



# CORPORATE TERMS & CONDITIONS

## IMPORTANT INFORMATION

**Please keep safe with your Policy Schedule and Benefit Table**



dental insurance advisers

Underwritten by

**+ medicash**  
A positive approach to health

# WELCOME TO YOUR DENTAL PLAN

**This dental plan, brought to you by Get Dental Plans, is provided and underwritten by Medicash - one of oldest and largest providers of health plans in the UK.**

The fact that you are now a Medicash policyholder means your company has made a real commitment to your health and wellbeing. Over the following pages, you'll find all the information you need to know about your plan, including how to make a claim and the important Terms and Conditions relating to your policy. You need to read these Terms and Conditions with your policy schedule and benefit table, which together make up the policy between you, the policyholder, and us.

Please check these carefully to confirm your cover before receiving treatment or paying for goods and services for which you intend to claim. Full details of each benefit are included elsewhere in this booklet.

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**IF YOU HAVE ANY QUESTIONS ABOUT YOUR POLICY  
OR ANY PART OF THESE TERMS AND CONDITIONS,  
SIMPLY CALL OUR CUSTOMER SERVICE TEAM  
ON 0151 702 0265.**

Lines are open Monday to Thursday from 8.45am to 5pm, and Friday from 8.45am to 4pm (except bank holidays).  
We may record calls for training and monitoring purposes.

BENEFIT TABLE		Level 1	Level 2	Level 3	Level 4
Routine Examinations...					
Cover for check-ups, routine investigations and exams, plus x-rays (yearly maximum)		£70	£100	£130	£160
Keeping your teeth healthy...					
Cover for a hygienist scale and polish (yearly maximum)		£80	£120	£160	£200
Orthodontic Treatments...					
Covers orthodontic treatments for those individuals who have been graded as a 4 or 5 on the IOTN Scale (yearly maximum)		£200	£300	£400	£500
Emergency Cover...					
Up to £400 of treatment per incident, maximum of two incidents per benefit year (yearly maximum)		£800	£800	£800	£800
Dental Accidents & Injury...					
Cover for treatment as a result of an injury or accident (yearly maximum)		£3,000	£4,000	£5,000	£6,000
Fillings...					
Amalgam or composite fillings including inlays and onlays (yearly maximum)		£75	£125	£175	£225
Restorative Treatments...					
Extractions, Dentures, Crowns, Bridges, Root Canals and Periodontal Treatments (yearly maximum) <sup>1</sup>		£400	£600	£1,000	£1,500
Implant Cover...					
Cover for the cost of dental implants required as part of your treatment plan (yearly maximum) <sup>2</sup>		£100	£350	£800	£1,200
Cosmetic & Preventative Care...					
Cover for cosmetic whitening, fissure sealants and gum shields for sports or teeth grinding <sup>3</sup> (yearly maximum)		£75	£100	£125	£150
Hospital Stays...					
Cover for each night that you spend in hospital under the care of a Specialist Consultant		£75	£75	£75	£75
		per night, up to 20 nights per benefit year			
Optional Extra - Optical Cover...					
Where selected by your employer and shown on your policy schedule, employees and their partners will be able to claim back the cost of eye tests, glasses and contact lenses. Children are not covered for this benefit (yearly maximum)		£200	£200	£200	£200

The benefit allowances shown above are the maximum amounts which can be claimed per benefit year by each individual covered on this plan, excluding the optional Optical Cover benefit which does not cover children. Child cover will cease on their 18th birthday.

<sup>1</sup> Cover is not provided for pre-existing conditions which you experienced symptoms or knew about before your policy started or increased level.

<sup>2</sup> Cover is not provided for pre-existing conditions or gaps that existed before the start of your policy or increase in level.

<sup>3</sup> Cosmetic whitening is limited to treatments performed by a dentist.

## 1. DEFINITIONS

Defined words are highlighted throughout this policy booklet in bold print. The explanation of the defined words is listed below and they have the same meaning wherever they appear in the policy.

**Acute dental condition** – A disease, illness or injury that is likely to respond quickly to **treatment** which aims to return **you** to the state of health **you** were in immediately before suffering from it, or which leads to **your** full recovery.

**Benefit** – This is the type of cover that **we** provide and the amount that **we** will pay **you** up to the maximum for each type of cover.

**Benefit date** – This is the date shown in your **policy schedule** and is the first date from which **you** are able to make a claim.

**Benefit table** – This is the table that shows the maximum amount that **we** will pay you for each type of cover for each **benefit period**.

**Benefit period** – This is the period of time that **you** can claim up to the maximum amount of **benefit**, as shown in the **benefit table**.

**Child or children** – Dependent children under the age of 18 born to **you** or **your partner**, legally adopted by **you** or **your partner** or for which **you** or **your partner** are the legal guardian.

**Clinically necessary** – Treatment that is received to treat a disease or replace defective or worn dental work in order to maintain or improve **your** level of oral health as recommended by **your dentist**.

**Cosmetic or aesthetic treatment** – This is any **dental treatment you** receive to change **your** appearance, and that is not **clinically necessary**. This includes the replacement of silver-coloured fillings with white fillings if they have not become worn or defective.

**Dangerous activities and sports** – This includes but is not limited to boxing and other contact sports, canyoning, gorge walking, hang-gliding, high diving, horse riding or horse jumping, ice hockey, martial arts, microlighting, mountain boarding, parasailing, polo, rock climbing or riding/driving in any kind of race, even if it is for charity.

**Dental accident** – A sudden and unexpected incident that happens by chance and which causes a dental injury that requires medical or dental attention.

