AVIVA

Membership Handbook

March 2016

Thank you for choosing us to provide health insurance for you.

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Note: Words in bold italics in this Membership Handbook are defined terms. These are words or phrases commonly used in the private health insurance industry. If ***you*** don't understand any of these terms, ***you*** can find full explanations in the Definitions section at the end of this Membership Handbook.

1. Your Contract

Everything *you* need to know about *your policy*

Your contract with ***us*** is made up of the following:

- ***Your*** Membership Handbook
- ***Your*** completed Application Form, whether completed by ***you*** or on ***your*** behalf (if applicable)
- ***Your*** Membership Certificate, which sets out ***your plan***, ***your membership number***, ***your*** commencement date and ***your*** next ***renewal date***
- ***Your*** Table of Cover, which outlines the ***benefits*** in ***your plan*** and which List of Medical Facilities applies to ***your plan***
- The Schedule of Benefits, which sets out the ***treatments*** and ***procedures we*** cover
- The General Practitioners Fees for Surgical Procedures Booklet ("GP Booklet") which sets out the ***treatments*** and ***procedures you***'ll be covered for when they are provided by ***your GP*** in their surgery
- The Lists (explained below)
- Terms of Business
- Data Protection Statement

Health insurance ***policies*** are contracts between the insurer and the ***policyholder***, because the ***policyholder*** (or in some cases their employer) is the person who has arranged and paid for the ***policy***. However, the terms and conditions of this contract will apply to all ***plans*** and all ***claim***s made under the ***policy***. Therefore where ***we*** refer to '***you***' and '***your***' throughout this Membership Handbook, ***we*** refer to both the ***policyholder*** and the ***member***(s) listed on the ***policy***. This also applies to ***members*** of ***group schemes***. If ***you*** are a ***member*** of a ***group scheme*** where ***your*** employer has arranged ***your*** cover and is paying all or part of ***your*** premium, the Group Schemes section in this Membership Handbook will also apply to ***you***.

You must ensure that the information that is provided to ***us*** when you are taking out a policy (whether in an application form or otherwise) is accurate and complete (even where the information is being provided to ***us*** by someone on ***your*** behalf). Otherwise it could mean ***we*** won't pay a ***claim*** under the ***policy*** and some or all of the ***members' plans*** under the ***policy*** may be cancelled. This may also cause difficulty should ***you*** wish to purchase health insurance elsewhere.

Understanding *your* cover

Health insurance cover can be difficult to understand so to help ***you*** check ***your*** cover ***we*** have set out a checklist below. ***We*** understand that it may be difficult for ***you*** to figure out whether ***you*** are covered yourself so if ***you***'re in any way unsure, please call ***us*** on **(021) 480 2040** and we'll walk ***you*** through it. In fact ***we*** would always advise ***you*** to check ***your*** cover with ***us*** before undergoing any ***procedure*** or ***treatment*** or being admitted to a ***medical facility***. When checking ***your*** cover with ***us*** ***you*** will need to tell ***us*** where ***you*** intend to have the ***procedure*** or ***treatment*** performed; the name of ***your health care provider*** and the ***procedure***/***treatment*** code. ***You*** can get this information from ***your health care provider***.

The checklists below explain what to look for to see if ***you*** are covered under ***your*** Day-to-day Benefits, Out-patient Benefits or In-patient Benefits. You will notice that some of ***your benefits*** will be classed as Maternity Benefits or Other Benefits on ***your*** Table of Cover. Some of these ***benefits*** are ***claimed*** as Out-patient Benefits or In-patient Benefits and the checklists below will apply to these.

Day-To-Day Benefits and Out-Patient Benefits

What to look for	Where to check
• Is the ***benefit*** covered under ***your plan***? • How much will ***we*** pay? • Is there an ***excess***?	***Your*** Table of Cover
• What terms and conditions apply to the ***benefit***? • Does a waiting period apply? • How can ***you claim***?	***Your*** Membership Handbook
• What does the ***benefit*** cover? • Are there any further criteria?	The Lists (if applicable)

