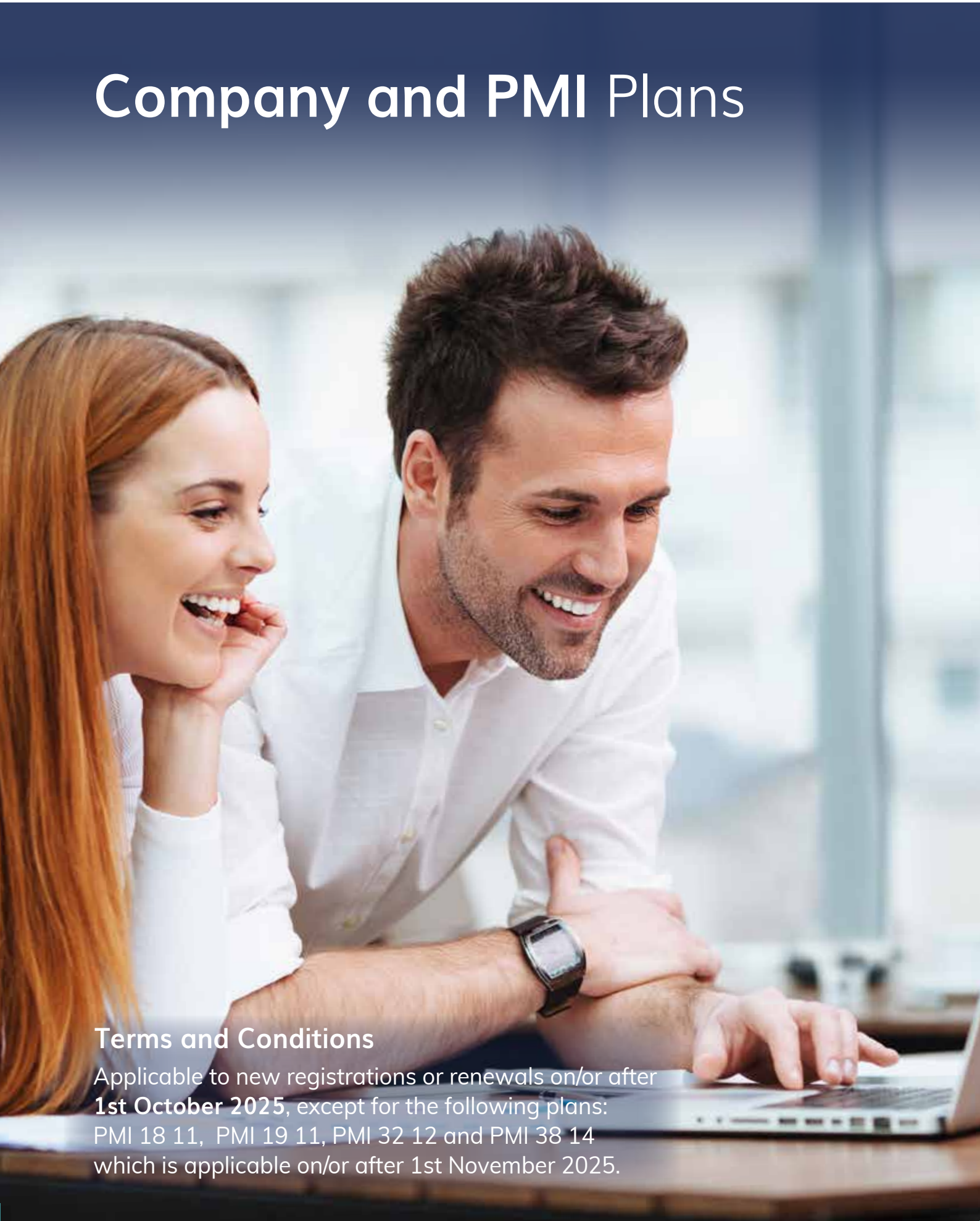
Company and PMI Plans



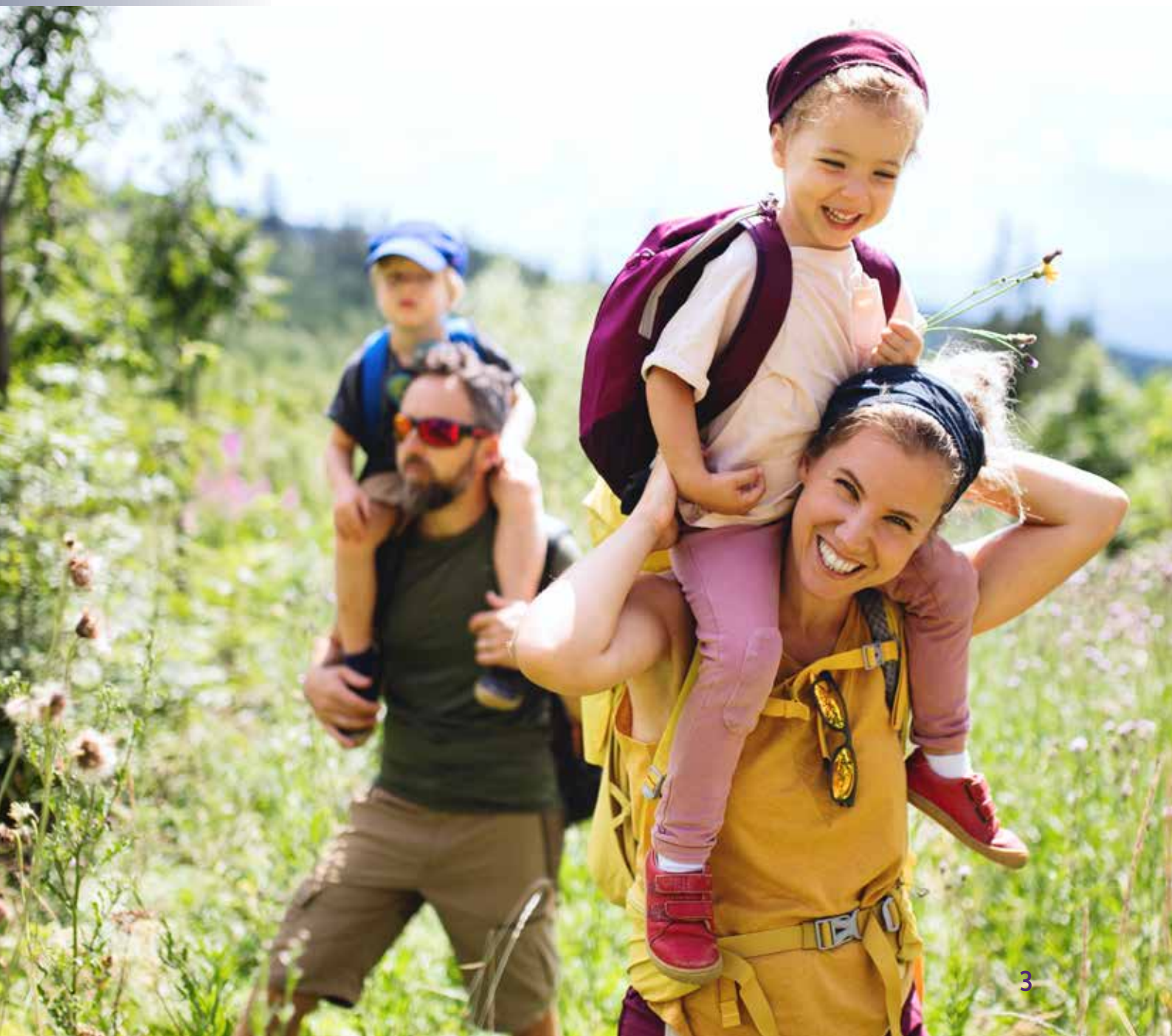
Terms and Conditions

Applicable to new registrations or renewals on/or after **1st October 2025**, except for the following plans: PMI 18 11, PMI 19 11, PMI 32 12 and PMI 38 14 which is applicable on/or after 1st November 2025.

Contents

Welcome

Thank you for choosing us as your trusted healthcare partner. This document makes it easier for you to understand the important legal information regarding your Plan, including how your cover works, how to make a claim, and key details about your Benefits.



Introduction

Your Policy

Your Policy is made up of:

(1) this **Terms and Conditions** document;

(2) the **Schedules of Benefits**;

(3) **Your Table of Benefits** issued to **You**; and

(4) **Your** Directory of Approved Medical Facilities.

> *Please note **We** may change the **Directories of Approved Facilities** and **Schedules** at any time, including during the year. **You** can find the most up to date directories on **Our** website at: vhi.ie.*

How Your Plan works

(1) **We** will cover the eligible costs, expenses and other payments set out in **Your Plan**. These are known as '**Benefits**'.

(2) The amount **We** will pay for each **Benefit** is set out in **Your Table of Benefits**. **You** must cover the remaining costs if applicable.

(3) Some **Benefits** are subject to a limit, which is the most **We** will pay for that **Benefit**.

(4) Some procedures have conditions that need to be met in order to be payable. **You** can contact **Your Consultant** or practitioner for details of conditions which apply to **Your** planned procedure.

(5) **You** may not be covered for all **Benefits** listed in this document. **Your Table of Benefits** will show which **Benefits** are included under **Your Plan**.

(6) In the event of a change to the **Directory of Approved Medical Facilities** where the contract between a participating hospital or treatment centre and Vhi is terminated for any reason other than the closure of that hospital or treatment centre, no Benefit will be payable. If this occurs, **We** will publish a notice in the media and the Hospital or treatment centre will be removed from **Our Directory of Approved Medical Facilities**.

> *__You__ should read this document carefully and check that it covers the __Benefits You__ require. If not, or if __You__ have any questions at all, __You__ should let __Us__ know immediately.*

Minimum Level of Benefits

Your **Plan** is designed to comply with the Health Insurance Act 1994 as amended and any associated Regulations. This means We are required by law to provide a minimum level of cover for**:**

(1) day care and In-Patient services,

(2) hospital Out-Patient treatment;

(3) maternity benefits,

(4) convalescence, and

(5) psychiatric treatment and substance abuse.

These legal requirements mean **Your Plan** may include **Benefits** that **you** do not need. This also means **We** may apply a lower **Excess** than shown in **Your Table of Benefits**, if required.

How to use this Document

This **Terms and Conditions** document is comprised of:

(1) General definitions: Some words and phrases have a specific meaning when used in this document. Those words and phrases, along with their meaning, are set out in **General definitions**. These words and phrases appear in **bold font.**

(2) Practitioner's registration requirements: Certain practitioners must hold certain registrations or **We** will not make payment. These practitioners' registration details are set out in the **Practitioner's registration requirements**. They also appear in bold font where used.

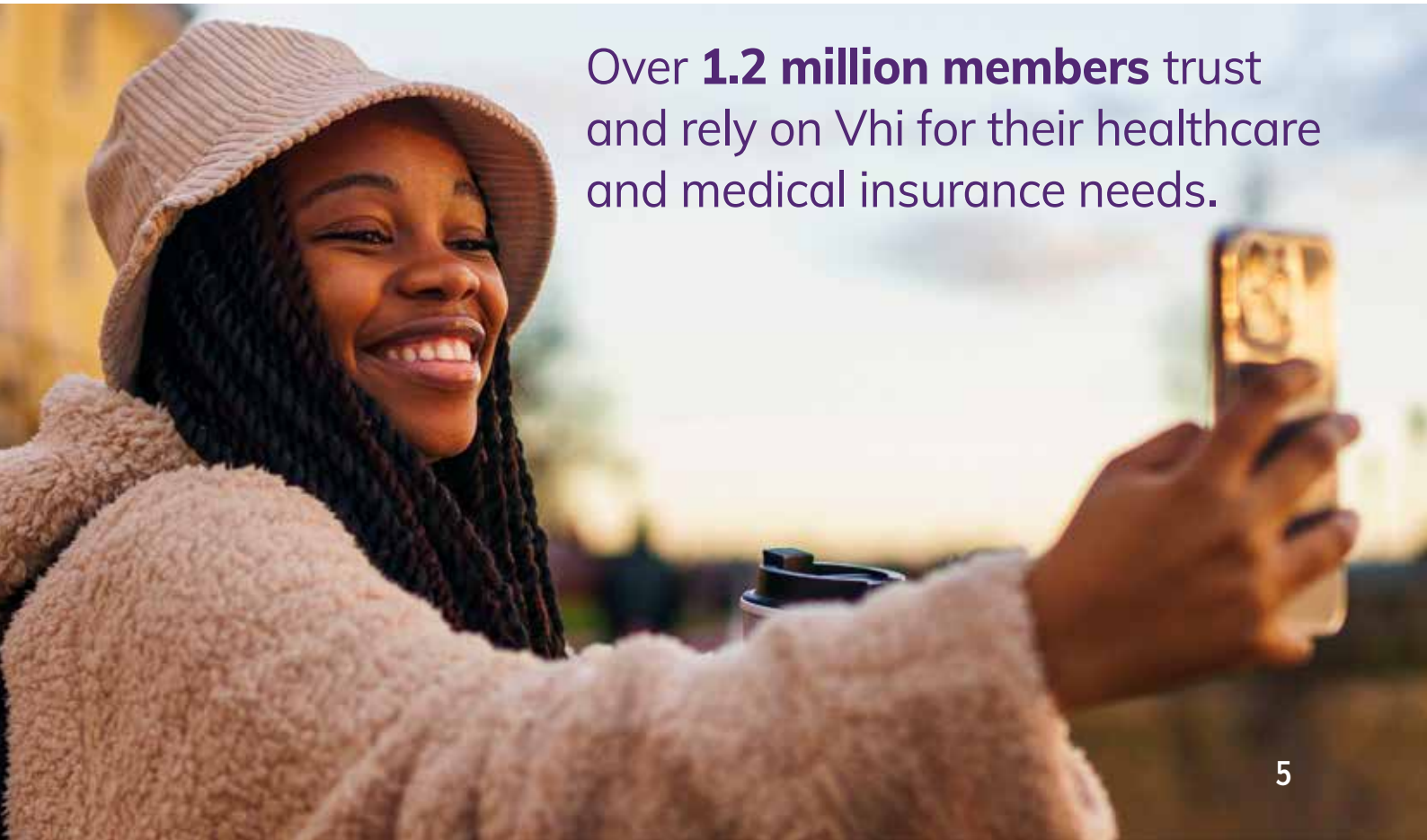
(3) General terms: These are the terms that apply to **Your Policy** as a whole and are applicable to all **Benefits**.

(4) Cover sections: To make it easier to find the **Benefit You** need, **We** have divided this document into sections which contain similar or related **Benefits**. Some of the cover sections include additional defined words, exclusions or conditions which apply to that cover section only, in addition to **General definitions** and **General terms**. Each of the **Benefits** has been divided into the following:

✓ **Benefit description**	This provides details of the **Benefit** covered under **Your Plan**.
? **Eligibility criteria**	If there are any specific limits, conditions or exclusions applying to a particular **Benefit**, they will show here.
★ **Not in Table of Benefits**	A star appears next to Benefits which will not be displayed in **Your Table of Benefits**.

(5) Additional information: To help **You** understand this document, **We** have added useful information throughout this document. This information appears in boxes which look like the following:

> i *Useful information and guidance is found in boxes like this one throughout this document.*



General Definitions

If any word or phrase below appears in this document in bold font, it has the meaning shown below. **You** may find additional defined terms in the cover sections in which they appear:

Accident

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

Accommodation

Hospital **accommodation**. This is comprised of:

Private accommodation

1. a room in a private hospital which has only one bed; or
2. a single occupancy 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

1. a room in a private hospital which contains not more than 5 beds; or
2. a multiple occupancy room approved by **Us** in a public hospital which contains more than one bed.

Semi-private rate

The amount the hospital would have charged if **You** had stayed in **Semi-private accommodation.**

Acute

A short, sharp and severe onset which requires immediate medical attention.

Approved Facility

A hospital, day hospital centre, treatment centre or medical diagnostic centre listed in the Directory of Approved Medical Facilities which is covered by **Your Plan.**

> *The most up-to-date Directory of Approved Medical Facilities is on* **Our** *website; vhi.ie.*

Benefit

The amount **We** will pay for any eligible claim, as set out in **Your Table of Benefits.**

Child

A person under 18 years of age at the **Renewal Date** (or at the time of joining if there is no past **Renewal Date**).

Clinical Indication/ Payment Condition

Certain procedure codes listed in the **Schedule of Benefits** have **Clinical Indications**, conditions of payment, and/or payment indicators attached to them. **Benefits** for these procedure codes are payable only when **Our** medical advisers determine that the relevant **Clinical Indications**, conditions of payment, and payment indicators have been fully satisfied.

Consultant

A Medical Practitioner with the criteria listed in the Practitioner's registration requirements who has been registered with **Us** as a

a. **Consultant** prior to 16 March 2009 and included on the General Division of the Medical Council Register
b. **Consultant** after 16 March 2009 and included on the Specialist Division of the Medical Council Register and in both cases where the Medical Practitioner:

1. holds a public hospital **Consultant** post and is not prevented from engaging in private practice by virtue of their public hospital contract and approved for registration by **Us** in an **Approved Facility**;
2. has been granted practice privileges for a **Consultant** post, and approved for registration by **Us**, in an **Approved Facility**; or
3. is solely providing **Out-Patient** services in private rooms.

CORU

The Republic of Ireland's Health and Social Care Professionals Council and the Registration Boards.

Day Care Procedures

Treatment or investigation shown as Day Care in the **Schedules of Benefits**.