**Dental Treatment** – This is any dental work undertaken on **your** teeth and gums which is covered under this **policy**. Treatment will usually last from the date **you** receive **your** first treatment to the date **you** have **your** final treatment.

**Dentist** – This is any dental practitioner who is registered as a dentist and holds a current licence with the General Dental Council in the **UK** at the time **you** received **your dental treatment**. They cannot be a member of **your** immediate family or employed by any business that **you** own or are a named director of.

**GP** – A General Practitioner (GP) who is registered and holding a current licence with the General Medical Council to practice medicine in the **UK** at the time of your **treatment** or appointment. **We** do not cover **treatments** provided by a retired GP or a GP who was under suspension at the time of **your treatment**.

**Inpatient** – This is when **you** stay in hospital for one or more nights in order to receive **dental treatment** or for a continuation of dental care. **You** must have been allocated **your** own bed for each night of **your** inpatient stay.

**Our, us or we** – Mediacash Health Benefits Ltd, One Derby Square, Liverpool L2 1AB. A company limited by guarantee, registered in England (number 258025), is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

**Outpatient** – This is any dental care in an NHS, private hospital or recognised treatment centre that does not require an overnight stay and is not covered on this policy.

**Partner** – **Your** husband, wife or partner who lives with **you** on a permanent basis, regardless of gender.

**Policy** – This is **our** contract of insurance with the **policyholder**, in which **we** provide the cover as explained in the **policy schedule**, the **benefit table** and these Terms and Conditions.

**Policyholder** – This is the first person named in the **policy schedule** who is responsible for any **child premiums** due and will usually receive any **benefits we** pay. **We** will write to this individual in connection with all correspondence. **You** agree by taking out this **policy** that **you** have the explicit consent of everyone named on **your policy** to receive these communications; that these may contain health information relating to anyone covered on the **policy**; and information related to their claims.

**Policy schedule** – This is the document that shows the date **your policy** started, the level of cover **you** have chosen and the people covered under the **policy**.

**Pre-existing conditions** – This is a condition which **you** had experienced symptoms of or knew about prior to taking out this **policy**. It includes any 'Restorative Treatments' or Implants which were planned or recommended in the 12 months before joining this plan. If **you** have not had a dental examination in the 12 months prior to the start date of the plan, then any 'Restorative Treatments' or Implants identified, recommended or undertaken at **your** first dental examination will be classed as a pre-existing condition and will not be covered.

**Premiums** – These are the payments made for **your policy**.

**Professional sports** – This is any sport for which **you** receive payment or non-charitable sponsorship.

**Self inflicted injuries** – This is when **you** need **treatment** for an injury **you** have caused to yourself. This includes misusing drugs, alcohol, solvents or other addictive substances, and self-abuse.

**Specialist Consultant** – A Specialist Consultant who is registered on the General Medical Council on their Specialist Register or on the General Dental Council Specialist Register.

**United Kingdom (UK)** – The UK includes England, Wales, Scotland and Northern Ireland only. The Channel Islands and the Isle of Man are excluded from cover on this plan.

**You or your** – This is you, the **policyholder**, and your **partner** and dependent **children** where covered.

## 2. BECOMING A POLICYHOLDER / WHO CAN HAVE COVER

- 2.1 This plan is not available to purchase on an individual basis. It is only available where the employer is paying to cover their employees who reside in the **UK**.
- 2.2 Eligible employees will be provided with cover at the level determined by their employer, the cost of which will be met by their employer. **You** have the right to opt out of this cover by notifying **your** employer.
- 2.3 Where appropriate **your** employer may choose to cover **your partner** on the same level as **you**, the cost of which will be met by them. **You** have the right to opt out of this cover by notifying **your** employer.
- 2.4 **You** can choose to pay an additional **premium** to add **your children** who are under 18 to **your policy** at the same level of cover as **you**. **Children** can only be added at the start of a new **benefit period**. Cover for **children** will cease on their 18th birthday and **your premium** will decrease accordingly from the following month.
- 2.5 **We**, like any responsible insurer, and to the extent permitted by all applicable laws, reserve the right to decline an application for a **policy** or request to upgrade cover. If **your** application is not accepted, **we** will refund any premium that **you** have paid for the cover that **we** have declined to offer.
- 2.6 If **you**, **your partner** or any dependent **children** covered on this plan have not been to the dentist in the 12 months prior to the start date of the plan, then any 'Restorative Treatments' or Implants identified, recommended or undertaken at **your** first dental examination will be classed as a **pre-existing condition** and will not be covered.
- 2.7 There is no restriction regarding the age of an eligible employee taking out the cover provided by their employer. **Your partner** must be less than 70 years of age at the date of joining.
- 2.8 **You** do not need a medical to be accepted as a **policyholder**. **We** will cover **you** and where cover is provided for them, **your partner** and dependent **children**, subject to the Terms and Conditions and **benefit** rules of this plan.
- 2.9 **Your policy schedule** shows when **you** commenced **your policy**, who is covered on the **policy** and the date from which **you** are able to make claims.
- 2.10 Changes to **your** level of cover will start from the next **benefit period**.
- 2.11 If **your** employer increases **your** level of cover **we** will not cover any **dental treatments** at the higher rate for which **you** have already started treatment, or which have been identified as being **clinically necessary** by **your dentist** prior to this change. These will be covered at **your** previous level of cover if applicable.
- 2.12 **We** will send **you** a new **policy schedule** after an amendment to **your** level of cover. The date of the amendment and the **benefit date** of these changes will be detailed in **your policy schedule**.

