Consumer Rights Statement

What rights do I have in relation to renewing my policy?

As a private health insurance customer, you have many rights. You have the right to start and renew cover regardless of your age, gender or health. All health insurers that are accepting business, are obliged to accept all applicants regardless of risk. Once you have health insurance, an insurer cannot stop cover or refuse to renew your insurance, except in limited circumstances.

Can I change my health insurance plan or insurer at any time?

You have the right to change your health insurance plan, or insurer, without penalty. The insurer may not impose additional waiting periods unless you are upgrading your cover. Even when you are upgrading your cover, an insurer may only impose an extra waiting period in respect to additional cover in the new policy. However, if you allow your health insurance to lapse for 13 weeks or more, you may have to start your waiting periods all over again.

What happens if I switch from my current insurer and wish to return to them at a later date?

If you switch insurer and later decide you want to switch back, you may do so without penalty as long as you switch to an equivalent level of cover. However, the insurer may impose waiting periods for any extra benefits available on your new plan.

Will my age affect my insurance premium?

Health insurers may not charge you a higher net premium because of your age or claims experience. This has the same effect that all insurers must charge all consumers, with certain exceptions, the same premium for a given level of cover regardless of their age, gender or health. A discounted premium is available for full time students up to 21. A discounted premium may also be available if you are in a group scheme.

Further information on your consumer rights is available on the internet at www.hia.ie or by ringing the Health Insurance Authority at 01 406 0080.
1) Definitions

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

Accommodation
Hospital accommodation is defined as follows:

Private accommodation
A room in a private hospital which has only one bed or a Vhi Healthcare approved room 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 Vhi Healthcare approved bed in a public hospital which is a designated private bed under the Health Services (in-patient) Regulations, 1991 and in a room which contains not more than five beds.

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

Claim
When you ask us to pay benefits for a member included on your contract less any hospital or out-patient excess that may be applicable.

Excess
The following definitions apply to each excess:

Hospital Excess
The excess of €75 applicable to all claims* for hospital benefit for treatment carried out in a private hospital listed in the Directory of Hospitals, where the subscriber/policy holder has selected the excess option on Plan B as indicated on the renewal notice.

* Except maternity benefits and certain cancer treatments (a full list of cancer treatments is available on request)

Out-patient Excess
The excess applicable to the out-patient scheme as listed in Section 6 of the Table of Benefits.

Health insurance contract
As defined in the Health Insurance Acts.

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

Hospitals
The following definitions apply to hospitals:

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

Hospital charges
Charges for: (i) hospital accommodation; (ii) services provided by a private hospital or clinic (such as hospital technical charges for the use of the operating theatre, radiology and pathology); and (iii) public hospital statutory levies.

Non-participating hospital
A hospital which does not have an agreement with us but which we recognise, so we will pay part of the hospital charges for Vhi Healthcare approved accommodation. Full details of benefits payable are available from any of our offices.

Participating hospital
A hospital which has an agreement with us on its charges and the services it provides to our members. We will pay the hospital charges for Vhi Healthcare approved accommodation and services if the member is insured under the appropriate plan.

Medical condition
Any disease, illness or injury.

Medically necessary
Means treatment or a hospital stay which in the opinion of our Medical Director is generally accepted by the medical profession as appropriate with regard to good standards of medical practice and is:
(i) consistent with the symptoms or diagnosis and treatment of the injury or illness; (ii) necessary for such a diagnosis or treatment; (iii) not furnished primarily for the convenience of the patient, the doctor or other provider; and (iv) furnished at the most appropriate level which can be safely and effectively provided to the patient.

Membership
The following definitions apply to members:

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

Student
A person who is a dependant of the subscriber/policy holder and is of or over the age of 18 years and under 21 years and is receiving full time education.

Subscriber/Policy holder
The person with whom we have made the contract.

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

Patient
The following definitions apply to patients:

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

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

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

Plan
Any health insurance scheme we provide which covers the cost of treatment in private accommodation or semi-private accommodation.

Practitioner
The following practitioners are recognised by Vhi Healthcare:

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

Clinical Psychologist
A member of the Psychological Society of Ireland.

Consultant
A medical practitioner who has a current full registration with the Irish Medical Council and who: (i) holds a public consultant post in the Republic of Ireland; or (ii) has held a public consultant post in the Republic of Ireland in the past and now practices within the same specialised field; or (iii) holds the necessary qualifications for a public consultant post in the Republic of Ireland together with evidence of appropriate general professional and higher specialist training to a standard required for such a post in the speciality in which he/she intends to work and has been appointed as a consultant to a Vhi Healthcare approved post in a Vhi Healthcare approved private hospital.
Non-participating consultant A consultant who does not enter into agreement with us to accept our benefits in full settlement of his/her fees. He/she receives the standard benefit as set out in the Schedule of Benefits for Professional Fees and may or may not charge an additional fee to patients.

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

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

Dietician A member of the Irish Nutrition & Dietetic Institute.

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

Midwife A midwife registered on the Midwife register with An Bord Altranais.

Occupational Therapist A member of the Association of Occupational Therapists of Ireland.

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

Physiotherapist A member of the Irish Society of Chartered Physiotherapists.

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

Procedures The following definitions apply to procedures:

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

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

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

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

Vhi Healthcare The Voluntary Health Insurance Board.

Year The period of cover shown in your most recent membership details.

You, your national daily newspapers. If you want to cancel your contract because of any such change, you can do this by writing to us within four weeks of the date we publish notice of the change.

We will tell you about changes to the Directory of Hospitals (and Treatment Centres) at least four weeks beforehand by publishing a notice in the major national daily newspapers. If you want to cancel your contract because of any such change, you can do this by writing to us within four weeks of the date we publish notice of the change.

We will pay any benefits we are required to pay under the Health Insurance Acts and any regulations thereunder, even if any part of your contract indicates otherwise.

2) Contract

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

(i) These Rules and Table of Benefits; (ii) The Directory of Hospitals (and Treatment Centres); (iii) The Directory of Approved MRI Centres; (iv) The Directory of Convalescent Homes; (v) The Schedule of Benefits for Private Hospital Services; (vi) The Directory of Consultants; (vii) The Schedule of Benefits for Professional Fees; (viii) The Schedule of Benefits for General Practitioners, and any amendment or variation made from time to time as per rule 2(g).

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

c) In the Schedule of Benefits for Private Hospital Services, we set out the benefits we will pay for private hospital services and the rules we will apply to the payment of these benefits.

d) In the Schedule of Benefits for Professional Fees, we set out the benefits we will pay to the consultants and general practitioners for each kind of treatment and the rules we will apply to the payment of these benefits.

e) In the Schedule of Benefits for General Practitioners, we set out the benefits we will pay to general practitioners for procedures and the rules we will apply to the payment of these benefits.

f) In the Directory of Convalescent Homes, we list the convalescent homes which are eligible for benefit. The most up-to-date Directory of Convalescent Homes is available on our website - www.vhi.ie. Copies are available on request.

g) We may change these directories and schedules during the year. The most up-to-date Directory of Hospitals is available on our website - www.vhi.ie. We will tell you about changes to the Directory of Hospitals (and Treatment Centres) at least four weeks beforehand by publishing a notice in the major national daily newspapers. If you want to cancel your contract because of any such change, you can do this by writing to us within four weeks of the date we publish notice of the change.

h) We will pay any benefits we are required to pay under the Health Insurance Acts and any regulations thereunder, even if any part of your contract indicates otherwise.
3) Joining Vhi Healthcare

a) Additional people may be included on your contract at any time. If you apply to include your child on your contract within 13 weeks of his/her birth, we will insure him/her from the date of birth and we will not apply rules 3(c) and 3(d). Subscribers/policy holders who enrol their new born children within 13 weeks of the child’s date of birth will not be charged any additional subscription for that child until the first or next renewal date after his/her birth.

