Hospital Plans

Rules - Terms and Conditions

Applicable to new registrations or renewals on/or after 1st May 2014.

This document sets out the terms and conditions that apply to your plan and should be read in conjunction with the other documents that form part of your policy with us, your Table of Benefits, the Directories, the Schedules and your policy details. The words used in this document may have specific meanings and these are found in the Glossary.

When reading your Table of Benefits, you should look at the benefits that are listed under your plan and this will tell you which benefits are included and the level of cover, if any, that applies.

1) Contract

a) The terms of your policy with us are in the following documents:

(i) These Terms and Conditions
(ii) Your Table of Benefits
(iii) The Directories
(iv) The Schedules
(v) Your policy details and any amendment or variation made from time to time as per Rule 1(b).

b) We may change the Directories and Schedules during the year. The most up-to-date Directory of Hospitals (and Treatment Centres) is available on our website - www.vhi.ie.

c) We will pay any benefits we are required to pay under the Health Insurance Acts and any Regulations thereunder, even if any part of your policy indicates otherwise. This may result in a lower excess being applied to your claim than otherwise indicated in your Table of Benefits.

d) Certain procedure codes listed in the Schedules have clinical indications and/or conditions of payment and/or payment indicators attached to them. Benefit for these procedure codes is payable only when, in the opinion of our Medical Director, the relevant clinical indications and/or conditions of payment and/or payment indicators have been satisfied in full.

e) In the event of a change to the Directory of Hospitals (and Treatment Centres) where

(1) a participating hospital or treatment centre becomes a non-participating hospital or treatment centre or
(2) the contract between a participating hospital or treatment centre and Vhi Healthcare is terminated for any reason other than the closure of that hospital or treatment centre, we will publish a notice in the major national daily newspapers four weeks in advance of such a change taking effect.

2) Joining Us

a) Your spouse, partner or dependent children can be included on your policy at any time. If you apply to include your child on your policy within 13 weeks of his/her birth, we will insure him/her from the date of birth and we will not apply the New Conditions or Pre-existing Waiting Periods set out in Rule 2(c). Subscribers/policyholders who enrol their new born children within 13 weeks of the child's date of birth will not be charged any additional subscription for that child until the first or next renewal date after his/her birth.

b) You can only make other changes to your policy at renewal date.

c) **If a customer has an accident after he/she is included, we will pay benefits for the treatment needed. However, for other treatment, we will pay benefits if it is carried out after the customer has been insured continuously for a minimum period of time, called a waiting period. The waiting periods are as follows:**

Waiting periods and pre-existing conditions						
Age when included	**Accident or injury**	**New conditions**	**Pre-existing conditions**	**Maternity**	**Out-patient medical expenses**	**Day-to-day medical expenses** ***(incl. Lifestage benefits)****
Under 50 years	None	26 weeks	5 years	52 weeks	None	None
50 – 54 years	None	26 weeks	5 years	52 weeks	None	26 weeks
55 – 59 years	None	52 weeks	7 years	52 weeks	None	52 weeks
60 – 64 years	None	52 weeks	10 years	52 weeks	None	52 weeks
65+ years	None	104 weeks	10 years	52 weeks	None	104 weeks

**Includes fitness screening*

The above waiting periods do not apply to sports injury cover, wellness programmes or employee assistance programmes.

When determining whether a medical condition pre-exists membership, it is important to note that it is the date of onset of the condition that is considered rather than the date on which the member becomes aware of the condition, as medical conditions may be present for some time before giving rise to symptoms or being diagnosed.

d) If there is a break of more than 13 weeks in a person's health insurance contract with us and another insurer registered under the Health Insurance Acts, 1994 - 2012, the application will be treated as a new application for cover.

e) If a person transfers from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, 1994 - 2012, benefits will only be payable up to the level of cover offered by that contract. Additional benefits will be subject to Rule 3(b).

f) If a customer has transferred from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, 1994 - 2012, the time that he/she was insured under the other contract will be offset against the normal joining conditions (New Conditions Waiting Period, Pre-existing Conditions Waiting Period and Maternity Waiting Period). For benefits listed in the Day-to-day medical expenses (including Lifestage benefits) or Out-patient medical expenses sections of your Table of Benefits, please refer to Rule 3(b).

g) The policy is intended for people resident in Ireland and only people resident in Ireland are eligible to be included on the policy. Please refer to Rule 6(b).

h) You can cancel your health insurance contract within 14 days of the date of issue of the Terms and Conditions. We will refund the premium you have paid and will recover from you any benefit we have paid.

3) Renewing the policy

a) Your policy will last for one year unless we agree to a shorter period. At the renewal date, you can renew your policy by paying the premium we request. The Rules and your Table of Benefits in place at the renewal date will then apply to your policy.

b) You can change your plan at your renewal date. If you upgrade your plan (i.e. subscribe for additional benefits), the payment of additional benefits will be subject to the following waiting periods:

Waiting periods and pre-existing conditions						
Age at the time of change	**Accident or injury**	**New conditions**	**Pre-existing conditions**	**Maternity**	**Out-patient medical expenses**	**Day-to-day medical expenses *(incl. Lifestage benefits)****
Under 50	None	26 weeks	2 years	52 weeks	None	None
50 – 54 years	None	26 weeks	2 years	52 weeks	None	52 weeks
55 – 64 years	None	52 weeks	2 years	52 weeks	None	52 weeks
65+ years	None	104 weeks	5 years	52 weeks	None	104 weeks

**Includes fitness screening*

The above waiting periods do not apply to sports injury cover, wellness programmes or employee assistance programmes.

When determining whether a medical condition pre-exists a change in cover, it is important to note that it is the date of onset of the condition that is considered rather than the date on which the member becomes aware of the condition, as medical conditions may be present for some time before giving rise to symptoms or being diagnosed.

i) If you change your plan (with the exception of the benefits listed in the Day-to-day Medical Expenses or Out-patient Benefits sections of your Table of Benefits), and you or any of the customers included on the policy receive treatment during the applicable waiting period for a medical condition which in the opinion of our Medical Director you already had on the renewal date on which you changed your plan and if the benefit payable for your claim is higher on your new plan, we will only pay the benefits which we would have paid if you had not changed your plan until the applicable waiting period has expired.

ii) If you have an accident after you change your plan we will pay the benefits applicable to your new plan.

iii) If you change your plan and reduce your excess or increase your annual maximum benefit amount for benefits listed in the Day-to-day medical expenses or Out-patient medical expenses section of your Table of Benefits, we will only pay the benefits which we would have paid if you had not changed your plan until the applicable waiting period has expired.

c) If you change your plan at your renewal date and subsequently wish to revert to your previous plan, you may do so within 14 days of the date of issue of the amendment notification and we will pay the benefits which we would have paid if you had not changed your plan.

4) Subscriptions and Charges

a) You must pay your premium when it becomes due for the duration of your policy. The subscriber/policyholder is responsible for ensuring payments are made.

In the event that you do not commence payment of your premium in accordance with the payment terms of your policy, we reserve the right to cancel your policy and we will not pay any benefits.

In the event of non-payment in accordance with the payment terms of your policy during the course of your policy term, such non-payment will constitute a breach of your policy. In such circumstances we will not pay any benefits for the policy term and we will seek recovery of the losses and expenses incurred by us as a result of your non-payment. These losses and expenses will be calculated as follows:

(i) In the event that no claims have been paid, this will amount to the health insurance levy calculated on a pro-rata basis, together with an administration charge of fifty euro;

(ii) In the event that claims have been paid, this will amount to the total outstanding premium due to us.

b) For customers who pay by salary deduction, the translation of annual premia into monthly or weekly instalments may result in the collection of marginally more or less than the annual premium as a result of rounding to the nearest cent.

c) Subscribers/policyholders with dependants who are students may apply for a discount on their annual subscription depending on your plan. The student subscription rate will apply from the date of application for new customers, and from the next renewal date (following application for the student rate) for existing customers. The student rate will automatically revert to the adult rate with effect from the next renewal after the student's birthday upon which he or she ceases to satisfy the definition of a student.

d) Where a subscriber/policyholder has multiple products and the subscription received does not equal the invoice issued for the combined premium, we will allocate the amount paid proportionately to each product based on the premium due.

e) All payments received by Vhi Healthcare are lodged to our bank account for security reasons. All payments will be receipted. This does not imply that Vhi Healthcare accept said payment as fulfilment of your contract, if the amount does not match the amount requested or the agreed portion of same. Your payment may be returned, if there is no valid contract in place.