Specified Diagnostic Tests	1. Electrocardiograph (ECG), 2. Electroencephalogram (EEG), 3. Cardiac stress tests, 4. Holter monitor, 5. Cardiac event monitor, and 6. Blood pressure monitor.
Excess	The initial amount **You** pay for treatment or service if **You** claim on **Your** health insurance. There are two types of **Excess** which may apply: **Hospital Excess** A **Hospital Excess** is an amount that **You** have to pay towards a private hospital claim. **The Everyday Medical Expenses Excess** is an amount that is deducted from the eligible amount payable to **You**.
Everyday Medical Expenses	The Medical Expenses listed in **Your Table of Benefits** under the heading **Everyday Medical Expenses.**
Fully Participating Consultant	A **Consultant** who enters into an agreement with **Us** to accept **Our Benefits** in full settlement of their fees.
Health Insurance Acts	The Health Insurance Act 1994 and any associated Regulations.
Health Insurance Contract	A contract of insurance within the definition of the **Health Insurance Acts**.
In-Patient Treatment	**Medically Necessary** treatment received during a stay in a hospital bed of at least 24 hours. This includes: 1. **Semi-private accommodation**; and 2. **Private accommodation**.
Ireland	Means the Republic of Ireland.
Medically Appropriate	Any tests or investigations that are considered **Medically Appropriate** by **Our** medical advisers in accordance with best practice.
Medical Facility	Hospital, day hospital centre, treatment centres or medical diagnostic centres.
Medically Necessary	Any treatment, diagnostic test, service or hospital stay considered necessary by **Our** medical advisers in accordance with standards of medical practice.
Member	**You** and anyone that is named as an insured person on **Your Policy** details.
New Condition	A medical condition where the onset date, as determined by medical advice, is after the date **You** were included under **Your Policy** (or from the **Renewal Date** if the **Policyholder** changes the **Plan**).
Non-Participating Consultant	A **Consultant** who does not enter into an agreement with **Us** to accept **Our Benefits** in full settlement of their fees or charges. Such **Consultant** receives the **Non-Participating Benefit** as set out in the **Schedule of Benefits** for Professional Fees and may charge an additional fee to **Members**.
Out-Patient	**Medically Necessary** treatment which does not involve **In-Patient Treatment, Day Care Procedures** or **Side Room Procedures**.
Out-Patient Procedures	Treatment given to an **Out-Patient** which is listed in the **Schedules**.
Period Of Cover	The period shown in **Your Policy** documents as **Your Period Of Cover**.
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**.

Policy	The contract entered into between **You** and **Us**, which is made up of the following documents: **1.** the **Terms and Conditions,** as applicable; **2.** **Your Table of Benefits**; **3.** Directory of Approved Medical Facilities; **4.** the **Schedules of Benefits**; and **5.** any amendment or variation made from time to time to 1. to 4. above.
Pre-Existing Condition	Any ailment, illness or condition where according to medical advice the signs or symptoms of which existed at any time in the 6 months immediately before **You** became covered under **Your Plan** or before **You** changed **Your Plan**.
Policyholder	The person to whom **We** have issued the **Policy**.
Registered Insurer	Any insurer registered under the **Health Insurance Acts**.
Renewal Date	The date on which **Your Policy** renews a further 12 months unless a shorter time is agreed by **Us**.
Terms and Conditions	'The Company Plans Terms and Conditions' and/or 'Hospital Plan Terms and Conditions', as applicable.
Schedules of Benefits	The Schedules which form part of **Your Policy** are made up of the following and where each of the following is referenced under **Your Policy**, they have the meaning as set out in: **1.** The Schedule of Benefits for Private Hospital Services; **2.** The Schedule of Benefits for Professional Fees; **3.** The Schedule of Benefits for General Practitioners; and **4.** The Schedule of Benefits for Medical Screening.
Table of Benefits	**Your** '**Table of Benefits**' which sets out the **Benefits** which **We** will pay on **Your** chosen **Plan**.
Technical Charges	Charges for the use of: **1.** Operating theatre; **2.** Radiology technical; **3.** Pathology technical; **4.** Radiation oncology technical; **5.** Specified drugs; and **6.** Blood and blood products, which are set out in the **Schedule of Benefits** for Private Hospital Services.
Therapeutic Procedures	An action or administration of therapeutic agents to produce an effect that is intended to alter or stop a pathologic process.
Waiting Period	The period from the start of when **You** became covered by **Us** on a continuous basis, during which **We** will not pay **Benefits**. **We** will only pay **Benefits** when **You** have been insured continuously for a minimum period of time. Please see '**Waiting Periods**' in the General terms below.
We/Us/Our	Vhi Healthcare DAC and Vhi Insurance DAC.

> *So **You** are clear as to who does what:*
> *Vhi Healthcare DAC trading as Vhi Healthcare provides all services relating to the general administration of **Your Policy**, including issuing documents and collecting premiums.*
> *Vhi Insurance DAC trading as Vhi Insurance underwrites **Your Policy** and looks after the administration of claims.*

You/Your	Any adult, including any **Young Adult**, named on **Your Policy** as an insured person.
Young Adult	Any person who is 18 years of age up to and including 25 years of age at the time of joining or at the date of the renewal of their **Policy**.
Visit	Attendance with an approved practitioner.

> *Extended visits or consecutive visits performed on the same day, are considered a single visit.*

General Terms

The following terms apply to all **Benefits** and all claims under **Your Policy**. **You** will find additional terms in the cover sections in which they appear:

Joining Us and Paying Your Premium

Becoming a Member

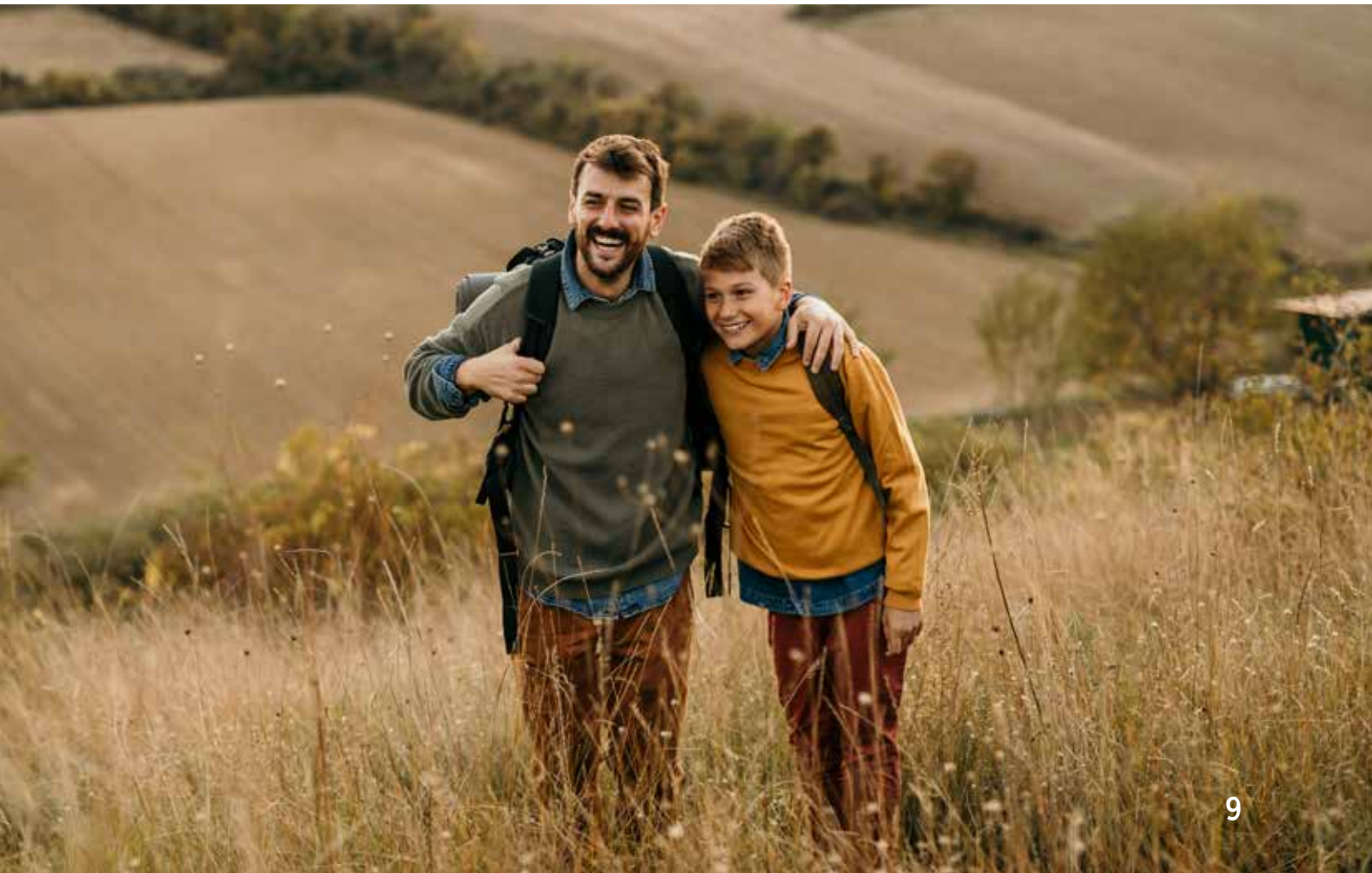
1. **You** can become a **Member** and start a **Policy** with **Us** at any time.
2. Before becoming a **Member**, **You** must provide **Us** with the information **We** reasonably require. All information **You** provide must be true, complete and accurate. **We** may ask for proof of any information **You** give to **Us**. This includes any information provided during the course of **Your Policy**.

Authorised Individuals and Communications

1. **We** will correspond with, and take instructions from, the **Policyholder** in relation to the administration of **Your Policy**. **You** can authorise another to deal with the administration of **Your Policy** on **Your** behalf. If **You** would like to do this contact **Us** for details. This does not apply to claims.
2. **We** will generally communicate with **You** electronically where **You** have provided **Us** with an email address. If **We** don't have **Your** email address **We** will write to **You** at **Your** postal address. **We** may contact **You** via phone, SMS or through **Our** App, in accordance with **Your** preferences.

Irish Residency

Your Policy is intended only for people resident in the Republic of Ireland and is not available to anyone who is not. **We** consider someone to be a resident in the Republic of Ireland if they live here for at least 180 days in each calendar year. The **Policyholder** named on the **Policy** must ensure that everyone covered under **Your Policy** complies with this requirement.



Paying the Premium

1. The premium must be paid when it becomes due for the duration of **Your Policy.** The **Policyholder i**s responsible for ensuring payments are made.
2. If **You** pay by salary deduction, the division of the annual premium into monthly or weekly payments may result in the collection of marginally more or less than the annual premium. This happens because payments are rounded to the nearest cent.
3. If **You** have more than one product and **You** do not pay the full amount, **We** will allocate the amount paid proportionately to each product based on the overall premium due.

> *For example, if **You** have 2 products with **Us** with premiums of €100 and €50 respectively, the total premium will be €150. If **You** only make a payment of €100 (i.e. two-thirds of the amount owed) **We** will treat that payment as if **You** have paid two-thirds of the premium for each product.*

4. **We** will lodge all payments received in **Our** bank account. **We** will send a receipt for all payments. However, this does not mean the payment has been accepted as fulfilment of **Your** contract if the amount received does not match the amount requested or the agreed portion of same. The payment may be returned, if there is no valid contract in place.
5. If **You** do not pay the premium as agreed:
   a. where no claims have been paid, **We** can recover the amount of the health insurance levy plus an administration charge of €50; or
   b. where claims have been paid, **We** can recover the amount of the unpaid premium.

> ***We** will not provide any further insurance to **You** unless all outstanding amounts have been fully paid.*

Complaint Procedure

1. To make a complaint **You** may:
   a. call **Us** on 056 444 4444, Monday to Friday, 8am to 7pm and Saturday from 9am to 3pm;
   b. complete **Our** complaints enquiry form on vhi.ie/contact **us**/help and support/complaints; or
   c. Email **Us** at: info@vhi.ie
2. If **You** are not happy with the outcome of **Your** complaint **You** may refer the matter to The Financial Services and Pensions Ombudsman:

Address:	The Financial Services and Pensions Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, D02 VH29.
Phone:	(01) 567 7000
Fax:	(01) 662 0890
Email:	info@fspo.ie
Website:	www.fspo.ie

The decision of The Financial Services and Pensions Ombudsman is binding on all parties. However, if a party is dissatisfied with the decision they may appeal to the High Court.

If **You** do not wish to use **Our** complaint procedure **You** can refer **Your** dispute directly to the Courts.

Data Analysis

To adjudicate claims, administer **Your Policy**, manage **Our** business, and plan financially, Vhi will use **Your** data (including current and historical claims). This helps **Us** predict and manage costs, analyse trends, set pricing, assess profitability, and conduct modelling and propensity studies. Additionally, **We** need to process **Your** data to comply with regulatory and legislative obligations. **We** strive to use aggregated or anonymous data whenever possible, so **You** won't be identifiable from the data. However, some tasks require processing **Your** data without anonymising it. **We** also perform auditing and quality control to ensure **Our** processes are robust and followed correctly. When processing health-related claims data, **We** do so because it is necessary and proportionate for providing health insurance policies as part of **Our** business.

Data Sharing

We may share **Your** data with trusted third parties who process data on **Our** behalf, both inside and outside the European Economic Area. Vhi collaborates with the following third parties to provide **Your Policy** and comply with legislation:

1. Hospitals and primary care providers
2. Service providers
3. Group schemes
4. Vhi Group companies
5. Other insurers
6. Regulators and government bodies

For more details, please refer to **Our** Data Protection Notice available at vhi.ie.

Waiting Periods

Waiting Periods

1. Some treatments and conditions are subject to a **Waiting Period**. The **Waiting Period** is the period of time from the start of when **You** first became covered by **Us** or another **Registered Insurer** on a continuous basis, during which **We** will not pay **Benefits.**
2. If no **Waiting Period** is specified below, this means there is no **Waiting Period** and **You** are covered from the first day of **Your Period Of Cover**.

> *The **Waiting Period** starts from the date **You** first take out insurance with **Us** or a **Registered Insurer** that provides equivalent cover. This means that if **You** renew **Your Policy** without a gap in cover, the **Waiting Period** does not start again.*

Accidents

There is no **Waiting Period** for treatments required as a direct result of an **Accident** occurring after **You** have been included on **Your Policy**. The following **Waiting Periods** apply to **Your Policy**:

Specific Waiting Periods

Treatment or condition	Waiting Period
New Conditions:	**26 weeks**
Pre-Existing Conditions:	**5 years**
Benefits under the Maternity & fertility programme:	**52 weeks**
Pre-Existing Conditions following an upgrade to **Your Plan** at renewal:	**2 years** (for treatments and conditions covered by the upgrade)
Benefits under the Maternity & fertility programme following an upgrade to **Your Plan** at renewal:	**52 weeks**

Determining Pre-Existing Conditions

Our medical advisers will determine whether a condition is a **Pre-Existing Condition**. Whether the signs or symptoms are consistent with the condition existing before the start of **Your Period of Cover** is what determines whether it is a **Pre-Existing Condition**, not the date when **You** became aware of the condition or the condition is diagnosed.

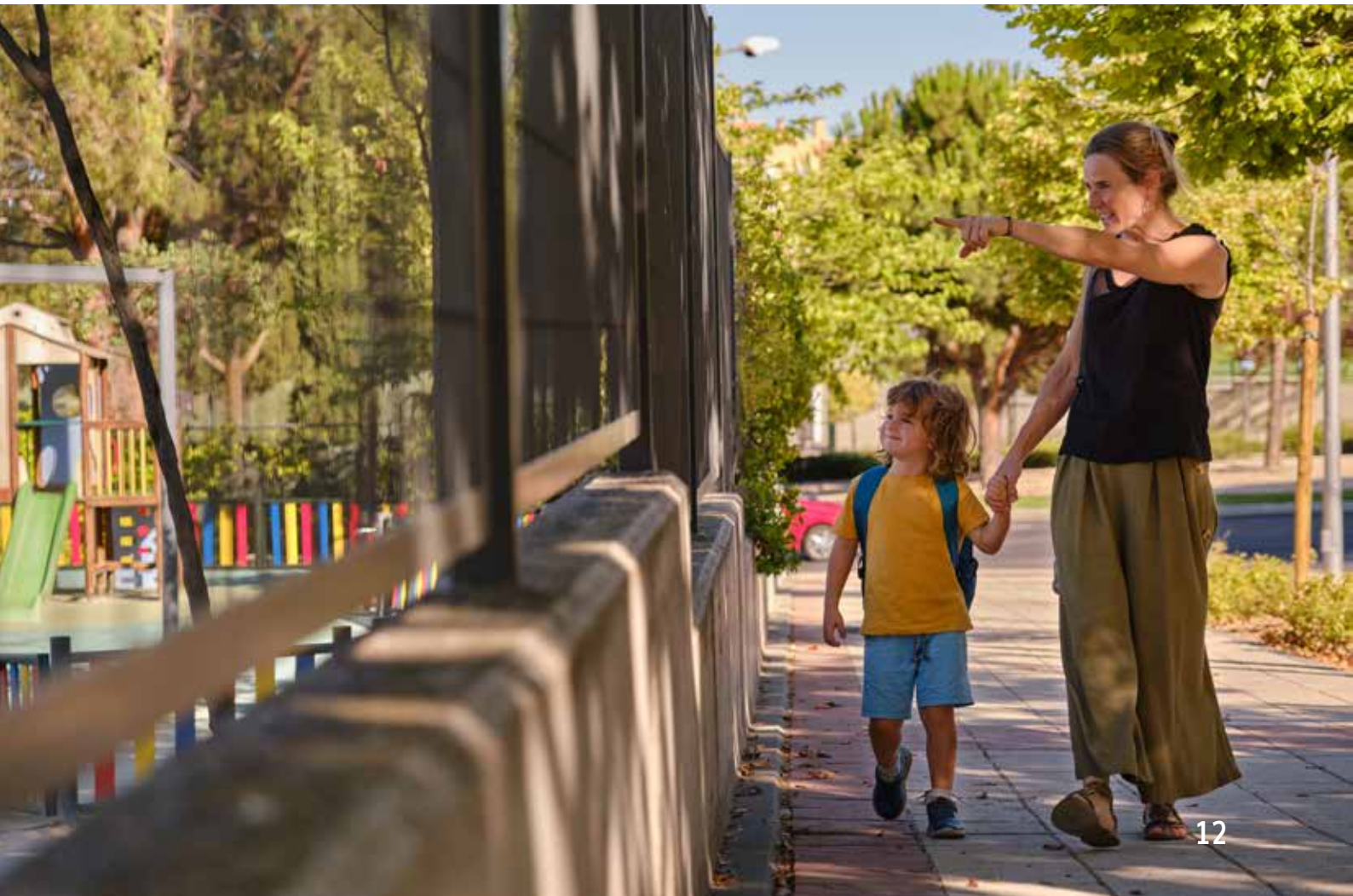
> *If **You** are switching to a **Plan** with lower cover, **You** won't have to serve any **Waiting Periods** (unless **You** are currently serving new customer **Waiting Periods**).*
> *If **You** are switching to a **Plan** with higher cover, **You** will have to serve **Waiting Periods** as outlined under **Specific Waiting Periods** for higher levels of cover.*

Break in Cover

If there is a break in cover for more than 13 weeks (including at renewal), **We** will treat **Your Policy** as a new **Policy**. This means that all of the **Waiting Periods** will start again from the date **Your** new **Policy** starts. If there is a break in cover for 13 weeks or less, the **Waiting Periods** will not start again.