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

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

<table>
<thead>
<tr>
<th>Member’s Age When He/She is Included</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 55</td>
<td>26 weeks</td>
</tr>
<tr>
<td>55 to 64</td>
<td>52 weeks</td>
</tr>
<tr>
<td>65 or over</td>
<td>104 weeks</td>
</tr>
<tr>
<td>Maternity or pregnancy - related conditions</td>
<td>52 weeks</td>
</tr>
</tbody>
</table>

d) No benefits are payable for medical conditions the date of onset of which is determined on the basis of medical advice to have been prior to the date the member was included on the contract, unless the member has been insured continuously for a minimum period of time. The minimum period is as follows:

<table>
<thead>
<tr>
<th>Member’s Age When He/She is Included</th>
<th>Minimum Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 55</td>
<td>5 years</td>
</tr>
<tr>
<td>55 - 59</td>
<td>7 years</td>
</tr>
<tr>
<td>60 or over</td>
<td>10 years</td>
</tr>
</tbody>
</table>

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

e) If there is a break of more than 13 weeks in a person’s health insurance contract with us or another insurer registered under the Health Insurance Acts, the application will be treated as a new application for membership.

f) If a person transfers from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, 1994 to 2003, benefits will only be payable up to the level of cover offered by that contract. Additional benefits will be subject to rule 4(b).

g) If a member has transferred from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, 1994 to 2003, the time he/she was insured under the other contract will be offset against the normal joining conditions (waiting period, pre-existing illness and maternity).

h) The Scheme is intended for people resident in Ireland and only people resident in Ireland are eligible to join the Scheme. Please refer to Rule 7(b).

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

4) Renewing the contract

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

b) You can change your level of cover at your renewal date. If you change your cover (i.e. subscribe for additional benefits) and you or any of the members included on the contract receive treatment during the following two years* for a medical condition which, in the opinion of our Medical Director, you already had on the renewal date on which you changed your plan, we will only pay the benefits which we would have paid if you had not changed your plan.

* Five years for those aged 65 years or over, or 52 weeks for maternity or pregnancy related conditions.

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

c) If you change your plan or level of cover, additional benefits will be subject to rule 4(b). If you change your plan or level of cover and wish to revert to your previous plan or level of cover, you may do so within 14 days of the date of issue of the amendment notification and we will pay the benefits which we would have paid if you had not changed your plan.
5) Subscriptions
a) You must pay your subscription within 15 days after it becomes due. Otherwise, we will not pay any benefits and will cancel your contract. The subscriber/policy holder is responsible for ensuring payments are made.
b) For members who pay by salary deduction, the translation of annual premia into monthly or weekly installments may result in the collection of marginally more or less than the annual premium as a result of rounding to the nearest cent.
c) Subscribers/policy holders to Plans A to E and Plans A to C Option with dependants who are students (as defined) may apply for a discount on their annual subscription. The student subscription rate will apply from the date of application for new members, and from the next renewal date (following application for the student rate), for existing members. The student rate will automatically revert to the adult rate with effect from the next renewal date after the student’s 21st birthday.

6) Benefits
a) Hospital Benefit

Hospital benefit is payable for in-patient treatment in a participating or non-participating hospital listed in the Directory of Hospitals and which is covered by your plan, in private and semi-private accommodation. Details of the benefits payable are contained in the Table of Benefits at the back of this Rules document.

b) Professional fee benefit

We will pay consultants’ or general practitioners’ fees for medically necessary treatment which is covered by the Schedule of Benefits for Professional Fees (refer 2 (d)) and is carried out in a participating or a non-participating hospital. If a consultant is a non-participating consultant, we will pay the standard benefit as set out in the Schedule of Benefits for Professional Fees, even if your treatment is provided on an emergency basis and you may have to pay an additional amount yourself. If the treatment is carried out in a hospital listed in the Directory of Hospitals which is not covered by your plan, benefit for consultant or general practitioner fees will not be payable. However, professional fee benefit as set out in the Schedule of Benefits for Professional Fees is payable for out-patient procedures, with the exception of out-patient radiotherapy.

c) Out-patient benefit

Out-patient benefit is payable for treatment as specified in Section 6 of the Table of Benefits.

d) General conditions

We will pay benefits for in-patient and day-patient treatment, side room procedures and out-patient procedures, for a maximum of 180 days per member in any calendar year, less any days treatment within the same calendar year which has been paid under any other health insurance contract.

e) The benefits which we will pay will depend on the terms of your contract on:

(i) the first day of a hospital stay or (ii) the date of the treatment if the member is not staying in hospital.

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

g) We will pay the actual amount the member is charged or the benefits payable under the contract, whichever is lower.

h) If you use hospital accommodation which requires a higher healthcare plan than you hold, the level of benefits payable, if any will be as outlined in the Table of Benefits at the back of this Rules document. Where a hospital is listed in the Directory of Hospitals and not covered by your plan, no benefit will be payable.

i) Day care procedures

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

j) Side room procedures

Hospital benefit is payable for side room procedures carried out in a Vhi Healthcare approved hospital listed in the Directory of Hospitals and which is covered by your plan. If it is medically necessary for the member to receive the treatment as a day-patient or as an in-patient, we will pay the full benefits for the hospital charges in accordance with the level of cover under your plan.

k) MRI (magnetic resonance imaging)

We will pay the benefits set out in the Table of Benefits for an MRI scan subject to the following conditions:

(i) The member is referred for an MRI scan by a consultant or general practitioner in the Centres listed for cover for consultant or general practitioner referrals or where the member is referred for an MRI scan by a consultant to a Centre which is listed for cover for consultant referrals only; (ii) The MRI scan is carried out in an approved MRI centre listed in the Directory of Approved MRI Centres and which is covered by your plan; (iii) The MRI scan is to investigate or rule out certain medical conditions. A list of the approved clinical indications for which benefit is payable appears at the back of this Rules document.

l) Convalescence

We will pay the convalescence benefits listed in Section 4 of the Table of Benefits where each of the following is satisfied in full:

(i) if the consultant decides and our Medical Director agrees, that it is necessary for medical reasons for a member to stay in a Convalescent Home.

(ii) if the stay in the Convalescent Home is immediately after a medically necessary stay in hospital, which is eligible for Vhi Healthcare benefit, even if the hospital is not covered by your plan.