- 2.13 If **your** level of cover reduces for any reason, **we** will pay all **benefits** at the lower rate from the date of the change.
- 2.14 **You** must satisfy yourself that this plan and the level of cover **you** have are right for **you**. **We** will not provide advice but **you** are free to seek information or advice from a professional advisor.
- 2.15 If **you** add children to **your** cover, **your policy** contains a 14 day cooling off period from the date **we** accept **your** application. If **you** decide to change **your** mind during this cooling off period **you** should contact **us** on **0151 702 0203**. Provided that **you** have not made, or intend to make a claim, **we** will refund any additional amount already paid to **us**.
- 2.16 The **policyholder** and **we** have legal rights under the **policy**. No clause or term of this **policy** will be enforceable, by virtue of the contract (Rights of Third Parties Act 1999) or any other person, including any family member. Where **your** employer contributes towards **your premium** and administers the **policy**, they also have legal rights under the **policy**.
- 2.17 When **you** or **your** employer give **us** information about **your** family members, **we** will take this as confirmation that **you** or **your** employer have their explicit consent to do so.

### 3. PREMIUMS

- 3.1 **Your** cover will continue on condition that the **premium** due each month is paid and **you** abide by the Terms and Conditions of the plan.
- 3.2 **Premiums** include Insurance Premium Tax and are subject to review in respect of any changes in taxation or claims experience.
- 3.3 **We** reserve the right to deduct any **premiums** due to **us** from any **benefits** payable to **you**.

#### Employer paid cover

- 3.4 If **you** leave **your** employment and/or **your** employer ceases to pay for **your** cover, **you** will not be entitled to use any of the services or claim any **benefits** included in the plan beyond the date that **your premiums** are paid up to. **We** may offer **you** the opportunity to transfer to an alternative product.
- 3.5 **Your** employer paid cover may be treated as a benefit in kind and may be subject to appropriate taxation.

#### Additional child cover

- 3.6 For employees who have chosen to add their **children** to their cover, this element of the policy is a monthly renewable contract that remains in force if **you** continue to pay **your premiums** when they are due. Renewal is automatic and binding and no renewal papers or other forms of notification will be issued. Cover for **children** will cease on their 18th birthday and **your premium** will decrease accordingly from the following month.
- 3.7 If the **premiums** for **your children** are more than six weeks in arrears, their cover will cease and **your** cover will revert back to the employer paid level. Any claims paid in relation to **your children** during the period **your premiums** were not paid at the correct rate will need to be repaid to **us**.

## 4. REFUND OF PREMIUMS

- 4.1 **We** will only refund **your premiums** if:
- i **you** or **your** employer cancel **your policy** within 14 days of joining or amending **your** cover, and **you** have not made a claim;
  - ii **you** have paid **your premiums** in advance and **you** have correctly notified **us** that **you** wish to cancel **your policy**;
  - iii **you** have notified **us** that **you** have paid too much; or
  - iv in the unfortunate event that **you** die.
- 4.2 If **you** cancel **your policy** with **us**, **we** will refund any **premiums you** have paid for any period to come. However, **we** may deduct a £25 administration charge.
- 4.3 If **you** have overpaid **us**, **we** may deduct this from **your** future **premiums**. Or, if **you** ask **us** to, **we** will pay **you** a refund if **you** have overpaid **us** by more than £25.
- 4.4 **We** will only refund **premiums** to the originating source.
- 4.5 **We** will not refund any overpayments of **premiums** for periods that are more than six years prior to the date of request.
- 4.6 **We** will only refund bank charges that **you** have had to pay because of **our** error. **We** will not refund any bank interest **you** may have lost.

## 5. CLAIMS

- 5.1 To receive any of the **benefits** under **your policy**, **you** must complete and sign a claim form. **You** must use the claim form **we** provide. **You** can download a claim form via **our** website at [www.medicash.org/getdentalclaims](http://www.medicash.org/getdentalclaims) or **you** can request a claim form by phoning **us** on **0151 702 0265**.
- 5.2 **You** must give **us** the information or proof **we** need to support **your** claim, as explained in Sections 5 and 11. **We** will not be able to pay **your** claim if **you** do not have enough supporting evidence. If **you** have any questions about a claim, including whether or not **you** are eligible to make a claim, please phone **us** on **0151 702 0265**.
- 5.3 **We** will not pay any charges **you** may have to pay to fill in a claim form, or charges for any medical or dental information **you** need to support **your** claim. **You** are responsible for paying these charges.
- 5.4 Whenever **you** claim, **we** may ask **your dentist, GP or Specialist Consultant** for more information to confirm whether the **dental treatment** is related to a **pre-existing condition, self inflicted injuries** or was identified prior to any increase in cover. If **we** need to look at **your** dental history **we** will need some time to do this before **we** can confirm whether or not **we** can cover **your** claim.
- 5.5 Where **we** need access to **your** dental records, refusal to release these could result in **your** claim being declined.
- 5.6 For **benefits** where **we** require a receipt in order to pay a claim **you** must pay for the **treatment** in full before **you** can make the claim. **We** will not pay for any element of **your** receipt paid for using loyalty or reward points.
- 5.7 **We** will not pay **your** claim unless it is received within 26 weeks of the following:
- i **you** have fully paid for **your treatment**; or
  - ii **you** received **treatment** or finished a course of **treatment**.



- 5.8 All receipts must be fully paid originals and should show:
- i the name, address and qualifications of the practitioner who provided **your treatment**;
  - ii the date of the **treatment**;
  - iii the name and address of the person who received the **treatment**; and
  - iv a breakdown and description of the **treatment**.

**We** do not accept joint receipts, photocopies, credit card or debit card receipts, receipts without showing details of the **treatment** received, or estimates for **treatments** to be received.