Transfer from Another Insurer

If **You** transfer from a **Health Insurance Contract** with another insurer registered in Ireland under the Health Insurance Act, **Benefits** will only be payable up to the level of cover offered by that contract until the expiry of the **Waiting Periods**.



Practitioner's Registration Requirements

We will make payment for treatments with the following practitioners if they hold the corresponding registrations and qualifications listed below:

Acupuncturist	A practitioner who is a current member of: **1.** the Acupuncture Council of Ireland, **2.** the Acupuncture Foundation Professional Association, **3.** the British Acupuncture Council, or **4.** Professional Register of Traditional Chinese Medicine.
Audiologist	A diagnostic Audiologist registered with the Irish Academy of Audiology or the Irish Society of Hearing Aid Audiologists.
Breast Feeding Consultant	A member of the Association of Lactation Consultants in Ireland, and who holds International Board Certificate Lactation Consultant membership.
Chiropodist/ Podiatrist	A practitioner who is currently a member of: **1.** the British Chiropody & Podiatry Association, **2.** the Institute of Chiropodists & Podiatrists (Rep. of Irl.), **3.** the Irish Chiropodists/ Podiatrists Organisation Ltd., or **4.** Podiatry Ireland.
Chiropractor	A practitioner who is currently a member of either: **1.** the Chiropractic Association of Ireland, or **2.** the McTimoney Chiropractic Association of Ireland.
Consultant	A **Consultant** on the Specialist Division of the Medical Council Register who has been registered with **Us** as a **Consultant**, or a medical practitioner on the General Division of the Medical Council Register.
Counsellor	A practitioner who is currently a member of: **1.** a chartered member of the Psychological Society of Ireland (PSI), **2.** a practitioner registered with the Irish Association of Counselling and Psychotherapy (IACP), **3.** a practitioner registered with the Irish Council of Psychotherapy (ICP), or **4.** a practitioner registered with the Irish Fertility Counsellors Association (IFCA).
Dental Practitioner	A Dental Practitioner with a full current registration with the Irish Dental Council and a primary dental qualification. They must provide community based dental care.
Dietitian	A member of the Irish Nutrition and Dietetic Institute or registered on the Register for Dietitians at **CORU**.
General Practitioner (GP)	A **General 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 the Nursing and Midwifery Board of Ireland (NMBI) register.
Nurse/Practice Nurse	A **Nurse** registered with the Nurse and Midwifery Board of Ireland (NMBI).
Nutritionist	A member of the Irish Nutrition and Dietetic Institute or registered on the Register for Dietitians at **CORU**.
Occupational Therapist	A member of the Association of Occupational Therapists of Ireland or registered on The Occupational Therapists Registration Board at **CORU**.

Optometrist	An Optometrist registered with either the: **1.** Opticians Board, or **2.** Optical Registration Board at **CORU**.
Orthoptist	A member of the Irish Association of Orthoptists or the British Orthoptic Society.
Osteopath	A practitioner who is currently a member of either: **1.** the Osteopathic Council of Ireland, or **2.** the Irish College of Osteopathic Medicine (ICOM).
Psychologist	A chartered member of the Psychological Society of Ireland (PSI).
Physical Therapist	A practitioner who is currently a member of: **1.** the Orthopaedic and Soft Tissue Therapists of Ireland (ROSTI) **2.** the Irish Association of Physical Therapists **3.** the Irish College of Osteopathic Medicine (ICOM) .
Physiotherapist	A member of the Irish Society of Chartered Physiotherapists or registered on the Physiotherapists Registration Board at **CORU**.
Psychotherapist	A practitioner who is currently a member of: **1.** the Psychological Society of Ireland (PSI), **2.** the Irish Association of Counselling and Psychotherapy (IACP), **3.** the Irish Council of Psychotherapy (ICP), or **4.** the Irish Fertility Counsellors Association (IFCA).
Reflexologist	A practitioner who is currently a member of: **1.** the Irish Reflexologists, **2.** the Irish Reflexologists Institute, or **3.** the National Register of Reflexologists.
Speech and Language Therapist	A practitioner who is currently a member of: **1.** the Irish Voice Association, **2.** the Irish Association of Speech and Language Therapists, or **3.** the Register for Speech and Language Therapists at **CORU**.

Making Changes to Your Policy

Adding Members	**You** can add new **Members** to **Your Policy** at any time.
Removing Members	If **You** ask **Us** to remove a **Member** from **Your Policy** at renewal, **We** may contact that **Member** to let them know.
Adding Newborn Children	If **You** add **Your Child** within 13 Weeks of their birth, **We** will: **1.** cover the **Child** from birth, **2.** not apply the **Waiting Periods** set out in '**Waiting Periods**' in the General terms section, and **3.** not charge any additional premium for that **Child** until the first **Renewal Date** after their birth.
Other Changes	Changes to **Your Policy**, including removing **Members** as shown, can only be made at Renewal, other than in exceptional cases. Further information is also available on **Our** website at vhi.ie. Please contact **Us** if **You** do need to make a change at any other time. If **You** make any changes at renewal **You** can revert these changes within 14 days. This 14 days starts either at **Your Renewal Date** or 2 days after the issue date of **Your Policy Documents**.

Additional Charges and Refunds

1. If **You** make a change to **Your Policy**, this may result in an additional premium being payable by **You**, or a part-refund of premium by **Us**. Where **You** are required to pay an additional premium, the change will not be effective unless **You** pay the additional premium in accordance with what has been agreed.
2. If a change to a **Policy** 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.

Waiting Periods

If **You** make a change to **Your Plan**, the **Waiting Periods** will apply from the date of the change in respect of those changes.

Renewal and Cancellation

Automatic Renewal

To ensure **You** remain covered, **Your Policy** will automatically renew at the **Renewal Date**. **We** will not automatically renew **Your Policy** where **You** have breached the terms of **Your Policy**.

If **You** do not want to renew **Your Policy, You** must let **Us** know within **Your** 14-day cooling off period. The 14-day cooling off period begins on the later of:

a) **Your Policy Renewal Date**, or
b) 2 days after **We** issue **Your Policy** documents.

Cancellation by You

When **You** first join **Us**, **You** can cancel **Your Policy** if **You** decide **You** no longer want or need it. **You** must let **Us** know within **Your** 14-day cooling off period. The 14-day cooling off period begins on the later of:

a) **Your Policy** start date, or
b) 2 days after **We** issue **Your Policy** documents.

This means **We** will return the premium to **You** and **You** must repay any **Benefits** paid by **Us** and **You** will not be able to submit claims for expenses incurred during those 14 days.

> *If **You** don't cancel **Your Policy** at renewal within the timeframes above, **You** will not be able to cancel **Your Policy** or make other changes (other than in limited cases) until the following **Renewal Date**.*

Cancellation by Us

Cancellation by Us We can cancel/terminate **Your Policy** at any time if:

1. the premium has not been paid in accordance with what has been agreed, by letting **You** know in writing,
2. **You** make a fraudulent or false/misleading claim, or
3. there has been any other breach of **Your Policy**, by **You** by letting **You** know in writing.

> ***We** will not provide a subsequent health insurance contract to **You** until the losses and expenses incurred have been settled or where no settlement has been made until after the original contract term has passed.*

Group Scheme

Where **You** are a **Member** of a Group Scheme or Corporate Group and they are contributing to the cost of **Your Policy**, **We** may action any request by them to amend, renew or cancel **Your Policy**.

Making a Claim

Some procedures have **Payment Conditions** or **Clinical Indications** which need to be met in order for the procedure to be covered. **Your Consultant** is aware of any criteria associated with **Your** treatment.

Policy Period

If the **Period Of Cover** is less than one year, the limits and **Excess** applied to some **Benefits** will be proportionally reduced based on the **Benefit** limit and **Excess** being based on a **Period Of Cover** of a year.

Proportional Reduction of Limits

$$\text{Amount } \textbf{We} \text{ pay} = \frac{\textbf{Benefit} \text{ limit} \times \textbf{Your} \text{ actual } \textbf{Period Of Cover}}{\textbf{Period Of Cover} \text{ of a year}}$$

Payments

There are two different ways a payment can be made under this **Policy**, either:

1. Direct pay – This is where **We** pay the treatment provider directly; or
2. Pay and claim back – This is where **You** have to pay for the treatment and then claim the amount of any covered **Benefit** from **Us**.

> *Whether or not a particular treatment is covered by a direct pay arrangement will depend on the type of treatment, the level of **Your Policy** and the facility providing the treatment. In most cases the treatment provider will be able to confirm whether a treatment is covered by a direct pay arrangement. If **You** are not sure, **You** can check via MyVhi, the 'Check your Health Cover' feature in the Vhi app or by calling **Us**.*

Other Insurance Cover

If **You**, or anyone else covered by **Your Policy**, are entitled to claim under any other insurance policy for any of the costs, charges or fees, **We** will only pay the amount in **Excess** of the other insurance. **You** must tell **Us** if **You** have other insurance when making a claim. **We** do not allow dual insurance. This means that **You** cannot hold two policies that cover the same expenses with **Us**.

Excess

We will not make any payment unless the **Excess** is exceeded.
Hospital excesses are paid by **You** directly to the hospital. The hospital will then send the remaining bill directly to Vhi.
Everyday Medical Expenses Excess is deducted from the eligible amount **You** claim back from **Us**.
We will not refund the **In-Patient Treatment Excess** amount.
You can find more information on excesses at vhi.ie.

Shortfall in Benefits

A shortfall is the amount of **Your** treatment that is not covered by **Your Policy**. **You** must pay this amount yourself.

Payment Currency

We will pay **Your Benefits** in euro.

Electronic Payments

For payment made by Single Euro Payment Area (SEPA) **You** must provide the accurate and correct bank identifier code (BIC) and international bank account number (IBAN) on **Your** claim form or **Our** Snap and Send system.

> *If the details **You** provide are incorrect and any attempted payment is returned then **We** will send a cheque.*

Information Requests

1. In order to establish eligibility for **Benefits We** may contact the facility and **Your** treating practitioners, including where relevant **Your GP**, to request copies of all necessary information. This includes copies of facility or medical records relating to the treatment or services.

2. By signing the claim form, **You** confirm the details on the form are correct and **You** authorise the doctors and hospital to supply **Us** with information **We** request.
3. If a parent or legal guardian signs the claim form in relation to their **child**, they confirm the details on the form are correct and authorise the doctors and hospital to supply **Us** with the information **We** request.

Prior Approval/ Pre-Certification

1. Some treatments and procedures are only covered where pre-authorised by **Us**. **We** will only give **Our** approval where:
   a. there are specific **Clinical Indications**, or
   b. **We** consider the treatment will result in a positive prognosis, based on medical evidence.
2. If a treatments or procedure needs prior approval by **Us,** this will be shown in the **Schedule of Benefits**, and **We** will have made **Your Consultant** aware of this requirement. To apply for prior approval, **Your Consultant** must submit a request in writing to **Us** for pre-authorisation.
3. Where **We** have given prior approval, the approval is valid for 60 days from the date of issue by **Us**. If the treatment takes place after 60 days, a new prior approval application may be required.

Direct Pay

1. Where **We** have a direct payment arrangement with a hospital, the hospital will send the claim form and invoices directly to **Us. We** will pay the hospital directly for eligible **Benefits** based on the information provided to **Us**. **We** will then let **You** know the details of the **Benefits We** have paid. **We** have direct payment arrangements with most **Approved Facilities**.
2. Where **We** have to pay **Benefits** for doctors' fees directly to the doctor under the Taxes Consolidation Act 1997, **We** will send **You** the details of such payments. If under this Act **We** are still required to pay **Benefits** directly to the doctor, where **You** have also paid the doctor directly **You** will need to ask the doctor for a refund of any amounts **You** have paid.

Determining which Benefits Apply

The **Benefits We** cover will be based on the terms of **Your Policy** on:
1. the first day of **Your** hospital stay; or
2. the date of treatment if **You** are not staying in hospital.

We will not cover any **Benefit** that is not included under **Your Plan**.

Hospital Invoices

Hospital invoices and receipts must be in a format specified by **Us**. If they are not, **We** may be unable to calculate **Your** exact **Benefit** for hospital charges. **We** will calculate the **Benefit** due as best **We** can from the information supplied and pay the amount due directly to the hospital.

Pay and Claim Back

1. Some hospitals do not have a direct payment arrangement with **Us**. **You** must pay these hospitals directly. **We** will pay the eligible **Benefits** for the hospital charges directly to **You** after **You** submit a completed claim form with the paid receipts to **Us**. However, **We** are required by law to pay doctors' fees associated with hospital claims directly to the doctor. **You** can find the claim form and more information on how to claim on vhi.ie/claims.
2. **Our** Snap and Send claiming system can be used to claim **Everyday Medical Expenses**. These must be submitted within a reasonable timeframe. Reasonable timeframe is defined as **Your** current renewal period and **Your** previous two renewal periods, if insured. Claims submitted outside of this timeframe are not eligible for payment. Additional terms and conditions apply to the Snap and Send claiming system. These are available on MyVhi.

Claim Form and Receipts

1. **We** will only pay **Your** claim when **We** receive:
   - **a.** a completed claim form signed by **You**, and
   - **b.** the original paid invoices or receipts, and
2. **We** will only pay **Your child's** claim when **We** receive:
   - **a.** a completed claim form signed by their parent or legal guardian, and
   - **b.** the original paid invoices or receipts.
3. Invoices and receipts will not be returned following assessment of the claim. **You** may wish to retain copies before sending them to **Us**.

Signing on Behalf of a Child

If a parent or legal guardian signs the claim form, they authorise Vhi to correspond with **You** in relation to the claim and to issue any payment directly to **You**. If the **child** turns 18 while the claim is in progress, Vhi will continue to correspond with **You** until the claim is concluded.

Receipts Format

Invoices or receipts must contain:

1. the patient's name;
2. the practitioner's name/registration details;
3. type of treatment;
4. date of treatment; and
5. amount paid.

What We will Pay

We will pay the lower of:

1. the amount **You** are actually charged; or
2. the **Benefits** payable under the **Policy**.

Maximum Payment

For eligible **Benefits We** will pay up to the specified maximum limits which apply to **Your Policy**. These are set out in **Your Table of Benefits**.

Clinical Indications

Some treatments are only covered where there are specific **Clinical Indications**. **We** will only cover these treatments where the **Consultant** has confirmed that the **Clinical Indications** are present. The **Clinical Indications** and other criteria are included in the **Schedule of Benefits**. **We** will have made **Your Consultant** aware of this requirement.

Validation

The details provided on the claim form are used for validation purposes against the details **We** hold. If **You** need to update **Us** or have not provided **Us** with specific details such as **Your** address, phone number, email address or bank account details then please log on to MyVhi to update **Your** details. Alternatively, **You** can contact **Us** on (056) 444 4444.

Governing Law & Acts

Governing Law

Your Policy is governed by the laws of the Republic of Ireland.

European Accessibility Act

In accordance with the European Union (Accessibility Requirements of Products and Services) Regulations 2023, Vhi have set out their compliance in their Accessibility Statement which can be accessed at https//www1.vhi.ie/accessibility.

Changes to Your Circumstances

Changes to Your Circumstances

We ask that **You** notify **Us** immediately of any change in circumstances which are material to **Your Policy** or which could alter the information or assumptions on which **Your Policy** is based. This applies before the start of **Your Policy** and throughout **Your Period Of Cover**.

Third Party Claims

Legal Action and Proceedings

Where **You** require treatment as a result of an injury caused through the fault of another person and **You** propose to pursue a legal claim against that party, **We** will pay **You** the **Benefit** if **You** (or **Your** parent or legal guardian if **You** are under 18):

1. complete the claim form in full and sign the injury section of the claim form. This includes an undertaking to include all **Benefits** paid in any claim against the third party,
2. submit a fully completed undertaking from **Your** solicitor that *"In consideration of Vhi 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 (details of which will be supplied to me by Vhi) and subject to any court order to the contrary, to repay to Vhi – out of the net proceeds of the settlement that comes in to **Our** hands – all monies recovered in respect of such expenses paid by Vhi";*
3. inform **Us** as soon as reasonably possible of any arrangements for settlement discussion or hearing dates,
4. in circumstances where a reduced settlement is anticipated, **You** contact **Us** as soon as **You** know that money paid by **Us** may not be recovered in full, and
5. provide **Us** with documents from **Your** legal representative confirming the amount of the proceeds recovered, if a reduced settlement has been agreed.

An undertaking will not be required from **Your** solicitor and refunds will not be sought if the total eligible **Benefit** payable in respect of an injury does not exceed the threshold amount of €1,000. However, if subsequent claims are submitted in respect of the same incident increasing the total **Benefit** payable to €1,000 or more, an undertaking must be completed.

No Legal Action or Proceedings

Where **You** require treatment as a result of an injury caused through the fault of another person and **You** do not propose to pursue a legal claim against that party and where **Our** legal advisers view is that expenses are recoverable from that party, **We** will pay the **Benefit** if **You**:

a. complete the claim form in full and sign the injury section of the claim form. This includes an undertaking to include all **Benefits** paid in any claim against the third party,

b. immediately notify **Us** in writing if any such claim is started, and

c. if started, submit a fully completed undertaking from **Your** solicitor that "*In consideration of Vhi 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 (details of which will be supplied to me by Vhi) and subject to any court order to the contrary, to repay to Vhi – out of the net proceeds of the settlement that comes in to **Our** hands – all monies recovered in respect of such expenses paid by Vhi*".