Charges/Refunds

f) If a change to a Customer Account results in a premium refund or shortfall of less than or equal to €10, no refund or charge will be made due to the administration costs involved.

5) Benefits

The following benefits and associated terms and conditions are only relevant where they are included in the Table of Benefits applicable to your plan. You must consult your Table of Benefits to ensure that a benefit is covered and the appropriate level of cover, if any.

1) **General Conditions**
We will pay benefits for in-patient and day-patient treatment, side room procedures, out-patient procedures and Vhi HomeCare treatment for a maximum of 180 days per customer in any calendar year, less any days treatment within the same calendar year which has been paid under any other health insurance contract (for benefit in respect of psychiatric treatment and addiction treatment, please refer to Rules 5(21) and 5(22)).

2) The benefits which we will pay will depend on the terms of your policy on:
(i) the first day of a hospital stay or (ii) the date of the treatment if the customer is not staying in hospital.

3) If the benefits do not cover the full cost of the treatment, the customer is responsible for any balance.

4) We will pay the actual amount the customer is charged or the benefits payable under the policy, whichever is lower.

5) If you use hospital accommodation which requires a higher level of cover than you hold under your plan, the level of benefits payable, if any, will be as outlined in your Table of Benefits.
Where a hospital is not listed in the Directory of Hospitals (and Treatment Centres), no benefit will be payable or where a hospital is listed in the Directory of Hospitals (and Treatment Centres) and not covered by your plan, no benefit will be payable.

6) **Hospital Benefit**
Hospital benefit is payable for in-patient treatment in a participating or non-participating hospital listed in the Directory of Hospitals (and Treatment Centres) and which is covered by your plan, in private and semi-private accommodation. Details of the benefits payable are contained in your Table of Benefits.

7) **Professional Fee Benefit**
We will pay consultant or general practitioner fees for medically necessary treatment which is covered by the Schedules of Benefits and is carried out in a participating or a non-participating hospital. If a consultant or general practitioner is non-participating, we will pay the standard benefit as set out in the Schedules of Benefits (even if your treatment is provided on an emergency basis), and you may have to pay an additional amount yourself. If the treatment is not covered by your plan or is carried out in a hospital which is not covered by your plan, benefit for consultant or general practitioner fees will not be payable.

However, professional fee benefit as set out in the Schedule of Benefits for Professional Fees is payable for out-patient procedures with the exception of out-patient radiotherapy.

8) **Day-to-day Medical Expenses Benefit**
If included in your plan, Day-to-day medical expenses benefit is payable for treatment as specified in your Table of Benefits.

9) **Out-patient Medical Expenses Benefit**
If included in your plan, Out-patient medical expenses benefit is payable for treatment as specified in your Table of Benefits.

10) **Day Care Procedures**
Hospital benefit is payable for specified day care procedures carried out in an approved day care facility listed in the Directory of Hospitals (and Treatment Centres) and which is covered by your plan. If the day care procedures are performed in an in-patient setting (private or semi-private) the approved day care charges only are payable. If it is medically necessary for the customer to receive the treatment as an in-patient, we will pay the full benefits for the hospital charges in accordance with the level of cover under your plan.

11) **Side Room Procedures**
Hospital benefit is payable for side room procedures carried out in an approved hospital listed in the Directory of Hospitals (and Treatment Centres) and which is covered by your plan. If it is medically necessary for the customer to receive the treatment as a day-patient or as an in-patient, we will pay the full benefits for the hospital charges in accordance with the level of cover under your plan.

12) **Out-Patient Procedures**

Benefit is payable for out-patient procedures carried out on an out-patient basis. Where an out-patient procedure is carried out in a hospital which is not covered by your plan, professional fee benefit is payable only in accordance with Rule 5(7). However hospital charges arising in hospitals which are not covered under your plan are not eligible for benefit. No benefit is payable for Out-patient Radiotherapy carried out in a hospital, which is not covered by your plan.

13) **Fixed Price Procedures (FPPs)**

We will provide the benefit set out in Section 1 of your Table of Benefits for Fixed Price Procedures available in the Directory of Hospitals (and Treatment Centres) included in the Fixed Price Procedure Hospital List. Please note that the level of cover may vary depending on the type of Fixed Price Procedure. Some of these procedures when carried out in other hospitals are not called Fixed Price Procedures and in these circumstances benefit is payable in accordance with the benefits associated with your level of cover for these hospitals, as set out in your Table of Benefits, and not as a Fixed Price Procedure. If you are in any doubt about the level of cover payable in respect of any procedure or treatment, we recommend that you contact us prior to admission.

14) **Specified Orthopaedic and Ophthalmic Procedures**

If included in your plan, we will provide the benefits set out in Section 1 of your Table of Benefits for Specified Orthopaedic and Ophthalmic Procedures. It is important to note that these specified orthopaedic and ophthalmic procedures are available in hospitals other than the designated private hospitals and where these specified orthopaedic and ophthalmic procedures are carried out in hospitals other than the designated private hospitals, the benefits associated with your level of cover for these hospitals is payable in accordance with the details set out in your Table of Benefits. If you are in any doubt about the level of cover payable in respect of any procedure or treatment, we recommend that you contact us prior to admission.

15) **MRI Scans**

Benefit for MRI scans is subject to the following conditions:

(i) The member is referred for an MRI scan by a consultant or general practitioner in the Centres listed for cover for consultant or general practitioner referrals or where the member is referred for an MRI scan by a consultant to a Centre which is listed for cover for consultant referrals only; and

(ii) The MRI scan is carried out in an approved MRI centre listed in the Directory of Approved MRI Centres; and

(iii) The MRI scan is to investigate or rule out certain medical conditions. A list of the approved clinical indications for which benefit is payable appears in the Schedule of Benefits for Professional Fees.

In-Patient MRI Scans

If the patient, during the course of a medically necessary stay in a participating hospital listed in the Directory of Hospitals (and Treatment Centres) which is covered by your plan and for which hospital benefit is payable, has an eligible MRI scan performed in an approved MRI centre listed in the Directory of Hospitals (and Treatment Centres) and covered by your plan, we will pay the benefit set out in Section 8 of your Table of Benefits.

Out-patient MRI scans

If the patient attends a Centre which is categorised as a Category 1 MRI Centre or a Category 2 MRI Centre in the Directory of Approved MRI Centres, we will pay the benefit set out in Section 8 of your Table of Benefits.

If the patient attends an MRI Centre which is not included in the Directory of Approved MRI Centres, no benefit is payable for either the hospital charge or the consultant's fee.

16) **PET-CT Scans**

Benefit for PET-CT scans is available to customers subject to the following criteria:

- Prior Approval; and
- The customer is referred for a PET-CT scan by a consultant; and
- The PET-CT scan is carried out in a PET-CT Centre covered by your plan and as specified in the Directory of PET-CT Centres and
- The PET-CT scan is carried out for one of the clinical indications as specified by us to all consultants.

17) **Dexa Scans**

We will pay the benefit listed in your Table of Benefits towards the cost of a dexa scan, subject to the following criteria:

(i) The customer is referred for a dexa scan by a general practitioner or consultant to an approved dexa scan centre listed in the Directory of Hospitals (and Treatment Centres); and

(ii) The customer meets the eligibility criteria and one of the clinical indications as specified in the Schedule of Benefits for Medical Screening.

18) **Mammograms**

We will pay the benefit listed in your Table of Benefits towards the cost of a mammogram, subject to the following criteria:

(i) The customer is referred for a mammogram by a general practitioner or consultant to an approved mammogram centre listed in the Directory of Hospitals (and Treatment Centres); and

(ii) The customer meets the eligibility criteria and one of the clinical indications as specified in the Schedule of Benefits for Medical Screening.

19) **Convalescent Care**

We will pay the benefit listed in Section 5 of your Table of Benefits towards convalescent care where each of the following is satisfied in full:

(i) If the consultant decides and our Medical Director agrees, that it is necessary for medical reasons for a customer to receive convalescent care in a Convalescent Home;
(ii) If the care is immediately after a medically necessary stay in hospital which is eligible for benefit, even if the hospital is not covered by your plan;
(iii) If the customer occupies single room accommodation in a Convalescent Home listed in Directory of Convalescent Homes.

