HEALTH
INSURANCE

Irish Life
health

Key Terms & Conditions

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Thank you for choosing Irish Life Health

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1 SCHEDULE OF BENEFITS

THE SCHEDULE OF BENEFITS AND GP BOOKLET

The Schedule of Benefits sets out the treatments and procedures we cover and which of these need to be pre-authorised. It shows the clinical indicators that must be present in order for a procedure or treatment to be covered. It also specifies that certain treatments and procedures will only be covered if they are performed by a certain type of health care provider or if they are performed in a certain place (i.e. in a hospital).

The GP Booklet sets out the procedures and treatments that we will cover when they are carried out by your GP in their surgery. It also shows which of these procedures and treatments require pre-authorisation and sets out any clinical indicators that apply.

Both of these documents contain medical language which is really designed to be read by doctors and consultants. For this reason, we would advise you to contact us or your health care provider before undergoing your procedure or treatment to confirm whether it will be covered by us.

The Schedule of Benefits and the GP Booklet can be accessed on our website at Irishlifehealth.ie or a hard copy can be requested from us.

THE LISTS

These Lists show what is covered under certain benefits and in some cases contain criteria which must be satisfied before the benefit will apply. We will let you know throughout your Membership Handbook or in your Table of Cover when it is necessary to refer to a List in connection with a benefit. The Lists are available on our website www.irishlifehealth.ie/privacy-and-legal/schedule-of-benefits/

The following is a brief explanation of each of the Lists:

1. The List of Special Procedures
This confirms which procedures are covered under the Listed Special Procedures benefit.

2. The List of Cardiac Procedures
This confirms which procedures are covered under the Listed Cardiac Procedures benefit.

3. The List of Post-Operative Home Help (POHH) Procedures
The post-operative home help benefit is only available following certain procedures. These are set out in the List of Post-Operative Home Help (POHH) Procedures.

4. The List of Medical and Surgical Appliances
This list confirms the medical and surgical appliances for which you can claim a contribution from us under the medical and surgical appliances benefit. It also sets out the contribution that can be claimed for each appliance.

5. The List of Orthopaedic Procedures Subject to Co-Payment
This list specifies the orthopaedic procedures where a co-payment applies when such procedures are carried out in a private or high-tech hospital.

6. The List of Cardiac Procedures Subject to Co-Payment
This list specifies the cardiac procedures where a co-payment applies when such procedures are carried out in a private or high-tech hospital.

7. The List of Clinical Indicators for Cardiac MRI and Cardiac CT Scans
This list sets out the clinical indicators that must be satisfied for cardiac MRI and cardiac CT scans.

8. The List of Gender Reassignment Procedures
This list confirms which procedures are covered under the gender reassignment benefit.

2 WAITING PERIODS

WAITING PERIODS

A waiting period is the amount of time that must pass before you will be covered under your plan or before you will be covered to the level of cover available under your plan. Previous foreign health insurance coverage is not taken into account for waiting periods.

There are a number of different types of waiting periods:

- Initial waiting periods
- Pre-existing condition waiting periods
- Upgrade waiting periods

INITIAL WAITING PERIODS

Initial waiting periods apply when you take out health insurance for the first time or when you take out health insurance after your health insurance has lapsed for more than 13 weeks. You will not be covered during your initial waiting period.

Initial waiting periods do not apply in the following circumstances:

- To claims made in respect of children who have been added to your policy within 13 weeks of the date of their birth
- To claims made in respect of adopted children who have been added to your policy within 13 weeks of the date of their adoption
- To claims in respect of emergency care for accidents and injuries.

The table below sets out the initial waiting periods applied by Irish Life Health. These waiting periods will apply from the date you took out health insurance with Irish Life Health or another insurer for the first time, or, from the date you took out health insurance with Irish Life Health or another insurer after your health insurance had lapsed for more than 13 weeks.

Initial Waiting Periods

Benefit	Under 55 years old	55 years and older
All In-patient Benefits including Overseas Benefits Gender Reassignment Benefit Medicall Ambulance Cost Health In the Home PET CT Scans	26 weeks	
Maternity in-patient benefits Home birth Grant in aid Infertility benefit: IVF, ICSI, IUI	52 weeks	
All Day-to-Day Benefits Genetic Testing: Initial consultation Genetic Testing: Test for specified genetic mutations Convalescence Benefit Parent Accompanying Child Parent Accompanying Child (no minimum stay) Cancer Support Benefit	None	26 weeks

Benefit	Under 55 years old	55 years and older
Medical & Surgical Appliances All Out-patient Benefits Personalised Package/Extra Benefits (excluding Home birth grant in aid and Infertility Benefit: IVF, ICSI, IUI) Healthy Minds Companion expenses Minor Injury Clinic Cover Minor Injury Clinic Cover (HSE)	None	
Child Home Nursing	None	N/A

PRE-EXISTING CONDITION WAITING PERIODS

Where you make a claim which relates to a pre-existing condition, a pre-existing condition waiting period will apply. A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time in the six months before you took out health insurance for the first time or before you took out health insurance after your health insurance had lapsed for more than 13 weeks.