(iii) if the member occupies single room accommodation in a Convalescent Home listed in Vhi Healthcare’s Directory of Convalescent Homes.

m) Child nursing

We will pay up to €100 a day for a maximum of 14 days per calendar year towards the cost of nursing care at home for a member under 18 years of age at his/her last renewal if his/her general practitioner or consultant decides that, for medical reasons, the member needs to receive care following a stay in a hospital of at least 5 days. This nursing care must commence within two weeks of their discharge from hospital and must be completed within six weeks of their discharge. The person giving the care must be a nurse registered with An Bord Altranais.
n) Parent accompanying child
We will pay the benefits listed in Section 4 of the Table of Benefits, towards the accommodation and travel costs of a parent/guardian accompanying a child (including new born children) who is under 14 years at their last renewal date during that child’s hospital admission. The benefit is only payable where the child has received medically necessary treatment that is eligible for Vhi Healthcare benefit. The claiming member must be a parent/guardian of the child insured with Vhi Healthcare. Accommodation costs are limited to hotel, B&B, hostel and hospital accommodation. Travel costs are limited to public transport, taxi, hackney and car parking costs. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.

o) Transport costs
We will pay for the cost of an ambulance/intermediary ambulance where each of the following is satisfied in full:
(i) If the doctor certifies that it is medically necessary because the member is seriously ill or disabled;
(ii) If the ambulance/intermediary ambulance is used to transfer the member to a hospital listed in the Directory of Hospitals (and Treatment Centres) covered by the member’s plan and which is eligible for benefit; or to transfer the member between hospitals listed in the Directory of Hospitals (and Treatment Centres) where at least one hospital is covered by the member’s plan; or to transfer the member from a hospital covered by your plan and listed in the Directory of Hospitals and Treatment Centres to an MRI Centre listed in the Directory of approved MRI Centres; or to transfer the member to a convalescent home listed in the Vhi Healthcare Directory of Convalescent Homes, if the stay in a convalescent home is approved; or to transfer the member from a hospital covered by your plan and listed in the Directory of Hospitals and Treatment Centres to a hospice;
(iii) If Vhi Healthcare benefit is payable in respect of treatment received by the member in the hospital, MRI Centre or convalescent home, to or from which the ambulance/intermediary ambulance transported the member;
(iv) If the ambulance/intermediary ambulance company is approved by Vhi Healthcare.
The payment of ambulance/intermediary ambulance costs does not guarantee the eligibility for benefit of other charges relating to your claim. Where the doctor determines that the most appropriate level of transport required is a taxi, benefit will be payable directly to the hospital from which the patient is transferred subject to criteria (ii) and (iii) above.

p) Psychiatric treatment
(i) We will only pay for in-patient psychiatric treatment in a psychiatric hospital listed in the Directory of Hospitals or an approved psychiatric unit of a hospital listed in the Directory of Hospitals; and (ii) We will pay for day care psychiatric treatment for approved day care programmes in St. John of God Hospital, Stillorgan and St. Patrick’s Hospital, Dublin. (Please contact us for further details).

q) Substance abuse
Each member on your policy is entitled to a maximum of 91 days benefit (less any days paid for by another Health Insurance Contract) for alcoholism and drug abuse in any five year period. The five year period is calculated as the immediate five years prior to the discharge date of any such claim.

r) Breast reduction
Benefit for breast reduction is subject to prior approval and payable only if specific criteria, as set out in the Schedule of Benefits, are satisfied in full.

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

t) PET-CT Scans
Benefit for PET–CT scans is available to members subject to the following criteria:
• Prior Approval
• The member is referred for a PET-CT scan by a consultant
• The PET-CT scan is carried out at Beacon Hospital, Blackrock Clinic, Galway Clinic, Mater Private Hospital, Whitfield Clinic or Hermitage Medical Clinic
• The PET-CT scan is carried out for one of the clinical indications as specified by us to all Consultants.

u) Out-patient Procedures
Vhi Healthcare benefit is payable for out-patient procedures carried out in an approved hospital listed in the Directory of Hospitals and which is covered by your plan. Where an out-patient procedure is carried out in a hospital listed in the Directory of Hospitals which is not covered by your plan, professional fee benefit is payable in accordance with rule 6b. Hospital charges listed within Section 6 of the Table of Benefits may be included under the out-patient scheme and are subject to the out-patient excess. No professional fee or hospital benefit is payable for Out-patient Radiotherapy carried out in a hospital listed in the Directory of Hospitals, which is not covered by your plan.

v) Cancer Care Support Benefit
We will pay the benefits listed in Section 9 of the Table of Benefits towards the accommodation costs of a member in a hotel, hostel or B&B when a member travels to receive out-patient chemotherapy and/or out-patient radiotherapy treatment in a Vhi approved hospital covered by your plan. Only claims accompanied by dated receipts on headed paper will be eligible for benefit.
7) Cover outside Ireland

Treatment outside Ireland

a) We will only pay for emergency treatment a member receives outside Ireland if he/she needs such emergency treatment because of an unexpected illness or accident that arises during a temporary stay abroad. We will pay up to the plan amounts outlined in Section 8 of the Table of Benefits, per temporary stay abroad. You may also claim for expenses listed under Section 6 of the Table of Benefits. All eligible benefits associated with emergency or prior approved treatment abroad will be issued by Vhi Healthcare in euro, with the exchange rate from the European Central Bank being applied to all charges as at the date of the patient’s admission/treatment, where applicable.

b) Only members resident in Ireland for at least 180 days each calendar year are eligible for cover outside Ireland and/or repatriation in accordance with Rules 7(a), 7(c) & 7(d). Where a member intends to travel abroad for longer than 180 days, Vhi Assist or any other Vhi insurance benefit will not be available in respect of medical treatment abroad.

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

(i) For surgical procedures* that are currently available in Ireland we will pay up to the benefit that we would have paid in respect of the same surgical procedure, including professional fees, in Ireland for your level of cover up to a maximum of the plan amounts specified in Section 8 of the Table of Benefits.

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

(ii) For treatment that is not available in Ireland we will pay up to the plan amounts specified in Section 8 of the Table of Benefits, unless a reasonable alternative treatment is available here in which case the benefit will be as outlined in (i) above.

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

Vhi Assist

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

i) A direct payment facility in respect of the benefits referred to in paragraph (a) above where the treatment is received as an inpatient or in the A&E / Outpatient Department of a hospital. All other medical expenses can be claimed in accordance with Section 6 of the Table of Benefits.

ii) • A 24 hour emergency telephone service

• Medical Advice and information on your case

• Maintaining regular contact with the attending medical providers and monitoring of the member’s ongoing care where necessary, if he/she is hospitalised

• Making contact with the member’s doctor in Ireland and immediate family, as well as his/her employer if required.

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

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

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

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

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

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

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

We will also arrange and pay the travel costs of one adult to accompany the child/children up to a maximum of €1,000.

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

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

(g) You must also notify Vhi Healthcare in writing if you instigate any action against a third party following an accident abroad. Please refer to section 12 of this booklet for further details.

Emergency Treatment Abroad Form

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

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

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

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

• Injuries caused during mountaineering (above 4000 metres), motor competitions or professional sports
• Injuries you receive while breaking the law
• Injuries caused by air travel unless you are a passenger on a licensed aircraft operated by an airline
• Treatment of illnesses or injuries which are caused directly or indirectly by war, civil disturbance or any act of terrorism
• Routine Dental Treatment
• For routine maternity or pregnancy related conditions
• If the member travels against medical advice
• If the member travels abroad to get treatment
• For Convalescence or Rehabilitation services

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

• Illnesses or Accidents arising from drinking alcohol or taking drugs
• Deliberately injuring yourself
• Any nervous or psychiatric condition

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 Multi Trip from Vhi Healthcare.