20) **Transport Costs**

We will pay for the cost of an ambulance/intermediary ambulance where each of the following is satisfied in full:

(i) If the doctor certifies that it is medically necessary because the customer is seriously ill or disabled;
(ii) If the ambulance/intermediary ambulance is used: to transfer a customer, who is an in-patient of a hospital, between hospitals listed in the Directory of Hospitals (and Treatment Centres) where at least one hospital is covered by the customer's plan; or to transfer the customer from a hospital covered by your plan and listed in the Directory of Hospitals (and Treatment Centres) to an MRI Centre listed in the Directory of Approved MRI Centres; or to transfer the customer to a convalescent home listed in the Directory of Convalescent Homes, if the stay in a convalescent home is approved; or to transfer the customer from a hospital covered by your plan and listed in the Directory of Hospitals (and Treatment Centres) to a hospice;
(iii) If benefit is payable in respect of treatment received by the customer in the hospital, MRI Centre or convalescent home, to or from which the ambulance/intermediary ambulance transported the customer;
(iv) If the ambulance/intermediary ambulance company is approved by us.

The payment of ambulance/intermediary ambulance costs does not guarantee the eligibility for benefit of other charges relating to your claim. Where the doctor determines that the most appropriate level of transport required is a taxi, benefit will be payable directly to the hospital from which the patient is transferred subject to criteria (ii) and (iii) above.

21) **Psychiatric Treatment**

(i) We will only pay for in-patient psychiatric treatment in a psychiatric hospital listed in the Directory of Hospitals (and Treatment Centres) or an approved psychiatric unit of a hospital listed in the Directory of Hospitals (and Treatment Centres) and which is covered by your plan for the maximum number of days per customer in any calendar year listed in Section 3 of your Table of Benefits, less any days treatment within the same calendar year which has been paid under any other health insurance contract; and (ii) We will pay for day care psychiatric treatment for approved day care programmes in St. John of God Hospital, Stillorgan and St. Patrick's Hospital, Dublin.

22) **Addiction Treatment**

Each customer on your policy is entitled to addiction treatment for:

(i) Alcoholism and drug abuse subject to a maximum of 91 days benefit (less any days paid for by another health insurance contract) in any five year period. The five year period is calculated as the immediate five years prior to the discharge date of any such claim; and
(ii) Pathological gambling subject to the maximum number of days per customer in any calendar year listed in Section 3(a) of your Table of Benefits, less any days treatment within the same calendar year which has been paid for under any other health insurance contract.

23) **Breast Reduction**

Benefit for breast reduction is subject to prior approval and payable only if specific criteria, as set out in the Schedules of Benefits for Professional Fees and Private Hospital Services, are satisfied in full.

24) **Dental Treatment**

Many dental procedures eligible for benefits are classified as day care or side room procedures and many must also be authorised by our dental advisors prior to being performed. Your dental practitioner will need to send a Pre-certification Form and radiological evidence to our Claims Department for assessment by our dental advisors. (i) We will not pay benefits for dental/oral-surgical and orthodontic treatment and treatments related to functional disorders of the chewing system, including out-patient consultations, except for those dental/oral-surgical procedures listed in the Schedule of Benefits for Professional Fees and the treatments listed under the Day-to-day medical expenses or Out-patient medical expenses section of your Table of Benefits (if included under your plan); and (ii) Professional fee benefit is payable for non-cosmetic osseointegrated mandibular implants only if specific criteria, as set out in the Schedule of Benefits, is satisfied in full. In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components.

25) **Cancer Care Support Benefit**

We will pay the benefit listed in Section 5 of your Table of Benefits towards the accommodation costs of a customer in a hotel, hostel or B&B when a customer travels to receive out-patient chemotherapy and/or out-patient radiotherapy treatment in a hospital listed in the Directory of Hospitals (and Treatment Centres) covered by your plan. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.

26) **Return Home Benefit**

If included in your plan, we will pay the benefit listed in Section 5 of your Table of Benefits, towards travel costs incurred by a customer on their discharge from hospital to their home. The benefit is only payable following a medically necessary stay in hospital of at least 5 days which is eligible for benefit. Travel costs are limited to public transport, taxi, hackney and car parking costs. Only claims accompanied by dated receipts on headed paper will be eligible for benefit. The benefit is subject to a maximum of 3 claims per calendar year.

27) **Maternity**

(i) **Hospital Charges**

We will pay the benefits listed in Section 4 of your Table of Benefits towards the cost of hospital charges for normal confinements in a participating or non-participating hospital listed in the Directory of Hospitals (and Treatment Centres) and which is covered by your plan, in private and semi-private accommodation.

If there are significant medical complications arising from the pregnancy or delivery which necessitate a stay in hospital, we will pay the hospital benefits as listed in Section 1 of your Table of Benefits.

(ii) **Consultants' Fees**

We will pay part of the consultant's delivery fee as listed in the Schedule of Benefits for Professional Fees. The amount we will pay will be higher for a caesarean delivery. Benefits in respect of consultant's fees are only payable where your consultant personally delivers your baby and where the delivery takes place in a hospital listed in the Directory of Hospitals (and Treatment Centres), and which is covered by your plan.

(iii) **Home Births**

We will pay a contribution up to the benefit listed in Section 4 of your Table of Benefits for medical expenses incurred for home births and home nursing by a nurse.

Note: Contribution to midwife expenses incurred by a customer for home birth is only available when the midwife is registered on the midwives division of An Bord Altranais register and where the midwife has medical indemnity insurance.
It is the responsibility of the insured customer to ensure that the nurse is registered and has indemnity insurance.

(iv) **Post-natal Home Nursing**

If included in your plan, we will pay the charges for home nursing by a nurse if we pay the charges for normal confinement, up to the benefit listed in Section 4 of your Table of Benefits, provided that they are incurred within 3 days after your delivery. The combined amount of benefit for post-natal home nursing and hospital charges cannot exceed the limit set out in Section 4 of your Table of Benefits.

28) **Pre- and Post-natal Care**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of pre- and post-natal care provided the person giving the care is a General Practitioner, Consultant or Midwife.

29) **Foetal Screening**

If included in your plan, we will pay benefit in accordance with the level of cover under Section 1 for chorionic villus sampling, amniocentesis and cordocentesis where there is a high risk of specified foetal abnormalites and where specific conditions outlined in the Schedule of Benefits for Professional Fees have been satisfied. If these conditions are not satisfied, we will pay the benefit listed in your Table of Benefits (depending on your Plan) towards the cost of these procedures.

30) **Post-natal Home Help**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of domestic home help following the birth of your child from a Home Help provider approved by us (contact us for further details or refer to www.vhi.ie/downloads for a list of providers). The charges must be incurred within 6 weeks of the birth.

31) **Ante-natal Course**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of an ante-natal course. The person giving the course must be a midwife. Only claims accompanied by a dated receipt on headed paper will be eligible for benefit.

32) **Breast Feeding Consultation**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of a breast feeding consultant. Only claims accompanied by a dated receipt on headed paper will be eligible for benefit.

33) **Paediatrician Benefit**

If included in your plan, we will pay the benefit listed in your Table of Benefits for the first visit of your child to a Consultant Paediatrician within 1 year of the birth.

34) **Baby Massage Classes Benefit**

If included in your plan, we will pay the benefit listed in your Table of Benefits for baby massage classes carried out by members of the International Association of Infant Massage for your child in the year of the birth.

35) **Child Home Nursing**

We will pay the benefit listed in Section 5 of your Table of Benefits for the cost of nursing care at home for a customer who is under 18 years of age at his/her last renewal date if his/her general practitioner or consultant decides that, for medical reasons, the customer needs to receive care following a stay in a hospital of at least 5 days. This nursing care must commence within two weeks of their discharge from hospital and must be completed within six weeks of their discharge. The person giving the care must be a nurse registered with An Bord Altranais.

36) **Parent Accompanying Child**

We will pay the benefits listed in Section 5 of your Table of Benefits towards the accommodation and travel costs of a parent/guardian accompanying a child (including new born children) for up to 14 days per child per calendar year following a stay in excess of 3 days in hospital, who is under 14 years at their last renewal date, during that child's hospital admission. No benefit is payable for the first 3 days. The benefit is only payable where the child has received medically necessary treatment in Ireland that is eligible for benefit. The claiming customer must be a parent/guardian of the child insured with us. Accommodation costs are limited to hotel, B&B, hostel and hospital accommodation. Travel costs are limited to public transport, taxi, hackney and car parking costs. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.

37) **Child Counselling**

If included in your plan, we will pay the benefits listed in your Table of Benefits for eight child counselling visits in the year, for a customer who is under the age of 16 at their last renewal date and who is referred by a General Practitioner or Consultant to a Clinical Psychologist, as defined.