You will not be covered for a pre-existing condition during your pre-existing condition waiting period. Our medical advisers will decide whether your claim relates to a pre-existing condition. Their decision is final.

Pre-existing condition waiting periods do not apply in the following circumstances:

- To claims made in respect of children who have been added to your policy within 13 weeks of the date of their birth
- To claims made in respect of adopted children who have been added to your policy within 13 weeks of the date of their adoption.

The following table sets out the pre-existing condition waiting periods applied by Irish Life Health. These waiting periods will apply from the date you took out health insurance for the first time (with Irish Life Health or another insurer), or from the date you took out health insurance (with Irish Life Health or another insurer) after your health insurance had lapsed for more than 13 weeks.

Pre-Existing Condition Waiting Periods

Benefit	Under 55 years old	55 years and older
All In-patient Benefits including Overseas Benefits Gender Reassignment Benefit PET-CT Scans Health In the Home	5 years	
Maternity in-patient benefits Home birth Grant in aid Infertility benefit: IVF, ICSI, IUI	52 weeks	
All Day to Day Benefits All Out-patient Benefits Personalised Package/Extra Benefits (excluding Home birth grant in aid and Infertility Benefit: IVF, ICSI, IUI) Genetic Testing: Initial consultation Genetic Testing: Test for specified genetic mutations Healthy Minds Medicall Ambulance Cost Medical & Surgical Appliances Companion expenses Convalescence Benefit Child Home Nursing Parent Accompanying Child Parent Accompanying Child (no minimum stay) In-patient Support Benefit Cancer Support Benefit Minor Injury Clinic Cover Minor Injury Clinic Cover (HSE)	None	

UPGRADE WAITING PERIODS

An upgrade waiting period will apply when you upgrade your cover (i.e. you purchase a plan with more comprehensive cover than your previous plan). This may happen if you change your plan with us or when coming to Irish Life Health from another health insurer. We will apply an upgrade waiting period to claims where your treatment relates to a pre-existing condition. Where an upgrade waiting period applies, we will cover you up to the level that was available under the benefit that you are claiming of your previous plan. Where the benefit you are claiming was not available on your previous plan, you will not be covered.

A pre-existing condition is any ailment, illness or condition that, on the basis of medical advice, the signs or symptoms of which existed at any time in the period of six months ending on the day on which

- you took out health insurance for the first time
- or you took out health insurance after your health insurance had lapsed for more than 13 weeks
- or you upgraded your cover to a higher level plan.

In these circumstances, you will be covered up to the level of cover that was available on the plan that you previously held before upgrading your cover.

Please see the upgrade waiting period table below for the details of upgrade waiting periods by benefit type. Our medical advisers will determine when your ailment, illness or condition commenced. Their decision is final. The table below sets out the upgrade waiting periods applied by Irish Life Health. These waiting periods will apply from the date you upgraded.

Upgrade Waiting Periods

Benefit	Under 55 years old	55 years and older
All In-patient Benefits including Overseas Benefits Gender reassignment benefit Medicall Ambulance Cost Health In the Home PET CT Scans	2 years	
Maternity in-patient benefits Home birth Grant in aid Infertility benefit: IVF, ICSI, IUI	52 weeks	
Convalescence Benefit Parent Accompanying Child Parent Accompanying Child (no minimum stay) Cancer Support Benefit Medical & Surgical Appliances	None	52 weeks
All Day to Day Benefits Genetic Testing: Initial consultation Genetic Testing: Test for specified genetic mutations	None	26 weeks
All Out-patient Benefits Personalised Package/Extra Benefits (excluding Home birth grant in aid and Infertility Benefit: IVF, ICSI, IUI) Companion expenses Healthy Minds Minor Injury Clinic Cover Minor Injury Clinic Cover (HSE)	None	
Child Home Nursing	None	N/A

3 HOSPITAL & OUTPATIENT EXCESSES

EXCESS

Excess is the part of a claim which must be paid by the member and which applies after all co-payments and shortfalls are paid.