- 5.9 The **benefit period** in which a claim is paid is determined by:
- i the date **you** had the **treatment**; or
  - ii the date of **your dental accident** or injury.
- 5.10 **We** will not pay **your** claim:
- i if the date of **your treatment** is after the date that **your policy** is paid up to;
  - ii if **you** have paid in advance for **your treatment**, but the **treatment** has not yet taken place; or
  - iii if **you** are breaking the Terms and Conditions of **your policy**.
- 5.11 If **your** claim is also covered by another insurance **policy**, **we** will not pay more than **our** proportionate share, which cannot be more than the total cost of the **treatment** or receipt. When **you** make a claim **you** must tell **us** about any other cover **you** have, and **you** must give **us** permission to contact the other insurance company.
- 5.12 If **you** have more than one insurance **policy** with **us** or another insurer, **you** cannot claim for more than 100% of the cost of **your treatment** or receipt.
- 5.13 To protect all of **our** policyholders, **we** will take action against anyone who makes a false or fraudulent claim or deliberately provides misleading information. Such action includes, but is not limited to, refusal to accept liability to pay a claim, termination of **your policy** without refund and may take legal action or contact the police.

#### Subrogation clauses

- 5.14 If **you** are claiming for **benefits** that relate to an injury or condition caused by another person, they may be liable to pay some of the costs of **your** claim. If this is the case:
- i **you** should tell **us** as quickly as possible if **you** believe a third party caused the injury or condition, or if **you** believe they were at fault. If **we** need further information **we** may contact **you** or the third party;
  - ii **we** will pay **our** proper share of the claim and recover what **we** pay from the third party;
  - iii **you** must include all amounts paid by **us** in respect of the injuries in **your** claim against the third party;
  - iv **you** (or **your** solicitors) must keep **us** fully informed about the progress of **your** claim and any action against the third party or any pre-action matters;
  - v **you** (or **your** solicitors) must keep **us** informed of the outcome of any action or settlement (providing **us** with access to the details of any such settlement);
  - vi should **you** successfully recover any monies from the third party they should be repaid directly to **us** within 21 days of receipt on the following basis:
    - if the third party settles in full, **you** must repay **our** outlay in full; or
    - if the third party pays **you** a percentage of **your** claim for damages, **you** must repay **us** the same percentage of **our** payment to **you**; or
    - if **your** claim is repaid as part of a global settlement (where **our** outlay is not individually identified), **you** must repay **us** the same proportion that the global settlement is of **your** total claim for damages against the third party.

- 5.15 If **you** do not repay to **us** **we** will be entitled to recover the same from **you**.
- 5.16 The rights and remedies in these subrogation clauses are in addition to and not instead of the rights or remedies provided by law.

## 6. BENEFIT PAYMENTS

- 6.1 The type of cover that **we** provide and the amount that **we** will pay **you** for each type of cover are known as **benefits**, and are detailed in the **benefit table**.
- 6.2 The amounts shown in the **benefit table** are the maximum amounts that **you** can claim for each **benefit** in any one **benefit period**.
- 6.3 **We** pay **your benefits** in British pounds sterling direct into **your** bank or building society account, or by cheque to the last address supplied to **us**. If **you** want to arrange for **us** to pay another person, **you** will have to write to **us** at the time **you** make **your** claim.
- 6.4 **We** reserve the right to recover any overpayments made to **you** either directly, or by adjusting any future **benefit** payments made to **you**.

## 7. CANCELLATION AND TERMINATION

- 7.1 **You** may cancel **your policy** at any time. **You** should notify **your** employer who will give notice to **us**. If **you** cancel within 14 days of joining or amending **your policy**, as long as **you** have not made a claim, **we** will refund all or the amended portion of the **premiums** that **you** or **your** employer have paid.
- 7.2 **We** have the right to cancel **your policy** at any time. **We** will give **you** at least 28 days written notice of this. However, if **we** think that **you** have committed fraud, **we** will cancel **your policy** immediately, notify **your** employer and may take legal action or contact the police. **We** will notify **you** of any changes by writing to **you** at the last address supplied to **us**. **We** will not be responsible if, for any reason, **you** do not receive the notice **we** send **you**. If **you** have selected to have **your** communications from **us** sent via email, **we** will use the last email address registered against **your** preferences to **us** to send this notification.
- 7.3 If **your** employer, or their appointed representative, cancels **your** cover **we** will not give **you** 28 days written notice of this as it is the responsibility of **your** employer, or their appointed representative, to notify **you** in this circumstance.
- 7.4 **We** will end all of the cover and **benefits** of **your policy**, or the **child** upgrade element, automatically if:
- i **you** cancel **your policy**;
  - ii **we** cancel **your policy**;
  - iii in the unfortunate event of **your** death;
  - iv **you** are behind with **your child's premiums** by more than six weeks; or
  - v **your** employer notifies **us** that **you** are no longer eligible.
- 7.5 **We** reserve the right to cancel a **policy** and offer an alternative with 28 days notice should **we** consider your claims to be unsustainable.
- 7.6. Should **your** cover cease, any cover for **your** dependent **children** will also cease.

