 benefits (in-patient or day case admission) you will need to ask the hospital/clinic 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 you can download 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 send you a cheque, or pay the money into your bank account if you prefer.

Dependent child claims cannot be submitted online. These should be sent to us in the post.

## 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 Morrisons health care cash plan has been designed to allow colleagues 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. Any disputes will be governed by the courts of England and Wales on a non-exclusive basis. 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 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. Prescription spectacles including frames, prescription sunglasses and prescription 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

We will refund **half** the amount paid by you for NHS or private prescription charges 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.

We will pay you for:

1. NHS prescription charges
2. Private prescription charges
3. An NHS prepayment certificate where multiple NHS prescriptions are needed

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

## Help to keep you ticking over

### Physiotherapy/Osteopathy/Chiropractic

We will refund **half** the amount paid by you to a qualified and registered physiotherapist, osteopath or chiropractor 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. A Private Medical Insurance (PMI) excess that has been paid by you to your PMI provider in order to access physiotherapy, osteopathy or chiropractic 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 or chiropractic. Examples of treatments that we do not cover are; aromatherapy, herbal therapies, sports massage, 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 although you may be able to claim for these under the 'specialist medical aids' benefit
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, sports massage, 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

We will pay you at the relevant fixed nightly amount up to a maximum of 30 nights per benefit claiming year, each time you are 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 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

We will not pay you for:

1. 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. Hotel ward accommodation costs
6. Out-patient treatment
7. Nursing treatment plans, Community Matron Service or virtual ward treatment
8. Ante or post natal admission for a dependent child who you register on your policy
9. Parental stay where you accompany a dependent child who is admitted as an in-patient
10. In-patient stays for pre-existing conditions in the first 6 months from the date of joining or upgrading a policy

### Recuperation

We will pay a fixed amount, determined by your level of cover, if you spend a minimum of 14 consecutive nights in hospital as an in-patient and a valid claim has been made under the hospital in-patient benefit. This is payable once in each benefit claiming year and only after you have been discharged from hospital. We will not pay the recuperation benefit in the first 6 months from the date of joining or upgrading a policy where the in-patient stay was for a pre-existing condition.

### Hospital day case admission

We will pay you at the relevant fixed daily amount up to a maximum of 10 days per benefit claiming year, each time you are treated in a recognised hospital/clinic 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. 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. An admission to a day case ward or unit for treatment of a medical condition
2. The first 10 occasions in each benefit claiming year

We will not pay you for:

1. Attending hospital as an outpatient or for accident and emergency visits
2. Maternity, geriatric and psychiatric treatments and hospice care
3. Pre-admission appointments
4. Cancelled operations or procedures
5. Day case admission immediately prior to or following an overnight stay in hospital for which a claim may be payable under the hospital in-patient benefit
6. Day case admission for pre-existing conditions in the first 6 months from the date of joining or upgrading a policy

### 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 5
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

## Home care

We will refund **half** the amount paid by you for local authority or accredited agency charges to provide care services 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. Cleaning, laundry and shopping services provided to you

We will not pay you for:

1. Home nursing and day/night sitting
2. Day centre attendance
3. Maternity charges

## Hearing aids

We will refund **half** the amount paid by you to a recognised hearing aid dispenser for new hearing aids up to the appropriate maximum in each benefit claiming year. This maximum is determined by your level of cover. If you enter into a credit agreement to pay for your hearing aid, the date of your credit agreement will then also become the start date of your benefit claiming year.

We will pay you for:

1. New hearing aids

We will not pay you for:

1. Hearing aid contract schemes
2. Hearing aid repairs
3. Replacement hearing aid batteries
4. Any other type of amplifying aid or device
5. Hearing aids to treat a pre-existing condition in the first 6 months from the date of joining or upgrading a policy
6. Missed appointment charges

## Specialist medical aids

We will refund **half** the amount paid by you for specialist medical aids and surgical appliances prescribed to you by a registered 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. Abdominal, lumber supports, surgical corsets and trusses
2. Mastectomy items
3. Surgical stockings
4. Arch supports and orthotic insoles
5. Nebulisers
6. Wigs when supplied through a medical prescription

We will not pay you for:

1. Surgical implants
2. Mobility aids including but not limited to wheelchairs and crutches
3. Sexual and contraceptive aids
4. Surgical shoes
5. Repairs and batteries
6. Specialist medical aids prescribed for a pre-existing condition in the first 6 months from the date of joining or upgrading a policy

# Here to help

To discuss any aspect of your Morrisons health care cash plan please call the Sovereign Health Care team on:

## 01274 841 130

Lines are open Monday to Thursday 9am to 5pm and Friday 9am to 4pm.