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

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

8) Exclusions

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

a) Treatment which is not medically necessary treatment.

b) Vaccinations and routine or preventative medical examinations, including screenings, bone density scans and check-ups.

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

d) Long term nursing care and maintenance.

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

f) Contraceptive measures or their reversal.

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

h) Any treatment which is in any way related to artificially assisted reproduction.

i) Treatment or programmes for weight reduction or eating disorders other than anorexia nervosa and bulimia nervosa.

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

k) Experimental drugs and treatments.

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

m) Nursery fees.

n) Any charge for special nursing in hospital.

do) Any charge made for a medical report.

p) Treatment of illnesses or injuries which are caused directly or indirectly by war, civil disturbance or any act of terrorism.

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

r) Expenses for which the member is not liable.

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

t) Cosmetic treatment - unless it is needed (i) to restore the member’s appearance after an accident or (ii) because the member was severely disfigured at birth.

u) Ophthalmic procedures for correction of short-sightedness, long-sightedness or astigmatism.
9) Claims
In-patient treatment, day care, side room and out-patient procedures

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

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

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

- Payment of that estimate will be a complete discharge of our obligations to you.

- You must do this within six months of the date the treatment started.

- We will then pay the benefits for the hospital charges to you.

- You must use all the benefits we pay to you for the services for which you are claiming.

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

- Hospital invoices must be in a format specified by us. If they are not, we may be unable to calculate your exact benefit for hospital charges in which case we will calculate the benefit due to you as best we can from the information supplied, and we will pay this amount.

- Payment of that estimate will be a complete discharge of our obligations to you.

- You must do this within six months of the date the treatment started.

- We will then pay the benefits for the hospital charges to you.

- You must use all the benefits we pay to you for the services for which you are claiming.

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

e) Out-patient cover

We will pay benefits for eligible expenses listed in Section 6 of the Table of Benefits as a lump sum at the end of each year. We will only pay the benefits when you send us a claim form which you have completed and signed, together with receipts. You must do this within three months of the end of the year.

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

f) If you or another member are entitled to claim under any other insurance policy for any of the costs, charges or fees for which you are insured under this contract, we will pay only our rateable proportion of these costs. When making a claim you must tell us if you have other insurance.

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

10) Disputes

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

b) If you do not wish to avail of the procedure outlined in rule 10(a) you may refer your dispute directly to the Courts.

11) General

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

b) We will send any letters and notices about your contract, by ordinary post, to the address which you give us. So, you must tell us if you change your address.

c) The member must notify Vhi Healthcare immediately of any change to their policy or circumstances which could alter the assumptions on which the contract is based or which are material to same.

d) If any member makes, or tries to make, a dishonest application or claim we have the right to: (i) refuse to renew his/her membership; or (ii) cancel his/her membership immediately. We also have the right to refuse to pay any benefits for the member.

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

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

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

h) We will pay all your benefits in euro.

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

j) In accordance with the Health (Provision of Information) Act, 1997, Vhi Healthcare provides government agencies responsible for national health screening programmes with the name, address, date of birth, RSI number and Vhi Healthcare policy number of members of a requested demographic. No other information about our members is released. Vhi Healthcare also fully complies with the requirements of all Data Protection legislation.
12) Third Party Claims

a) As outlined in Rule 8(s) expenses which are recoverable from a third party, are excluded from benefit, however:

b) Legal Action/Proceedings

Where a claim is submitted to Vhi Healthcare in respect of treatment required as a result of an injury caused through the fault of another person and where you propose to pursue a legal claim against that party, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policy holder if you are under 18 years):
(i) complete in full and sign the injury section of the claim form which includes an undertaking to include all benefit paid by Vhi Healthcare in any claim against the third party responsible for causing the injury and
(ii) submit a fully completed undertaking, which will be relied on by Vhi Healthcare once a copy of the Authorisation Form is received from the Personal Injuries Assessment Board, refer to rule 12(d) from your solicitor in the form prescribed by Vhi Healthcare:-
"In consideration of Vhi discharging the eligible hospital and medical expenses of my/our client, I/we hereby undertake to include as part of my/our client’s claim the monies so paid by Vhi (details of which will be supplied to us by Vhi) and subject to any court order to the contrary, to repay to Vhi – out of the proceeds that come into our hands – all such monies paid by Vhi"
(iii) notify Vhi Healthcare in writing if it is proposed that the case will be settled and
(iv) provide Vhi Healthcare with full written details of any settlement.

c) No Legal Action/Proceedings

Where a claim is submitted to Vhi Healthcare in respect of treatment you require as a result of an injury caused through the fault of another person, and you do not propose to pursue a claim against the third party and, in the view of our legal advisers, expenses are recoverable from that party, Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policy holder if you are under 18 years):
(i) complete in full and sign the injury section of the claim form which includes an undertaking to include all benefit paid by Vhi Healthcare in any claim which may subsequently be made against the third party responsible for causing the injury and
(ii) immediately notify Vhi Healthcare in writing of the instigation of any such claim and to repay the benefit paid by Vhi Healthcare in full, subject to any court order to the contrary.

d) Personal Injuries Assessment Board

Where you make your application to the Personal Injuries Assessment Board ("PIAB"), Vhi Healthcare will pay benefit in accordance with these rules provided that you (or the subscriber/policy holder if you are under 18 years) complete in full and sign the injury section of the claim form. This undertaking provided by you also authorises Vhi Healthcare to provide the PIAB with details of all monies paid by Vhi Healthcare relating to your application, and for the PIAB to release to Vhi Healthcare details of the PIAB assessment in relation to the monies paid by Vhi Healthcare. Where the PIAB decides that the case is more appropriately dealt with by the court, due to some legal dispute and issues a letter of Authorisation, Vhi Healthcare will rely on the undertaking that has been provided by your solicitor, in accordance with 12b(ii) above, and a copy of the Authorisation from PIAB to proceed to the courts.

e) Criminal Injuries Compensation Tribunal Claims

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

f) Threshold Amount

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

g) Unsuccessful/Withdrawn Claims

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

h) Disclosure

It is the responsibility of a member to disclose to Vhi Healthcare full details of any action to be pursued against a third party in relation to any incident/accident in respect of which Vhi Healthcare has paid benefit. Failure to do so will result in the refusal of any subsequent claims relating to the accident/incident.
### SECTION 1

<table>
<thead>
<tr>
<th>Hospital charges (in participating hospitals)</th>
<th>Benefits (as a percentage of the hospital charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong></td>
<td>*<em>A / A Option</em></td>
</tr>
<tr>
<td>Day care &amp; side room</td>
<td>Full cover</td>
</tr>
<tr>
<td>Semi-private accommodation</td>
<td>Full cover</td>
</tr>
<tr>
<td>Private accommodation</td>
<td>Semi-private rate. See directory of hospitals (and treatment centres) for full cover exceptions.</td>
</tr>
</tbody>
</table>

**b) Private Hospitals and Treatment Centres**

**Group 1** (other than for certain investigations and treatments referred to below; also see notes below)

| Day care & Side room & Out-patient procedures & Out-patient radiotherapy | 60% (see Note 1) | Full cover | Full cover | Full cover | Full cover |
| Semi-private accommodation                      | 60% (see Note 1) | Full cover | Full cover | Full cover | Full cover |
| Private accommodation                           | 45% (see Note 1) | Semi-private rate. See directory of hospitals (and treatment centres) for full cover exceptions. | Full cover | Full cover | Full cover |