## 8. YOUR RIGHTS – DATA PROTECTION, COMPLAINTS AND COMPENSATION

### Data protection

- 8.1 For the purposes of the Data Protection Act 2018 (the Act) **we** are the Data Controller in relation to any personal data **you** provide to **us**. **We** adhere to the Act and shall respect **your** rights under the Act.
- 8.2 Under the principles of the Act, **we** will endeavour to make sure that **your** personal or sensitive information held by **us** is:
- i processed fairly and lawfully;
  - ii processed for specified and lawful purposes;
  - iii adequate, relevant and not excessive;
  - iv accurate and kept up to date;
  - v kept for no longer than is necessary;
  - vi kept secure.
- 8.3 **We** will treat any sensitive and medical information **we** receive with the strictest confidence.
- 8.4 When **you** take out **your policy**, **you** agree that the information provided to **us**, either directly, via **your** employer or their appointed representative, together with any further information concerning **your policy**, can be used by **us** for the purpose of providing **you** with the **benefits** for which **you** have applied and for maintaining **your** records. This will include the recording and monitoring of sensitive personal data such as data relating to health and medical conditions.
- 8.5 Claims for **children** can only be submitted by the main **policyholder**, or their **partner** where it is a Dual plan. It is **your** responsibility to ensure that **you** have their explicit consent before submitting any claim on their behalf if they are aged 16 or over.
- 8.6 **We** may pass **your** information, and that of anyone else covered on **your policy**, to selected service partners for claims where applicable. Under the Act **you** have the right to object to **your** data being passed on for this purpose, but this may result in **us** being unable to provide all of **your benefits** or validate **your** claim. Where this occurs, **we** will not offer any reduction in **premiums** or refund for any claims that cannot be paid.
- 8.7 **We** maintain the highest standards of data security to protect **your** personal information, including data encryption and security procedures, like checking **your** identity when **you** call.
- 8.8 **We** may share **your** data with other relevant organisations when **we** set up and administer **your policy**, to check claims, to prevent fraud and to identify money laundering. If **you** object to this **we** will not be able to process **your** application and therefore will not be able to accept **your** application for a **policy**.
- 8.9 **We** will keep **you** informed about any changes to **your policy** and claims progress using the contact preferences supplied at the time of joining or as subsequently updated by **you**.
- 8.10 From time to time **we** may send **you** information about **our** other products and services or offers that **we** feel may be of interest to **you**. **You** can choose how **we** contact **you** regarding these offers and opt-out at any time. **You** can update **your** contact preferences by contacting **us** via phone, email or in writing.
- 8.11 **You** have the Right of Access to any information that **we** hold about **you**. To request a copy of this, please write to The Data Protection Officer, Medicash, One Derby Square, Liverpool L2 1AB. If any of **your** data is incorrect **you** can ask **us** to rectify this. To help **us** keep **your policy** up to date, please ensure **you** inform **us** when **you** move house or change **your** contact details such as telephone number or email.

- 8.12 **You** also have the Right of Erasure and the Right to Object under the Act. Where possible **we** will accommodate **your** request to have any data relating to **you** erased or to stop processing it in the manner requested, but please note that this could prevent **us** from processing **your** application for cover or having to cancel **your policy**. **We** keep information in line with the retention policy of **our** organisation. These retention periods take into account **our** needs to meet any legal, statutory and regulatory obligations and vary from one piece of information to the next. If **you** would like **your** data, or any part of it, restricting or erased please submit **your** request in writing to The Data Protection Officer, Medicash, One Derby Square, Liverpool L2 1AB.
- 8.13 **You** have the Right to Data Portability and where requested **we** will supply **you** with a copy of the data **we** hold on **you** electronically in a format that **you** can then share with another organisation.
- 8.14 Any information supplied about **you** is subject to **our** Privacy Policy, a copy of which can be found at [www.medicash.org/privacypolicy](http://www.medicash.org/privacypolicy)

### Complaints

- 8.15 If **you** are not happy with any part of **our** service, send the full details of **your** complaint to the Head of Customer Operations, Medicash, One Derby Square, Liverpool L2 1AB. **We** will endeavour to respond to **you** within five working days and will detail **our** complaints procedure.
- 8.16 If **you** are not satisfied with **our** response, **you** can take **your** complaint to the Financial Ombudsman Service, Exchange Tower, London E14 9SR. Alternatively telephone 0800 023 4567 or 0300 123 9123; or visit [www.financial-ombudsman.org.uk](http://www.financial-ombudsman.org.uk).

### Compensation

- 8.17 **We** are covered by the Financial Services Compensation Scheme (FSCS). If **we** cannot meet **our** responsibilities, **you** may be entitled to compensation from the scheme. This depends on the type of insurance **you** have and the circumstances of **your** claim. For more information about the compensation scheme, visit the FSCS website at [www.fscs.org.uk](http://www.fscs.org.uk), or write to FSCS, PO Box 300, Mitcheldean GL17 1DY.

## 9. OUR RIGHTS – HOW WE PROTECT OUR POLICYHOLDERS

- 9.1 **We** have the right to change **your policy** at any time. If **we** make changes, **we** will write to **you** and give **you** at least 28 days notice of any change.
- 9.2 **We** will notify **you** of any changes by writing to **you** at the last address supplied to **us**. **We** will not be responsible if, for any reason, **you** do not receive the notice **we** send **you**. If **you** have selected to have **your** communications from us sent via email, **we** will use the last email address registered against **your** preferences to send this notification.
- 9.3 **We** have the right to cancel **your policy** and refuse any claims **you** make if **you** or anyone acting for **you**:
- i makes a claim under the **policy**, knowing the claim is false or exaggerated in any way;
  - ii makes a statement to support a claim, knowing the statement is false;
  - iii sends **us** evidence to support a claim, knowing the documentation is false; or
  - iv makes a claim for any injury or **dental accident** that **you** or they have caused deliberately.

- 9.4 To detect and prevent fraud or improper claims **we** may check **your** details with fraud protection agencies. If **we** reasonably suspect fraud **we** will record and investigate this, including working with other organisations and other insurers to pool information about applications or claims which are believed to be fraudulent.
- 9.5 The terms of this **policy** are governed by English Law. In the event of a dispute arising under this **policy** the parties will submit to the exclusive jurisdiction of the courts of England and Wales. All communications must be made in English. **We** can provide communications in alternative formats upon request such as large print or audio.