Injuries Board

If **You** make an application to the Injuries Board, **We** will pay **Benefits** provided **You** (or **Your** parent or legal guardian if **You** are under 18):

1. complete the claim form in full and sign the injury section of the claim form. This includes an undertaking to include all **Benefits** paid in any claim against the third party,

2. submit a fully completed undertaking from **Your** solicitor that "*In consideration of Vhi 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 (details of which will be supplied to me by Vhi) and subject to any court order to the contrary, to repay to Vhi – out of the net proceeds of the settlement that comes in to **Our** hands – all monies recovered in respect of such expenses paid by Vhi*".

3. authorise **Us** to provide the Injuries Board with details of all money paid by **Us** relating to **Your** application,

4. authorise the Injuries Board to release details to **Us** of the Injuries Board's assessment in relation to the money paid by **Us**, and

5. allow **Us** to commence court proceedings if the Injuries Board decides that the case is more appropriately dealt with by the court, and issue a letter of authorisation if required.

Criminal Injuries Compensation Tribunal Claims

If **You** pursue a claim through the Criminal Injuries Compensation Tribunal, **We** will pay **Benefits** provided **You** (or **Your** parent or legal guardian if **You** are under 18 years old):

1. complete the claim form in full and sign the injury section of the claim form. This includes an undertaking to include all **Benefits** paid in any claim against the third party,

2. provide **Us** with a copy of the written confirmation from the Criminal Injuries Compensation Tribunal,

3. authorise **Us** to seek details of any settlement directly from the Criminal Injuries Compensation Tribunal and

4. authorise the Criminal Injuries Compensation Tribunal to release information regarding the details of any settlement to **Us**.

Unsuccessful Third Party Claims	If a claim against a third party is not successful or is withdrawn, **We** will not seek a refund of the **Benefit** paid, provided **Your** solicitor sends **Us** full written details of the case outlining the reasons why the case was unsuccessful or discontinued to **Our** satisfaction.
Disclosure	**You** must disclose full details of any action to be pursued against a third party to **Us** in relation to an incident or **accident** where **We** have paid **Benefit.** If **You** do not, **We** will not pay any subsequent claims relating to the incident or **accident**.

Fraudulent Claims

Fraudulent Claims	If **You** make, or attempt to make, a fraudulent claim, **We** can 1. terminate **Your Policy** with effect from the date of the fraudulent act; 2. not pay any **Benefits** under **Your Policy** from the date of termination; 3. not return any premiums paid under the insurance contract; and 4. refuse to renew **Your Policy**.
Audits	**We** carry out regular audits of claims and where fraud is suspected, **We** will carry out a full investigation. **We** may refer details of any claim submitted, where **We** suspect fraud, to the authorities to take appropriate action.

General Exclusions

We will not cover any **Benefits** for:

Some Treatments	any treatment that is: 1. not **Medically Necessary**; or 2. not intended to cure or alleviate a medical condition.
Long Term Care	any treatment or hospital stay which in the opinion of **Our** medical advisers is consistent with long term care.
Experimental Treatments	experimental drugs and treatments.
Special Nursing	charges for special nursing in hospital.
Medical Report	charges for a medical report.
Practitioner Services to Relatives	treatments, tests or consultations given by a practitioner to their partner, children, siblings, parents or themselves.
Not Liable for Third Parties	expenses which **You**, or the person covered by **Your Policy**, are not liable for. expenses which **You**, or the person covered by **Your Policy**, are entitled to recover from a third party.
Non-Approved Facilities	treatment in or charges from a hospital or treatment centre which is not an **Approved Facility**. This includes if **You** are receiving treatment in an **Approved Facility**, and **You** are transferred to a hospital or treatment centre which is not an **Approved Facility**.

> *Where **You** receive treatment in an **Approved Facility** and **You** are transferred to another hospital for additional treatments or admission to an ICU, it is **Your** responsibility to check what **Benefits**, if any, are available.*

Non-Eligible Treatment	investigations or treatments related to complications arising from treatment which is not eligible for **Benefit**.
Non-Recommended drugs	drugs which are: **a**. not recommended for reimbursement by the National Centre for Pharmacoeconomics, unless otherwise approved by **Us**; or **b**. unlicensed.
Gender Affirmation	reversal of previous **gender affirmation** surgery.

We will not cover any **Benefits** for any of the following, other than where specifically shown as covered by **Your Policy**:

Ophthalmic Procedures	ophthalmic procedures for correction of short-sightedness, long-sightedness or astigmatism.
Preventative Medicine	vaccinations, routine or preventative medical examinations. This includes screening, bone density scans and check-ups, other than where specifically covered by **Your Plan**.
Hearing and Dental	**a**. hearing aids and cochlear implants; or **b.** dentures, orthodontic treatment or orthodontic appliances (such as braces).
Contraception	contraceptive measures or the reversal of contraceptive measures.
Reproduction	treatments related to artificially assisted reproduction.
Weight Reduction	treatment for weight reduction, other than bariatric surgery procedures specified in **Your Policy**.
Alternative Medicine	alternative medicine or treatments.
Cosmetic Treatment	Cosmetic Treatments. This includes tests, investigations, consultations and treatments of any complications arising from cosmetic treatments. However, **We** will still cover such treatments where required to restore **Your** appearance following an **Accident** or because **You** were severely disfigured at birth.

Hospital Care

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions**:

Approved Hospice
A centre listed in the Directory of Approved Medical Facilities, which is approved for care of the terminally ill.

Day Care Procedures
Treatment or investigation which is **Medically Necessary** and shown as Day Care in the **Schedule of Benefits**.

> *This does not include overnight stays or **Side room procedures**.*

Specified Fixed Price Procedures
Specified Fixed Price Procedures (FPP) **We** use to describe a variety of specified major complex procedures (e.g. cardiac and neurosurgery).

Side Room Procedures
Treatment or investigation for which an extended period of recovery is not required and is shown as side-room in the **Schedule of Benefits** for Professional Fees.

Specified Ophthalmic Procedures
Ophthalmic procedures **We** approve which are carried out in an **Approved Facility**. A list of these procedures is available from **Us** on request.

Specified Orthopaedic Procedures
Orthopaedic procedures **We** approve which are carried out in an **Approved Facility**. Orthopaedic procedures principally concern hip, knee or shoulder replacements. A list of these procedures is available from **Us** on request.

Cover Conditions

These additional Conditions apply to the 'Hospital Care' section.

In-patient, Day Care and Side Room Procedures
For **In-Patient Treatment, Day Care Procedures and Side Room Procedures** **We** will:

1. only cover up to 180 days per person during **Your Period Of Cover** in any calendar year.
2. deduct any day's treatment within the same calendar year that have been paid under any other **Health Insurance Contract**.

✓ Benefit Description We will cover:	? Eligibility Criteria
Day Care Procedures a contribution towards the cost of **Day Care Procedures** carried out in an **Approved Facility**.	**We** will pay the **Benefit** shown in **Your Table of Benefits.** If a **Day Care Procedure** is performed in an **In-Patient** setting, then **We** will only pay **approved Day care** charges.
ℹ *If it is **Medically Necessary** for **You** to be treated as an **In-patient**, **We** will cover **You** under **Semi-private accommodation** or **Private accommodation** below, subject to the terms of **Your Plan**.*	
Side Room Procedures a contribution towards the cost of **Side room Procedures** carried out in an **Approved facility**.	
ℹ *If it is **Medically Necessary** for **You** to be treated as an **In-patient**, **We** will cover **You** under **Semi-private accommodation** or **Private Accommodation** below, subject to the terms of **Your Plan**.*	
Outpatient Procedures a contribution towards the cost of **Out-Patient Procedures** performed in an **Approved Facility**.	**We** will pay the **Benefit** shown in **Your Table of Benefits** towards the cost of professional fees for Outpatient procedures performed in an Outpatient Setting.
Semi-Private accommodation a contribution towards the cost of **In-Patient Treatment** in an **Approved Facility** in **Semi-private accommodation.**	If **You** use **accommodation** (including ICU) that needs a higher level of cover than **You** have, **We** will only cover the amount shown in **Your Table of Benefits.** This includes: **1.** transfers to hospitals; and **2.** transfers to ICUs in hospitals that require 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**.
ℹ *The availability of **Private accommodation** or **Semi-private accommodation** is determined by the facility, and not **Us**. Some facilities may only have one type of **Accommodation**. If this is the case, **You** may be required to pay any shortfall if the **Accommodation** provided is a higher level than is covered by **Your Plan**.*	
Private accommodation a contribution towards the cost of **In-Patient Treatment** in an **Approved Facility** in **Private accommodation**.	If **You** use **Accommodation** (including ICU) that needs a higher level of cover than **You** have, **We** will only cover the amount shown in **Your Table of Benefits**. This includes: **1.** transfers to hospitals; and **2.** transfers to ICUs in hospitals that require a higher level of cover than **You** have.
ℹ *The availability of **Private accommodation** or **Semi-private accommodation** is determined by the facility, and not **Us**. Some facilities may only have one type of **Accommodation**. If this is the case, **You** may be required to pay any shortfall if the **Accommodation** provided is a higher level than is covered by **Your Plan**.*	

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Professional Fees a contribution towards the fees paid to **Consultants** or **GPs** for carrying out treatments which are: 1. **Medically Necessary**; 2. covered by the **Schedule of Benefits**; and 3. carried out in an **Approved Facility**.	If the **Consultant** or **GP** giving the treatment is **Non-Participating** with Vhi, **We** will pay the **Non-Participating Benefit** set out in the **Schedule of Benefits**. This applies even if the treatment is given in an emergency. **You** will need to pay any shortfall.
ℹ *If **Your** treatment is not covered by **Your Plan** or is carried out in a facility not covered by Your Plan, the Professional Fee is not eligible for **Benefit**. However, a Professional Fee **Benefit** is payable for **Out-Patient Procedures** performed in a practitioner's own rooms with the exception of Out-patient radiotherapy as set out in the **Schedule of Benefits**.*	
★ **Breast Reduction** a contribution towards the cost of breast reduction treatment.	**We** will pay the costs if: 1. **Your Consultant** obtains **Our** prior approval on **Your** behalf, and 2. **You** satisfy the criteria as set out in the **Schedule of Benefits**.
ℹ *Your Consultant will be able to advise **You** as to what criteria apply.*	
Transport Costs a contribution towards the cost of an ambulance or intermediary ambulance where **Medically Necessary**.	1. **We** will cover such costs where: a. a doctor certifies it is **Medically Necessary** because **You** are seriously ill or disabled; b. the ambulance or intermediary ambulance company is approved by **Us**; and c. **You** are an **In-Patient** and it is used to transfer **You**: i. between hospitals listed in the approved list of Medical Facilities where at least one of the hospitals is an **Approved Facility**; ii. from an **Approved Facility** to another **Approved Facility** which is a scan centre, or a convalescent home for a stay approved by **Us**. iii. from an **Approved Facility** to an **Approved Hospice**; or iv. from an **Approved Facility** to **Your** home for end-of-life care; and d. a **Benefit** is payable under this **Policy** for treatment received by **You** in the **Approved Facility** to or from which the ambulance or intermediary ambulance has transported **You**;

✓ Benefit description We will cover:	? Eligibility Criteria
	2. Payment of the cost of an ambulance or intermediary ambulance does not mean **You** are covered for other costs relating to a claim. 3. If the doctor determines that a taxi is the most appropriate level of transport required, **We** will pay the **Benefit** directly to the hospital **You** were transferred from.
Return Home Benefit a contribution towards travel costs incurred by **You** on **Your** discharge from hospital to **Your** home following a **Medically Necessary** stay in hospital of at least 5 days which is eligible for **Benefit**.	1. **We** will provide cover: a. towards travel costs for public transport, taxi, hackney and car parking costs; and b. for claims accompanied by dated receipts on headed paper. 2. This **Benefit** is subject to a maximum of 3 claims per calendar year.
Dental Procedures a contribution towards the cost of: 1. dental procedures which are classified as a **Day Care Procedure** or a **Side room procedure** as outlined in the **Schedule of Benefits** and noted as required precertification; and 2. non-cosmetic osseointegrated mandibular implants.	1. **We** will cover the costs of treatment where: a. **Your Dental Practitioner** has sent a pre-certification form and radiological evidence to **Our** claims department for assessment by **Our** dental advisors; and b. the treatment is authorised by **Our** dental advisors before being performed. 2. The Professional fee **Benefit** is payable for non-cosmetic osseointegrated mandibular implants where the criteria set out in the **Schedule of Benefits** are satisfied in full. 3. In addition, a grant-in-aid of €532.29 is payable towards the cost of components for each implant. 4. **We** will not pay for treatment related to functional disorders of the chewing system, including **Out-Patient** consultations, unless listed in the **Schedule of Benefits** for Professional Fees and treatments listed under **Everyday Medical Expenses**.

i *If it is **medically necessary** for your **child** (up to age 18) to undergo routine dental treatment under General Anaesthetic in an **Approved Facility, We** will:*

- *Cover the hospital stay, subject to prior approval, up to the level of cover outlined in the **Table of Benefits** on **Your Child's Plan**.*
- *Provide a contribution towards the Anaesthetist's fees.*

*Please note: **We** do not cover the dentist's Professional Fees for this treatment.*

✓ Benefit Description We will cover:	? Eligibility Criteria
Gender affirmation surgery a contribution towards the cost of **gender affirmation** surgery.	**We** will cover costs where: 1. **We** have given **Our** prior approval, 2. **You** are aged 18 or over, and 3. Specific criteria are satisfied in full. Please contact **Us** for details of these criteria.
Radiotherapy and Chemotherapy a contribution towards the cost of radiotherapy and chemotherapy: 1. **In-Patient Treatment;** 2. **Day Care Procedures;** 3. **Side Room Procedures;** and 4. **Out-Patient Procedures** carried out on an **Out-Patient** basis, required during the **Period Of Cover**.	1. **We** will deduct any days' treatment within the same calendar year that have been paid under any other **Health Insurance Contract**. 2. **We** will not cover **Out-Patient radiotherapy** treatment, in a hospital that is not an **Approved Facility**. 3. For **Out-Patient procedures** in a hospital that is not an **Approved Facility**, **We** will: a. pay professional fees which are covered elsewhere by **Your Policy**; and b. not pay any hospital charges.
Convalescent Care a contribution towards **Your convalescent care accommodation** charges.	**We** will cover the **Benefit** of **convalescent care** where: 1. a **Consultant** and **Our** medical advisers agree that it is **Medically Necessary**; 2. the care immediately follows a stay in hospital which is eligible for **Benefit** under **Your Policy**, even if the hospital is not covered by **Your Plan**; and 3. **You** stay in a Convalescent Home currently registered and approved by the Health Information and Quality Authority (HIQA) in line with the Health Act 2007. Details can be found at www.hiqa.ie/find-a-centre. Please refer to vhi.ie/claims for further details on how to claim.

✓ Benefit description **We will cover:**	? Eligibility Criteria
Vhi Hospital@Home the agreed charges of care at home for **Acute** conditions of the same type and level as would have been provided in a hospital. This includes emergency back-up care.	**We** will provide this **Benefit** if: 1. treatment in a hospital would have been required, 2. specified requirements of **Vhi Hospital@ Home** are satisfied, including age eligibility, 3. the medical condition is an eligible medical condition, and 4. the referral is from: a. a **GP** relating to a **Member** in their own home or a Nursing Home in the Greater Dublin area or within 30km radius of Galway City, or b. a **Consultant** attached to a hospital which is an **Approved Facility** for **Benefit**, by one of the following routes: i. **Accident** and Emergency Department, ii. hospital In-patient ward, or iii. **Consultants'** rooms. Please refer to vhi.ie or contact **Us** for up-to-date conditions. Please contact **Us** if **You** have a question regarding whether a condition is eligible for this **Benefit**.
Specified Fixed Price Procedures - Cardiac a contribution towards the cost of **cardiac level 1 and level 2 Specified Fixed Price Procedures** carried out in an **Approved Facility**.	The level of **Benefit** payable will depend on: 1. the type of the Fixed Price Procedure; and 2. the level of cover under **Your Plan.**
i *Some procedures when carried out in other hospitals are not called **Fixed Price Procedures**. If this is the case, **We** will pay the **Benefit** associated with **Your** level of cover for that hospital as set out in **Your Table of Benefits**. These will not be treated as **Fixed Price Procedures**. If **You** are in any doubt, **We** recommend that **You** contact **Us** before admission.*	
Specified Fixed Price Procedures - Non-Cardiac a contribution towards the cost of a **non-cardiac Specified Fixed Price Procedures** carried out in an **Approved Facility**.	The level of **Benefit** payable will depend on: 1. the type of the Fixed Price Procedure; and 2. the level of cover under **Your Plan**.
i *Some procedures when carried out in other hospitals are not called **Fixed Price Procedures**. If this is the case, **We** will pay the **Benefit** associated with **Your** level of cover for that hospital as set out in **Your Table of Benefits**. These will not be treated as **Fixed Price Procedures**. If **You** are in any doubt, **We** recommend that **You** contact **Us** before admission.*	

✓ Benefit Description We will cover:	? Eligibility Criteria
Specified Orthopaedic Procedures a contribution towards the cost of **Specified Orthopaedic Procedures** for: 1. **Day Care Procedures**; and 2. **In-Patient Treatment**.	**We** will provide this **Benefit** for procedures carried out in hospitals which are designated private hospitals.

i *In some hospitals certain **Specified Orthopaedic Procedures** may be carried out as **Specified Fixed Price Procedures**. If this is the case, **We** will pay the Benefit outlined under **Specified Orthopaedic FPPs**, if included in **Your Table of Benefits**. If **You** are in any doubt, **We** recommend that **You** contact **Us** before admission.*

Specified Ophthalmic Procedures a contribution towards the cost of **Specified Ophthalmic Procedures** for: 1. **Day Care Procedures**; and 2. **In-Patient Treatment**.	**We** will provide this **Benefit** for procedures carried out in hospitals which are designated private hospitals.

i *In some hospitals certain **Specified Ophthalmic Procedures** may be carried out as **Specified Fixed Price Procedures**. If this is the case, **We** will pay the **Benefit** outlined under **Specified Ophthalmic FPPs**, if included in **Your Table of Benefits**. If **You** are in any doubt, **We** recommend that **You** contact **Us** before admission.*

Mental Health & Wellbeing

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions**:

Approved Day Care Programme	Mental health day-treatment programmes which are **Day Care Procedures**. provided by: **1.** St. John of God Hospital, Stillorgan, **2.** St. Patrick's Hospital, Dublin, **3.** Lois Bridges, Dublin, **4.** The National Eating Disorder Recovery Centre, Dublin, or **5.** Hampstead Hospital, Dublin.
Day Care Procedures	Treatment or investigation which is **Medically Necessary** and received during a stay in hospital in a Day Care bed for an approved mental health Day Care programme or which is shown as Day Care in the **Schedule of Benefits**.
Pathological Addiction **Substance Abuse and Addiction**	An addiction to gambling, gaming, sex or pornography. An addiction to alcohol, drugs or other substances.

