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

Morr_10_2023