## 10. GENERAL EXCLUSIONS

As with most other dental plans, there are a number of general exclusions which apply to all benefits on the plan. These are outlined below.

### WHAT WE DO NOT COVER ON ANY BENEFIT

- ✗ Any **dental treatments** or purchases which occur outside the **UK**
- ✗ Consumables, including but not limited to toothbrushes, dental floss, mouth wash, bleaching agents or any other dental hygiene product
- ✗ Any claim which is not received within 26 weeks of the date of the **dental treatment** or **you** are discharged from hospital
- ✗ Charges for missed appointments
- ✗ Any **dental treatments** or services which are provided by a member of **your** immediate family or any business that **you** own or are a named director of
- ✗ Any **dental treatments** that are required as a result of **your** participation in **professional sports**
- ✗ Any **dental treatments** that are required as a result of **your** participation in non-professional sports where the appropriate mouth and/or head protection has not been worn
- ✗ Any **dental treatment** needed due to **your** participation in any **dangerous activities and sports, self-inflicted injuries**, or involvement in a criminal act
- ✗ Any **dental treatment**, care or repair to, or in connection with, 'tooth jewellery'
- ✗ Charges made by **your dentist**, or any other person, for completing **your** claim form
- ✗ If **you, your partner** or any dependent **children** covered on this plan have experienced symptoms or have not been to the dentist in the 12 months prior to the start date of the plan, then any 'Restorative Treatments' or Implants identified, recommended or undertaken at **your** first dental examination will be classed as a **pre-existing condition** and will not be covered
- ✗ Any **treatments** or **benefits** arranged, paid or facilitated through **your** employer or another employee (except where that employee is **your partner** and they are not doing this for any other employee in the business).

# 11. BENEFIT RULES

## 11.1 Routine Examinations

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council, up to a maximum in any one **benefit period**, for check-ups, routine investigations and exams, plus x-rays. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

WHAT WE COVER
<ul style="list-style-type: none"><li>✓ Dental check-ups</li><li>✓ Routine investigations and examinations</li><li>✓ Dental x-rays</li><li>✓ Dental CT, CAT or CBCT scans.</li></ul>
WHAT WE DO NOT COVER
<ul style="list-style-type: none"><li>✗ <b>Our</b> general exclusions as set out in Section 10</li><li>✗ Dental care contracts or dental care plan fees</li><li>✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers</li><li>✗ Any procedures or <b>dental treatments</b>, these are covered elsewhere within this <b>policy</b></li><li>✗ The cost of hypnosis or sedation.</li></ul>

## 11.2 Keeping Your Teeth Healthy

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council, up to a maximum in any one **benefit period**, for a scale and polish or other hygienist fees in order to maintain **your** level of oral health. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

WHAT WE COVER
<ul style="list-style-type: none"><li>✓ A scale and polish completed by a <b>dentist</b>, dental hygienist or other dental care professional</li><li>✓ Other hygienist fees required in order to maintain <b>your</b> oral health, for example the application of anti-bacterial gels</li><li>✓ The cost of local anaesthetic required for this <b>dental treatment</b>.</li></ul>
WHAT WE DO NOT COVER
<ul style="list-style-type: none"><li>✗ <b>Our</b> general exclusions as set out in Section 10</li><li>✗ Dental care contracts or dental care plan fees</li><li>✗ Fissure sealants and fluoride treatments, these are covered under the 'Cosmetic &amp; Preventative Care' <b>benefit</b></li><li>✗ The cost of hypnosis or sedation.</li></ul>

### 11.3 Orthodontic Treatments

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council, up to a maximum in any one **benefit period**, for orthodontic **treatments** which are **clinically necessary** for the correction or prevention of malocclusion, or any other irregular alignment or positioning of **your** teeth. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To claim this **benefit** **your** teeth must have been graded as 4 or 5 on the IOTN (Index of Orthodontic Treatment Need) scale. This scale is used to determine the severity of the irregularities in your teeth and the impact on your health, for example:  
Grade 4:
  - protrusion of front teeth by more than 6mm from the normal position
  - position of the upper and lower teeth is more than 2mm out in terms of symmetry and interferes with normal function
  - lower front teeth protrude in front of the upper teeth by more than 3.5mm
  - teeth that are more than 4mm out of line from the normal position
  - a deep bite that affects normal function.Grade 5:
  - teeth that are prevented coming through into the mouth due to an obstruction such as but not limited to crowding or additional teeth
  - multiple teeth missing
  - the position of upper front teeth that protrude by more than 9mm from the normal position
  - congenital or developmental problems with the skull or jaw such as but not limited to cleft lip and palate.
- iii **You** must ask **your** dentist or orthodontist to grade **your** teeth on the IOTN scale before undertaking any **dental treatment** under this **benefit**. Failure to do so may result in **us** refusing to pay **your** claim.
- iv To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

#### WHAT WE COVER

✓ Orthodontic **treatments** graded as 4 or 5 on the IOTN scale (see above).

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ **Treatments** which are not **clinically necessary**
- ✗ Orthodontic **treatments** which are rated 1 to 3 on the IOTN scale
- ✗ Cosmetic braces such as but not limited to Invisalign braces.

### 11.4 Emergency Cover

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council or **Specialist Consultant** for an emergency appointment, up to a maximum in any one **benefit period**. The maximum **benefit** amounts applicable to **your** level of cover per instance, and per **benefit period**, is shown in **your benefit table**.
- ii A dental emergency is classed as a non-planned appointment for the relief of severe pain, haemorrhaging, an inability to eat, or any **acute dental condition** which is a threat to **your** general health.