38) **Consultant Consultations**

We will pay the benefit listed in your Table of Benefits towards the cost of a consultation, excluding maternity and the 1st visit to a Consultant Paediatrician.

39) **Optical and Eye Testing**

If included in your plan, we will pay up to the benefit listed in your Table of Benefits for eye tests and/or prescription spectacles and contact lenses in a 24 month period. This 24 month period begins on the date that treatment is first received, or prescription spectacles or contact lenses are first purchased. Eye tests must be carried out by an Optometrist registered with the Opticians Board or by an Ophthalmic Surgeon or Ophthalmic Physician registered with us.

40) **Hearing Test**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of a hearing test provided the test is carried out by an Audiologist.

41) **Clinical Psychologist**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of a Clinical Psychologist.

42) **Accident & Emergency Cover**

If included in your plan, we will pay the benefit listed in your Table of Benefits in respect of the public hospital out-patient levy.

43) **Vhi SwiftCare Benefit**

If included in your plan, we will pay the benefit listed your Table of Benefits towards the cost of an initial consultation with a General Practitioner in an approved Vhi SwiftCare Clinic. If the patient attends a Vhi SwiftCare Clinic for an initial consultation, payment will be made directly to the centre and will not be subject to an excess.

44) **Travel Vaccination**

If included in your plan, we will pay the benefit listed in your Table of Benefits for travel vaccinations administered by a General Practitioner or Consultant.

45) **Out-patient Mental Health Treatment**

(i) If included in your plan, we will pay the benefit listed in Section 3 of your Table of Benefits towards the cost of a mental health assessment in an Out-patient Mental Health Centre listed in the Directory of Hospitals (and Treatment Centres).

(ii) We will pay the benefit listed in Section 3 or the Day-to-day medical expenses or out-patient medical expenses section of your Table of Benefits towards the cost of a mental health therapy session in an approved Out-patient Mental Health Centre.

46) **Lifestage Screening**

We will pay the benefit listed in your Table of Benefits towards the cost of a Lifestage screening, in a 24 month period provided we determine it to be medically appropriate, subject to it being provided in a Vhi Medical Centre, as listed in the Directory of Hospitals (and Treatment Centres). This 24 month period begins on the date that the screening tests are performed. Customers under the age of 18 years at their last renewal are not covered for screening.

47) **Fitness Screening**

If included in your plan, we will provide the benefit listed in your Table of Benefits for an agreed fitness screening carried out in the Sports Injury Clinic, Santry.

48) **Vhi HomeCare Benefit**

Benefit is payable in accordance with agreed charges for treatment of specified conditions provided by Vhi HomeCare subject to satisfaction of the following criteria:

1. The referral is from a General Practitioner relating to a patient in their own home or a Nursing Home in the Greater Dublin Area, or

2. The referral is from a Consultant attached to a hospital listed for benefit from one of the following routes:

   Accident & Emergency Department
   Hospital in-patient wards
   Consultants' Rooms

Please refer to www.vhi.ie/homecare for the most up-to-date details regarding referring hospitals and conditions approved for cover. You may contact us also if you have a question as to whether a condition comes into this category.

49) **Sports Physician**

If included in your plan, we will pay the benefits listed in your Table of Benefits towards the cost of a consultation with a Sports Benefit Physician.

50) **Sports Injury Programmes**

If included in your plan, we will provide the benefit set out in your Table of Benefits for bodily injury which in the opinion of our Medical Director is consistent with a Sports Injury and meets the criteria in full of the relevant Sports Injury Programme.

It is important to note that, for the purpose of this plan, such programmes are only available in the Sports Surgery Clinic, Santry. When the relevant investigations, treatments or procedures are carried out in other hospitals they do not constitute the Vhi Sports Injury Programmes and in such circumstances benefit is payable only in accordance with the benefits set out in your Table of Benefits. If you are in any doubt about the level of cover payable in respect of any procedure or treatment, we recommend that you contact us prior to treatment.

51) **Emergency Dental Treatment**

If included in your plan, we will pay the benefit listed in your Table of Benefits towards the cost of emergency dental treatment following a Sports Injury. The patient must present to the dentist within 24 hours of receiving a Sports Injury. Only claims accompanied by a dated receipt on headed paper and certified by the dentist that emergency dental treatment was necessary, will be eligible for benefit.

52) **Emergency Care Treatment**

If included in your plan, we will cover any charges incurred during your initial consultation in an approved Vhi SwiftCare Clinic for a sports injury. The patient must present to the Vhi SwiftCare Clinic within 48 hours of receiving the sports injury.

53) **Home nursing**

If included on your plan, we will pay the benefit listed in Section 5 of your Table of Benefits towards home nursing care for a customer who is over 18 years of age at his/her last renewal date and where each of the following is satisfied in full:

(i) If the consultant decides and our Medical Director agrees, that it is necessary for medical reasons for a customer to receive Home Nursing Care at home;
(ii) If the care is immediately after a medically necessary stay in hospital which is eligible for benefit, even if the hospital is not covered by your plan;
(iii) If the person giving the care is a Nurse registered with An Bord Altranais.

54) **Heart Check**

We will pay the benefit listed in your Table of Benefits towards the cost of a heart check, in a 24 month period provided we determine it to be medically appropriate, subject to it being provided in a Vhi Medical Centre, as listed in the Directory of Hospitals (and Treatment Centres). This 24 month period begins on the date that the check is performed. Customers under the age of 18 at their last renewal are not covered for this benefit.

55) **Cancer Check**

We will pay the benefit listed in your Table of Benefits towards the cost of a cancer check, in a 24 month period provided we determine it to be medically appropriate, subject to it being provided in a Vhi Medical Centre, as listed in the Directory of Hospitals (and Treatment Centres). This 24 month period begins on the date that the check is performed. Customers under the age of 18 at their last renewal are not covered for this benefit.

6) Cover outside Ireland

Treatment outside Ireland

a) We will only pay for emergency treatment a customer receives outside Ireland if he/she needs such emergency treatment because of an unexpected illness or accident that arises during a temporary stay abroad. We will pay up to the plan amounts outlined in Section 7 of your Table of Benefits, per temporary stay abroad inclusive of all professional fees. You may also claim for expenses listed under the Day-to-day medical expenses or Out-patient medical expenses section of your Table of Benefits. All eligible benefits associated with emergency or prior approved treatment abroad will be issued by us in euro, with the exchange rate from the European Central Bank being applied to all charges as at the date of the patient's admission/treatment, where applicable.

b) Only customers resident in Ireland for at least 180 days each calendar year are eligible for cover outside Ireland and or repatriation in accordance with Rules 6(a), 6(c) & 6(d). Where a customer intends to travel abroad for longer than 180 days, Vhi Assist or any other benefit will not be available in respect of medical treatment abroad.

c) We will in certain circumstances, subject to prior approval and satisfaction in full of specified criteria, pay benefit if the customer travels abroad to get a therapeutic procedure performed, as outlined in sections (i) and (ii) below:

(i) For therapeutic surgical procedures* that are currently available in Ireland we will pay up to the average benefit that we would have paid in respect of the same surgical procedure, including professional fees, in Ireland for your level of cover up to a maximum of the plan amounts specified in Section 7 of your Table of Benefits.

**as per the current Schedule of Benefits for Professional Fees, Surgery and Procedures Section.*

(ii) For a therapeutic procedure that is not available in Ireland we will pay up to the plan amounts specified in Section 7 of your Table of Benefits, unless a reasonable alternative therapeutic procedure is available here in which case the benefit will be as outlined in (i) above.

The customer will be liable for all costs that arise above the benefit payable, including all travel and accommodation expenses. The benefit will only be paid out once the treatment has been received and the customer submits the relevant completed Claim Form with all required documentation.

Note: Benefit is not payable for (a) assessments, investigations or diagnostic procedures required in reaching a medical diagnosis or (b) for follow-up assessments, investigations or non-therapeutic procedures required in the on-going management of the patient. The costs arising for any of these will be eligible for inclusion in accordance with the eligible Day-to-day medical expenses or Out-patient medical expenses listed in your Table of Benefits.