**Group 2** (other than for certain investigations and treatments referred to below; also see notes below)

| Day care & Side room & Out-patient procedures & Out-patient radiotherapy | 60%          | Full cover | Full cover | Full cover | Full cover |
| Semi-private accommodation                      | 35%          | 45%        | 55%        | Full cover | Full cover |
| Private accommodation                           | 25%          | 35%        | 40%        | Semi-private rate | Full cover |

**c) Certain investigations & treatments** – herein referred to as Fixed Price Procedures (contact us for details of these)*

| Blackrock Clinic, Mater Private Hospital, Beacon Hospital | 35% | 90% | 90% | Full cover | Full cover |
| Galway Clinic                                            | 0%  | 90% | 90% | Full cover | Full cover |

**d) Northern Ireland (non-directory Hospitals)**

| Plan A €126.97 excess per day Plan A Option €63.49 excess per day | Full cover | Full cover | Full cover | Full cover |

**e) Northern Ireland (directory Hospitals)**

| Plan A €126.97 excess per day Plan A Option €63.49 excess per day | Full cover | Full cover | Full cover | Full cover |

**Notes:**

1. Members on Plan A/A Option have no cover for Galway Clinic.
2. ‘Semi-Private Rate’ means the amount which the hospital would have charged if the member had stayed in semi-private accommodation.
3. * Members subscribing to the Option Plans are fully covered for many major heart surgery procedures in the Mater Private Hospital, Blackrock Clinic and Beacon Hospital. Members subscribing to Plans B - C Option are fully covered for many major heart procedures in the Galway Clinic.
4. The availability of semi-private or private accommodation is determined by the hospitals and is outside the control of Vhi Healthcare.
5. Members subscribing to Plan B with Excess will have the same benefits as Plan B, subject to the hospital excess.
6. Members subscribing to Plan E will receive full benefit in non-participating hospitals provided the rates are those normally charged by that hospital.
7. Group 1 and Group 2 hospitals and treatment centres are identified in the Directory of Hospitals (and Treatment Centres).
**SECTION 2**

<table>
<thead>
<tr>
<th>Consultants’ Fees</th>
<th>All plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient treatment</td>
<td>For in-patient treatment, Day Care Procedures and Side Room Procedures specified in the Vhi Healthcare Schedule of Benefits for Professional Fees, we will pay the charge in full if the consultant is a participating consultant. If the consultant is non-participating, we will pay the standard benefit as set out in the Schedule of Benefits for Professional Fees and you may have to pay an additional amount to the consultant yourself. The standard benefit is lower than the benefit we will pay to a participating consultant. If you contact us, we will tell you whether or not a consultant is a participating consultant. If the hospital is not covered by your Plan, benefit will not be payable for the consultants’ fees.</td>
</tr>
<tr>
<td>Day-care procedures</td>
<td>For Out-patient Procedures, we will pay the benefits specified in the Schedule of Benefits for Professional Fees in accordance with Rule 6(b), even if the hospital is listed in the Directory of Hospitals (and Treatment Centres) and is not covered by your plan. No professional fee is payable for Out-patient Radiotherapy if the hospital is not covered by your plan. The same benefits apply to treatment carried out by a general practitioner which is listed in the Schedule of Benefits for General Practitioners. For subscribers/policy holders and their dependants subscribing to Plan E professional fees will be paid at the higher participating rates.</td>
</tr>
<tr>
<td>Side room procedures</td>
<td></td>
</tr>
<tr>
<td>Out-patient procedures</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 3**

<table>
<thead>
<tr>
<th>Maternity</th>
<th>All plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hospital charges:</td>
<td>Members are fully covered for up to 3 days hospital charges for a normal confinement subject to the following limits:</td>
</tr>
<tr>
<td>Plan</td>
<td>Public Hospital Benefit</td>
</tr>
<tr>
<td>Plan A/A Option</td>
<td>Full Cover</td>
</tr>
<tr>
<td>Plan B/B Option</td>
<td>Full Cover</td>
</tr>
<tr>
<td>Plan C/C Option</td>
<td>Full Cover</td>
</tr>
<tr>
<td>Plan D</td>
<td>Full Cover</td>
</tr>
<tr>
<td>Plan E</td>
<td>Full Cover</td>
</tr>
<tr>
<td>If there are significant medical complications arising from the pregnancy or delivery which necessitate a stay in hospital, we will pay the hospital benefits as listed in Section 1. Hospital benefits listed in Section 1 will also be payable for a caesarean delivery.</td>
<td></td>
</tr>
<tr>
<td>b) Consultants’ Fees:</td>
<td>We will pay part of the consultant delivery fee - as listed in the Schedule of Benefits for Professional Fees. The amount we will pay is higher for a caesarean delivery. We will also pay the benefits listed in the Schedule of Benefits for Professional Fees for: • the anaesthetist’s fee for giving an epidural; • consultant’s fees for in-patient pathology tests; and • a paediatric consultation.</td>
</tr>
<tr>
<td>c) Home births:</td>
<td>A contribution is payable for medical expenses incurred for home births subject to the following limits:</td>
</tr>
<tr>
<td>Plan</td>
<td>Benefit</td>
</tr>
<tr>
<td>Plan A/A Option</td>
<td>€2,275</td>
</tr>
<tr>
<td>Plan B/B Option</td>
<td>€3,150</td>
</tr>
<tr>
<td>Plan C/C Option</td>
<td>€3,150</td>
</tr>
</tbody>
</table>

**SECTION 4**

<table>
<thead>
<tr>
<th>Convalescence Benefit</th>
<th>All plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convalescent home charges for up to the first 14 nights only, in single room accommodation in convalescent homes listed in Vhi Healthcare’s Directory of Convalescent Homes.</td>
<td></td>
</tr>
<tr>
<td>Plan A/A Option</td>
<td>€45</td>
</tr>
<tr>
<td>Plan B/B Option</td>
<td>€51</td>
</tr>
<tr>
<td>Plan C/C Option</td>
<td>€58</td>
</tr>
<tr>
<td>Plan D</td>
<td></td>
</tr>
<tr>
<td>Plan E</td>
<td></td>
</tr>
<tr>
<td>Child nursing</td>
<td>We will pay up to €100 a day for a maximum of 14 days per calendar year.</td>
</tr>
<tr>
<td>Parent accompanying child</td>
<td>We will provide a maximum daily benefit of up to €40 for A-E and Option Plans from day 4 onwards. No benefit is available for the first 3 days.</td>
</tr>
</tbody>
</table>

**SECTION 5**

<table>
<thead>
<tr>
<th>Transport costs</th>
<th>All plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Ambulance costs (see rule 6(o))</td>
<td>We will provide full cover.</td>
</tr>
<tr>
<td>b) Taxi costs (see rule 6(o))</td>
<td>We will provide full cover.</td>
</tr>
</tbody>
</table>
### SECTION 6