## The simple way to manage the cost of your everyday wellbeing.

The Morrisons health care cash plan, provided by Sovereign Health Care, gives you money back on a range of everyday health care costs and can help you to budget towards your family's health care.

It's reassuring to know that when those regular check-ups are due or an unexpected health problem occurs, there is help at hand to support you with the costs.



Provided by Sovereign Health Care

Morrisons Since 1899

Morr_12_2019

Morrisons

# Health care cash plan

Exclusively for Morrisons colleagues

**Policy terms and conditions from 1 January 2024**

Provided by Sovereign Health Care

# Table of benefits – what your cash plan covers

The table below summarises the yearly cover provided by the Morrisons health care cash plan. Please read these terms and conditions carefully. Premiums include insurance premium tax (IPT).

| Levels of cover | | Level 2 | Level 3 | Level 4 | Level 5 | Level 6 |
|---|---|---|---|---|---|---|
| **Weekly premium** (per person) | | £1.95 | £2.94 | £3.93 | £5.07 | £6.63 |
| **Four weekly premium** (per person) | | £7.80 | £11.76 | £15.72 | £20.28 | £26.52 |
| Everyday essentials | Payback | | | | | |
| **Dental** including treatment, check-ups and x-rays | 100% | up to £70 | up to £105 | up to £140 | up to £175 | up to £210 |
| **Optical** including glasses, contact lenses and eye tests | 100% | up to £90 | up to £135 | up to £180 | up to £225 | up to £270 |
| **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 £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Chiropody/Podiatry** | 50% | up to £50 | up to £75 | up to £100 | up to £125 | up to £150 |
| **Acupuncture/Homeopathy/Reflexology/ Earwax removal** | 50% | up to £150 | up to £225 | up to £300 | up to £375 | up to £450 |
| **Health screening** including well person 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** 6 month qualifying period for pre-existing conditions | Max 30 nights | £20 per night | £30 per night | £40 per night | £50 per night | £60 per night |
| **Recuperation** 6 month qualifying period for pre-existing conditions | Fixed amount | £90 | £135 | £180 | £225 | £270 |
| **Hospital day case admission** 6 month qualifying period for pre-existing conditions | Max 10 days | £18 per day | £27 per day | £36 per day | £45 per day | £54 per day |
| **Hospital consultant fees and diagnostic tests** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| 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 |
| **Home care** for local authority or accredited agency care services such as cleaning, laundry and shopping | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |
| **Hearing aids** 6 month qualifying period for pre-existing conditions | 50% | up to £100 | up to £150 | up to £200 | up to £250 | up to £300 |
| **Specialist medical aids** 6 month qualifying period for pre-existing conditions | 50% | up to £250 | up to £375 | up to £500 | up to £625 | up to £750 |

## Free cover for up to four dependent children aged under 18

Up to four dependent children, aged under 18, are covered at the same level as the policyholder for all benefits excluding birth/adoption, home care, hearing aids and specialist medical aids. Cover provides separate yearly maximums for the policyholder and each of their covered dependent children.

# Welcome to Sovereign Health Care!

Thank you for joining Sovereign Health Care. We provide the Morrisons health care cash plan exclusively to colleagues.

Your Morrisons health care 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 Morrisons health care 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 (please note, you cannot currently make dependent child claims 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. You also have access to a 24-hour confidential telephone helpline and digital services to support your wellbeing

### 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

### 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 sign the application form. For the purposes of our contract you will be classed as a 'consumer' (also known as a retail client).