✓ Benefit Description We will cover:	? Eligibility Criteria
Mental Health Treatment (excluding Substance Abuse and Addiction services) the cost of: 1. **In-Patient Treatment** for mental health at a hospital which is an **Approved Facility;** and 2. an **Approved Day Care programme.**	1. **We** will cover costs of **In-Patient Treatment** for mental health, including **Pathological Addiction**, up to the number of days listed in **Your Table of Benefits** per person in a calendar year. 2. **We** will not cover the treatment of **Substance Abuse and Addiction** under this **Benefit**. 3. **We** will deduct in-patient days' treatment within the same calendar year that have been paid under any other **Health Insurance Contract**.
Mental Health Treatment (Substance Abuse and Addiction services only) the cost of treatment for **Substance Abuse and Addiction** in a hospital which is an **Approved Facility.**	1. **We** will cover costs of **In-Patient Treatment** for **Substance Abuse and Addiction** for up to 91 days in total per person in any five year period. This is calculated as the five years immediately before the discharge date of any such claim. 2. **We** will deduct **In-Patient** days' treatment within the previous five year period that have been paid under any other **Health Insurance Contract.**
Mental Health Assessment a contribution towards the cost of an **Out-Patient** Mental health assessment at an **Approved Out-Patient Mental Health Centre**.	**We** will cover the **Benefit** for one Mental health assessment in a 24-month period, starting from the date that the assessment is first carried out.
Mental Health Therapy a contribution towards the cost of **Out-Patient** Mental health Therapy at an **Approved Out-Patient Mental Health Centre**.	**We** will not apply visit limits when the **Out-Patient** Mental health Therapy is provided by a **Consultant Psychiatrist**.
Meditation App a contribution towards the annual subscription costs of specified meditation app.	1. **We** will provide this **Benefit** for meditation apps that **We** approve. Further details can be found at vhi.ie/emotional-wellbeing. 2. **We** will pay this **Benefit** against one app, once per renewal year.
Employee Assistance Programme a contribution towards the cost of Structured Telephone Counselling or Face-to-Face Counselling as part of the Employee Assistance Programme.	**We** will pay this **Benefit** when it is carried out by an Employee Assistance Programme Counsellor.

Maternity & Baby

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

(Some **Benefits** in this section may be under other sections in **Your Table of Benefits** depending on the **Plan You** hold).

Cover Conditions

These additional Conditions apply to this cover section.

Twins and Multiple Pregnancies	Twins or multiple children will be treated as one pregnancy for the purposes of this cover section.

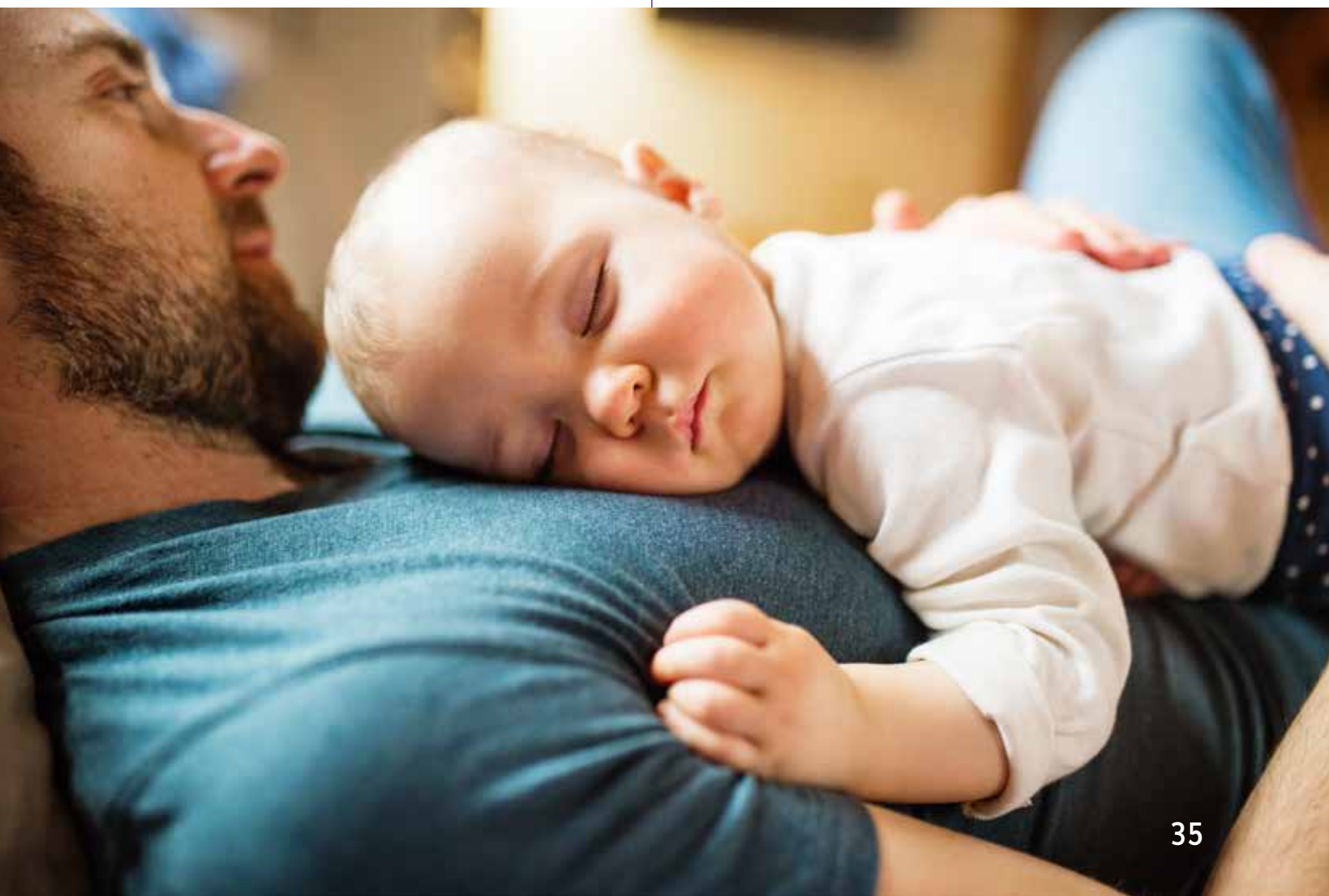
✓ Benefit Description **We will cover:**	? Eligibility Criteria
Public hospital Benefit – Private and Semi-Private accommodation the cost of hospital charges: 1. for normal confinement in **Private accommodation** and **Semi-private accommodation**; and 2. incurred as a result of significant medical complications arising from the pregnancy or delivery, and which necessitates a stay in hospital.	1. **We** will cover charges for an **Approved Facility**. 2. **We** will pay the **Benefit** in **Your Table of Benefits** for normal confinement. 3. **We** will pay the **Benefit** in the Hospital Care Section of **Your Table of Benefits** following medical complications.
Public Hospital Benefit – In-Patient maternity Consultant fees' a contribution towards the cost of **Consultant's** delivery fees where **You** receive **In-Patient Treatment** as listed in the **Schedule of Benefits** for Professional Fees.	1. **We** will cover a **Benefit** where: a. where **Your Consultant** personally delivers **Your** baby; b. where the delivery takes place in a hospital listed in the Directory of Approved Medical Facilities; and c. where the **Consultant** is a **Fully Participating Consultant**; and 2. The amount **We** pay will be higher for Caesarean deliveries.
Home Births a contribution towards medical expenses for: 1. Home Births; and 2. home nursing by a **Nurse**.	**We** will pay towards medical expenses incurred with a practitioner who: 1. is registered on the midwives division of the Nursing and Midwifery Board of Ireland (NMBI), and 2. has medical indemnity insurance. Please refer to vhi.ie/claims for further details on how to claim.

i *It is **Your** responsibility to ensure that the **Midwife** is registered and has medical indemnity insurance.*

✓ Benefit Description We will cover:	? Eligibility Criteria
Post-natal Home Nursing a contribution towards the charges for Home Nursing by a **Nurse** following a 1 night or 2 night stay in hospital.	1. **We** will cover **Benefit** for charges incurred in the 3 days after hospital delivery of **Your** baby. 2. The amount shown in **Your Table of Benefits** includes any amounts paid under this cover for hospital charges.
Maternity Yoga and Pilates Classes a contribution towards the cost of **Maternity** Yoga or Maternity Pilates Classes.	**We** will provide this **Benefit** for the insured **Member** attending the classes.
Antenatal Course a contribution towards the cost of an Antenatal Course.	**We** will pay towards costs incurred: **1.** for courses given by a **Midwife**; and **2.** incurred by the adult **Member** using the service.
Breast Feeding Consultation a contribution towards the cost of a **Breast Feeding Consultant**.	**We** will pay towards costs incurred: 1. where **You** have a dated receipt on headed paper; and 2. by the adult **Member** using the service.
Baby Massage Classes a contribution towards the cost of Baby Massage Classes.	**We** will pay towards costs incurred: 1. for courses carried out by a member of the International Association of Infant Massage; 2. up to 1 year after the birth of the **Child**; and 3. by the insured adult **Member** using the service.
Baby Swim Classes a contribution towards the cost of Baby Swim Classes for **Your** insured **Child**.	1. **We** will provide this **Benefit** up to 1 year after the birth of the **Child**. 2. **We** will pay this **Benefit** once for each insured **Child**.
Maternity Scan a contribution towards the cost of a Maternity Scan at any stage of pregnancy.	**1.** **We** will pay the **Benefit** if **You** are pregnant and the scan is carried out by a **GP**, **Consultant** Obstetrician or sonographer. **2.** **We** will pay for the number of scans listed in **Your Table of Benefits** per year.
Vaccinations for Meningitis B and Chicken Pox a contribution towards the cost of Meningitis B and Chicken Pox vaccinations for **Your Child** or children.	**We** will cover the **Benefit** for vaccinations administered by a: **1.** **GP**, **2.** **Consultant**, or **3.** **Nurse.**
Child Home Nursing a contribution towards the cost of nursing care at home for **Your** insured **Child** if they need **Medically Necessary** care at home following a hospital stay of more than 5 days.	**We** will pay **Benefit** for care where: 1. recommended by a **GP** or **Consultant**, 2. commenced within 2 weeks of the **child's** discharge from hospital, 3. completed within 6 weeks of the **child's** discharge from hospital, and 4. given by a **Nurse**. Please refer to vhi.ie/claims for further details on how to claim.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Parent Accompanying Child a contribution towards **Your** costs for: **1.** accommodation; and **2.** travel, when accompanying **Your Child** in respect of **Medically Necessary** treatment in Ireland which is eligible for **Benefit** and where **Your Child** is insured with **Us**.	**1.** **We** will cover the **Benefit**: a. where **Your Child's** hospital stay exceeds 3 days, b. where **You** are the parent or guardian of the **Child**, and c. where **You** have a dated receipt on headed paper. (This does not apply to costs for electric vehicle charging.) **2.** **We** will pay the **Benefit** shown in **Your Table of Benefits**, starting from the date of admission, subject to the following: a. accommodation costs are limited to hotel, hostel, hospital and B&B accommodation, and b. travel costs are limited to public transport, taxi, hackney, petrol or diesel, electric vehicle charging costs and car parking costs. **3.** For electric vehicle charging costs, **We** will calculate the **Benefit** payable based on a set rate per kilometre as determined by Us and the total distance travelled by **You** for treatment. The distance allowed for travel will be determined using the fastest route on AA Route Planner. The current rate payable is available at vhi.ie. For Hybrid Vehicles, **You** may claim under the electric vehicle charging **Benefit** or the petrol/diesel Benefit once per treatment. **4.** Please refer to vhi.ie/claims for further details on how to claim.
Post-natal home help a contribution towards the cost of domestic help following the birth of **Your Child.**	**We** will pay towards costs incurred: **1.** within 6 weeks of the birth; **2.** by the adult **Member** using the service; and **3.** if the home help provided is accredited or reputable.

✓ Benefit Description We will cover:	? Eligibility Criteria
Foetal screening the cost of chorionic villus sampling, amniocentesis and cordocentesis. This **Benefit** is also claimable for non-invasive prenatal testing (foetal DNA).	**We** will cover the **Benefit** if You are pregnant and administered by: 1. **GP**; 2. **Consultant**; or 3. **Sonographer.**
i *__We__ will pay __Benefit__ in accordance with the level of cover under Hospital Cover for chorionic villus sampling, amniocentesis and cordocentesis where there is a high risk of specified foetal abnormalities and where specific conditions outlined in the __Schedule of Benefits for Professional Fees__ have been satisfied.*	
Paediatric First Aid Course a contribution towards the cost of **You** doing a paediatric first aid course.	**We** will cover **Benefit**: 1. where the course is provided by the Irish Red Cross (www.redcross.ie); and 2. where **You** are over 18 years old.
New Parents Food Pack a contribution towards the cost of a nutritional food pack if **You** are a new parent.	1. **We** will provide this **Benefit** up to 1 year after the birth of the **Child**. 2. to access this **Benefit** contact **Us** to register **Your** new **Child** on **Your Policy** and **We** will provide **You** with a voucher code.



Vhi Fertility Programme

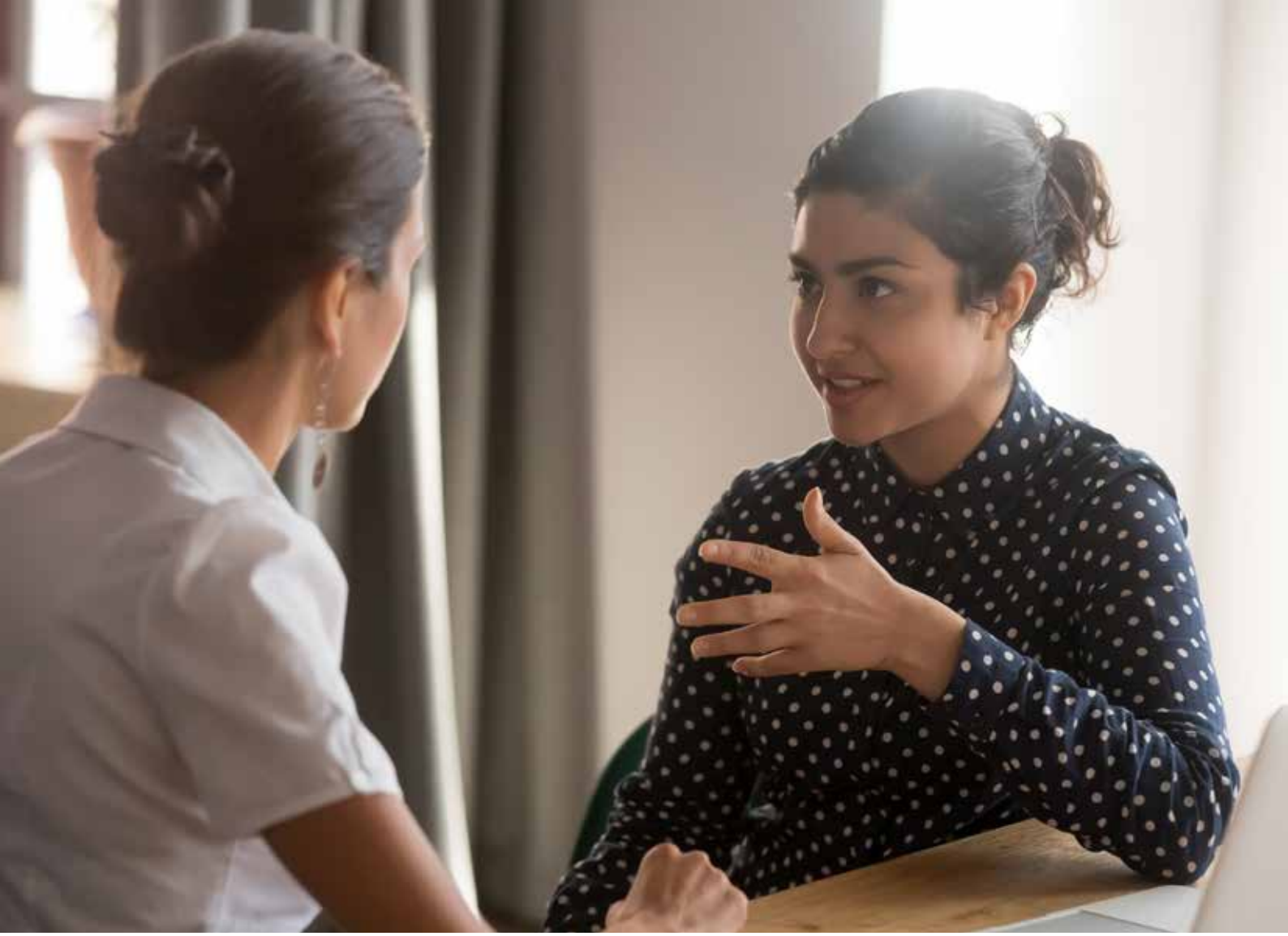
We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions**:

Fertility Programme Counsellor A counsellor who has an agreement with a Vhi Approved Fertility Treatment Centre to provide counselling services.