- iii **Your** claim must be supported by proof of **dental treatment** detailing the dates and costs of each individual treatment or, in the case of NHS treatment, each course of treatment. The proof must be a document issued by the treating practice.
- iv Medicash may ask for additional evidence from **you** or **your** dentist to show that the appointment was unplanned.
- v Medicash will not cover any **treatment** carried out at a follow-up appointment. This will be claimable from **your** other **benefits** shown in **your benefit table**.

#### WHAT WE COVER

- ✓ **Dental treatment** undertaken during an emergency dental appointment
- ✓ The cost of local anaesthetic required for this **dental treatment**
- ✓ Examinations and x-rays
- ✓ Extractions, temporary fillings, or the provision of a permanent filling if a temporary filling is not required
- ✓ Construction of a temporary crown, inlay, bridge or veneer
- ✓ Re-cement of crown, inlay, bridge or veneer
- ✓ Other temporary **dental treatments** deemed to be **clinically necessary** by **your dentist**.

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Any **dental treatment** carried out at a follow-up appointment, these would be covered under the other **benefits** on **your** plan
- ✗ The cost of hypnosis or sedation.

### 11.5 Dental Accidents and Injury

Cover for **dental treatment** required as a result of a **dental accident** or injury. **You** can only claim this **benefit** if **you** have attended a **dental accident** appointment in the **UK** within five days of the **dental accident** or injury.

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council or **Specialist Consultant**, up to a maximum in any one **benefit period**, within **your** chosen premium level. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii A **dental accident** is classed as an injury caused to **your** teeth and gums by a direct impact to the outside of the oral cavity. This includes damage to dentures whilst being worn.
- iii **Your** claim must be supported by proof of **treatment** detailing the dates and costs of each individual **treatment** or, in the case of NHS **dental treatment**, each course of **treatment**. The proof must be a document issued by the treating practice.
- iv Medicash require the following information from **your dentist** in order to process the claim:
  - Date of the **dental accident**;
  - Full report of the incident and all dental injuries sustained;
  - The **treatment** plan;
  - The date that the **treatment** or episode of **treatment** will start and finish;
  - The name of the **dentist**, dental consultant, **Specialist Consultant** or Surgeon responsible for the **treatment** if applicable;
  - Detailed **treatment** costs.



Cover is limited to the **treatment** described in the **treatment** plan and cannot be combined with any other **benefit** shown in **your benefit table**.

- v Medcash may ask for extra evidence to show how the injury was sustained, evidence that the injury is not as a result of periodontal disease, or evidence that if the injuries resulted from taking part in sports, other than **dangerous sports and activities**, that the appropriate mouth guards were worn.

#### WHAT WE COVER

- ✓ **Dental treatment** relating to a **dental accident** or injury if there has been a **dental accident** appointment within five days of the **dental accident** or injury
- ✓ The cost of local anaesthetic required for this **dental treatment**
- ✓ The cost of dentures and repairs to dentures resulting from the **dental accident** or injury
- ✓ Replacement veneers, implants, dentures and orthodontics resulting from the **dental accident** or injury.

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Injuries that existed before **you** took out the plan
- ✗ Any **dental treatment** which is not **clinically necessary**
- ✗ Injuries caused by food or drink ingestion
- ✗ Injuries caused other than by a direct impact to the outside of the oral cavity
- ✗ Damage to dentures not being worn
- ✗ **Dental treatment** relating to periodontal disease, this is covered under the 'Restorative Treatments' **benefit**
- ✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers
- ✗ Fees charged for preparing reports
- ✗ Damage caused by oral hygiene procedures
- ✗ The cost of hypnosis or sedation.

### 11.6 Fillings

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council, up to a maximum in any one **benefit period**, for **clinically necessary** restorative **dental treatments**. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

#### WHAT WE COVER

- ✓ Fillings, including inlays and onlays
- ✓ The cost of local anaesthetic required for these **dental treatments**.

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Any **dental treatments** which are not **clinically necessary**
- ✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers
- ✗ Dental x-rays and scans needed to carry out the **dental treatment**, these are covered under the 'Routine Examinations' **benefit**
- ✗ The cost of hypnosis or sedation.

## 11.7 Restorative Treatments

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council or **Specialist Consultant**, up to a maximum in any one **benefit period**, for **clinically necessary** restorative **dental treatments**. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

### WHAT WE COVER

- ✓ Extractions
- ✓ The cost of new dentures
- ✓ Repairs to dentures
- ✓ Dental crowns and bridges
- ✓ Dental crowns, bridges or attachments to a dental implant
- ✓ Root Canals
- ✓ Periodontal Treatments, including root planing, flap or pocket reduction surgery between the tooth and gum, bone grafts, soft tissue grafts or guided tissue regeneration around the tooth
- ✓ The cost of local anaesthetic required for these **dental treatments**
- ✓ Study casts and wax-ups.

### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Any **dental treatments** which are not **clinically necessary**
- ✗ Any bone surgery, excluding bone grafts, or laser treatments recommended as part of your periodontal treatment plan
- ✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers
- ✗ Dental care contracts or dental care plan fees
- ✗ Dental x-rays and scans needed to carry out the **dental treatment**, these are covered under the 'Routine Examinations' **benefit**
- ✗ Replacement dentures if the existing denture can be repaired according to accepted dental standards or if they have been lost
- ✗ Costs that relate to replacement dentures where the original denture was fitted in the last three years
- ✗ Fissure sealants and fluoride treatments, these are covered under the 'Cosmetic & Preventative Care' **benefit**
- ✗ **Pre-existing conditions**
- ✗ Appliances needed to treat teeth grinding or wear, such as mouth guards. These are covered under the 'Cosmetic & Preventative Care' **benefit**
- ✗ The cost of hypnosis or sedation.