### Policy start date and renewal

Your policy starts on the date shown on your policy certificate. It will renew automatically each month until it is cancelled or you allow it to lapse (where cover ends because you have, for example, left the employment of Morrisons or stopped paying your policy premiums).

### Who can join?

You can apply to join the Morrisons health care cash plan as long as you are employed by Morrisons.

You can also pay to cover your partner or a family member, and you can cover up to four of your dependent children (aged under 18) free of charge. See the sections 'Cover for your partner or a family member' and 'Free cover for dependent children' for more details.

You must also be a permanent UK resident for tax purposes with an address in the UK. Please note, this does not apply if you work at the Morrisons Gibraltar store, in which case you should read the separate addendum for amendments to these terms and conditions which apply in Gibraltar only.

We will decide whether to accept your application to join, renew a policy or change your level of cover. We have the right to refuse your application for any reason without giving you an explanation.

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

If you keep to these terms and conditions, you can continue to hold a policy for as long as you are an employee of Morrisons. If you stop being a Morrisons employee, you, your partner or family member, and your dependent children will no longer be eligible for cover under the Morrisons health care cash plan. You may be able to transfer to a different Sovereign Health Care cash plan. See the section 'Ending your policy' for more details.

### No medical is needed

You do not need a medical to join Sovereign Health Care and the Morrisons health care cash plan.

### You can claim straightaway, except for benefits with a qualifying period

When you join the Morrisons health care cash plan, you can claim straightaway for treatment received on or after your start date, except for benefits which have a qualifying period.

You will not be covered for those benefits until the qualifying period has ended (regardless of when you claim).

We recommend that you read this section with the 'Qualifying periods', 'Pre-existing conditions' and 'Benefits explained' sections before going ahead with any treatment which you intend to claim for under your policy.

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

## Qualifying periods

For the birth/adoption benefit there is a six month qualifying period. This means we will not accept claims for a birth or adoption which took place within the first six months of the policy.

If you have a pre-existing condition, there is a six month qualifying period for certain benefits. See the 'Pre-existing conditions' section below for more information.

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

## Pre-existing conditions

In this section the words, "**pre-existing conditions**" mean any illnesses or injuries which affect 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
- Recuperation
- Hospital day case admission
- Hospital consultant fees and diagnostic tests
- Hearing aids
- Specialist medical aids

You can still join the Morrisons health care cash plan if you are affected by a pre-existing condition, but your policy will not cover you for treatment relating to the pre-existing condition until after the six month qualifying period has ended.

We will accept claims for treatment for pre-existing conditions as long as the treatment is received at least six months after the start date of your policy.

If you increase your level of cover, your cover for pre-existing conditions will only increase six months after the date of the increase. See the section 'Changing your level of cover' for more information.

## Checking whether you can claim

If you need to check whether or not you can claim for treatment under your policy, please call us on **01274 841130**.

## Your level of cover

Your level of cover is 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.

## Changing your level of cover

You can apply to increase or decrease your level of cover at any time, but you must stay at your new level of cover for at least 12 months before you can change it again. You can change your level of cover by filling in and submitting the appropriate application form to us. We will decide whether to accept your application to change your level of cover (we have the right to refuse your application).

If you increase your level of cover you will automatically be covered at the higher level of cover for all benefits from the effective date of your upgrade, unless there is a qualifying period for a benefit or 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 as long as your policy has been in place for the relevant qualifying period and your premium payments are up to date. See the sections '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 will end immediately from the date we accept your application.

In all cases, the benefit we pay will depend on the level of cover in force on the date of the treatment, not the date you claim.

If you change your level of cover, your claiming year will not change and any claims we have already paid to you will count towards the maximum entitlement under your new level of cover.

## Cover for your partner or a family member

When you join the Morrisons health care cash plan you also have the option of paying to cover your partner or a family member, either when you apply to join or at a later date. If you decide to do this, your partner or family member will have their own policy in their own name. However, you will pay for your partner's or family member's policy by the same payment method as your own policy.

If you pay for your partner's or family member's policy and we make changes to the policy or the premiums, we will write to you and your partner or family member separately to tell you about the changes.