✓ Benefit Description We will cover:	? Eligibility Criteria
Fertility initial consultation a contribution towards the cost of an initial consultation regarding **Your** fertility.	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities.
Fertility Tests a contribution towards the cost of Fertility Tests for the insured **Member**.	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities. The Fertility Tests which are available may vary between centres.
Egg Freezing a contribution towards the cost of Egg Freezing for the insured female **Member.**	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities. No **Benefit** is payable towards storage costs.
Sperm freezing a contribution towards the cost of sperm freezing for the insured male **Member**.	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities. No **Benefit** is payable towards storage costs.
Intrauterine implantation (IUI) a contribution towards the cost of intrauterine implantation (IUI) for the insured female **Member**.	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities.
In-vitro fertilisation (IVF)/ Intracytoplasmic sperm injection (ICSI) a contribution towards the cost of in-vitro fertilisation (IVF) for the insured female **Member** or intracytoplasmic sperm injection (ICSI) for the insured female **Member**.	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities.



✓ Benefit Description **We will cover:**	? Eligibility Criteria
Preimplantation Genetic Testing (PGT) a contribution towards the cost of Preimplantation Genetic Testing (PGT).	1. **We** will cover the **Benefit** towards the cost where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities. 2. **We** will cover the costs of Preimplantation Genetic Testing where **Our** clinical criteria are met.
Frozen Embryo Transfer a contribution towards the cost of Frozen Embryo Transfer for the insured female **Member.**	**We** will cover the **Benefit** where the treatment is carried out in a Vhi Approved Fertility Treatment Centre, as outlined in the Directory of Approved Medical Facilities.
Fertility Counselling a contribution towards the cost of individual or group counselling sessions as part of a fertility programme.	**We** will cover the **Benefit** where the treatment is carried out by a **Fertility Programme Counsellor**.

Cancer Support Benefits

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions**:

Approved Genetic Testing Centre	A centre listed in the approved list of genetic centres shown in the Directory of Approved Medical Facilities, which is approved for the type of testing concerned.
Designated Specialist	**Our** approved doctor or **Consultant** specialising in cancer genetics.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Initial visit for Genetic Testing for Cancer a contribution towards an initial visit with **Our Designated Specialist.**	**We** will pay towards costs of visits: 1. where the referral has been made by a **GP** or **Consultant**; and 2. carried out in an **Approved Genetic Testing Centre.**
Genetic Testing for Cancer a contribution towards the cost of **Your** tests for genetic mutations associated with: 1. hereditary breast-ovarian cancer syndrome; 2. hereditary non-polyposis colorectal cancer (HNPCC), or 3. Lynch Syndrome.	**We** will cover the **Benefit** when: 1. recommended by a **Designated Specialist,** 2. carried out in an **Approved Genetic Testing Centre,** and 3. where **Our** medical criteria are satisfied. **Our** underwriters will not be made aware of genetic data resulting from this **Benefit**.

✓ Benefit Description We will cover:	? Eligibility Criteria
Direct Pay Mammograms a contribution towards the cost of mammograms.	**We** will cover a **Benefit** for cost of mammograms: 1. where the referral was made by a **GP** or **Consultant**; and 2. carried out in **Our** Approved Mammogram Centres.
*For details of cover for other mammograms, please refer to the radiology / X-rays & scans **Benefits** in **Your Table of Benefits,** if applicable.*	
Cancer Care Support – Accommodation, Travel and Parking Costs a contribution towards the costs: 1. for one night's accommodation in a hotel, hostel or bed and breakfast where **You** travel more than 50km; 2. travel by public transport, taxi, hackney or petrol, diesel or electric vehicle charging for **Your** car where **You** travel more than 50km; and 3. car parking costs, incurred as a result of **Out-Patient** chemotherapy or **Out-Patient** radiotherapy treatment or cancer related immunotherapy.	1. **We** will provide a **Benefit**: a. where treatment takes place in an **Approved Facility**, and b. where claims are accompanied by dated receipts on headed paper. This does not apply to costs for electric vehicle charging. 2. For electric vehicle charging costs, **We** will calculate the **Benefit** payable based on a set rate per kilometre as determined by **Us** and the total distance travelled by **You** for treatment. The distance allowed for travel will be determined using the fastest route on AA Route Planner. The current rate payable is available at vhi.ie. For Hybrid Vehicles, **You** may claim under the electric vehicle charging **Benefit** or the petrol/diesel **Benefit** once per treatment. 3. Car parking costs incurred as a result of **Out-Patient** chemotherapy or **Out-Patient** radiotherapy treatment or cancer related immunotherapy. Please refer to vhi.ie/claims for further details on how to claim.
Medical Tattooing (Eyebrow & Areola) for Cancer Patients a contribution towards the cost of Medical Tattooing of eyebrows and areola for cancer patients.	**We** will cover a **Benefit** following or during **Your** cancer treatment. This **Benefit** is also available prior to cancer treatment following oncologist referral.

Medical & Surgical Appliances

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown**.**

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions**:

Approved Medical and Surgical Appliances	A specialised device used to support a particular medical condition, illness or injury.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Vhi Healthcare Approved Medical & Surgical Appliances A contribution towards the cost of **Approved Medical and Surgical Appliances.**	1. For some appliances **We** will cover such costs if **You** provide **Us** with a specific referral letter to confirm the **Approved Medical and Surgical Appliances** are **Medically Necessary.** 2. **Our Approved Medical and Surgical Appliances** may change from time to time. See vhi.ie for the most up-to-date list.

Cardiac Support

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Cardiac Care Programme - Medfit Cardiac Care Programme a contribution towards the cost of a personalised exercise and behavioural programme.	**We** will cover a **Benefit** when carried out at Medfit Proactive Healthcare, Blackrock, Co. Dublin (Medfit.ie), which is aimed at reducing the risk of a heart event.
Cardiac Care Programme - Urgent Cardiac Care Benefit the cost of attending the Mater Private (Heart and Vascular Centre) for the Urgent Cardiac Care Service.	**You** will have access to a specialist Cardiologist, cardiology **Nurse**, cardiac catheterisation laboratory and electrocardiogram (ECG) facilities.
Cardiac Care Programme - Medfit Cardiac Rehabilitation Programme a contribution towards the cost of a personalised exercise and behavioural programme aimed at helping **You** recover from a cardiac event such as heart surgery, stenting or heart attack.	**We** will pay the **Benefit** if: 1. **You** have an **In-Patient Treatment** cardiac admission; and 2. The programme is carried out at Medfit Proactive Healthcare, Blackrock, Co. Dublin (medfit.ie).
Annual Cardiac Review a contribution towards the cost of a **Consultant** Cardiologist visit and **Diagnostic tests** which are: 1. stress test; 2. Electrocardiogram (ECG); 3. holter monitor; 4. blood pressure monitor; or 5. event monitor.	1. **We** will cover a **Benefit** when carried out on an **Out-Patient** basis by a **GP**, **Consultant**, **Nurse** or in a **Approved Facility**. 2. No **Benefit** is payable for shortfalls submitted against any other part of **Your Plan**. 3. Receipts for blood tests are not eligible under this **Benefit**.

Cover Outside Ireland

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

These additional Conditions apply to the 'Cover Outside Ireland' section

Temporary Stay Abroad	**We** will only pay **Benefits** under Cover Outside Ireland for a stay/stays outside of the Republic of Ireland of no more than 180 days in a calendar year.
Recognised Hospitals	**We** may provide **Benefits** in any internationally recognised hospital.
Expenses	**You** can also claim for expenses listed under **Everyday Medical Expenses** in **Your Table of Benefits**, where applicable.
Documentation in English	All documentation must be in English. This includes claim forms, receipts, invoices and medical reports.
Euro	**We** will only pay **You** in euro. The exchange rate will be the market rate from the European Central Bank applicable at the earliest of either the start of **Your** treatment or the date of **Your** admission. Currency Exchange Rates may fluctuate at times and if this results in a shortfall, **You** will be liable for the shortfall.
Vhi Assist	If **You** use Vhi Assist **We** will provide some of **Your** personal details to the international assistance company on a strictly confidential basis. If **You** contact **Us**, the assistance company will be able to access **Your** membership details. The assistance company will provide **Us** with details of **Your** illness or injury. This information will be held on the assistance company's system and it will only be used to provide services and **Benefits** under **Your Policy**.
Contact Us	If **We** are not contacted before **You** receive medical treatment, **You** may not be eligible for **Benefit**.
Continued Medical Treatment	If **You** are repatriated or return home and require continued medical treatment or follow-up treatment in Ireland, the claim for this treatment will be subject to the terms and conditions of **Your Plan**.
Repatriation	**We** may repatriate **You** to Ireland at any time during **Your** overseas trip if **You** have become ill or have an **Accident** and it is agreed with **Your** doctor and **Our** medical advisers. If **You** refuse this assistance, **We** will not pay any further **Benefits** towards **Your** medical care under **Your Policy**.
EHIC	The European Health Insurance Card (the EHIC) allows holders to access health care services when travelling to, or on holiday in a European Union or European Economic Area country. There is no charge for the EHIC card. It is a free public service. Please visit www.ehic.ie to obtain information on applying for this card.
Proceedings against Third Parties	**We** are entitled to bring proceedings in **Your** name against any third party to recover any payment made under this cover for treatment outside of the Republic of Ireland. Any amount recovered will belong to **Us**. **You** must notify **Us** in writing if **You** start any action against any third party following an **Accident** abroad. Please refer to the third party claims section of the terms and conditions for further details.

What is Vhi Assist?

Vhi Assist is **Our** emergency treatment abroad service provided by an international assistance company. 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 Vhi MultiTrip.
Where **You** intend 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.

Vhi may assist You by:

1. providing a direct payment facility in respect of eligible **Benefits** where possible. Please note some overseas doctors or facilities may not accept payment from **Us** by direct settlement. Where this occurs, **You** must pay **Your** bills directly to the overseas doctors or facilities and submit a claim to **Us**.
2. providing a 24 hour emergency telephone service.
3. maintaining regular contact with **Your** overseas doctors.
4. monitoring **Your** ongoing care where necessary, if **You** are hospitalised.
5. making contact with **Your** doctor in Ireland, immediate family and **Your** employer if required.
6. recommending a local hospital, where possible, where **Members** will be able to receive appropriate treatment

If **You** need to make a claim, **You** must:

1. contact Our helpline before receiving any medical treatment on:
   USA and Canada 1800 364 9022 ▪ Rest of the world +353 1 448 2444
2. in the event of an emergency, or where **You** are unable to call, appoint a designated contact to call for **You**.
3. indicate at the outset whether **You** hold separate travel insurance in respect of **Your** trip abroad and provide details of **Your** travel insurance cover.
4. use the file reference number provided to **You** once **You** have made initial contact with **Us** in all subsequent correspondence with **Us** regarding **Your** treatment.

Vhi Assist is for Emergency Treatment Abroad and Repatriation Benefits only.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Emergency Treatment Abroad the cost of emergency treatment per calendar year for **You** as shown in **Your Table of Benefits** in: 1. an **In-patient** setting; 2. **Day Care** setting; or 3. an **Out-Patient** department, in a recognised hospital outside the Republic of Ireland where needed due to an unexpected illness or **Accident** that arises during a temporary stay abroad.	**We** will only cover the **Benefit** shown in **Your Table of Benefits**.

*As **We** do not have direct payment arrangements with overseas hospitals **You** may need to pay directly and then submit receipts and a completed claim form to **Us** to refund **You**.*

__We__ may request a detailed medical report and a "fit-to-fly" certificate from __Your GP__ or __Consultant__.

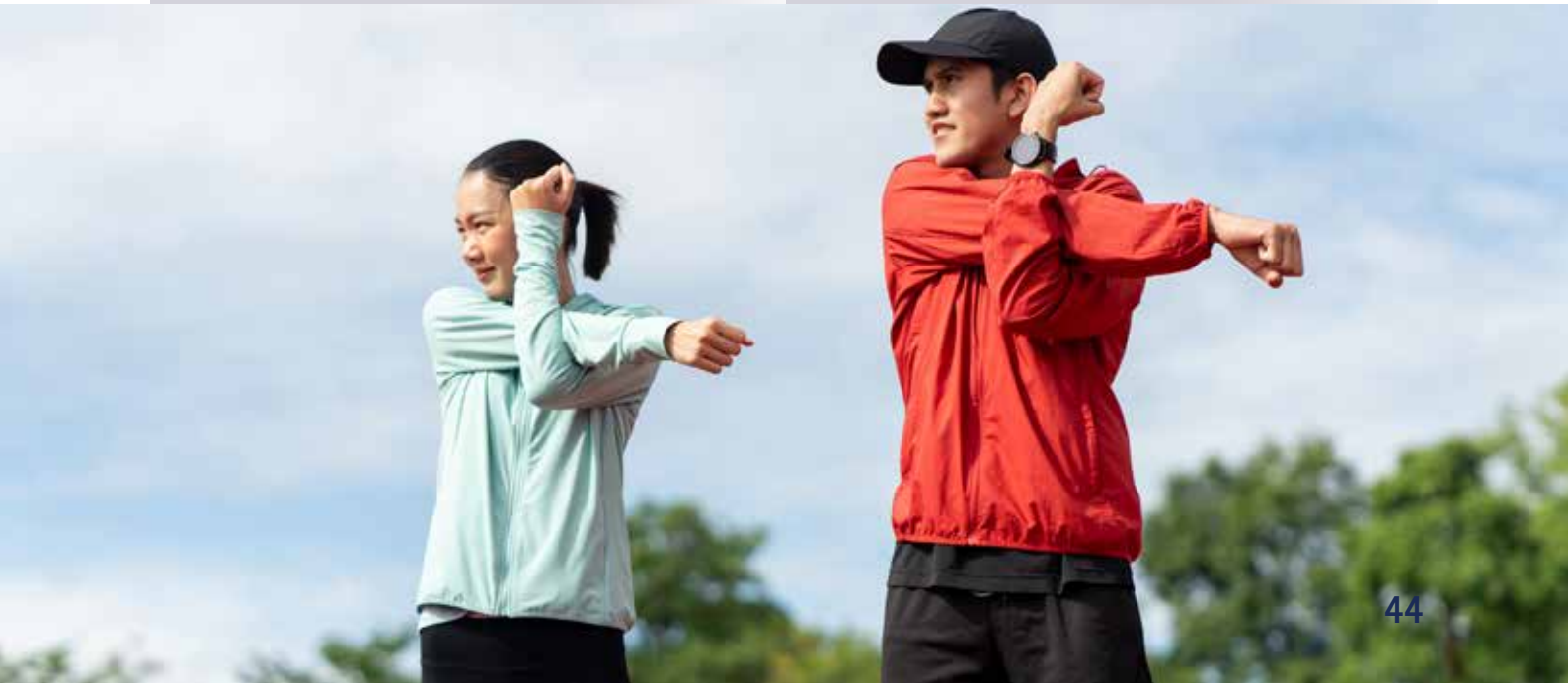
Emergency Treatment Abroad Cover Exclusions

These additional Exclusions apply to the 'Emergency Treatment Abroad' Cover section.

High Risk Activities

We will not cover any **Benefits** for:
Any high-risk activities or dangerous sports, including the following:

- solo mountain climbing
- luge
- boxing, wrestling, karate
- hang-gliding
- micro-lighting
- professional sports
- horse jumping, polo, point-to-point, steeplechasing or horse racing
- off-piste skiing or snowboarding unless accompanied by a qualified guide
- any form of martial arts or unarmed combat
- high diving
- parasailing
- weightlifting
- hunting or shooting
- paraskiing
- white water canoeing
- heli-skiing
- quad biking
- sports competitions
- canyoning
- safari with guns
- motor competitions
- aqua lung diving below 30 metres
- shark feeding or shark cage diving
- bobsleighing
- racing of any kind other than on foot
- skeleton
- yachting outside territorial waters
- mountaineering over 4,000 metres
- ski-jumping, racing, or stunting
- white or black water rafting (grades 5 and 6)
- flying or any aerial activity except travelling as a fare paying passenger on a licensed airline
- solo caving, cave diving or potholing
- any other especially Hazardous pursuits or activity except when organised as a holiday interest where **You** are given tuition by experts employed by the local organiser



Medical Reports	the cost of medical reports.
Clinical Trials	participation in clinical trials or treatment associated with clinical trials.
No Return Ticket	treatment if **You** do not have a return ticket to the Republic of Ireland or if **You** do not intend on returning to the Republic of Ireland.
Routine Maternity	routine maternity or pregnancy related conditions and diagnostics, such as scans, x-rays, blood tests, consultations and delivery which are not specifically covered by **Your Plan**.
Last Trimester	pregnancy related conditions when travelling abroad in **Your** last trimester, unless such cover is specified under **Your Plan**.
Rehabilitation	convalescence or rehabilitation services.
Routine Dental	routine dental treatment.
Travel against Advice	treatment if **You** travel against medical advice.
Substance Accidents	illness or **Accidents** arising from **You** drinking alcohol or taking drugs.
Self-Harm	incidences arising from **You** deliberately injuring yourself.
Negligence	injuries caused by **Your** negligence.
Safety Equipment	injuries where appropriate safety equipment is not used or is misused.
Illegal Activities	injuries **You** receive while **You** are breaking the law.
Do Not Travel Country	**You** travelling to a country which is listed in the Irish Department of Foreign Affairs as a country with a security status of "do not travel". Refer to Website www.dfa.ie for guidance.
War Injury	**You** becoming injured or ill because of war, chemical, biological or nuclear disaster, civil disturbance or terrorism.
Prior Approval	**You** travelling abroad to receive treatment without obtaining **Our** approval before travelling.
Prior Knowledge	**You** travelling abroad with the knowledge **You** may require treatment without obtaining **Our** approval before travelling.
Following Discharge	charges **You** incur following discharge from hospital.
Not Medically Necessary	treatment which is not acutely **Medically Necessary**.
Planned Return	treatment which could reasonably be provided on **Your** planned return to the Republic of Ireland.
Refusal to Follow Advice	**You** refusing to follow advice from the treating doctor or **Our** medical advisers.
Follow-up Treatment	follow-up treatment abroad which is not approved by **Us** before it starts.
Telephone Use	telephone use.
Prescription Costs	prescription or pharmacy costs.
Taxis	use of taxis.
Out-Patient MRI	MRI scans performed on an **Out-Patient** basis unless approved by Vhi Assist.
Terms and Conditions	items listed in the exclusions section of **Your** terms and conditions.