<table>
<thead>
<tr>
<th>Out-patient Cover</th>
<th>Plans A – C</th>
<th>Plans D, E and A-C Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) General practitioner visits</td>
<td>Up to €13 per visit</td>
<td>Up to €20 per visit</td>
</tr>
<tr>
<td>b) Consultant consultations</td>
<td>Up to €39 per visit</td>
<td>Up to €51 per visit</td>
</tr>
<tr>
<td>c) Pathology - consultants’ fees</td>
<td>Up to €20 per referral in an approved out-patient centre</td>
<td>Up to €20 per referral in an approved out-patient centre</td>
</tr>
<tr>
<td>d) Radiology - consultants’ fees</td>
<td>Up to €60 per procedure</td>
<td>Up to €60 per procedure</td>
</tr>
<tr>
<td>e) Pathology, radiology or other diagnostic tests</td>
<td>50% of agreed charges in an approved out-patient centre (see Directory of Hospitals and Treatment CENTRES) up to €500 per member per year</td>
<td>50% of agreed charges in an approved out-patient centre (see Directory of Hospitals and Treatment CENTRES) up to €500 per member per year</td>
</tr>
<tr>
<td>f) Public hospital out-patient levy</td>
<td>Up to €13 per episode of care</td>
<td>Up to €20 per episode of care</td>
</tr>
<tr>
<td>g) Physiotherapy</td>
<td>Up to €13 for each session with a physiotherapist if the member needs physiotherapy because of a medical condition. The physiotherapist must be a member of the Irish Society of Chartered Physiotherapists.</td>
<td>Up to €385 in the year in which the birth happens</td>
</tr>
<tr>
<td>h) Pre- &amp; post-natal care carried out by a G.P., consultant or midwife</td>
<td>Up to €255 in the year in which the birth happens</td>
<td>Up to €385 in the year in which the birth happens</td>
</tr>
<tr>
<td>i) Vhi Healthcare approved medical and surgical appliances</td>
<td>50% up to a maximum of €1,000 per member per year</td>
<td>50% up to a maximum of €1,000 per member per year</td>
</tr>
<tr>
<td>j) Alternative medicine</td>
<td>Up to €13 per visit to a maximum of twelve combined visits in a year where treatment is provided by an acupuncturist, chiropractor, osteopath, reflexologist and physical therapist as defined in this Rules document.</td>
<td>Up to €20 per visit to a maximum of twelve combined visits in a year</td>
</tr>
<tr>
<td>k) Dietetics, Occupational Therapy, Podiatry/Chiropody, Speech Therapy &amp; Clinical Psychology</td>
<td>Up to €13 per visit to a maximum of twelve combined visits in a year where treatment is provided by a dietician, occupational therapist, podiatrist/chiropodist, speech therapist and a clinical psychologist as defined in this Rules document.</td>
<td>Up to €20 per visit to a maximum of twelve combined visits in a year</td>
</tr>
<tr>
<td>l) Eye testing</td>
<td>Up to €20 every 24 months when carried out by an Optometrist registered with the Opticians Board, or by an Ophthalmic Surgeon or Ophthalmic Physician registered with Vhi Healthcare</td>
<td>Up to €20 per 12 month period in excess of any social welfare benefit paid</td>
</tr>
<tr>
<td>m) Dental check-up</td>
<td>€20 per 12 month period in excess of any social welfare benefit paid</td>
<td>€20 per 12 month period in excess of any social welfare benefit paid</td>
</tr>
<tr>
<td>n) Mental Health Therapy Session</td>
<td>Up to €20 per visit in an approved out-patient mental health centre to a maximum of 12 visits per member per year</td>
<td>Up to €20 per visit in an approved out-patient mental health centre to a maximum of 12 visits per member per year</td>
</tr>
</tbody>
</table>

**Annual Excess per person**
- Plans A – C: €250
- Plans D, E and A – C Option: €200

**Annual Maximum per person**
- Plans A – C: €3,200
- Plans D, E and A – C Option: €4,000

### SECTION 7

A list of approved clinical indications for MRI scans for which the following benefits are payable appears at the back of this Rules document.

**In-patient MRI scans**

If the patient, during the course of a medically necessary stay in a participating hospital listed in the Directory of Hospitals (and Treatment CENTRES) which is covered by your plan and for which hospital benefit is payable, has an eligible MRI scan performed in an approved MRI CENTRE listed in the Directory of Approved CENTRES and which is covered by your plan, we will provide benefit for the MRI charges, in accordance with the level of cover under the patient’s plan in the admitting hospital. We will provide full cover for the consultant’s fee if he/she is participating.

**Out-patient MRI scans**

- We will provide full cover for MRI charges for all plans if the patient attends an Approved MRI CENTRE listed as ‘Out-patient MRI Scans - Category 1’ in the Directory of Approved CENTRES. • If the patient attends an Approved MRI CENTRE that is listed in the Directory of Approved CENTRES as ‘Out-patient MRI Scans - Category 2’ and which is covered by your plan, we will pay the agreed hospital charges and the consultant’s fee, subject to an excess of €125 per scan. The consultant’s fee is subject to a maximum of the participating benefit listed in the Vhi Healthcare Schedule of Benefits for Professional Fees. • If the patient attends an Approved MRI CENTRE that is listed in the Directory of Approved CENTRES as ‘Out-patient MRI Scans - Category 3’ a maximum of €200 for all plans can be included as part of an out-patient benefit claim and the appropriate out-patient excess will apply. • If the patient attends an out-patient, an Approved MRI CENTRE that is not listed in the Directory of Approved CENTRES as ‘Out-patient MRI Scans - Category 1’, ‘Out-patient MRI Scans - Category 2’, or ‘Out-patient MRI Scans - Category 3’, no benefit is payable for either the hospital charge or the consultant’s fee for all plans.

**Out-patient CT scans**

- If the patient attends the Advanced Radiology Centre for out-patient CT scans (with GP or Consultant referral) payments will be made directly to the centre and will not be subject to an excess.

### SECTION 8

**Treatment outside Ireland**

<table>
<thead>
<tr>
<th>Plans A &amp; B</th>
<th>Plans C, D &amp; E and Option Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to €65,000</td>
<td>Up to €100,000</td>
</tr>
</tbody>
</table>

### SECTION 9

**Cancer Care Support – All Plans**

We will pay for one night’s accommodation up to €100, for each treatment, to a maximum of €1,500 per calendar year.
# Directory of Hospitals (and Treatment Centres)

## Participating Hospitals

For the purposes of this Directory of Hospitals the plan reference also denotes the Option Plan equivalent, i.e. A equates to Plan A Option etc. For members subscribing to Plan B with Excess, cover in private hospitals is subject to the hospital excess. Only hospitals that do not have a direct-payment arrangement with us are listed in bold.

