Company & PMI Plans Terms & Conditions (T&Cs) Changes Explained

The T&Cs changes applicable to your upcoming renewal are shown below. These changes impact you if the benefit is available on your plan, as outlined in your Table of Benefits.

1. Updated General T&Cs

Cooling off period

We have clarified the cooling off period start date from the inception/renewal of the policy. The rule now reads as follows:

> 2, h) and 4, f) *The 14 day period starts from the inception date of the Policy, or 2 days after the issue date of the Policy Details, whichever is the latter.*

Renewing the Policy

Prior to your renewal we will issue you with your renewal documents which will include your premium for the upcoming renewal. The rule now reads as follows:

> 3 a) *Your Policy will last for one year unless We agree to a shorter period. Prior to Your renewal date, We will issue you with renewal documents where We will set out the premium payable for the subsequent year. The policyholder can renew the policy by paying the premium We request. The T&Cs and your Table of Benefits in place at the Renewal Date will then apply to the Policy.*

Cancellation / Termination of Policies

We have updated the heading to reflect the cancellation/termination wording. We have also clarified the cooling off period start date from the inception/renewal of the policy. The rule now reads as follows:

> *Cancellation / Termination of Policies*
> 4, f) *Cancellation by the Policyholder*
>
> *At time of joining:*
> *When the Policyholder signs up for a Policy, Vhi Healthcare will accept their instruction to cancel the Policy within 14 days. The 14 day period starts from the inception date of the Policy, or 2 days after the issue date of the Policy Details, whichever is the latter.*
>
> *At renewal date:*
> *The Policy will renew automatically on the date notified to the Policyholder on the Policy renewal documentation, unless the Policyholder contacts Us to cancel the Policy in advance of this Renewal Date. We will accept the Policyholder's instruction to cancel the Policy within 14 days. The 14 day period starts from the renewal date of the Policy, or 2*

days after the issue date of the Policy Details, whichever is the latter. After the expiration of those 14 days the Policyholder will not be in a position to either cancel or make changes to the Policy until the next Renewal Date (subject to certain exceptions – contact Us for details).

Cancellation / Termination by Us
Clarification of Our rules surrounding cancellation/termination of a policy by Us. The rule heading now reads as follows:

4, g) *Cancellation / Termination by Us*

We have updated our termination rule to reflect scenarios relating to negligent misrepresentation or fraudulent applications/claims. The rule now reads as follows:

4, g, iii) *In the event that You make or try to make, a negligent misrepresentation or a fraudulent application or claim, which relates to Your Policy with Us or any other Health Insurance Contract, such action will constitute a breach of the Policy and We may terminate the Policy with immediate effect. We may also refuse to renew the Policy and/or refuse to pay any benefits under the Policy.*

Group Schemes

We have updated the rule to also include termination of the policy. The rule now reads as follows:

10, 2, c, i) *group number, employee title and name (Policyholder), address, date of birth of the Policyholder, employee number, PPS number, effective date of the Policy, date of cancellation or termination of the Policy, level of cover, premium amounts, including where relevant name, date of birth and address (if different) for their partner and/or their dependants and shall not include any personally identifiable health related data.*

We have updated our termination rule to reflect scenarios relating to negligent misrepresentation or fraudulent applications and claims. The rule now reads as follows:

10, 5) *In the event that a Customer makes, or tries to make, a negligent misrepresentation or a fraudulent application or claim, which relates to his/her Policy with Us or any other Health Insurance Contract, Rule 4 (g) will apply. Customers should be aware that We undertake regular audits of Claims and in all instances where negligent misrepresentation or fraud is suspected in respect of a particular claim, a full and comprehensive investigation will be carried out. In addition, We reserve the right to refer the details of any Claim submitted which is suspected to be fraudulent, to the appropriate authorities to take the appropriate action.*

Claiming Timelines

We have amended the time limit for claiming for Non-Direct Payment to Hospitals. The six month timeframe has been removed. The rule now reads as follows:

8, c) *Non-direct payment to hospital*
If We do not have a direct payment arrangement with the hospital, You must send Us a claim form completed and signed by You and Your doctor, together with the relevant invoices.
• Hospital invoices must be in a format specified by Us. If they are not, We may be unable to calculate Your exact benefit for hospital charges in which case We will

calculate the benefit due to You as best We can from the information supplied, and We will pay this amount.
• Payment of that estimate will be a complete discharge of Our obligations to You.
• We will then pay the benefits for the hospital charges to You.
• You must use all the benefits We pay to You for the services for which You are claiming.

We have extended the time limit for you to claim your out-patient / day to day / lifestage medical expenses. The rule now reads as follows:

8, e) *Out-patient / day-to-day and lifestage medical expenses*
We will pay benefits for eligible expenses listed in Your Table of Benefits when You send Us a claim form which You have completed and signed, together with receipts or when You use Our Snap and Send Claiming system (please note that separate additional T&Cs apply to the Snap and Send claiming system and will be available on MyVhi). You must submit your claim within a reasonable timeframe. Reasonable timeframe is defined as expenses incurred in your current renewal period or the previous two renewal periods (i.e. 3 years), if insured. Any claims submitted outside of this reasonable timeframe will not be eligible for payment.