✓ Benefit Description We will cover:	? Eligibility Criteria
Repatriation Cover **Your** repatriation to Ireland at any time during **Your** overseas trip if **You** have become ill or have an **Accident** and it is agreed with **Your** doctor and **Our** medical advisers.	1. **We** will cover costs where: a. **You** require medical assistance at the airport or during **Your** flight; b. **You** are deemed stable and fit to fly by **Your** treating doctor and **Our** medical advisers. This must be supported by a detailed medical report in English by **Your** treating medical doctor or **Consultant**; c. **You** have a medical report from **Your** doctor or **Consultant** in English stating **You** are stable and fit to fly; d. **Your** doctor recommends, and **Our** medical advisers agree that transport back to the Republic of Ireland for further treatment is **Medically Necessary**; e. all arrangements are made through **Us**; and f. repatriation to the Republic of Ireland is directly back from the country where **You** are being treated. 2. **We** will cover transportation costs where **You** use the organised transportation. 3. **We** will cover costs for an air ambulance where the doctor and **Our** medical advisers consider that **Your** accommodation on a commercial flight is not **Medically Appropriate.**
Evacuation to a Medical Facility the cost of **Your**: 1. evacuation to the nearest: a. **Medical Facility**; or b. country where treatment can be administered; or 2. repatriation to the Republic of Ireland if it is nearer.	**We** will pay the costs if the treatment is: 1. not available in the country in which **You** are travelling; and 2. needed because of an emergency.
Companion Benefit costs incurred by **Your** travel companion for additional: 1. travel to accompany **You** during **Your** repatriation; 2. accommodation incurred by **Your** companion whilst **You** are in hospital; and 3. travel to accompany **Your** evacuation to the nearest **Medical Facility** or country.	1. **We** will pay the costs where **Your** companion: a. is travelling with **You**; and b. stays beyond their scheduled return date to the Republic of Ireland as a result of **Your** illness or **Accident**. 2. **We** will pay up to: a. €1,000 for additional travel expenses; b. €1,000 for additional accommodation costs; and c. €500 for evacuation costs.

✓ Benefit Description We will cover:	? Eligibility Criteria
Travelling with Children costs of: 1. **Child** or **children** travelling with **You** to: a. return home; or b. continue to a destination specified by **You**; and 2. one adult to accompany the **Child** or children.	1. **We** will pay the costs where: a. **You** require repatriation; and b. the **Child** or children are under 14 years old. 2. **We** will pay up to a. €1,000 for each **Child**; and b. €1,000 for one adult to accompany the **Child** or children.
Child Hospitalisation the costs of an adult accompanying a **Child** under 14 years while the **Child** is hospitalised.	1. All arrangements must be made by **Us**. 2. **We** will pay up to €500 for one adult to accompany the **Child** or children.
Death the costs of arranging the return of **Your** remains to the Republic of Ireland following **Your** death during a temporary stay abroad.	

Repatriation Cover Exclusions

These additional Conditions apply to the 'Cover outside Ireland' section

We will not cover any **Benefits** for:

Out-Patient	consultations in a **Consultant's** room or **Out-Patient** setting. These may be covered under another **Benefit** subject to applicable **Excess**, limits and terms and conditions.
Substance Accidents	illness or **Accident**s arising from **You** drinking alcohol or taking drugs.
Self-Harm	incidences arising from **You** deliberately injuring yourself.
High Risk Activities	any high-risk activities or dangerous sports, as defined in Emergency Treatment Abroad Cover exclusions.
Negligence	injuries caused by **Your** negligence
Safety Equipment	injuries where appropriate safety equipment is not used or is misused.
Illegal Activities	injuries **You** receive while **You** are breaking the law.
War and Unsafe Conditions	incidences where there is war, civil disturbance or terrorism and **We** do not consider it safe to end **Our** medical repatriation staff into the area where **You** are.
High Risk Country	**You** travelling to a country which is listed in the Irish Department of Foreign Affairs as a country with a security status of "high risk". Refer to Website www.dfa.ie for guidance.
War Injury	**You** becoming injured or ill because of war, chemical, biological or nuclear disaster, civil disturbance or terrorism.
Repatriation to Other Countries	**You** requesting to be repatriated to a country other than the Republic of Ireland.

> i *For PublicPlus Care and PublicPlus Care Day-To-Day only, where **We** agree that it is appropriate the **Benefit** can be used to return **You** if **You** are ill, injured or deceased to a country other than the Republic of Ireland.*

Planned Treatment Abroad	repatriation back to the Republic of Ireland following planned treatment abroad.

Elective Treatment Abroad

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Elective Treatment Abroad - Surgical Procedures Available in Ireland (including Gender Affirmation Surgery) **We** will cover 1. The costs of **Your** planned elective treatment abroad during a temporary stay abroad for **Medically Necessary** surgical treatments or diagnostic procedures listed in **Schedule of Benefits** Professional Fees – Surgery and Procedures 2. The average **Benefit We** would have paid for the same procedure in the Republic of Ireland.	**We** pay the costs where: 1. **You** apply in advance; 2. **Your** Irish based **Consultant** completes the application form; 3. **We** receive the application form at least 20 business days before commencement of **Your** treatment; 4. **You** provide a copy of the referral letter from **Your** Irish Based **Consultant** to **Your** treating **Consultant** detailing the medical urgency of **Your** treatment; 5. **We** have pre-authorised the treatment and given **You** written approval to travel before **You** start travelling; and 6. any specific criteria set by **Us** are satisfied.
Elective Treatment Abroad – Treatment Not Available in Ireland (including Gender Affirmation Surgery) the costs of **Your** planned elective treatment abroad during a temporary stay abroad for: 1. **Medically Necessary** surgical treatments or diagnostic procedures which are not available in Ireland; 2. **Therapeutic Procedures** which are not available in the Republic of Ireland; or 3. **Medically Necessary** hospital admissions for follow-up assessments which are not available in the Republic of Ireland after a **Therapeutic Procedure** where **You** received a **Benefit** in accordance with 2. above.	1. **We** pay the costs where: a. **You** apply in advance; b. **Your** Irish based **Consultant** completes the application form; c. **We** receive the application form at least 20 business days before commencement of **Your** treatment; d. **You** provide a copy of the referral letter from **Your** Irish based **Consultant** to **Your** treating **Consultant** detailing the medical urgency of **Your** treatment; e. **We** have pre-authorised the treatment and given **You** written approval to travel before **You** start travelling; and f. any specific criteria set by **Us** are satisfied. 2. For a **Therapeutic Procedure** that is not available in Ireland **We** will pay up to the maximum limit outlined in **Your Table of Benefits**, per calendar year, as applicable to **Your Plan** at the time of **Your** treatment, unless a reasonable alternative **Therapeutic Procedure** is available here in which case **We** will pay the average **Benefit We** would pay in Ireland for this alternative procedure.

*As **We** do not have direct payment arrangements with overseas hospitals **You** may need to pay them directly and then submit receipts to **Us** so **We** can refund **You**.*

Elective Treatment Abroad Exclusions

These additional Exclusions apply to the 'Elective Treatment Abroad' Cover section.

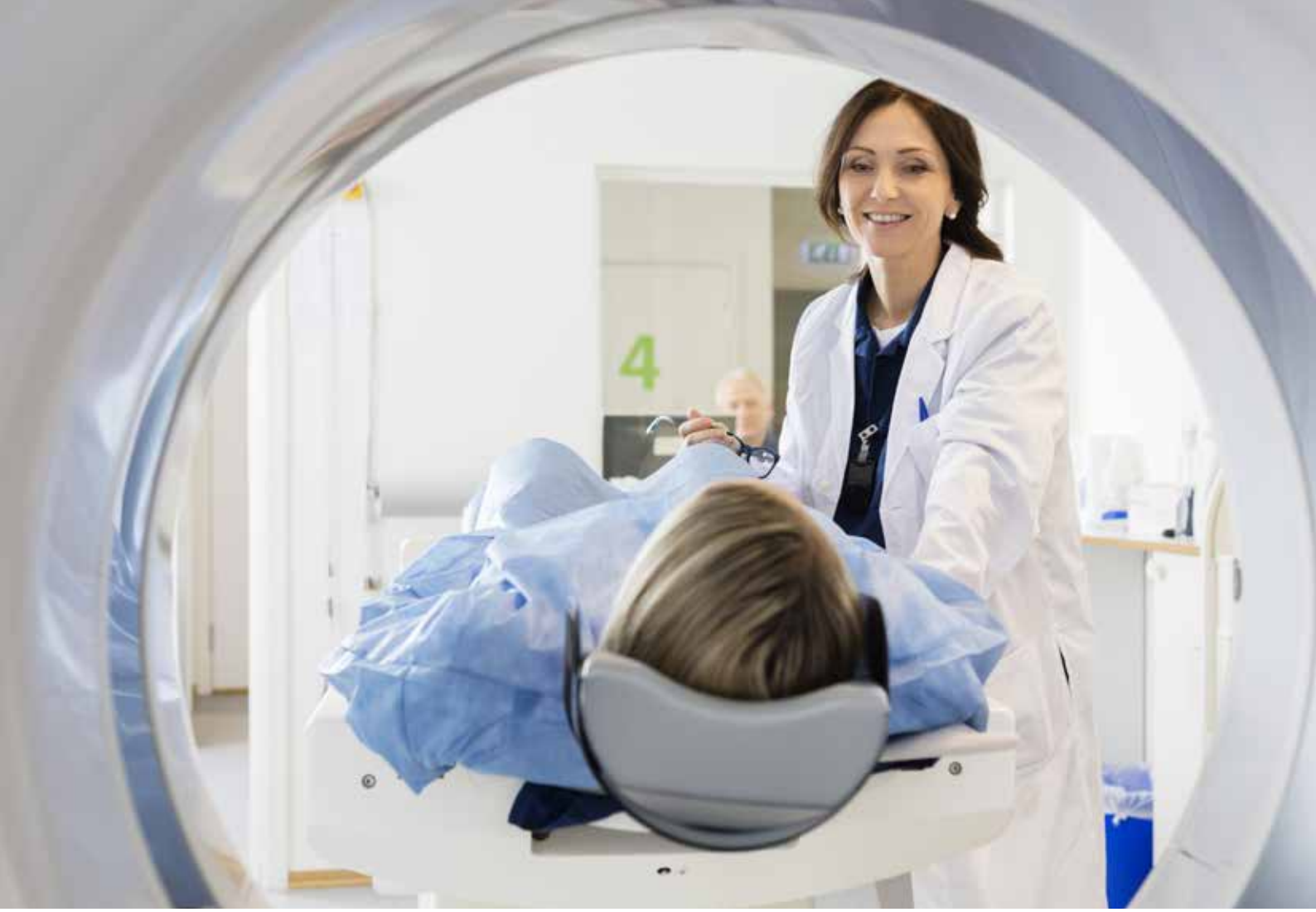
We will not cover any **Benefits** for:

Consultations	consultations in a **Consultant's** room or **Out-Patient** setting. These may be covered under another **Benefit** subject to applicable **Excess**, limits and terms and conditions.
Assessments Investigations and Diagnostic Procedures	assessments, investigations or diagnostic procedures except: a. for **Medically Necessary** surgical treatments or diagnostic procedures listed in Professional Fees, Surgery and Procedures Section of **Your Table of Benefits**, which are available in the Republic of Ireland; b. for **Therapeutic Procedures** which are not available in the Republic of Ireland; or c. for **Medically Necessary** hospital admissions for follow-up assessments which are not available in the Republic of Ireland after a **Therapeutic Procedure** where **You** received **Benefit** in accordance with b above.
Out-Patient	**Medically Necessary** treatment that can be carried out on an **Out-Patient** basis.
Unproven Treatment	new or unproven forms of surgical procedures.
Clinical Trials	participation in clinical trials or treatment associated with clinical trials.
Transplant Waiting List	treatment if **You** are currently on a national waiting list for transplants which are not listed in the **Schedule of Benefits**.
No Return Ticket	treatment if **You** do not have a return ticket to the Republic of Ireland.
Repatriation	repatriation back to the Republic of Ireland following planned treatment abroad.
Planned Treatment EU Rights	treatment payable under the Treatment Abroad Scheme (TAS) (E112) or the EU Directive 2011/24/EU Application of patients' rights in Cross Border Healthcare. Please visit www.eu-patient.eu for further details.
Routine Maternity	routine maternity or pregnancy related conditions and diagnostics, such as scans, x-rays, blood tests, consultations and delivery which are not eligible for **Benefits** which are not specifically covered by **Your Plan**.
Rehabilitation	convalescence or rehabilitation services.
Routine Dental	routine dental treatment.
Mental Health	treatment related to a Mental health condition.
Substance Abuse	treatment for **alcohol or substance abuse** or **pathological gambling**.
Treatment Not in the Schedule	treatment which is available in the Republic of Ireland, but which is not listed in the **Schedule of Benefits**.
Equivalent Treatment Not on Your Plan	treatment which is equivalent to treatment which is available in the Republic of Ireland but not listed under **Your Plan**.
Travel Against Advice	treatment received if **You** travel against medical advice.
Medical Reports	the cost of medical reports.
Travel and Accommodation	travel and accommodation expenses.
Terms & Conditions	items listed in the exclusions section of **Your** terms and conditions.

Diagnostic Scans

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Direct Pay MRI Scan the cost of MRI Scans to investigate or rule out certain medical conditions where, 1. there is a **Clinical Indication**; and 2. **You** are referred to a centre with direct pay arrangements. **We** will pay the centre directly.	1. **We** will cover the **Benefit** for referrals made by: a. **Consultant** or **GP** in the centres listed for **Consultant** or **GP** referrals, or b. **Consultant** to a centre listed for **Consultant** referrals. 2. **We** will cover scans carried out in an **Approved Facility**.
Pay & Claim Back MRI Scan a contribution towards the cost of MRI Scans to investigate or rule out certain medical conditions where: 1. there is a **Clinical Indication**, and 2. **You** are referred to a 'pay and claim back' centre.	1. **We** will cover the **Benefit** for referrals made by a: a. **Consultant** or **GP** in the centres listed for **Consultant** or **GP** referrals; or b. **Consultant** to a centre listed for **Consultant** referrals. 2. **We** will cover the **Benefit** for scans carried out in an **Approved Facility**; 3. **You** must pay the centre and submit a claim to **Us** using the Non-Direct MRI claim form on **Our** Website; and 4. **We** will not pay the amount of the **Excess**.
PET-CT Scans the cost of PET-CT Scans where there is a **Clinical Indication**.	**We** will cover the cost of PET-CT Scans where: 1. **We** have given prior approval 2. the referral was made by a **Consultant**, and 3. carried out in an **Approved Facility**.
ℹ *Your Consultant will be able to advise You as to which Clinical Indications apply.*	
Direct Pay Oncology CT Scans the cost of Oncology-CT Scans where there is a diagnosis of cancer and a **Clinical Indication**.	**We** will provide cover where: 1. the CT Scan is required as part of **Your** oncology treatment or review; 2. **You** are referred for a CT Scan by a **GP** or **Consultant**; and 3. the CT scan is carried out in an **Approved Facility**.
Direct Pay Cardiac CT Scans the cost of Cardiac CT scans.	**We** will provide cover where: 1. **You** are referred for a Cardiac CT scan by a **Consultant**; and 2. the CT scan is carried out in an Approved Cardiac Direct Pay CT Scan Centre listed in the Directory of Outpatient Scan Centres.



✓ Benefit Description **We will cover:**	? Eligibility Criteria
Direct Pay CT Scans **(other than Oncology and cardiac)** the cost of CT Scans.	**1.** **We** will cover the cost of CT Scans: **a.** where the referral was made by a **GP** or **Consultant**; and **b.** carried out in a facility listed in the Directory of **Outpatient** Scan Centres, when carried out for one of the **Clinical Indications** as specified by **Us** to all **Consultants**.
Direct Pay Dexa Scans the cost of Dexa Scans.	**We** will cover the cost of Dexa Scans: **1.** where the referral is made by a **GP** or **Consultant**; and **2.** carried out in an approved Dexa Scan Centre.

*If **You** do not attend a Direct Pay Dexa Scan Centre, please refer to the radiology / X-rays & scans **Benefit** in **Your Table of Benefits**, if applicable.*

Everyday Medical Expenses

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown. (Some **Benefits** in this section may be under other sections in **Your Table of Benefits** depending on the **Plan You** hold).

✓ Benefit Description We will cover:	? Eligibility Criteria
General Practitioner a contribution towards the cost of consultations with a **GP**.	Please refer to Practitioner Registration requirements in the General terms.
Consultant consultations a contribution towards the cost of consultations with a **Consultant**.	**We** will not cover costs for maternity consultations; or **Your child's** first visit to a **Consultant** paediatrician If eligible under another **Benefit**.
Dental Practitioner a contribution towards the cost of **Your** visit to a **Dental Practitioner**.	Please refer to Practitioner Registration Requirements in the General terms.
Practice Nurse a contribution towards the cost of **Your** visit to a **Practice Nurse**.	Please refer to Practitioner Registration Requirements in the General terms.
Physiotherapist a contribution towards the cost of **Your** visit to a **Physiotherapist**.	Please refer to Practitioner Registration Requirements in the General terms.
Travel Vaccination a contribution towards the cost of Travel Vaccinations.	**We** will cover a **Benefit** for Travel Vaccinations administered by a: 1. **GP;** 2. **Consultant;** or 3. **Nurse.**
Hearing Test a contribution towards the cost of a hearing test.	**We** will cover a **Benefit** if the test is carried out by an **Audiologist**.
Hearing Aid a contribution towards the cost of **Your** Hearing Aid.	
Flu Vaccination a contribution towards the cost of **Your** Flu Vaccination.	**We** will cover costs for treatment carried out by a: 1. **GP,** 2. **Consultant,** 3. **Nurse,** or 4. Pharmacist**.**
Prescription Costs a contribution towards the cost of **Your** Prescription.	**We** will cover the **Benefit** of drugs prescribed by a **General Practitioner**, **Consultant** or **Dentist**.