In-Patient Benefits

What to look for	Where to check
• Is the ***treatment*** or ***procedure*** an ***established treatment***? • Is the ***treatment*** or ***procedure medically necessary***? • Is ***your health care provider*** registered with ***Aviva*** and a participating ***health care provider***? • Will ***you*** be admitted to a ***medical facility*** and if so which one? • If not, where will ***you*** be having ***your procedure*** or ***treatment*** performed?	***Your health care provider***
• Is ***your treatment*** or ***procedure*** covered (is it listed in the Schedule of Benefits)? • Do any ***clinical indicators*** apply and do ***you*** meet them? • Does ***your treatment*** or ***procedure*** need to be ***pre-authorised***? • Is ***your treatment*** or ***procedure*** covered when it is carried out by the type of ***health care provider you*** are attending (i.e. is it covered when carried out by a ***GP***, ***dentist***, ***oral surgeon***, ***periodontist***)? • If ***your treatment*** or ***procedure*** is not going to be performed in a hospital or treatment centre, is it covered when it is carried out in ***your health care provider***'s rooms?	The Schedule of Benefits or ***your health care provider***
• Which List of Medical Facilities applies to ***you***? • What's ***your*** level of cover? i.e. Do ***you*** need to pay an ***excess***, shortfall or co-payment?	Table of Cover
• If ***you*** are being admitted to a ***medical facility***, is it included in the Lists of Medical Facilities covered under ***your plan***? • Does a waiting period apply? • How can ***you claim***? • Are there any further criteria?	***Your*** Membership Handbook

As ***you*** can see, ***you*** will need to take many factors into account to see whether ***your*** health expenses are covered. Below is a short explanation of the contractual documents and other factors that ***you*** need to take into account to see if ***you*** are covered.

Membership Handbook

This document:

- will help guide ***you*** through ***your*** health insurance cover
- explains the general terms and conditions of ***your*** contract with ***us***
- explains all our ***benefits*** including the terms and conditions which apply to each (but please note that all these ***benefits*** may not be available on ***your plan***)
- sets out the things that are not covered under ***your plan***
- explains how to make a ***claim***

Section 12 of this Membership Handbook contains tables which show the ***medical facilities*** that are covered under our ***plans***. They also show if ***we*** pay them directly (known as ***direct settlement***) or if ***you*** need to pay them yourself and ***claim*** this back from ***us***. ***You*** will be covered for the ***medical facilities*** specified in one of four lists shown in the tables (***your*** "List of Medical Facilities"). ***Your*** Table of Cover shows which List of Medical Facilities applies to ***you***.

Table of Cover

Your Table of Cover sets out the ***benefits*** that are available under ***your plan***.

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 **Avivahealth.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 this 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 **Avivahealth.ie**. 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***. See section 2.2 of this Membership Handbook for further information on this ***benefit***.

2. The List of Cardiac Procedures

This confirms which ***procedures*** are covered under the Listed Cardiac Procedures ***benefit***. See section 2.2 of this Membership Handbook for further information on this ***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 Clinical Indicators for GP Referral for MRI Scans

This list sets out the ***clinical indicators*** that must be satisfied when you are referred for a MRI scan by a ***GP.***

Ground rules

We will only cover the costs of ***medical care*** which our ***medical advisers*** believe is an ***established treatment*** which is ***medically necessary***. In addition ***we*** only cover ***reasonable and customary costs***.

Clinical indicators

In some cases medical criteria known as ***clinical indicators*** need to be satisfied before our ***medical advisers*** will consider the ***treatment*** or ***procedure*** to be ***medically necessary***. If ***clinical indicators*** apply, they will be set out alongside the ***procedure*** or ***treatment*** in the Schedule of Benefits or in the List of Clinical Indicators for Cardiac MRI and Cardiac CT Scans and the List of Clinical Indicators for GP Referral for MRI Scans.

Pre-authorisation

We must ***pre-authorise*** certain ***procedures*** and ***treatments*** before they will be covered. If ***your treatment*** or ***procedure*** needs to be ***pre-authorised***, this will be specified in the Schedule of Benefits/GP Booklet. To get ***pre-authorisation***, your ***healthcare provider*** must submit a request in writing to Aviva in order for your claim to be considered for benefit. We will assess your request as soon as possible but in any case within 15 working days.

Your health care provider

In most cases ***your treatment*** or ***procedure*** will be carried out by ***your consultant*** but there are some ***treatments*** and ***procedures*** listed in the Schedule of Benefits and GP Booklet which can be performed by ***your GP***, ***dentist***, ***oral surgeon*** or ***periodontist***. The professional fees of health professionals can be covered as an In-patient Benefit, an Out-patient Benefit or a Day-to-day Benefit depending on type of care ***you*** receive.

Generally when ***you*** receive a ***procedure*** or ***treatment*** that is listed in the Schedule of Benefits, ***your health care provider***'s fees will be covered under ***your*** In-patient Benefits. ***We*** fully cover ***health care providers*** who are registered with ***us*** and have agreed to accept payment from ***us*** in full settlement of their professional fees (i.e. a participating ***health care provider***). ***You*** will have to pay most, or all, of ***your health care provider***'s fees yourself if they are not registered with ***us*** or are not participating. Please see section 2.2 of this Membership Handbook for a full explanation about how ***your health care provider***'s professional fees are covered under ***your*** In-patient Benefits.

