Private Dental Insurance

Insurance Product Information Document

This product is underwritten by Hamilton Insurance DAC, who are auth orised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority and the Prudential Regulation Authority in connection with its UK branch. Firm's reference number 484148. Registered office: 2 Shelborne Buildings, Crampton Avenue, Ballsbridge, Dublin 4, D04W3V6

Company: Healix Insurance Services Ltd **Product:** Advantage Health Dental Care Plan for employees of Lloyds Register Quality Assurance

This document is only intended to provide a summary of the main policy coverages and exclusions and is not personalised to your specific needs in any way. Complete pre-contractual and contractual information on the product and the insurer is provided in your policy document.

What is this type of insurance?

This insurance policy provides reimbursement for a range of eligible routine and essential dental treatment..

What is insured?

This insurance covers you for the reimbursement of the following dental costs, incurred during the period of cover and up to the individual treatment limits set out in your policy document.

	Cover
✔ Examinations	Up to the treatment limits in your chosen plan
✔ Hygiene treatments	
✔ X-rays	
✔ Restorative treatments	
✔ Oral cancer (lifetime limit)	Up to £20,000
✔ NHS treatment costs (bands 1-4)	100% reimbursement
✔ Mouthguard	Pearl/Silver/Platinum/Diamond 100%NHS/£45/£60/£75
✔ Anaesthetic fee	Pearl/Silver/Platinum/Diamond 100%NHS/£60/£80/£100
✔ Emergency treatment	Pearl/Silver/Platinum/Diamond 100%NHS/£30/£45/£60
✔ Overnight hospital stay	Pearl/Silver/Platinum/Diamond £0/£35/£50/£65
✔ Child orthodontics	Pearl/Silver/Platinum/Diamond 100%NHS/£325/£550/£775
✔ Apisectomy	Pearl/Silver/Platinum/Diamond 100%NHS/£50/£80/£110
✔ Personal Protective Equipment (annual limit)	Pearl/Silver/Platinum/Diamond £0/£30/£30/£30

These are not the full benefits of your plan. Please refer to the Benefit Table in your policy for the full list of treatments and maximum payable per procedure for your chosen plan.

What is not insured?

Please refer to the General Exclusions section of your policy document for a full list of exclusions.

No benefits will be paid for:

- ✘ Cosmetic treatments and treatments not clinically necessary.
- ✘ Any treatment resulting from self-inflicted injury.
- ✘ Treatment received prior to the commencement of the period of cover; and treatment received after the period of cover ceases.
- ✘ Any treatment once the annual maximum number of treatments or maximum annual benefit limit has been reached for that treatment.
- ✘ Travelling expenses or telephone calls in connection with any treatments or charges for completing the claim form.
- ✘ Any claims for the replacement of dentures damaged whilst not being worn.
- ✘ Any treatment relating to damage or injury caused whilst participating in any contact sport when the appropriate tooth, mouth or head protection was not being worn.
- ✘ Oral cancer diagnosed or suspected prior to the commencement date of the policy.
- ✘ Oral cancer resulting from smoking.
- ✘ Child orthodontic treatment for patients with grade 1 or 2 on the Index of Orthodontic Treatment Need (IOTN).
- ✘ Implants unless you have purchased the additional implant cover. And where you have done so:
- ✘ Implants in the site of 2nd or 3rd molars.
- ✘ Complications in relation to covered implants.
- ✘ Implant treatment which is necessary, prescribed or planned prior to your date of entry into the policy.

Are there any restrictions on cover?

- Certain treatments are limited to maximum number of treatments in any one period of cover e.g. 2 routine examinations per year, 4 medium x-rays per year.
- Specific treatments must have a minimum durability for any subsequent treatment to be covered under the policy for example fillings and root canal treatments must last for at least 2 years.
- There are sub-limits within the oral cancer benefit.
- If your employer allows you to add dependents to the policy, your children must be under 26 years of age and in full time education, living with parents/guardians outside term time at the start date of their cover. Family cover will cover up to a maximum of 3 children and the benefits shall be shared amongst the children.
- We will not be held responsible for any treatment costs which have been authorised, if the policy then terminates or your employer cancels the policy and treatment has not yet taken place.
- We will only pay up to the maximum amount payable per treatment and up to the annual aggregate maximums as shown in the benefit table in your policy documentation.

Where am I covered?

Cover is provided on a worldwide basis.

What are my obligations?

- You must submit your claim as soon as possible and in any event within 180 days of completion of treatment, unless there is a justifiable reason for the delay. Ensure your dentist has provided you with the appropriate treatment invoice and submit this, along with any other required information, via one of the four methods detailed in the claims section of your policy wording.
- You must give consent for us to get, at our expense, any dental records, photographs or x-rays we need to assess the eligibility of a claim from the practitioner who has treated you or any of your dependants.
- All insured people must be residents of the UK, Channel Islands or Isle of Man. You must tell us if any insured person no longer meets this criteria and we'll remove them from the policy at renewal.
- You must only receive treatment from a qualified dental practitioner registered with the General Medical Dental Council or another person properly qualified to perform the required treatment.

When and how do I pay?

If your company has agreed to provide the cover to you free of charge, your employer will pay the premium. Alternatively, you pay your premium through your employer via monthly payroll deduction.

When does the cover start and end?

Your cover starts on the day you join the scheme, defined as the date of entry in your policy document, subject to any qualifying conditions that may be set by your employer; and ends on the date of termination of your cover or the review date, as defined in your policy document, whichever occurs first.

How do I cancel the contract?

If you decide that for any reason this policy does not meet your needs you can cancel your policy within the first 14 days of receiving your policy documents. Your cover will cease and you will receive a full refund of any premiums that have been paid during the 14 days, provided no claim has been made or is pending. There will be no refund of premiums if you choose to cancel your policy after the first 14 days and your cover will continue until the next review date at which point you may de-select the benefit on your Employee Benefits platform.