If you pay for your partner's or family member's policy, we can discuss payment of their policy premiums with you. However, we can't discuss anything else relating to their policy with you unless they have given us permission to do so by filling in a 'Third party authorisation form' or calling us to give us their authorisation instruction over the phone. See the section 'Third party authorisation' for more information.

## Free cover for dependent children

The policy covers up to four dependent children, free of charge, at the same level of cover as the policyholder for all benefits excluding birth/adoption, home care, hearing aids and specialist medical aids, as shown in the table of benefits on page 2. For the purposes of these terms and conditions, the words "**dependent child**" mean your child (biological or legally adopted) who permanently lives with you, is aged under 18 and who is not a policyholder in their own right. The words "**dependent children**" shall be construed accordingly.

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.

If both parents or guardians are policyholders, 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.

You cannot currently make dependent child claims online – you must send these by post.

If your dependent child is born in hospital you can only claim for that child from the date they are discharged from hospital.

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. If they would like to join Sovereign Health Care in their own right and they tell us within 13 weeks of their 18th birthday, they will receive complete continuation of cover as long as their parent's or guardian's premium payments are up to date.

## Cooling off period – your right to change your mind

If you decide your policy does not meet your needs for any reason, you can cancel it 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 in writing or by phoning our customer support team on **01274 841130**.

Any premiums paid during the cancellation period will be refunded. Premiums will not be refunded if a claim has been made during the cancellation period or if the cancellation period has ended before you cancel.

If you cancel your policy, it is your responsibility to tell your employer, bank or building society to stop taking the premium payments from your salary, pension or bank or 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 include insurance premium tax (IPT) at the current rate.

You are responsible for making sure your premiums are paid, regardless of whether a third party (such as your partner) pays the policy premiums on your behalf.

Your policy is a rolling contract. This means it will continue until you or we end it. Premiums are due in line with the payment method (usually payroll deduction or Direct Debit for Morrisons Gibraltar employees) and the payment frequency agreed at the start of the policy. Each premium pays for the period of cover to come. Premiums are not refundable. Making payments in advance does not extend the length of your rolling contract with us by more than one calendar month.

When you take out your policy, or increase your cover, we will tell you when your first payment will be collected. To make sure your premiums are up to date, it may be necessary to take payment for two or more months' premiums when the first payment is due.

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

Premiums must be fully up to date at the time of any claim. If they are not, we will be entitled to suspend your cover and may not pay any claims. If premiums remain unpaid for 13 weeks, we will cancel your policy and will not refund any premiums paid.

If we change your premium, you must pay the new rate from the date the change is made, unless we tell 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 third party's permission to change the premium payments for your policy.

## Our right to change your policy

It may sometimes be necessary for us to change your policy, including, for example, the amount you pay for it, the benefits available to you under it, and the rules relating to it. If we tell you we have changed your policy and we do not hear from you, we will assume that by continuing to pay your policy premiums you are agreeing to the change. However, if you let us know in writing that you do not agree to the change, we will cancel your policy from the next automatic renewal date.

If we make a significant change to the policy, we will try to give you at least 30 days' notice in writing. 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.

If we need to change the policy on less notice due to, for example, a change in any relevant regulation or legislation, we will tell you about the change as soon as possible.

## Ending your policy

You can end your policy at any time by giving us at least 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 'How to contact us' for our contact details.

If you end your policy, it is your responsibility to tell your employer, bank or building society to stop taking the premium payments from your salary or bank or building society account. We will not refund any premiums that are paid during your notice period.

If you leave the employment of Morrisons, you, your partner or family member and dependent children will no longer be eligible for cover under the Morrisons health care cash plan. We may invite you to join a different Sovereign Health Care cash plan. If you apply within 30 days of leaving the employment of Morrisons 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. Please note, the premiums charged and cover provided under the policy you transfer to will be different to the Morrisons health care cash plan. If you are a Morrisons Gibraltar employee, you will not be able to transfer to a different Sovereign Health Care cash plan as we do not sell our products outside the UK. You should read the separate addendum to these terms and conditions which apply in Gibraltar only.