✓ Benefit description **We will cover:**	? Eligibility criteria
Pre- & Post-natal care a contribution towards the cost of pre- & post-natal care incurred by **You**, being the insured pregnant **Member**.	1. **We** will pay towards costs incurred with a: a. **GP,** b. **Consultant,** c. **Sonographer**, or d. **Midwife.** 2. **We** will not pay more than once for each pregnancy.
Paediatrician Benefit a contribution towards the cost of **Your Child's** first visit to a **Consultant** Paediatrician.	**We** will pay towards a visit within 1 year of the birth.
Vasectomy a contribution towards the cost of a vasectomy, including any related consultations pre-procedure and post-procedure.	1. The vasectomy must be carried out by a: a. **GP**, or b. **Consultant**, in their own room. 2. **We** will accept one receipt and it must detail the name and date of the procedure and any related consultation dates.
Intrauterine system (IUS) hormonal coil a contribution towards the cost of an Intrauterine system (IUS) hormonal coil where the coil or system is a: 1. Mirena, 2. Jaydess, or 3. Kyleena.	**We** will cover a **Benefit** for treatment carried out by: 1. **GP;** 2. **Consultant;** or 3. **Nurse.**

✓ Benefit Description We will cover:	? Eligibility Criteria
STI Screening (Sexually Transmitted Infection) a contribution towards the cost of sexually transmitted infection (STI) screening.	**We** will cover the **Benefit** where the screening is carried out by a: 1. **GP,** 2. **Consultant,** or 3. **Nurse,** in their own room.
Neurodiversity Assessment a contribution towards the cost of a neurodiversity assessment for Autism Spectrum Disorder, Developmental Delay, Attention Deficit Hyperactivity Disorder, Developmental Coordination Disorder or Dyspraxia, Learning Disability, Intellectual disability, Speech Delays and Sensory Processing Disorders.	**We** will cover the **Benefit** where the assessment is carried out by a: 1. **GP,** 2. **Consultant,** 3. **Psychologist,** 4. **Speech** and, or 5. **Occupational Therapist.**
Pathology/ Blood – Consultants Fees a contribution towards the cost of Pathology / Blood tests with a **Consultant Pathologist** on an **Out-Patient** basis.	**We** will not cover any maternity or fertility related procedures under this **Benefit**.
Pathology/ Blood Tests – Technical Charges a contribution towards the cost of **Technical Charges** from a blood test with a **Consultant Pathologist** on an **Out-Patient** basis.	1. **We** will cover the **Benefit** for **Technical Charges** if performed at an **Approved Facility**. 2. **We** will not cover any maternity or fertility related procedures under this **Benefit**.

✓ Benefit Description We will cover:	? Eligibility Criteria
Radiology / X-rays and scans – Consultant Fees a contribution towards the cost of listed procedures in the **Schedule of Benefits** when performed by a **Consultant** Radiologist on an **Out-Patient** basis.	**We** will not cover any maternity or fertility related procedures under this **Benefit.**
Radiology/ X-rays and scans – Technical Charges a contribution towards the cost of **Technical Charges** for listed procedures in the **Schedule of Benefits** when performed by a **Consultant** Radiologist on an **Out-Patient** basis.	1. **We** will cover the **Benefit** for **Technical Charges** if performed at an **Approved Facility**. 2. **We** will not cover any maternity or fertility related procedures under this **Benefit**.
Specified Diagnostic Tests a contribution towards the cost of the **Diagnostic Tests** carried out on an **Out-Patient** basis.	**We** will cover a **Benefit** towards **Diagnostic Tests** that are carried out 1. by a **GP; Consultant** or **Nurse;** or 2. in a facility listed in the Vhi Directory of Approved Medical Facilities.
Alternative therapy a contribution towards a visit to an alternative therapist.	**We** will cover a **Benefit** towards the following alternative therapists: 1. **Acupuncturist,** 2. **Chiropractor,** 3. **Osteopath,** 4. **Physical therapist,** and 5. **Reflexologist.**
Complementary therapy a contribution towards a visit to a complementary therapist.	**We** will cover a **Benefit** towards the following professionals: 1. **Chiropodist,** 2. **Podiatrist,** 3. **Dietitian,** 4. **Nutritionist,** 5. **Occupational therapist,** 6. **Speech and language therapist,** 7. **Orthoptist,** and 8. **Strength and conditioning coach.**
Optical – Eye Tests a contribution towards the costs of eye tests.	1. **We** will cover a **Benefit** towards eye tests if they are carried out by an: a. **Optometrist,** b. **Ophthalmic** Surgeon registered with **Us**, or c. **Ophthalmic** Physician registered with **Us**. 2. **We** will provide this **Benefit once** in a 24 month period unless otherwise stated in **Your Table of Benefits.** The 24 month period starts on the date You have Your eye test performed.

✓ Benefit Description We will cover:	? Eligibility Criteria
Optical – Glasses & Contact Lenses a contribution towards the costs of: 1. Prescription Glasses; 2. Contact Lenses; and 3. repairs to prescription glasses.	**We** will provide this **Benefit** in a 24 month period, unless otherwise stated in **Your Table of Benefits**, which starts on the earliest of the date when: 1. the prescription glasses are first purchased, or 2. the contact lenses are first purchased.
Emergency Dental Treatment a contribution towards the cost of emergency dental treatment following an **Accident**.	**We** will cover the **Benefit** where: 1. **You** present to a **Dental Practitioner** within 5 days of the **Accident**, 2. the **Dental Practitioner** certifies that the emergency treatment was necessary, and 3. the claim is accompanied by a dated receipt on headed paper.
SELFCheck™ Testing Kits Purchased Online a contribution towards the cost of a SELFCheck™ Home Self Testing, purchased through any online pharmacy.	1. **We** will cover the **Benefit** of SelfCheck™ Home Self Testing Kit where **You** are over 18 years old. 2. **We** do not take responsibility for the findings of a SELFCheck™ Home Self Testing Kit test. All follow-ups should be conducted by **You** with a qualified medical practitioner.
Psychologist / Counsellor / Psychotherapist a contribution towards the cost of visits to a **Psychologist, Counsellor** or **Psychotherapist**.	Please refer to the Practitioner Registration Requirements in the General Terms.
Strength and Conditioning Coach a contribution towards the cost of visits to a **Strength and Conditioning Coach**.	**We** will cover the **Benefit** when accredited with **UKSCA.**
Accident & Emergency Cover (Public Hospitals only) the public hospital **Out-Patient** levy.	
Home Nursing a contribution towards the cost of **Your** nursing care at home.	**We** will cover the **Benefit** where: 1. a **Consultant** and **Our** medical advisers agree that it is **Medically Necessary**; 2. the care immediately follows a **Medically Necessary** stay in an **Approved Facility**; 3. if the person providing the care is a **Nurse**; and 4. **You** are over 18 years of age at the date of **Your** last **Policy** renewal.

Other Support Benefits

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Some **Benefits** in this section may be under other sections in **Your Table of Benefits** depending on the **Plan You** hold.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions:**

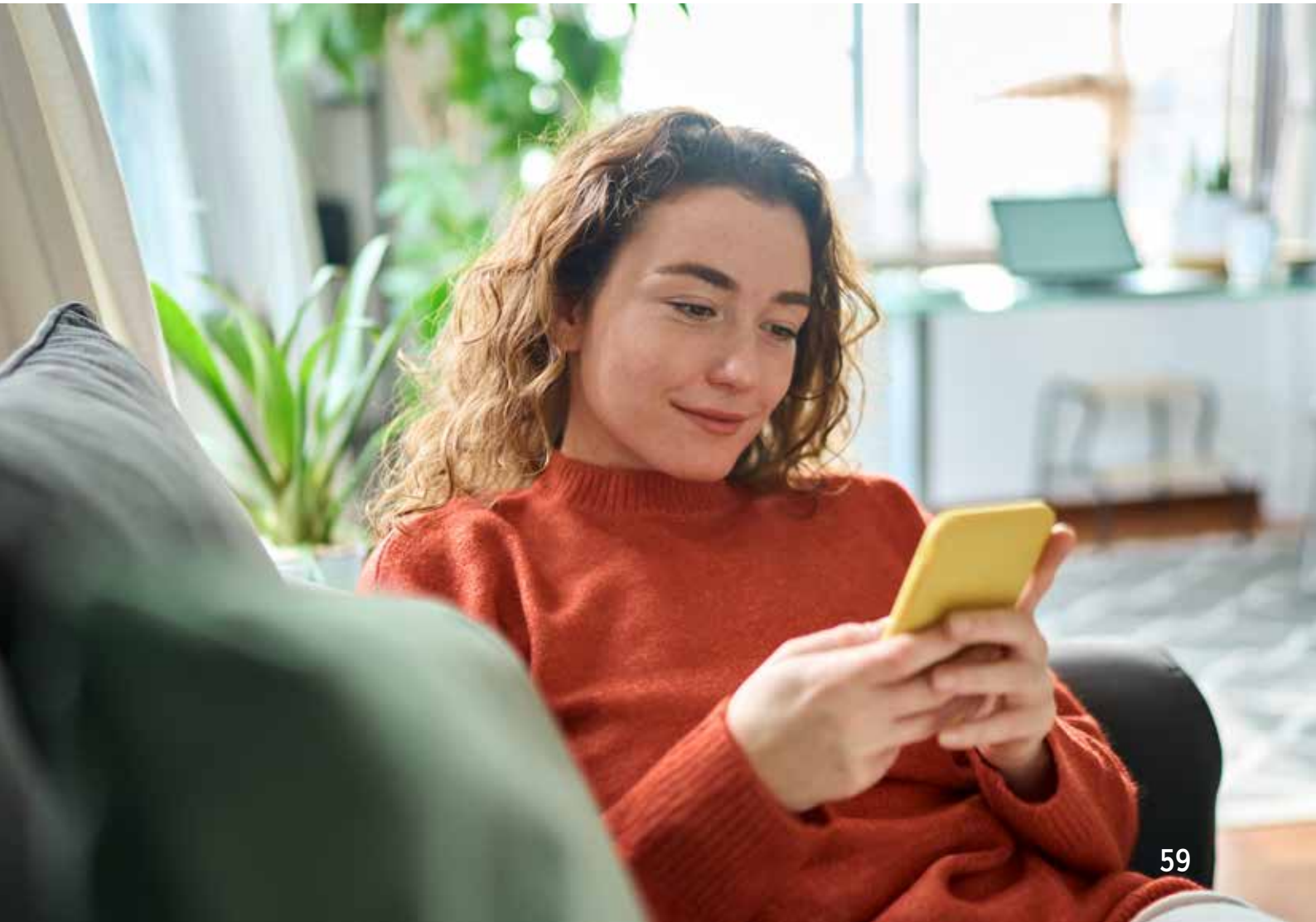
✓ Benefit Description **We will cover:**	? Eligibility Criteria
Vhi Second Opinion Service the cost of the Vhi Second Opinion service. This offers **You** a medical second opinion.	To use this service please contact 1800 247 724 for more details.
Vhi Midwife Support Service access to the Vhi Midwife Support service. This offers **You** support and advice throughout **Your** pregnancy and post-natal care.	This service can be accessed via the Vhi app.
Vhi NurseLine a telephone assessment and medical advice and information on specific medical issues.	To use this service please contact NurseLine on 1800 247 724 (local calls) or +353 56 775 3289 (when abroad). This service is available 24 hours a day, 365 days a year. Please see vhi.ie for more details.
Gender Affirmation Supports a contribution towards the cost of a Gender Affirmation Support for: **1.** Blepharoplasty, **2.** body contouring, **3.** face lifting, **4.** chin implants, **5.** facial bone reduction, **6.** feminisation or masculinisation of torso, **7.** hair removal, **8.** reduction thyroid chondroplasty, **9.** skin re-surfacing, **10.** lip reduction, **11.** Rhinoplasty, **12.** nose implants, and **13.** Hormone Replacement Therapy.	**We** will cover the **Benefit** where a **Clinical Psychologist** or **Consultant Psychiatrist** has certified that **You** satisfy all the following criteria: **1.** persistent, well-documented gender dysphoria, **2.** capacity to make a fully informed decision and to consent for treatment, **3.** if significant medical or mental health concerns are present, they must be reasonably well controlled, and **4.** **You** are aged 18 or over.
Manual Lymph Drainage a contribution towards the cost of Manual Lymph Drainage.	**We** will cover the **Benefit** where the person giving the care is a: **1.** **Physiotherapist,** **2.** **Physical therapist,** or **3.** Member of Manual Lymph Drainage (MLD) Ireland.

✓ Benefit Description We will cover:	? Eligibility Criteria
Fit-for-Life Mobility Programme a contribution towards the cost of Fit-for-Life Mobility Programme. Bookings can be made by contacting The Physio Company on (01) 518 0011. Further information can be found on vhi.ie/members.	1. **We** will cover **Benefit** where: a. the programme is carried out by a **Physiotherapist** employed by the Physio Company, and b. **You** are 18 years or older at **Your** last renewal. 2. Access to the services and the number of visits provided for each service will be based on **Your** clinical need, which will be determined by The Physio Company.
Private Emergency Department Care Package a contribution towards the cost of an emergency department visit in an approved Private Emergency Department.	To use this **Benefit** please contact the relevant emergency department directly. **We** will not cover people who are under 16 years old. Geographical limitations apply to the Private Ambulance **Benefit**. This service is available to **Members** located in Dublin, Kildare, Wicklow and Meath.
Fitness Screening and Personalised Exercise Programme the costs of fitness screening and a personalised exercise programme carried out in the Sports Surgery Clinic, Santry.	This **Benefit** is payable for **Members** aged 14 years and over. Please contact the Sports Surgery Clinic, Santry directly for further details.
Executive Health Screening a contribution towards the cost of Executive Health Screening in an approved Executive Screening Centre.	**We** will cover the **Benefit** where: **a.** **You** were over 18 years old at the date of **Your** last **Policy** renewal; **b.** **We** determine it to be **Medically Appropriate**; and **c.** the screening is carried out in a facility listed in the Vhi Directory of Approved Medical Facilities. **We** will pay this once in a 24 month period, provided **We** determine it to be **Medically Appropriate**. This period starts on the date that the screening test is performed.
Laser Eye Surgery a contribution towards the costs of Laser Eye Surgery for vision correction.	1. **You** are over the ages of 18 at the time of treatment 2. **Benefit** is payable per eye and **Your** receipt must indicate the eye that has been treated
Health Screening a contribution towards the cost of health screening.	1. **We** will provide this **Benefit** where the screening is performed: **a.** by a **GP** **b.** by a **Consultant** in their own rooms **c.** in an approved Out-Patient centre or **d.** in an approved Vhi Medical Centre 2. This **Benefit** is payable for **Members** aged 18 years and over at their last renewal.

Vhi Digital Services

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Vhi Digital Health Services a contribution towards the cost of an online: 1. **Physiotherapist,** 2. **Speech and language therapist,** and 3. **Dietitian.** through Vhi Digital Health Services for treatment or diagnosis. These services can be accessed via the Vhi app.	1. **We** will provide this **Benefit** to people 2 years or older.
Vhi Online Doctor a contribution towards the cost of an online doctor through Vhi Digital Health Services for treatment or diagnosis. These services can be accessed via the Vhi app.	1. **We** will provide this **Benefit** to people aged 2 years or older.



Vhi Clinical Services

We will pay the following when shown as covered in **Your Table of Benefits** up to the **Benefit** amount shown.

Cover Definitions

Where any word below appears in this cover in bold font, it has the meaning below. The definitions below are used in addition to **General Definitions:**

Vhi Health Screening A Health Check or Health Check Enhanced or Health Check Executive Vhi screening programme carried out in an **Approved Facility**.

Vhi Specialist An integrative medicine General Practitioner who has entered into agreement with Vhi 360 Health Centres to provide a 360 Health Clinic service.

✓ Benefit Description **We will cover:**	? Eligibility Criteria
Vhi 360 Core Services - Vhi 360 Urgent Care a contribution towards the cost of an initial consultation with a **GP** and follow-up treatment in a Vhi 360 Health Centre.	This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other **Benefits** on **Your Plan**.
Vhi 360 Core Services - Vhi 360 Paediatric Clinic a contribution towards the cost of an initial consultation and follow-up treatment with **Our** Paediatrics team. **Our** Paediatric Clinics are located within Vhi 360 Health Centres.	This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other **Benefits** on **Your Plan**.
Vhi 360 Core Services - Vhi 360 Health Clinics a contribution towards the cost of Vhi 360 Health Clinic consultation and treatment in a Vhi 360 Health Centre.	This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other benefits on **Your Plan**.
Vhi 360 Core Services - Vhi 360 Heath screening a contribution towards the cost of a **Vhi Health Screening**.	1. **We** will cover the costs where: a. **You** were over 18 years old at the date of **Your** last **Policy** renewal; b. **We** determine it to be **Medically Appropriate**; and c. the screening is carried out in a facility listed in the **Vhi Directory of Approved Medical Facilities**. 2. **We** will pay this once in a 24-month period, provided **We** determine it to be **Medically Appropriate**. This period starts on the date that the screening test is performed.

✓ Benefit Description We will cover:	? Eligibility Criteria
Vhi 360 Health Centre - Personalised Follow-Up package a contribution towards the cost of personalised follow-up visits, classes and sessions. Details can be found at vhi.ie/360health.	**We** will cover costs where a referral has been made from a Vhi Core Service in a Vhi 360 Health Centre.
Vhi 360 Follow on visits - Vhi 360 Health Centre Consultant and Specialist Led Care a contribution towards the cost of personalised follow-up visits, classes and sessions. Details can be found at vhi.ie/360health.	This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other **Benefits** on **Your Plan**.
Vhi 360 Follow on visits - Vhi 360 Health Centre Primary Care Practitioners a contribution towards the cost of a visit and **Medically Necessary** diagnostics with a Primary Care Practitioner in a Vhi 360 Health Centre.	This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other **Benefits** on **Your Plan**.
Vhi Health Centre Diagnostics a contribution towards the cost of an x-ray or ultrasound diagnostic scan in a Vhi 360 Health Centre.	1. **We** cover costs where a referral has been made by a **GP**. 2. This **Benefit** is only claimable once per visit. This means **You** cannot submit claims for shortfalls under any other **Benefits** on **Your Plan**.

Notes

Notes

Contact Us

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9am – 3pm Saturday

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