Generally an ***out-patient*** consultation with a ***consultant*** or a visit to ***your GP*** or ***dentist*** will be covered as a Day-to-day Benefit or an Out-patient Benefit. In these circumstances it doesn't matter if ***your consultant/GP/dentist*** is registered with ***Aviva*** or is participating. Day-to-day Benefits and Out-patient Benefits usually allow ***you*** to ***claim*** a contribution from ***us*** towards a certain number of visits to ***your consultant/GP/dentist*** in ***your policy year***. If these ***benefits*** are available under ***your plan***, the amount ***you*** can ***claim*** back per visit and the number of visits

for which ***you*** can ***claim*** will be shown in ***your*** Table of Cover.

Waiting periods

Your medical expenses will not be covered until after ***your*** waiting periods have expired. Waiting periods are explained in section 6 of this Membership Handbook.

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. See sections 2.1 and 2.2 of this Membership Handbook for more information on ***excesses***, shortfalls and co-payments.

Understanding changes to *your* cover

1. Changes to *your plan* on renewal

From time to time ***we*** alter the ***benefits*** available under our ***plans***. If ***we*** alter the ***plan*** that ***you*** are on, the changes will not affect ***you*** during ***your policy year*** but will apply if ***you*** purchase that ***plan*** for ***your*** next ***policy year***. Therefore, it is important to remember that where ***you*** renew on the same ***plan*** the ***benefits*** may not be the same as they were in ***your*** previous ***policy year***.

2. Changes to *your* cover throughout *your policy year*

In some cases the cover that is available under ***your plan*** may change throughout ***your policy year*** for the following reasons:

Changes to the Schedule of Benefits and the GP Booklet

We review and where necessary amend the Schedule of Benefits and GP Booklet four times each year to update the ***procedures*** and ***treatments*** that are covered by ***us*** and the ***clinical indicators*** that apply to ***procedures*** and ***treatments***. These changes become effective on 1st March, 1st June, 1st September and 1st December each year. ***You*** can find the most current versions of these on our website

Changes to the Lists of Medical Facilities

We may add ***medical facilities*** to the Lists of Medical Facilities from time to time. ***We*** may also need to remove ***medical facilities*** from the Lists of Medical Facilities if our arrangement with those ***medical facilities*** ends. The ***medical facilities*** which will be paid directly by ***us*** may also change from time to time. See section 2.2 of this Membership Handbook for further details. ***You*** can find the most current versions of these lists on our website

Changes to The Lists

We may need to make changes to the Lists from time to time to update the ***procedures***, ***treatments*** and appliances that are covered under certain ***benefits***. ***You*** can find the most current versions of these on our website

Changes to the status of ***health care provider***

Your health care provider's status with ***us*** (i.e. whether they are registered and are a participating ***health care provider***) may change from time to time. This means that the amount of their professional fees that ***we*** will cover may change throughout ***your policy year***. ***You*** can see whether ***your health care provider*** is registered with ***Aviva*** and whether they are a participating ***health care provider*** on our website. Please see section 2.2 of this Membership Handbook for further information on how ***your health care provider***'s status affects how their fees are covered.

Changes required by law

In the event that ***we*** are legally required to make changes to any of our contracts, ***policies*** or ***plans***, such changes shall effect ***your plan*** immediately.

The changes described above are automatically applied to all our ***plans*** as soon as they occur. ***You*** and the ***members*** named on ***your policy*** should always check the most recent Schedule of Benefits, GP Booklet, The List of Medical Facilities and Lists, and check whether ***your health care provider*** is registered with ***us*** and whether they are participating before undergoing any ***procedure*** or ***treatment***, or being admitted to a ***medical facility***. ***You*** can do this yourself by checking the most up to date information on our website or ***you*** can call ***us*** and ***we*** will check this for ***you***.

Acknowledgement

By entering this ***policy you*** are acknowledging that ***you*** have read this Membership Handbook and understand ***your*** cover. In particular, ***you*** are confirming that ***you*** understand the contractual documents that make up ***your*** contract with ***us*** and that ***your*** cover may change throughout ***your policy year***.

2. Your Cover & How to Claim

The ***benefits*** available under ***your plan*** are shown in ***your*** Table of Cover. They are divided into different sections mainly due to how they are ***claimed*** or the type of expenses covered.

The following sections of this Membership Handbook explain the different types of ***benefits*** offered by ***us***. Within each section is a table which lists our ***benefits***, shows the terms and conditions that apply to each ***benefit***, and tells ***you*** how to ***claim*** it.