If you are no longer eligible to be covered, we will write to you to let you know when your cover will end. If your cover ends because you are no longer eligible to be covered, you will be entitled to claim for treatment that was received on or before the date your policy ends. Please remember you must submit a claim within 12 months of the date any treatment was received or the date any hospital treatment was completed.

We can 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 weeks;
- there is reasonable evidence that you misled us or attempted to do so;
- you break these terms and conditions; or
- you are 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 do not have to refund any premiums you have already paid. We will pay any claims that we agreed we would settle before your policy ended, but we may try to recover any amounts we have paid to you that were not due under the terms of the policy.

If we make a business decision to stop providing the policy, we will give you 30 days' written notice. We will settle any outstanding claims in line with these terms and conditions.

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

If you have paid premiums before they were due, we may refund premiums which relate to a period after your cover ends. However, we can withhold these premiums if you owe us money. Nothing in these terms and conditions affects your legal rights as a consumer.

## 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.

Please note, this does not apply if you work at the Morrisons Gibraltar store, in which case you should read the separate addendum to these terms and conditions which apply in Gibraltar only.

# 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.

For Morrisons Gibraltar employees, we can pay claims by direct credit only – Morrisons Gibraltar employees should read the separate addendum to these terms and conditions which apply in Gibraltar only.

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.

For the birth/adoption benefit, we will need a copy of the relevant original full birth or adoption certificate or document.

If the policyholder has died and there is a claim or premium refund owing, we will need a copy of the policyholder's original death certificate.

Please note that we do not ask for original birth, adoption or death certificates or documents, and we take no responsibility for the loss of these documents if you send the original to us.

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.

## Claiming year explained

The time frame during which you can claim is called your 'claiming year' and depends on your cover start date, which is shown on your policy certificate.

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 cover started on 15 March 2024, your claiming year for all benefits would be 15 March 2024 to 14 March 2025. Your new claiming year would then start again for all benefits on 15 March 2025 for another year, and so on.

**If your cover started before 1 January 2024**, your claiming year was reset from this date, for all benefits, and runs for 12 months (1 January 2024 to 31 December 2024). Your new claiming year will then start again on 1 January 2025 for another year, and so on.

## Cover limits

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.

If you change your level of cover at any point, this does not change your claiming year.

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 benefits (in-patient or day case admission), 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 of admission and discharge, and the 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. You cannot currently make dependent child claims online and should send these by post.
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 Morrisons health care 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 the contract. Any disputes will be governed by the courts of England and Wales on a non-exclusive basis. 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.

# 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 Morrisons health care 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 pages 10 and 11.

# 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. 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

## Prescription charges, inoculations and vaccinations

We will refund half 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 half 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
6. Treatment received for pre-existing conditions in the first six months of joining or upgrading a policy

## Chiropody/Podiatry

We will refund half 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), although you may be able to claim for these under the 'specialist medical aids' benefit
6. Missed appointment charges

## Acupuncture/Homeopathy/Reflexology/Earwax removal

We will refund half 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 half 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.

**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 in-patient

We will pay you at the relevant fixed nightly amount, up to a maximum of 30 nights in each claiming year, each time you are admitted to a ward (not including an accident and emergency department) to receive treatment as an in-patient. For the purpose of this policy, an in-patient stay is classed as a full night only if you are admitted as an in-patient before 12 midnight. 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 details of the treatment (they should also sign and stamp the form). If you provide a copy of your hospital discharge summary, this must include the date of admission and discharge, and the reason you were admitted.

**What is covered**

1. Admission as an in-patient for treatment of a medical condition or as the result of an accident. If you are admitted as the result of an accident, the inpatient stay begins when you are formally admitted to a ward, not from the time you arrived at the hospital
2. Maternity in-patient admission, including for a caesarean section, where the hospital stay is for the insured mother only. We will not pay this benefit if the mother is only staying in hospital to be with her baby until they are discharged from hospital