<table>
<thead>
<tr>
<th>Hospitals (and Treatment Centres)</th>
<th>VHI Healthcare Plan Needed for Full Cover</th>
<th>Hospitals (and Treatment Centres)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan</td>
<td>General Hospital, Cavan PUB A A</td>
<td>Kerry</td>
</tr>
<tr>
<td>Clare</td>
<td>Bushypark Treatment Centre, Ennis ▲ Group 1 B B</td>
<td>Kerry General Hospital, Tralee PUB A A</td>
</tr>
<tr>
<td></td>
<td>Cahercomma Community Hospital Group 1 B B</td>
<td>Talbot Grove Centre ▲ Group 1 B B</td>
</tr>
<tr>
<td></td>
<td>Mid Western Hospital, Ennis PUB A A</td>
<td>Kilclare</td>
</tr>
<tr>
<td>Cork</td>
<td>Bon Secours Hospital Group 1 C B</td>
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<td>Lourdes Orthopaedic Hospital, Kilcreene PUB B -</td>
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<td>Milford Hospital PUB A A</td>
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<td>Shankill Hospital, Mallow Group 1 B B</td>
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<td>St. Mary’s Orthopaedic Hospital PUB A A</td>
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<td>Beaumont Hospital PUB B A</td>
<td>Hope House, Addiction Residential ▲ Group 1 B -</td>
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<tr>
<td></td>
<td>(incorporating St. Joseph’s Hospital, Raheny)</td>
<td>Treatment Centre, Foxford</td>
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<td>Blackrock Clinic Group 2 E D</td>
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<td>Bon Secours Hospital, Glaasnev Group 1 C B</td>
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<td>Cappagh National Orthopaedic Hospital PUB A</td>
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<td>M.S. Care Centre, Rathgar Group 1 B -</td>
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<td>Rhenumohtology Rehabilitation PUB A A</td>
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<td>Royal Victoria Eye and Ear Hospital PUB B A</td>
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<td>Rutland Centre, Templeogue ▲ Group 1 C B</td>
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<td>Sports, Surgery Clinic, Sandy Group 1 C B</td>
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<td>St. Patrick’s Hospital Group 1 B A</td>
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<td>St. Vincent’s University Hospital, Elm Park PUB B A</td>
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<td>St. Vincent’s Hospital, Fairview PUB A A</td>
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<td>Slanhouse Street (Out-patient treatment program covered under all plans)</td>
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<tr>
<td>Galway</td>
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<td>Portlincusa Hospital, Ballinasloe PUB A A</td>
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<td>Regional Hospital, Merlin Park PUB B A</td>
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<td>University College Hospital, Galway PUB B A</td>
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## Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Group 1 Private Hospital</th>
<th>Group 2 Private Hospital</th>
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<tr>
<td>PUB</td>
<td>Approved Out-Patient Centre</td>
<td>Approved Out-Patient Centre</td>
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<td>Covered for Specified Treatment programmes only</td>
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<td>stand alone day care unit</td>
<td>stand alone day care unit</td>
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<tr>
<td>Note</td>
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<td>Cover not available for Plan A or Option Members</td>
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For any further information please call us on our Number Line 01 278 1000. The hospitals listed below are non-participating. Full details of benefits payable are available from any of our offices.
## Directory of approved MRI Centres

<table>
<thead>
<tr>
<th>APPROVED MRI CENTRES</th>
<th>IN-PATIENT MRI SCANS</th>
<th>OUT-PATIENT MRI SCANS</th>
<th>REFERRAL TYPE COVERED</th>
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<tbody>
<tr>
<td>Aut Even Hospital, Kilkenny</td>
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<td>Consultant and GP</td>
</tr>
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<td>Beaumont Hospital, Dublin</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td></td>
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<td>Consultant</td>
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<td>Consultant and GP</td>
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<td>Consultant</td>
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<tr>
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<td>Consultant</td>
</tr>
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<td>Blackrock Clinic, Dublin</td>
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<td>Consultant</td>
</tr>
<tr>
<td>Bon Secours Hospital, Cork</td>
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<td>Consultant and GP</td>
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<tr>
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<td>Category 2</td>
<td>Consultant and GP</td>
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<tr>
<td>Cappagh National Orthopaedic Hospital, Dublin</td>
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<td>Consultant and GP</td>
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<tr>
<td>Charlemont Clinic, Dublin</td>
<td>✓</td>
<td>Category 1</td>
<td>Consultant and GP</td>
</tr>
<tr>
<td>Charter Medical Group, Dublin</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td>Children’s University Hospital, Temple Street, Dublin</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td>Galway Clinic</td>
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<td>Category 1</td>
<td>Consultant</td>
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<tr>
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<td>✓</td>
<td>Category 2</td>
<td>Consultant and GP</td>
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<tr>
<td>General Hospital, Letterkenny</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td>Hermitage Medical Clinic, Dublin</td>
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<td>Category 1</td>
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<td>Mater Misericordiae Hospital, Dublin</td>
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<tr>
<td>Mater Private Hospital, Dublin</td>
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<tr>
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<td>✓</td>
<td>Category 2</td>
<td>Consultant and GP</td>
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<tr>
<td>Mid-Western Regional, Limerick</td>
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<td>Consultant</td>
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<tr>
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<td>MRI Centre, Barringtons Hospital, Limerick</td>
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<td>MRI Centre Galway Ltd., Bon Secours Hospital</td>
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<td>MRI Unit, Clare Hospital</td>
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<tr>
<td>MRI Unit, Mercy University Hospital, Cork</td>
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<td>MRI Ireland at Portiuncula Hospital</td>
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<td>MRI Ireland at Sligo General Hospital</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td>MRI Centre Tralee Ltd, Bon Secours Hospital</td>
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<td>MRI Centre Tullamore, Tullamore General Hospital</td>
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<td>Northwood Imaging, Dublin</td>
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<td>Our Lady’s Children’s Hospital, Crumlin</td>
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<tr>
<td>Scancor Ltd, in Cork University Hospital</td>
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<tr>
<td>Sports Surgery Clinic, Santry Demesne, Santry</td>
<td>✓</td>
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<td>St. James’s Hospital, Dublin</td>
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<tr>
<td>St. Vincent’s Private Hospital, Dublin</td>
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<tr>
<td>St. Vincent’s University Hospital, Dublin</td>
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<td>Consultant and GP</td>
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<td>The Adelaide &amp; Meath Hospital, Dublin incorporating the National Children’s Hospital, Tallaght</td>
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<td>Trans Specialists Ltd, South Infirmary, Cork</td>
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<tr>
<td>Waterford Regional Hospital</td>
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<td>Consultant and GP</td>
</tr>
<tr>
<td>Whitfield Clinic, Waterford</td>
<td>✓</td>
<td>Category 2</td>
<td>Consultant and GP</td>
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</tbody>
</table>

- ✓ In-patient MRI Scans: Covered in accordance with the plan held as part of a medically necessary stay in a participating hospital listed in the Directory of Hospitals (and Treatment Centres).
- Out-patient Category 1: Full cover for agreed MRI Charges.
- Out-patient Category 2: Agreed MRI charges may be claimed upon receipt of paid accounts and are subject to an excess of €125 per scan. Refer Section 7 of your Table of Benefits.
- Category 1 providers (as indicated in the Directory) will be open at a minimum from Monday to Friday for eight hours each day.

* Established oncology patient of the hospital - direct payment reimbursement to the Hospital for established oncology patients of Beaumont Hospital applies to referrals from Oncologists in addition to Consultants of other disciplines where there is a diagnosis of cancer and where the MRI scan is required for the treatment of the patient’s cancer.

This Directory is subject to change. The most up-to-date version along with comprehensive information on cover arrangements, opening times and contact details for all MRI Centres is most readily available at the web address: www.vhi.ie/mri
List of Clinical Indications for MRI Scans*

* We recommend that if members are referred for an MRI scan and have any query about cover, they should phone Vhi Healthcare to confirm that the scan is eligible for benefit.