EXCESS/SHORTFALL/CO-PAYMENT

You will need to pay any excess, shortfall or co-payment that applies to a benefit or a group of benefits under your plan. You can't claim these expenses back from us. You can see if an excess, shortfall or co-payment applies by checking your Table of Cover.

HOW TO CALCULATE YOUR COVER UNDER YOUR DAY-TO-DAY BENEFITS AND OUTPATIENT BENEFITS

The amount that can be claimed under these benefits may be a set amount per visit or it may be a percentage of the cost of the visit up to a maximum amount per visit or per policy year. There may be a limit to the number of times in your policy year that you can claim a refund for a visit to a particular medical practitioner or for a particular service. Where this is the case, the service provider will be named in your Membership Handbook. In addition, the number of refunds that you can claim for specified practitioners collectively may be limited (this is known as "combined visits"). Please note that there may be a limit on the total amount that we will pay for Day-to-day Benefits or Outpatient Benefits in a policy year. This limit will apply before the deduction of any applicable policy excess.

In addition, an excess may apply to the total amount you claim under your Day-to-day Benefits or Outpatient Benefits in your policy year. So for example, where an excess applies to the Outpatient Benefits under your plan, it applies to the total amount you are claiming for all your Outpatient Benefits in your policy year. When you submit your receipts to us we will calculate the total amount due to be refunded to you under all your Outpatient Benefits, subtract the excess and refund you the balance.

For example:

	Consultant	GP
Cover shown on Table of Cover	€60 x 4 visits	€25 x 6 visits
Number of times you visited your health care provider in your policy year and how much you paid per visit	3 x €150	7 x €60
Total amount that you can claim	3 x €60 = €180 (3 being the number of times you visited a consultant and €60 being the maximum amount that can be claimed per visit)	6 x €25 = €150 (6 being the maximum number of times you can claim for a visit to a GP and €25 being the maximum amount that can be claimed per visit)
Total amount that you can claim under both benefits	€330 (i.e. €180 + €150)	
Less outpatient excess	€200	
Money we pay you back	€130	

IN-PATIENT OR DAY CASE EXCESS

In some cases you may be required to pay an amount of your bill before your cover begins. You can see if you have an excess on your In-patient Benefits in your Table of Cover. Excesses on In-patient Benefits apply each time you are admitted to a medical facility subject only to the following exceptions:

- Where you are admitted as an in-patient or day case patient for the purpose of receiving chemotherapy, the in-patient excess will only apply once for each course of treatment. Where it has been more than 12 months since your last chemotherapy session, your course of treatment will be considered to have ended and the excess will apply again for any further course of treatment.
- Where you are admitted as a day case patient for the purpose of receiving psychiatric treatment in a medical facility, the day case excess will only apply once for each course of treatment provided all days relevant to that course of treatment are submitted as a single claim. Where it has been more than 3 months since your last admission, your course of treatment will be considered to have ended and the excess will apply again for any further course of treatment.
- Where your Table of Cover states that an in-patient or day case excess is only payable on a certain number of admissions.
- We will not apply the in-patient excess where you are admitted as an in-patient or day case patient for the purpose of receiving radiotherapy treatment.

CO-PAYMENT FOR CERTAIN PROCEDURES

A co-payment is a large excess and is an amount that must be paid by you. You will need to make a co-payment for any of the orthopaedic procedures specified in the List of Orthopaedic Procedures Subject to Co-Payment and/or for any of the cardiac procedures specified in the List of Cardiac Procedures Subject to Co-Payment where such orthopaedic and/or cardiac procedures are carried out in a high-tech or private hospital. Co-payments may apply in addition to any other shortfall or excess on your plan. This will be displayed on your Table of Cover.

4 HOW TO CLAIM

OUTPATIENT, DAY TO DAY OR PERSONALISED PACKAGE BENEFITS

You need to pay the practitioner/health care provider yourself and then claim the amount that is covered back from us during or at the end of your policy year by scanning your original receipts and submitting them through our online claims tool (Irish Life Health Online Claiming) in your member secure area on **www.irishlifehealth.ie**. You must submit your receipts within six months of the end of your policy year. If your receipts are not received within these six months, your claim will not be paid.

You should keep your original receipts for your own records and in case the images are unclear and we request them to be resubmitted.

Please ensure that all receipts state:

- The amount paid
- The full name of the member receiving treatment and their date of birth
- The date the treatment was received
- The type of practitioner that you attended
- The name, address and qualifications of the practitioner providing the care on the practitioner's headed paper.