Contact Telephone Numbers

We have amended our contact telephone numbers:

Service	Old Contact Number	New Contact Number
Vhi Customer Service	*1890 44 44 44*	*(056) 444 4444*
Vhi Second Opinion Service	*1850 247 724*	*1800 247 724*

2. New General T&Cs

New claiming process

We have included a new rule in relation to the separate claiming processes where a health insurance and dental policy are both held. In such circumstances, the claims data from your Dental claim will be shared with us for a separate adjudication to determine any eligible benefit under your Health Insurance Policy. The rule now reads as follows:

8, e) *We may put in place separate claims process arrangements with certain customers who are part of a Group Scheme and who also hold a Vhi Dental Plan that covers dental costs in addition to those covered under a Policy with Us. Such separate claims process arrangements will involve the collection and processing of claims data under a Vhi Dental Plan and the subsequent sharing of this data with Us for separate adjudication for any eligible benefit under the terms and conditions of the Policy. In such circumstances the claimant will receive separate benefit statements from Us and Collinson Insurance Solutions Europe Limited in respect of any eligible benefits under the Vhi Dental Plan and/or the Vhi Policy. You will be notified separately if this arrangement applies to you.*

3. Updated Benefit T&Cs

Transport Costs

We have broadened the 'Transport Costs' rule to allow benefit for terminally ill members who wish to return home from hospital for end-of-life care. The rule now reads as follows:

> 5,20, ii) *If the ambulance/intermediary ambulance is used: to transfer a Customer, who is an In-patient of a hospital, between hospitals listed in the Directory of Hospitals and Treatment Centres (the 'Directory') where at least one hospital is covered by the Plan; or to transfer the Customer from a hospital covered by Your Plan and listed in the Directory to an MRI Centre listed in the Directory; or to transfer the Customer to a convalescent home listed in the Directory of Convalescent Homes, if the stay in a convalescent home is approved; or to transfer the Customer from a hospital covered by the Plan and listed in the Directory to a hospice; or from a facility listed in the Directory to home in respect of end-of-life care;*

Post-natal Home Help

We no longer provide a list of home help providers. As an alternative, you can chose an accredited/reputable provider. The rule now reads as follows:

> 5, 30) *If included in Your Plan, We will pay the benefit listed in Your Table of Benefits towards the cost of domestic home help following the birth of Your Child from an accredited/reputable Home Help provider. The charges must be incurred within 6 weeks of the birth. This benefit is payable to the Adult Customer availing of the service.*

Cancer Care Support Benefit

We have broadened the Cancer Care Support benefit to allow benefit for accommodation and/or travel costs. The rule now reads as follows:

> 5, 25) *We will pay the benefit listed in Section 5 of the Table of Benefits towards one night accommodation and/or travel costs of a Customer in a hotel, hostel or B&B when a Customer travels more than 50km to receive Out-patient chemotherapy and/or Out-patient radiotherapy treatment. We will also pay the benefit listed in the Table of Benefits towards car parking costs. The treatment must take place in a hospital listed in the Directory of Hospitals (and Treatment Centres) covered by the Plan. Travel costs are limited to public transport, taxi, hackney, petrol/diesel and car parking costs. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.*

Parent Accompanying Child

We have broadened the benefit to allow you to claim from date of admission where your child's hospital stay exceeds 3 days. The rule now reads as follows:

> 5, 38) *We will pay the benefits listed in Your Table of Benefits towards Your accommodation and travel costs when accompanying Your Child (including new born Children) for up to 14 days per Child per calendar year. The benefit is payable from the date of admission, provided the total stay is in excess of 3 days. The benefit is only payable where Your Child is insured with Vhi and has received medically necessary treatment in Ireland that is eligible for benefit. You must be a parent/guardian of the Child insured with Us. Accommodation costs are limited to hotel, B&B, hostel and hospital accommodation. Travel costs are limited to public transport, taxi, hackney, petrol/diesel and car parking costs. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.*

Cosmetic treatment

We have amended the exclusion rule in relation to cosmetic treatment. The exclusion rule now reads as follows:

> 7, xix) *(Exclusions) Cosmetic treatment, (including tests, investigations and consultations) and treatment of any complications arising from cosmetic treatment – unless it is needed (i) to restore Your appearance after an accident or (ii) because You were severely disfigured at birth.*

Practitioner's Family or self-performed tests or consultations

We have amended the exclusion rule in relation to treatment, tests or consultations by a family member or on own self. The exclusion rule now reads as follows:

> 7, xvi) *(Exclusions) Treatment, tests or consultations given by a practitioner to his/her wife/husband, children, parents or himself/herself.*

Dental Procedures and Orthodontic Treatment

We have amended our rule in relation to Dental Treatment and, for clarity, we have listed orthodontic treatment as an exclusion. The rules now read as follows:

> 5, 24) *Many dental procedures eligible for benefits are classified as Day Care or Side Room Procedures and many must also be authorised by Our dental advisors prior to being performed. Your Dental Practitioner will need to send a Pre-certification Form and radiological evidence to Our Claims Department for assessment by Our dental advisors. We will not pay benefits for dental/oral-surgical treatment and treatments related to functional disorders of the chewing system, including Out-patient consultations, except for those dental/oral-surgical procedures listed in the Schedule of Benefits for Professional Fees and treatments listed under the Day-to-day medical expenses or Outpatient medical expenses section of Your Table of Benefits (if included under Your Plan);*
> *Professional fee benefit is payable for non-cosmetic osseointegrated mandibular implants only if specific criteria, as set out in the Schedule of Benefits, is satisfied in full. In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components.*
>
> *7, v) (Exclusions) Hearing and sight tests, hearing aids, spectacles, contact lenses (except those specified in Your Table of Benefits), dentures, orthodontic treatment or orthodontic appliances (such as braces).*

Child Counselling

We have broadened the child counselling benefit by removing the word 'clinical' from the definition of Psychologist. The rule now reads as follows:

> 5, 39) *If included on Your Child's Plan, We will pay the benefits listed in the Table of Benefits for a Child who is referred by a General Practitioner or Consultant to a Psychologist, as defined.*

Psychologist

We have broadened the Psychologist benefit by removing the word 'clinical' from the definition of Psychologist. The rule now reads as follows:

> 5, 43) *If included in Your Plan, We will pay the benefit listed in Your Table of Benefits towards the cost of a Psychologist, as defined.*

Psycho-oncology Counselling

We have broadened the psycho-oncology counselling benefit by removing the word 'clinical' from the definition of Psychologist. The rule now reads as follows*:*

> 5, 74) *If included in Your Plan, We will pay the benefit listed in Your Table of Benefits towards the cost of psycho-oncology counselling where an insured Customer is referred by a General Practitioner or Consultant to a Psychologist, as defined. Only claims accompanied by a dated receipt on headed paper will be eligible for benefit.*

Psychology definition

The definition of a Psychologist has changed, to make the benefit more accessible for members. The definition now reads as follows:

> *A chartered member of the Psychological Society of Ireland for at least one of following disciplines - clinical, counselling, educational or psychotherapy.*

Accommodation

Private and Semi-Private Accommodation definitions are updated to reflect single and multiple occupancy wording, under the Health Services (In-Patient) Regulations, 1991. The definition now reads as follows:

> *Accommodation*
> *Hospital accommodation is defined as follows:*
>
> *Private Accommodation*
> *A room in a private hospital which has only one bed or 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*
> *A room in a private hospital which contains not more than five beds or a multiple occupancy room approved by Us in a public hospital which contains a designated private bed under the Health Services (In-Patient) Regulations, 1991 and in a room which contains not more than five beds.*

Audiologist

The accredited body name has been changed to the Irish Academy of Audiology. The definition now reads as follows:

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

Excesses

We have updated our excess definition to clarify the differences between the excess types. The definition now reads as follows:

> *Excesses*
> *Excesses may form part of Your policy and these are set out in Your Table of Benefits.*
> *An excess is the first part of any insurance claim that You have to pay.*
> *Hospital Excess*
> *A hospital excess is an amount that You have to pay for a private hospital claim.*
> *Day-to-Day / Out-patient Annual Excess*
> *An annual excess is an amount that is deducted from the amount payable to You*.

4. New Benefit T&Cs

Meditation App

We have included the benefit rule in relation to meditation apps. The rule reads as follows:

> 5, 86) *If included in Your plan, We will pay the benefit listed in Your table of benefits towards the annual subscription costs of specified meditation apps. You can claim back the benefit against one app, once per renewal year. See Vhi.ie/emotional-wellbeing for further details.*

Psychotherapy and Counselling

We have included a new rule, for Psychotherapy and Counselling and their associated registered bodies. The rule reads as follows:

> 5, 85) *If included in Your Plan, we will pay the benefits listed in your Table of Benefits for Psychotherapy and Counselling when the service is provided by a practitioner registered with one of the following bodies; Irish Association of Counselling and Psychotherapy (IACP); Psychological Society of Ireland (PSI); The Irish Council for Psychotherapy (ICP).*

Public Hospital Statutory levy

We have included the benefit rule in relation to the Public Hospital Statutory Levy. The rule reads as follows:

> 8, 87) *We will pay the public hospital statutory levy for Your In-patient and Day-patient treatment, in any 12 consecutive months, in accordance with The Health Act (1970). This levy is payable by Us directly to the public hospital. In the event that You are billed by the hospital Your receipt should be submitted to Us for payment.*

Your policy Terms & Conditions, Table of Benefits and Directory of Hospitals contain full details of all your cover.
If you have any questions, please call us on **(056) 444 4444.**