Vhi Assist

d) Provided that Vhi Assist are contacted immediately by the customer, we provide the following additional services to customers who require emergency treatment following an unexpected illness or accident while on a temporary stay abroad:

i) A direct payment facility in respect of the benefits referred to in paragraph (a) above where the treatment is received as an in-patient or in the A&E / Out-patient Department of a hospital. All other medical expenses can be claimed in accordance with the Day-to-day medical expenses or Out-patient medical expenses listed in your Table of Benefits.

ii)
- A 24 hour emergency telephone service
- A service to assist customers in replacing written prescriptions
- Medical Advice and information on your case
- Maintaining regular contact with the attending medical providers and monitoring of the customer's on-going care where necessary, if he/she is hospitalised
- Making contact with the customer's doctor in Ireland and immediate family, as well as his/her employer if required.

iii) Where possible, Vhi Assist can also recommend a local hospital where customers will be able to receive appropriate treatment.

iv) Repatriation cover is available, if after a customer has been treated, the attending doctor advises and our Medical Director agrees that it is necessary for medical reasons to transport him/her back to Ireland for further treatment. This benefit is available only where all arrangements are made under Vhi Assist.

v) Repatriation for further medical treatment will also be arranged by Vhi Assist if the patient is deemed stable and fit to fly by their attending doctor and our Medical Director agrees. The use of an air ambulance to repatriate patients will only be considered where it is deemed by the attending doctor and our Medical Director agrees that it is not medically appropriate for the patient to be accommodated on a commercial flight.

vi) A companion, who is with the patient when their illness occurs and accompanies them during repatriation, will be covered up to a maximum of €1,000 in additional travel expenses for returning to Ireland themselves.

vii) A further €1,000 is available for additional accommodation costs incurred by a companion who is with the customer when illness occurs and remains with the customer while they are hospitalised, beyond their scheduled return date to Ireland. These expenses (if approved by Vhi Assist) must be paid by the customer and claimed from us on their return to Ireland. Receipts must be provided in order to support all claims for this benefit and no benefit is available in respect of Day-to-day expenses once the customer has been discharged from hospital. Such expenses should be claimed under a customer's travel insurance.

viii) If a customer dies during a temporary stay abroad, Vhi Assist will arrange the return of their remains to Ireland.

ix) Where a child/children under 14 years are travelling with a customer who requires repatriation, we will arrange and pay necessary additional costs to return the child/children home or continue to their destination specified by the customer, up to a total maximum of €1,000 per child. We will also arrange and pay the travel costs of one adult to accompany the child/children up to a maximum of €1,000.

(e) If a case is being managed by Vhi Assist, the customer must indicate at the outset whether they hold separate travel insurance in respect of their trip abroad.

(f) Where you have made contact with Vhi Assist regarding your treatment abroad, the file reference provided to you at that time must be quoted in all subsequent dealings with us in relation to your treatment.

Recovery

(g) We shall be entitled at our own expense to institute any proceedings we consider reasonable in the customer's/subscriber's name to recover any payment made under the terms of your cover for treatment outside of Ireland and any amount so recovered shall belong to us. You must also notify us in writing if you instigate any action against a third party following an accident abroad. Please refer to Section 11 of this booklet for further details.

Emergency Treatment Abroad Form

(h) While Vhi Assist will provide the option of direct payment to medical providers treating customers abroad, the providers may not always accept such arrangements and therefore we cannot guarantee direct payment.

(i) If direct payment is not accepted, the customer should submit their receipts on their return to Ireland to Vhi, together with a completed part 1 & 2 of the 'Treatment Abroad Form', which is available from any of our offices or at www.vhi.ie. The medical details will be submitted directly to us through Vhi Assist.

(j) For cases not managed by Vhi Assist, we will require a fully completed 'Treatment Abroad Form' to be submitted in support of your claim for emergency hospital treatment abroad. The medical information on this claim form must be completed in English.

Exclusions

(k) Vhi Assist services or any other benefit in respect of treatment abroad, will not be available for any of the following:

- Injuries caused during mountaineering (above 4000 metres), motor competitions or professional sports
- Injuries you receive while breaking the law
- Injuries caused by air travel unless you are a passenger on a licensed aircraft operated by an airline
- Routine Dental Treatment
- Routine maternity or pregnancy related conditions
- If the customer travels against medical advice
- If the customer travels abroad to get treatment
- Convalescence or Rehabilitation services.

Repatriation services under Vhi Assist will not be available for any of the following:

- Illnesses or accidents arising from drinking alcohol or taking drugs
- Deliberately injuring yourself
- Any nervous or psychiatric condition
- In the case of war, civil disturbance or terrorism, where we do not deem it safe to send our medical repatriation staff into the area where the patient is staying. Vhi Assist does not take the place of travel insurance and we recommend that you buy travel insurance before you go abroad. You may wish to consider MultiTrip from Vhi Healthcare.

Also, where a customer intends to travel abroad for longer than 180 days in any calendar year, we recommend that you buy separate insurance cover for your trip. You may wish to consider Vhi International.

Please see www.vhi.ie or contact one of our offices for further details of our treatment abroad procedure.

7) Exclusions

In addition to cover limitations mentioned elsewhere, we will not pay benefits for any of the following:

a) Treatment which is not medically necessary treatment.

b) Vaccinations and routine or preventative medical examinations, including screenings, bone density scans and check-ups. (Unless specifically covered by your plan).

c) Treatment which is not intended to cure or alleviate a medical condition.

d) Treatment or a hospital stay which in the opinion of our Medical Director is consistent with long term care.

e) Hearing and sight tests, hearing aids, spectacles, contact lenses (except those specified in your Table of Benefits), dentures, or orthodontic appliances (such as braces).

f) Contraceptive measures or their reversal.

g) Any investigation or treatment relating to infertility carried out in the first twelve months of the policy.

h) Any treatment which is in any way related to artificially assisted reproduction (unless specified in your Table of Benefits).

i) Treatment or programmes for weight reduction or eating disorders other than anorexia nervosa and bulimia nervosa and those bariatric surgery procedures listed in the Schedule of Benefits for Professional Fees.

j) Alternative medicine: Cover is provided only for alternative therapies as specified in your Table of Benefits. However, no cover is provided for other alternative therapies, which include but are not limited to aromatherapy, homeopathy and spinology.

k) Experimental drugs and treatments.

l) Psychologists' fees, other than those specifically covered by your plan, as defined and listed in these Rules and your Table of Benefits where applicable.

m) Nursery fees.

n) Any charge for special nursing in hospital.

o) Any charge made for a medical report.

p) Treatment or tests given by a practitioner to his/her wife/husband, children or parents.

q) Expenses for which the customer is not liable.

r) Expenses which you are entitled to recover from a third party.

s) Cosmetic treatment and treatment of any complications arising from cosmetic treatment – unless it is needed (i) to restore the customer's appearance after an accident or (ii) because the customer was severely disfigured at birth.

t) Ophthalmic procedures for correction of short-sightedness, long-sightedness or astigmatism and lens extraction for prevention or treatment of glaucoma.

u) Where a patient is receiving treatment in a hospital or treatment centre listed in the Directory of Hospitals (and Treatment Centres) and is transferred to a hospital or treatment centre which is not listed for benefit in the Directory of Hospitals (and Treatment Centres), no benefit is payable for any out-patient or in-patient charges arising in the hospital or treatment centre not listed for benefit.

v) Any investigation or treatment related to complications arising from treatment which is not eligible for benefit.

w) Online Consultations with a Consultant from any Medical Speciality, including any prescription drugs or treatment prescribed following an online Consultation.

x) Drugs that are licensed but not recommended for reimbursement by the National Centre for Pharmacoeconomics unless otherwise approved by us.

8) Claims

In-patient treatment, day care, side room and out-patient procedures

a) We will only pay benefits when we receive a claim form completed and signed by the customer and the customer's doctor, and the original invoices or receipts.

- You sign the claim form a) to confirm that the details on the form are correct and b) to authorise the doctors/hospitals to supply the information requested, including copies of your medical records, if requested.

b) If we have a direct payment arrangement with a non-participating hospital, the hospital will send the claim form and invoices direct to us. Hospital invoices must be in a format specified by us. If they are not, we may be unable to calculate your exact benefit for hospital charges in which case we will calculate the benefit due to the hospital as best we can from the information supplied, and we will pay this amount direct to the hospital. We will send you details of the benefits we have paid. The Directory of Hospitals (and Treatment Centres) shows the hospitals with which we have a direct payment arrangement.

c) If we do not have a direct payment arrangement with the hospital, you must send us a claim form completed and signed by the customer and the customer's doctor, together with the relevant invoices.