**Head (including MRA if performed)**

For exclusion, further investigation and monitoring of:
- Tumour of the brain or meninges
- Skull base or orbital tumour
- Acoustic neuroma
- Pituitary tumour
- Inflammation of the brain or meninges
- Encephalopathy
- Encephalitis
- Suspect leukodystrophies
- ENT problems – following consultation with a Radiologist
- Demyelinating disease of the brain
- Congenital malformation of brain or meninges
- Venous sinus thrombosis
- Screening of intracranial aneurysm in the following high risk individuals:
  1. Positive family history, defined as two or more first degree relatives with
  2. Patients with polycystic kidney disease

For further investigation and monitoring of:
- Head trauma
- Epilepsy
- Stroke
- Post-operative follow-up after brain surgery

**Ophthalmic**

For further investigation of:
- Suspected intra-orbital or visual pathway lesions
- Dysthyroid eye disease
- Diplopia

**Spine**

For exclusion, further investigation and monitoring of:
- Tumour of the CNS or meninges
- Inflammation of the CNS or meninges
- Demyelinating disease
- Spinal cord compression (acute)
- Congenital malformations of the spinal cord, cauda equina or meninges
- Syrinx – congenital or acquired
- Myelopathy

For further investigation and monitoring of:
- Cervical radiculopathy with neurological signs
- Thoracic radiculopathy with neurological signs
- Lumbar radiculopathy with neurological signs
- Spinal canal stenosis
- Previous spinal surgery
- Trauma

For investigation of:
- Any cause of spinal disease in pregnancy

**Musculoskeletal System**

For exclusion, further investigation and monitoring of:
- Tumour arising in bone or other connective tissue
- Infection arising in bone or other connective tissue
- Osteonecrosis
- Derangement of the hip, knee, ankle, shoulder, elbow or wrist joints or their supporting structures
- Sacro-iliac joints in the following circumstances:
  1. There is a suspicion of the presence of ankylosing spondylitis and
  2. Patients have negative or inconclusive plain radiography films of the sacro-iliac joints and
  3. Patients are HLA B27 positive

For further investigation and monitoring of:
- Slipped upper femoral epiphysis
- Post inflammatory or post traumatic epiphyseal fusion in a person under 16 years of age
- Complex cases of juvenile dermatomyositis
- Gaucher’s disease
- Juvenile dermatomyositis by guiding biopsy

**Cardiovascular System (including MRA if performed)**

**Thoracic aortic disease**
- Abnormal aortic contour or size on chest X-ray, differentiation of mediastinal mass vs. vascular abnormality, to rule out aortic dissection, aneurysm, leaking thoracic aneurysm, exclude aortic source of peripheral embolisation, Y'Alsalva aneurysm, Marfan’s syndrome and aorta annular actasia, after therapy of aortic dissection of aortic arch anomalies, coarctation, following aortic angioplasty, peri-aortic abscess or infection
- Pericardial disease
- To assess pericardial thickness and detection of metastases, for diagnosing pericarditis and constriction, for diagnosing effusion and tamponade
- External or internal masses, pathology of lung and pleura
- Chest wall and mediastinal tumor invasion of the lung and pleura, lipoma, intracavity tumors, and differentiation of tumour from thrombus, assessment of vascular invasion, hiliar assessment, and paracardial/cardiac invasion, pleural diseases
- Pathology involving surrounding structures
- To evaluate intrinsic abnormalities of the pulmonary arteries, including central thrombi, aneurysms, stenoses, occlusions, dissection, and extra-vascular disease involving the pulmonary arteries
- Assessment of ventricular dysplasia
- Congenital heart disease
- Pulmonary atresia, severe obstruction to the right ventricular outflow tract, complex cyanotic heart disease, pulmonary venous anomalies, after surgery for correction of congenital heart disease
- Cardiac function, morphology, and structure
- After it has been determined that echocardiogram is inconclusive
- Sudden cardiac death screening
- Screening of first degree relatives (mother, father, brother, sister or child) of an individual who has experienced sudden cardiac death under 30 years of age following initial screening by ECG, echocardiogram and holter monitoring that has identified unusual results
- Diseases of the large veins
- Acquired and congenital abnormalities of the superior vena cavae, inferior vena cavae, and portal venous system (e.g. vena caval thrombus, differentiation of tumour thrombus and blood clot of the vena cava, superior vena cava syndrome, superior vena caval invasion or encasement by lung or mediastinal tumours, diagnosis of Budd-Chiari syndrome, and diagnosis of caval anomalies)
- Valvular heart disease
- After it has been determined that ECG and doppler studies are inconclusive
- To demonstrate complications of infarction
- Formation of an aneurysm, mural thrombus formation, to demonstrate regional wall motion or wall thickening abnormalities of a damaged left ventricle
- Others
- Post operative aortic graft infection or dehiscence
- For further investigation, in persons under the age of 16 years, of the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome
Abdomen
Characterisation of liver lesions when an ultrasound report is suggestive of haemangioma
Placenta Accreta / Percreta
Adenomyosis - Pre-procedural planning for uterine artery embolisation for fibroids
Assessment of fistulae/abscesses in patients with established Crohn’s disease following discussion with a multi-disciplinary team
For post operative evaluation of:
Perineal abscess
Perineal fistula
Assessment of the inferior vena cava in patients with known solid renal tumour
MR urography (MRU) in patients with urographic contrast allergy
MR urography in pregnancy

Magnetic Resonance Cholangiopancreatography (MRCP)
For further investigation of:
Pancreatic and biliary disease where conventional methodology has not revealed the definitive diagnosis and ERCP is considered undesirable

Magnetic Resonance Angiography (MRA)
For exclusion or further investigation of:
Stroke
Carotid and vertebro-basilar disease
Carotid or vertebral artery dissection
Intracranial aneurism
Intracranial arteriovenous malformation
Venous sinus thrombosis
Vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium
Obstruction of the superior vena cava, inferior vena cava or a major pelvic vein
Peripheral arteries to determine the presence and extent of peripheral arterial disease in lower extremities
For exclusion of:
Renal artery stenosis post renal transplant
Renal artery stenosis in patients with refractory hypertension requiring multiple therapies, or in patients with documented renal insufficiency in whom renal vascular disease is being considered and in whom angioplasty and stenting is being considered

Body
For further investigation and monitoring of:
Malignant soft tissue tumours for diagnosis and staging
For further investigation of:
Congenital uterine or anorectal abnormality

Breast
For the detection of:
Breast cancer - where mammogram and/or ultrasound are negative for pathology but there continues to be a high index of clinical suspicion (e.g. in persons with inherited BRCA1 and BRCA2 mutations)
Pre-operative evaluation of patients with:
Invasive lobular carcinoma
Multi-focal or multi-centric diseases and age less than 40yrs

Other Exceptions
As notified to the Vhi Medical Director and approved for benefit by Vhi Healthcare
Voluntary Health Insurance Board
An Bord Árachás Sláinte Shaorálaigh

Postal Address: IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.
Telephone Number: CallSave 1850 44 44 44
Lines open: 8am – 8pm Monday – Friday
9am – 3pm Saturday
Website: www.vhi.ie
E-mail: info@vhi.ie

Dublin
Vhi House, Lower Abbey Street, Dublin 1.
Fax (01) 799 4091

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

Dun Laoghaire
35/36 Lower George’s Street, Dun Laoghaire, Co. Dublin.
Fax (01) 619 7456

Galway
Vhi House, 10 Eyre Square, Galway.
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