5 HOSPITAL LISTS

The medical facilities covered under your plan are shown in your List of Medical Facilities. There are eight of these lists but only one will apply to your plan. You can see which one applies to you in your Table of Cover. All the Lists of Medical Facilities are contained in the tables of medical facilities in your Membership Handbook or online on www.irishlifehealth.ie/hospital-lists

6 CANCELLATION CHARGES

CANCELLING YOUR POLICY

Your policy or any of the plans listed on your policy may be cancelled before the end of your policy year for one of three reasons:

1. You no longer want health insurance with Irish Life Health

The policyholder can choose to cancel the policy or any of the plans listed on the policy at any time. To do this, they just need to call our customer services team or let us know in writing. If we're asked to remove a member from the policy, we reserve the right to tell them that they are no longer covered, however, please note that it is not our policy to do so. **It is the policyholder's responsibility to inform the members on their policy of any changes that affect their cover.**

2. Premiums are not kept up to date

We will cancel the policy or any of the plans listed on your policy if you do not pay your premium when it falls due. We will cancel the policy or any of the plans listed on the policy from the date that your premiums were paid up to (the Cancellation Date). We will not pay any claims for goods or services received after the Cancellation Date. We will send you a letter giving you 14 days' notice of our intention to cancel. We will send this to your last known address.

3. Incorrect Information/Fraud

We may cancel the policy or any of the plans on the policy if

- We are provided with incorrect information about any of the members named on the policy; or
- if any of the members named on your policy try to or make a fraudulent claim.

CONSEQUENCES OF CANCELLATION

Once a plan is cancelled, the member will no longer be covered. We will not pay any claims for goods or services received after the Cancellation Date. We will be entitled to recover any claim amount paid to a member for goods or services received after the Cancellation Date. The Out-patient Benefits and Day-to-day Benefits will be allocated on a pro rata basis. (e.g. where the GP visits benefit covers a contribution of up to €30 for up to 8 visits and the plan is cancelled after 6 months, the number of visits for which the member can claim will be reduced to 4). The yearly excess applicable to those benefits will not be reduced on a pro rata basis.

If a fully paid policy or plan is cancelled before the end of the policy year and no claims have been made before the policy or plan is cancelled, we will reimburse the policyholder for the cover the members have not received – i.e. from the Cancellation Date until the next renewal date. Please note we will apply a mid-term cancellation charge (you can find more information about this charge in the paragraph below). We will not return the amount of premium for any cover received before the date of cancellation. If we cancel a fully paid policy or plan before the end of the policy year due to the provision of incorrect information or fraud, we will not refund any of the premium that has already been paid.

MID-TERM CANCELLATION CHARGE

We will apply a mid-term cancellation charge if:

- You choose to cancel your policy or any of the plans listed in your policy before the end of your policy year;
- We are forced to cancel your policy or any of the plans listed in your policy due to non-payment of premium, because you or any of the members on the policy try to claim when you're/they're not entitled to or because you have provided us with incorrect information.

The mid-term cancellation charge is made up as follows:

- An administration fee of €25;
- The portion of the government levy which has not yet been paid by you. The government levy is a stamp duty which is payable on health insurance plans. A full explanation of the government levy is contained in the Definitions section of your Membership Handbook

We reserve the right to deduct the amount for the mid-term cancellation charge against any amount due to be refunded. In all other cases we will send you an invoice in respect of the mid-term cancellation charge.

COOLING OFF PERIOD

You can cancel your policy free of charge within 14 days from the date the policy was entered into or from the date you are given the policy documentation, whichever is the later. This is known as the cooling off period. We'll give you a full refund of premium unless you or any member has made a claim during this period. Should you wish to cancel your policy with effect from a date later than the start date, we will charge you for providing health insurance cover up to the date of cancellation and we will apply a mid-term cancellation charge in this case.

7 PAYMENT OPTIONS

PAYING YOUR PREMIUMS

All premiums must be paid in euro. We have a number of payment options which are outlined below.

You can pay your premium monthly by direct debit or annually, in full, by debit or credit card only. We do not accept payment by cheque.

If you have chosen to pay by direct debit, we will collect your premium on a monthly basis and it's up to you to make sure your monthly payments are available for collection. The first payment in any policy year may be more or less than your monthly premium if your policy start date is different to your chosen direct debit collection date. This may also occur if you decide to change your direct debit collection date mid policy year.

You can view your membership handbook in full by accessing the following link - **www.irishlifehealth.ie/help/handbooks/**

Irish Life Health dac is regulated by the Central Bank of Ireland.
Registered Office: Irish Life Centre, Lower Abbey Street, Dublin 1, Ireland.

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