**What is not covered**

1. Admission to a hospital, nursing home, residential home or other accommodation arranged only or partly for domestic reasons or to provide respite care (to give your carers a break)
2. Nights when a patient is allowed out of hospital for whatever reason
3. Admissions relating to alcohol, chemical or drug dependency, self-inflicted illness or injury, or conditions arising as a result of dependency on alcohol, chemical substances or drugs, or a self-inflicted illness or injury
4. Emergency admission due to drinking an excessive amount of alcohol or alcohol poisoning, taking any illegal substance, or drug or solvent abuse
5. Hotel ward accommodation costs
6. Outpatient treatment
7. Nursing treatment plans, community matron service or virtual ward treatment (also known as 'hospital at home')
8. Antenatal or postnatal admission for a dependent child who you register on your policy
9. Parental stay where you stay with a dependent child who is admitted as an in-patient
10. In-patient stays for pre-existing conditions in the first six months from the date of joining or upgrading a policy

## Recuperation

We will pay a fixed amount, which will depend on your level of cover, if you spend at least 14 nights in a row in hospital as an in-patient and you have made a valid claim under the hospital in-patient benefit. We will pay this only once in each claiming year and only after you have been discharged from hospital. We will not pay the recuperation benefit in the first six months from the date you join or upgrade a policy if the stay in hospital relates to a pre-existing condition.

## Hospital day case admission

We will pay you, at the relevant fixed daily amount, for up to a maximum of ten 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 ten 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. Admission to a day case ward immediately before or after an overnight stay in hospital for which we may pay a claim under the 'hospital in-patient' benefit
6. Admission to a ward for a pre-existing condition in the first six months from the date of joining or upgrading a policy

## Hospital consultant fees and diagnostic tests

We will refund half 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
8. Referrals to a hospital consultant for pre-existing conditions in the first six months from the date of joining or upgrading a policy

# Support when you need a helping hand

## Birth/Adoption of a child

We will pay a fixed amount for the birth or adoption of a child or children in each claiming year, as long as the correct premiums have been paid for the six month qualifying period. Before paying the birth or adoption benefit, we will need to see a copy of the full birth certificate or adoption papers, showing the name of the policyholder (or holders) and the child's name. We will pay this benefit for each child, and the amount we pay depends on your level of cover.

### What is covered

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 the 24th week of pregnancy (we will need to see a copy of the stillbirth certificate)

### What is not covered

1. A miscarriage before the 24th week of pregnancy
2. Foster children
3. Termination of pregnancy
4. The legal adoption of a child who is already related to you or your partner before the adoption takes place
5. Claims in the first six months from the date of joining or upgrading a policy

## Home care

We will refund half the amount you have paid for local authority or accredited agency charges to provide care services, up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

### What is covered

1. Cleaning, laundry and shopping services provided to you

### What is not covered

1. Home nursing and someone to sit with you during the day or night
2. The costs of attending a day centre
3. Charges relating to maternity care

## Hearing aids

We will refund half the amount you have paid to a recognised hearing aid dispenser for new hearing aids, up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

### What is covered

1. New hearing aids

### What is not covered

1. Hearing aid contract schemes
2. Hearing aid repairs
3. Replacing hearing aid batteries
4. Any other type of amplifying aid or device
5. Hearing aids to treat a pre-existing condition in the first six months from the date of joining or upgrading a policy
6. Missed appointment charges

## Specialist medical aids

We will refund half the amount you have paid for specialist medical aids and surgical appliances prescribed to you by a registered practitioner, up to the appropriate maximum amount in each claiming year. This maximum amount depends on your level of cover.

### What is covered

1. Abdominal and lumber supports, surgical corsets and trusses
2. Mastectomy items
3. Surgical stockings
4. Arch supports and orthotic insoles
5. Nebulisers
6. Wigs (when supplied through a medical prescription)

### What is not covered

1. Surgical implants
2. Mobility aids (including, but not limited to, wheelchairs and crutches)

3. Sex aids and contraception
4. Surgical shoes
5. Repairs and batteries
6. Specialist medical aids prescribed for a pre-existing condition in the first six months from the date of joining or upgrading a policy

# 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.

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.

# Here to help

If you have any questions about your Morrisons health care cash plan, please call or email the Sovereign Health Care 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



Provided by Sovereign Health Care

Morrisons

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