- Hospital invoices must be in a format specified by us. If they are not, we may be unable to calculate your exact benefit for hospital charges in which case we will calculate the benefit due to you as best we can from the information supplied, and we will pay this amount.
- Payment of that estimate will be a complete discharge of our obligations to you.
- You must do this within six months of the date the treatment started.
- We will then pay the benefits for the hospital charges to you.
- You must use all the benefits we pay to you for the services for which you are claiming.

d) By law, we have to pay benefits for doctors' fees direct to the doctor (except for Day-to-day medical expenses benefit). We also have to deduct withholding tax from the benefits we pay. We will send you details of the benefits we pay to the doctor. If you pay the doctor direct, we must still pay the benefits to the doctor and you will then have to ask the doctor for a refund of any amounts you paid.

e) Day-to-day Medical Expenses/Out-patient Medical Expenses

- We will pay benefits for eligible expenses listed in the Out-patient medical expenses sections of your Table of Benefits which are subject to an excess as a lump sum at the end of each year. We will only pay the benefits when you send us a claim form which you have completed and signed, together with receipts. You must do this within three months of the end of the year.

- For those benefits listed in the Day-to-day medical expenses (including Lifestage benefits) sections of your Table of Benefits which are subject to a €1 excess, you must send us a claim form completed and signed by the customer together with the relevant receipts. The benefit will be issued to the subscriber/policyholder and may be claimed quarterly.

- Please note that receipts will not be returned following assessment of your claim, therefore you may wish to retain copies prior to submission.

- We will deduct an annual excess (as specified in the Day-to-day medical expenses or the Out-patient medical expenses section of your Table of Benefits) from the eligible expenses of each customer insured on the policy.

f) If you or another customer are entitled to claim under any other insurance policy for all or any of the costs, charges or fees for which you are insured under this policy, our liability shall apply as excess of, and not as contributory with such other insurance. When making a claim you must tell us if you have other insurance.

g) If the renewal period is less than one year, the limits and excess applied to some benefits during this period are proportionally reduced.

h) In order to establish the eligibility and appropriateness of any claim, we may request access to and/or copies of your medical records including medical referral letters. By signing the claim form, you give us your consent to access this information. If you refuse to give us your consent, or withdraw such consent, we may refuse your claim and recoup any monies that we may have previously paid in respect of that medical condition. Where appropriate, this will be done directly from the medical providers concerned and you will be liable to settle these amounts directly.

At our own cost, we can also ask an independent medical consultant, chosen by us, to advise us about the medical facts relating to a claim.

i) Hospital claims statements are issued to the subscriber of the policy. If an insured person other than the subscriber on the policy wishes to have their claims statements issued directly to them instead, they should contact us, so that we can record their preference.

9) Disputes

a) If there is a dispute about whether we should pay all or part of a claim or you have any other complaints, you may refer the dispute to the Financial Services Ombudsman's Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2 (Tel: (01) 6620899) to decide on the matter. The decision of the Financial Services Ombudsman is binding on all the parties, but where one party is dissatisfied with the decision it may be appealed to the High Court.

b) If you do not wish to avail of the procedure outlined in Rule 9(a) you may refer your dispute directly to the Courts.

10) General

a) When you deal with us, you are acting for all the customers who are included on your policy.

b) We will send any letters and notices about your policy, by ordinary post, to the address which you give us. Where you have opted to receive policy documentation electronically, we will notify you via email instead. Accordingly, you must tell us if you change your postal or email address.

c) The customer must notify us immediately of any change to their policy or circumstances which could alter the assumptions on which the policy is based or which are material to same. If no additional material facts or change in material facts are declared to us within 14 days of the date of issue or receipt of the Terms and Conditions, whichever is later, we assume that no material change has occurred.

d) If any customer makes, or tries to make, a dishonest application or claim which relates to his/her policy with us or any other Health Insurance Contract, we have the right to:

   (i) refuse to renew his/her policy;

   (ii) cancel his/her policy immediately.

   We also have the right to refuse to pay any benefits for the customer. Customers should be aware that we undertake regular audits of claims and in all instances where fraud is suspected in respect of a particular claim, a full and comprehensive investigation will be carried out.

   In addition, we reserve the right to refer the details of any claim submitted which is in any respect fraudulent, to the appropriate authorities in order to prosecute the customer.

e) If you ask us to remove a customer from your policy, we have the right to tell the customer that he/she is no longer covered.

f) To pay your benefits, we may have to provide some of your membership details to the hospital, on a strictly confidential basis. We may also have to obtain copies of your medical records from the hospital/doctors concerned and this information will be treated in strict confidence.

g) If you use Vhi Assist, we have to provide some of your membership details to an international assistance company, also on a strictly confidential basis. The assistance company will in turn give us details of the customer's illness or injury. This information will be held on the assistance company's computer. It will only be used to provide Vhi Assist services and benefits.

h) We will pay your benefits in euro.

i) Your policy is governed by the laws of Ireland.

j) In accordance with the Health (Provision of Information) Act, 1997, we provide government agencies responsible for national health screening programmes with the name, address, date of birth, PPS number and the policy number of customers of a requested demographic. No other information about our customers is released. We also fully comply with the requirements of all Data Protection legislation.

k) The availability of semi-private or private accommodation is determined by the hospitals and is outside of our control.

l) **Data Protection:** The information which you provide to the Vhi Group ("Vhi") will be used within the Vhi group of companies for processing your application and claims, customer services and for the administration of any healthcare related products and services of which you and any other person on your policy avail. Data may also be used for statistical analyses and the detection and prevention of fraud. We may share your data with trusted third parties who process data on our behalf, inside and outside of the European Economic Area. We may also share your data with other insurers to verify your cover, and with state bodies as required by law. Sensitive personal data including up to date medical diagnoses information may be held, used and processed for the purpose of undertaking investigations into, and to adjudicate on, claims (including the length of your hospital stay and the treatment received) and for the purposes of Vhi providing information about products and services aimed at managing your health and wellbeing.

   By entering, renewing or amending an existing policy with us, you confirm that you explicitly consent to Vhi processing your personal data for the purposes described above, and have explained to each person who is included on your policy why we may ask for this information and what we will use it for. You also confirm that each person has agreed to this.

   You have the right, subject to certain exemptions, to access any personal data that we hold about you (for which we may charge you a small fee) and to have inaccuracies corrected. If you wish to avail of these rights, please write to the Data Protection Office, Vhi House, 20 Lower Abbey Street, Dublin 1.

Vhi's Data Protection Statement contains a further detailed breakdown of the personal data we collect in relation to our customers and how we use that personal data. The Data Protection Statement can be found at www.vhi.ie or should you wish to contact us on 1890 44 44 44, you can request a hard copy. If you have any queries regarding your data, please write to the Data Protection Officer, Vhi, Vhi House, 20 Lower Abbey Street, Dublin 1.

We may send you information about other products and services which may be of interest to you, provided you have indicated that you would like to receive such information. If you wish to change your preference in respect of receipt of these communications, please contact us at the above number or online at www.vhi.ie/contact/.

11) Third Party Claims

a) As outlined in Rule 7(r) expenses which are recoverable from a third party, are excluded from benefit, however:

b) **Legal Action/Proceedings**

Where a claim is submitted to Vhi Healthcare in respect of treatment required as a result of an injury caused through the fault of another person and where you propose to pursue a legal claim against that party, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policyholder if you are under 18 years):

(i) complete in full and sign the injury section of the claim form which includes an undertaking to include all benefit paid by Vhi Healthcare in any claim against the third party responsible for causing the injury, and

(ii) submit a fully completed undertaking, which will be relied on by Vhi Healthcare once a copy of the Authorisation Form is received from the Injuries Board (refer to Rule 11(d)) from your solicitor in the form prescribed by Vhi Healthcare:- "In consideration of Vhi Healthcare discharging the eligible hospital and medical expenses of my client, I hereby agree to include as part of my client's claim the monies so paid by Vhi Healthcare (details of which will be supplied to me by Vhi Healthcare) and subject to any court order to the contrary, to repay to Vhi Healthcare – out of the net proceeds of the settlement that come in to our hands – all monies recovered in respect of such expenses paid by Vhi Healthcare."

(iii) Inform Vhi Healthcare as soon as reasonably practicable of any arrangements for settlements discussion or hearing dates.

(iv) In circumstances of an anticipated reduced settlement undertake for contact to be made with Vhi Healthcare upon it being made known to you that monies so paid by Vhi Healthcare may not be fully recoverable.