## 11.8 Implant Cover

- i **We** will pay the amount **you** have paid to a registered member of the General Dental Council or **Specialist Consultant**, up to a maximum in any one **benefit period**, for **clinically necessary** implants. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

#### WHAT WE COVER

- ✓ **Dental treatment** relating the installation of a dental implant and its abutment
- ✓ The cost of local anaesthetic required for these **dental treatments**
- ✓ Dental surgical stents.

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Implants that are not **clinically necessary** and are being fitted for cosmetic purposes only
- ✗ The cost of crowns, bridges, dentures or any other items that will be fitted to the finished implant, these are covered under the 'Restorative Treatments' **benefit**
- ✗ Extractions necessary for the fitting of an implant, these are covered under the 'Restorative Treatments' **benefit**
- ✗ **Dental Treatment** for dental implants relating to the failure of an implant to integrate
- ✗ Breakdown of Osseointegration
- ✗ Peri-implantitis
- ✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers
- ✗ Dental x-rays and scans needed to carry out the **dental treatment**, these are covered under the 'Routine Examinations' **benefit**
- ✗ **Pre-existing conditions** and gaps that existed prior to the start of **your policy**
- ✗ The cost of hypnosis or sedation.

### 11.9 Cosmetic & Preventative Care

- We** will pay the amount **you** have paid to a registered member of the General Dental Council, up to a maximum in any one **benefit period**, for cosmetic and preventative care. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

#### WHAT WE COVER

- ✓ Cosmetic whitening undertaken by a **dentist**
- ✓ Fissure sealants and fluoride treatments
- ✓ Gum shields as recommended by **your** dentist for use in sports
- ✓ Mouth guards as recommended by **your** dentist to protect against teeth grinding.

#### WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ Prescription charges or fees for tablets and medicines, for example antibiotics or pain killers
- ✗ Dental x-rays and scans needed to carry out the **dental treatment**, these are covered under the 'Routine Examinations' **benefit**
- ✗ The cost of hypnosis or sedation.

11.10 Hospital Stays

- i **We** will pay the amount shown in **your benefit table** for each night **you** stay in hospital under the care of a **Specialist Consultant**, up to a maximum in any one **benefit period**. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii **Your inpatient** stay must have been referred by a **dentist**, dental consultant, **Specialist Consultant**, **GP** or Accident and Emergency Department and relate to a dental condition.
- iii To deal with **your** claim, **we** require a completed claim form that includes admission and discharge dates. The claim form must be stamped by the hospital and signed by a member of staff. Alternatively, you can attach your MED 10 certificate or hospital discharge note to **your** claim form.

WHAT WE COVER

- ✓ When **you** are admitted to hospital for a period of **dental treatment** or continuation of an ongoing dental condition
- ✓ Dental extractions, including the extraction of wisdom teeth, where **you** are admitted to hospital as an **inpatient** for at least one night.

WHAT WE DO NOT COVER

- ✗ **Our** general exclusions as set out in Section 10
- ✗ **Dental treatment** in a hospital where you have not been admitted as an **inpatient**
- ✗ Any time spent within the Accident and Emergency Department, prior to being admitted as an **inpatient**
- ✗ **Outpatient** appointments
- ✗ Any **inpatient** stay that is in relation to a cosmetic dentistry procedure.

## OPTIONAL EXTRA

### 11.11 Optical Cover

- i **We** will pay the amount **you** have paid, up to a maximum in any one **benefit period**. The maximum **benefit** amount applicable to **your** level of cover is shown in **your benefit table**.
- ii To deal with **your** claim, **we** need an original dated receipt as set out in Section 5 of these Terms and Conditions.

**We** may also need additional evidence that the practitioner has the appropriate qualifications and insurance.

Please see your  
**Policy Schedule**  
to see if your policy  
includes these  
services.

#### WHAT WE COVER

- ✓ Eye-health tests and eyesight tests carried out by a member of the General Optical Council
- ✓ Prescribed spectacles, prescribed contact lenses and prescribed sunglasses
- ✓ Payment under a contact lens scheme
- ✓ Prescription lenses for safety goggles **you** need for work
- ✓ Prescription lenses fitted to an existing frame
- ✓ Frames when fitted with prescription lenses
- ✓ Laser eye surgery.

#### WHAT WE DO NOT COVER

- ✗ Contact lens check-ups or solutions
- ✗ Non-prescribed lenses, spectacles, contact lenses or sunglasses
- ✗ Goggles for leisure activities
- ✗ Repairs to spectacles
- ✗ Registration, insurance and joining fees for a contact lens scheme
- ✗ Non-prescribed items
- ✗ Frames only
- ✗ Receipts where only a part payment or deposit has been paid including receipts showing a balance outstanding for payment
- ✗ Costs incurred for items ordered before the start of **your policy**
- ✗ Consumables
- ✗ Optical claims for **Children**.

## NOTES

[illegible]

[illegible]

# GET IN TOUCH

CALL

0151 702 0265

OR EMAIL

[claims@medicash.org](mailto:claims@medicash.org)



## YOUR DENTAL PLAN

This insurance is provided by Medicash Health Benefits Limited, One Derby Square, Liverpool L2 1AB. A company limited by guarantee, registered in England (number: 258025).

Medicash is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Medicash is covered by the Financial Services Compensation Scheme and the Financial Ombudsman Service.

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