(v) When a reduced settlement has been agreed, provide Vhi Healthcare with documentation from your legal representative which has been agreed between the Law Society and Vhi Healthcare confirming the veracity of the net proceeds recovered.

c) **No Legal Action/Proceedings**

Where a claim is submitted to Vhi Healthcare in respect of treatment you require as a result of an injury caused through the fault of another person, and you do not propose to pursue a claim against the third party and, in the view of our legal advisers, expenses are recoverable from that party, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policyholder if you are under 18 years):

(i) complete in full and sign the injury section of the claim form which includes an undertaking to include all benefit paid by Vhi Healthcare in any claim which may subsequently be made against the third party responsible for causing the injury, and

(ii) immediately notify Vhi Healthcare in writing of the instigation of any such claim and "subject to any Court Order to the contrary, to repay to Vhi Healthcare – out of the net proceeds of the settlement that come into our hands – all monies recovered in respect of such expenses paid by Vhi Healthcare."

d) **Injuries Board**

Where you make your application to the Injuries Board, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policyholder if you are under 18 years) complete in full and sign the injury section of the claim form.
This undertaking provided by you also authorises Vhi Healthcare to provide the Injuries Board with details of all monies paid by Vhi Healthcare relating to your application, and for the Injuries Board to release to Vhi Healthcare details of the Injuries Board assessment in relation to the monies paid by Vhi Healthcare.
Where the Injuries Board decides that the case is more appropriately dealt with by the court, due to some legal dispute and issues a letter of Authorisation, Vhi Healthcare will rely on the undertaking that has been provided by your solicitor, in accordance with Rule 11b(ii) above, and a copy of the Authorisation from the Injuries Board to proceed to the courts.

e) **Criminal Injuries Compensation Tribunal Claims**

If you are pursuing a claim through the Criminal Injuries Compensation Tribunal, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policyholder if you are under 18 years) complete in full and sign the injury section of the claim form and provide Vhi Healthcare with a copy of the written confirmation from the Criminal Injuries Compensation Tribunal. The undertaking provided by you also authorises Vhi Healthcare to seek details of any settlement directly from the Criminal Injuries Compensation Tribunal and for the Criminal Injuries Compensation Tribunal to release this information to us. In circumstances where such a case is unsuccessful, Vhi Healthcare will not seek a refund of the benefit paid.

f) **Threshold Amount**

Undertakings and refunds will not be sought if the total eligible benefit payable in respect of an accident does not exceed the threshold amount of €1,000. However if subsequent claims are submitted in respect of the same incident, which would increase the total benefit payable to €1,000 or more, an undertaking must be completed.

g) **Unsuccessful/Withdrawn Claims**

If a claim against a third party is not successful or is withdrawn, Vhi Healthcare will not seek a refund of the benefit paid provided that you arrange for full written details of the case to be supplied by your solicitor to the satisfaction of Vhi Healthcare outlining the reasons why the case was unsuccessful or was discontinued.

h) **Disclosure**

It is the responsibility of a member to disclose to Vhi Healthcare full details of any action to be pursued against a third party in relation to any incident/accident in respect of which Vhi Healthcare has paid benefit. Failure to do so will result in the refusal of any subsequent claims relating to the incident/accident.

12) Glossary

Accident

Bodily injury caused solely and directly by external, violent and visible means.

Accommodation

Hospital accommodation is defined as follows:

Private Accommodation

A room in a private hospital which has only one bed or a room approved by us in a public hospital which has only one bed and which is a designated private bed under the Health Services (In-Patient) Regulations, 1991.

Semi-private Accommodation

A room in a private hospital which contains not more than five beds or a bed approved by us in a public hospital which is a designated private bed under the Health Services (In-Patient) Regulations, 1991 and in a room which contains not more than five beds.

Semi-private Rate

The amount which the hospital would have charged if the customer had stayed in semi-private accommodation.

Benefit(s)

The amount we will pay for any claim as set out in the Rules, your Table of Benefits, the Schedule of Benefits for Private Hospital Services, the Schedule of Benefits for Professional Fees and the Schedule of Benefits for General Practitioners.

Claim

When you ask us to pay benefits for a customer included on your policy less any excess that may be applicable.

Day-to-day Medical Expenses

Depending on your plan, the benefits we provide for the range of services listed in your Table of Benefits under Day-to-day medical expenses.

Directories

The Directories which form part of your policy are made up of the following and where any of the following are referenced in your policy, they are taken to have the meaning as set out here:

The Directory of Hospitals (and Treatment Centres)

In the Directory of Hospitals (and Treatment Centres), we list the hospitals and treatment centres covered under your plan.

The Directory of Approved MRI Centres

In the Directory of Approved MRI Centres, we list the MRI Centres covered under your plan.

The Directory of Approved PET-CT Centres

In the Directory of PET-CT Centres, we list the PET-CT Centres covered under your plan.

The Directory of Convalescent Homes

In the Directory of Convalescent Homes, we list the convalescent homes which are eligible for benefit.

The Directory of Consultants

In the Directory of Consultants, we list the consultants who are participating consultants.

These Directories are available on our website at www.vhi.ie and on request and should be read in conjunction with these Terms and Conditions, your Table of Benefits and your policy details.

Excess

An amount that we will deduct from your claim, as set out in your Table of Benefits.

Health Insurance Contract

As defined in the Health Insurance Acts.

Hospice

An independent free-standing in-patient unit providing multi-disciplinary specialist services to the terminally ill under the supervision of a consultant in palliative medicine recognised by us.

Hospitals

The following definitions apply to hospitals:

Hospital Benefit

Benefits payable for in-patient treatment, day-care and side room procedures.

Hospital Charges

Charges for: (i) hospital accommodation; (ii) services provided by a private hospital or clinic (such as hospital technical charges); and (iii) public hospital statutory levies.

Non-participating Hospital

A hospital listed in the Directory of Hospitals (and Treatment Centres) which does not have an agreement with us but which we recognise, so we will pay part of the hospital charges for accommodation approved by us. Full details of benefits payable are available from any of our offices.

Participating Hospital

A hospital listed in the Directory of Hospitals (and Treatment Centres) which has an agreement with us on its charges and the services it provides to our customers. We will pay the hospital charges for accommodation and services approved by us if the customer is insured under the appropriate plan.

Technical Charges

Charges for the use of operating theatre, radiology technical, pathology technical, radiation oncology technical, specified drugs, blood and blood products, that are set out in the Schedule of Benefits for Private Hospital Services.

Lifestage Screening

A specified screening programme carried out in a Vhi Medical Centre, as listed in the Directory of Hospitals (and Treatment Centres).

Medical Condition

Any disease, illness or injury.

Medically Appropriate

Means tests or investigations that, in the opinion of our Medical Director, are medically appropriate having regard to best practice.

Medically Necessary

Means treatment or a hospital stay which in the opinion of our Medical Director is generally accepted by the medical profession as appropriate with regard to good standards of medical practice and is:

(i) consistent with the symptoms or diagnosis and treatment of the injury or illness;
(ii) necessary for such a diagnosis or treatment;
(iii) not furnished primarily for the convenience of the patient, the doctor or other provider; and
(iv) furnished at the most appropriate level which can be safely and effectively provided to the patient.

Customer

The following definitions apply to customers:

Customer

You and anybody who is named as an insured person on your policy details.

Child

A person under 18 years of age at the last renewal date (or commencement date if there is no past renewal date).

Student

A person who is a dependant of the subscriber/policyholder and is of or over the age of 18 years and under 21 or 22 years as stated in your policy details and is receiving full time education.

Subscriber/policyholder

The person to whom we have issued the policy.

Our/Us/We

Vhi Insurance Limited.

Out-patient Consultation

A visit to a consultant in his/her consulting rooms for a consultation about a medical condition.

Out-patient Medical Expenses

Depending on your plan, the benefits we provide for the range of services listed in your Table of Benefits under the heading "Out-patient medical expenses".

Patient

The following definitions apply to patients:

Day-patient

Medically necessary treatment received during a hospital stay in a day care bed (but which is not an overnight stay) for an approved psychiatric day care programme or a procedure listed in the surgery and procedure section of the Schedule of Benefits for Professional Fees, other than for a side room procedure.

In-patient

Medically necessary treatment received during a stay in a hospital bed of at least 24 hours.

Out-patient

(i) Medically necessary treatment which does not involve in-patient treatment, day care or side room procedures, and
(ii) Consultations with complementary and alternative medicine practitioners.

Plan

Any health insurance scheme we provide which covers the cost of treatment in private accommodation or semi-private accommodation along with other benefits set out in your Table of Benefits. Details of your plan are set out in your policy details.

Policy

The contract you have entered into with us and made up of the documents listed in Section 1 of these Terms and Conditions.

Policy Details

The document setting out the plan upon which you are insured along with details of those customers insured under the plan and the policyholder.

Practitioner

The following practitioners are recognised by us:

Audiologist

A diagnostic Audiologist who is registered with the Irish Society of Audiology or the Irish Society of Hearing Aid Audiologists.

Breast Feeding Consultant

A midwife who is a member of the Association of Lactation Consultants in Ireland and who holds International Board Certificate Lactation Consultant membership.

Chiropodist/Podiatrist

A member of the British Chiropody & Podiatry Association, or the Institute of Chiropodists & Podiatrists (Rep. of Irl.), or the Irish Chiropodists/Podiatrists Organisation Ltd., or the Society of Chiropodists & Podiatrists (Rep. of Irl.).

Clinical Psychologist

A full member of the Division of Clinical Psychology of the Psychological Society of Ireland.

Consultant

A medical practitioner who has a current full registration with the Irish Medical Council and who:

(i) holds a public consultant post in the Republic of Ireland; or
(ii) has held a public consultant post in the Republic of Ireland in the past and now practices within the same specialised field; or
(iii) holds the necessary qualifications for a public consultant post in the Republic of Ireland together with evidence of appropriate general professional and higher specialist training to a standard required for such a post in the speciality in which he/she intends to work and has been appointed as a consultant to a post approved by us in a private hospital approved by us.

Non-participating Consultant

A consultant who does not enter into agreement with us to accept our benefits in full settlement of his/her fees. He/she receives the standard benefit as set out in the Schedule of Benefits for Professional Fees and may or may not charge an additional fee to patients.

Participating Consultant

A consultant who enters into agreement with us to accept our benefits in full settlement of his/her fees and charges our customers accordingly.

Dental Practitioner

A dental practitioner with a current full registration with the Irish Dental Council, who holds a primary dental qualification. He/she is community based and provides dental care.

Dietician

A member of the Irish Nutrition & Dietetic Institute.

General Practitioner

A medical practitioner with a current full registration with the Irish Medical Council, who holds a primary medical qualification.

Midwife

A midwife who is registered on the midwives division of An Bord Altranais register.

Nurse

A nurse registered with An Bord Altranais.

Occupational Therapist

A member of the Association of Occupational Therapists of Ireland.

Optometrist

An Optometrist with a current full registration with the Opticians Board.

Orthoptist

A member of the Irish Association of Orthoptists or the British Orthoptic Society.

Physiotherapist

A member of the Irish Society of Chartered Physiotherapists.

Speech Therapist

A member of the Irish Association of Speech and Language Therapists.

Sports Physician

A Consultant Physician with a current specialist registration recorded in the Irish Medical Council's register, Specialty Division, in the specialty of Sports and Exercise Medicine.

Voice Coach

A member of the Irish Voice Association.

Prescriptions

Drugs or Medicines prescribed by a General Practitioner, Consultant or Dental Practitioner.

Procedures

The following definitions apply to procedures:

Day Care Procedure

Treatment or investigation which is marked as Day Care in the Schedule of Benefits for Professional Fees and the Schedule of Benefits for Private Hospital Services.

Fixed Price Procedure

Fixed Price Procedure (FPP) is a term we use to describe a variety of specified major complex procedures (e.g. cardiac and neurosurgery).

Out-patient Procedure

Treatment given to an out-patient which is listed in the Schedule of Benefits for Professional Fees or the Schedule of Benefits for General Practitioners.

Side Room Procedure

Treatment or investigation which is marked as side-room in the Schedule of Benefits for Professional Fees and Schedule of Benefits for Private Hospital Services and for which an extended period of recovery is not required.

Specified Orthopaedic and Ophthalmic Procedures

Specified Orthopaedic and Ophthalmic Procedure is a term that we use to describe a list of specified orthopaedic procedures (principally covering hip, knee or shoulder replacements) and ophthalmic procedures (principally covering cataract procedures) carried out in designated private hospitals. A list of these procedures is available from us on request.

Therapeutic Procedure

An action or administration of therapeutic agents to produce an effect that is intended to alter or stop a pathologic process.

Renewal Date

The renewal date shown in your most recent policy details or any anniversary of that date.

Schedules

The Schedules which form part of your policy are made up of the following and where each of the following are referenced in your policy, they are taken to have the meaning as set out here:

The Schedule of Benefits for Private Hospital Services
The Schedule of Benefits for Professional Fees
The Schedule of Benefits for General Practitioners
The Schedule of Benefits for Medical Screening

Sports Injury

Means bodily injury suffered as a direct result of participation in exercise or sport, competitive or recreational, where the direct consequence of that injury is to prevent the customer from participating in their desired exercise or sport for a period of at least 7 days directly following the occurrence of that injury.

Table of Benefits

The document that forms part of your policy with us and sets out the benefits we will pay in respect of your chosen plan.

Temporary Stay Abroad

A stay(s) outside of Ireland for any period up to but not exceeding 180 days in each calendar year.

Travel Vaccinations

Vaccinations against Hepatitis A, Hepatitis B, Typhoid, Malaria, Rabies and Polio.

Treatment

Any medical intervention for which benefits are payable.

Vhi HomeCare

The provision of acute care in the home which involves:

- treatment of patients with acute conditions who would otherwise have required treatment in a hospital bed
- provision of the level and type of services that would normally be provided in a hospital bed
- provision of those services within the home and
- provision of an appropriate level of emergency back-up.

Waiting Periods

The following definitions apply to waiting periods:

Waiting Period

A period during which we will not pay benefits for the customer until the customer has been insured continuously for a minimum period of time as set out in Section 2(c) and Section 3(b) respectively.

New Conditions

A medical condition where the date of onset of which is determined on the basis of medical advice to have been after the date the customer was included under the policy (or from the renewal date where you change your plan).

Pre-existing Conditions

A medical condition where the date of onset of which is determined on the basis of medical advice to have been prior to the date the customer was included on the policy (or prior to the renewal date when you changed your plan). This is applicable to all benefits other than those outlined in the Day-to-day Medical Expenses (including Lifestage benefits) or Out-patient Benefits section of your Table of Benefits.

Date of Onset

When determining whether a medical condition is pre-existing, it is important to note that it is the date of onset of the condition that is considered rather than the date upon which the customer becomes aware of the condition, as medical conditions may be present for some time before giving rise to symptoms or being diagnosed.

Maternity Waiting Period

Applicable to maternity related conditions.

Out-patient Medical Expenses Waiting Period

Applicable to the benefits listed in the Out-patient medical expenses section of your Table of Benefits.

Day-to-day Medical Expenses Waiting Period

Applicable to the Day-to-day medical expenses listed in your Table of Benefits.

Year

The period of cover shown in your most recent policy details.

You, Your

The subscriber/policyholder.

Definitions relating to Complementary and Alternative Medicine - being services not in accordance with the definition of medically necessary. It is advisable to discuss the suitability of a complementary or alternative therapy with a registered medical practitioner prior to commencing treatment. Visits to the following therapists are eligible for benefit:

Acupuncturist

A member of the Traditional Chinese Medicine Council of Ireland, or a member of the Acupuncture Foundation Ireland, or a member of the British Acupuncture Council, or a member of the Professional Register of Traditional Chinese Medicine.

Chiropractor

A member of the Chiropractic Association of Ireland or the McTimoney Chiropractic Association of Ireland.

Osteopath

A member of the Osteopathic Council of Ireland.

Physical Therapist

A member of the Register of Physical Therapists of Ireland or a member of the Irish Association of Physical Therapists or a member of the Irish Institute of Physical Therapists.

Reflexologist

A member of the Association of Irish Reflexologists or the Irish Reflexologists' Institute or the National Register of Reflexologists.

Voluntary Health Insurance Board
An Bord Árachais Sláinte Shaorálaigh

Postal Address: IDA Business Park, Purcellsinch,
Dublin Road, Kilkenny.

Telephone Number: **LoCall 1890 44 44 44**
Lines open: 8am – 6pm Monday – Friday
9am – 3pm Saturday

Website: www.vhi.ie
E-mail: info@vhi.ie

Dublin Vhi House, Lower Abbey Street, Dublin 1.
Fax (01) 873 4004

Cork Vhi House, 70 South Mall, Cork.
Fax (021) 427 7901

Kilkenny IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.
Fax (056) 776 1741