Please note that all these ***benefits*** may not be available under ***your plan***. ***You*** should check ***your*** Table of Cover to see which ***benefits*** apply to ***you*** and how much ***you*** can ***claim*** under each ***benefit***. ***You*** will also be able to see on ***your*** Table of Cover if an ***excess***, shortfall or co-payment applies.

How our ***benefits*** are categorised can change on different ***plans***, so ***you*** may notice that some of ***your benefits*** appear in different sections in this Membership Handbook and on ***your*** Table of Cover. If a ***benefit*** listed in ***your*** Table of Cover is not explained in the corresponding table in this Membership Handbook, please check the tables in other sections of this Membership Handbook. The terms and conditions that apply to our ***benefits*** (as described in the tables below) will always apply even if the ***benefit*** is positioned in a different section of ***your*** Table of Cover.

If a day-to-day ***excess*** or an ***out-patient excess*** applies to ***your plan***, this will always affect all the ***benefits*** included in those sections of ***your*** Table of Cover. It doesn't matter if one or more of ***your*** Day-to-day Benefits or Out-patient Benefits appear in a different section in this Membership Handbook.

You will always be covered to the level of cover set out in the ***Minimum Benefit Regulations*** for the medical services listed in those regulations (subject to any waiting periods). Please see section 6 and the Definitions section of this Membership Handbook for an explanation of the ***Minimum Benefit Regulations***. ***We*** will always deduct any withholding tax or other deductions required by law before paying ***your claim***.

2.1 Day-to-Day and Out-Patient Benefits

These ***benefits*** typically allow ***you*** to ***claim*** a refund from ***us*** of a set amount each time ***you*** visit certain medical practitioners or receive certain medical services. Day-to-day Benefits are not included on all ***plans***. If they are not covered on ***your plan*** and ***you*** wish to add day-to-day cover to ***your plan***, please call our customer service team on (**021) 480 2040** to see what options are available to ***you***.

There may be instances where Out-patient Benefits and Day-to-day Benefits apply to the same medical expenses. Where this occurs, ***we*** will apply the more favourable ***benefit*** for ***you*** when ***you*** make ***your claim***. Please note that ***you*** cannot ***claim*** for medical expenses twice as both an Out-patient Benefit and a Day-to-day Benefit.

Day-to-Day Benefits and Out-Patient Benefits	
Benefit	**Description / Criteria**
GP visits Dentist visits Physiotherapist* visits Acupuncturist* Chiropodist* Chiropractor* Dietician* Homeopath* Massage therapist* Medical herbalist* Occupational therapist* Osteopath* Physical therapist* Podiatrist* Reflexologist* Consultant fees (for out-patient consultations) Child speech and language therapist* Paediatrician benefit	Under these ***benefits we*** will contribute towards the costs of attending the practitioners named in the ***benefit***.
Out of hours GP visits	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of attending a ***GP*** in their capacity as an out of hours ***GP*** under the HSE's GP Out of Hours Service or for the costs of a home visit by a ***GP***.
Prescriptions	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of ***your*** prescriptions from a ***GP***, ***consultant***, ***dentist*** or prescribing nurse.
Public A&E cover	This ***benefit*** allows ***you*** to ***claim*** back some of the charge imposed by a ***public hospital*** when ***you*** attend the A&E department without a referral letter from ***your GP***.
Private A&E cover	This ***benefit*** allows ***you*** to ***claim*** back some of the charge imposed by a ***private hospital*** when you attend the A&E department without a referral letter from ***your GP***.
Child A&E visit	This ***benefit*** allows a child ***member*** to ***claim*** back some of the charge imposed by a ***public hospital*** when they attend the A&E department without a referral letter from their ***GP***.
A&E Cover (in choice of High Tech, Private and Public Hospitals)	This ***benefit*** allows ***you*** to ***claim*** back some of the charge imposed by a public, private or high tech hospital when ***you*** attend the A&E department without a referral letter from ***your GP***.
Optical (eye test and/or glasses/lenses combined)	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of an eye test and glasses/lens provided by a qualified optician, orthoptist, optometrist or an ophthalmologist.
Hearing test	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of a hearing test carried out by a qualified audiologist.
Voice coaching	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of voice coaching carried out by a speech and language therapist*.
Child counselling	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of child counselling carried out by a psychologist*.
Vaccinations	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of vaccinations provided by a nurse or a ***GP***.
Pathology: Cost of test	This ***benefit*** allows ***you*** to ***claim*** back some of the ***hospital costs*** for pathology.
Pathology: Consultant fees	This ***benefit*** allows ***you*** to ***claim*** back some of the ***consultant's*** fee for pathology.
Radiology: Cost of test	This ***benefit*** allows ***you*** to ***claim*** back some of the ***out-patient costs*** for radiology (including X-Rays, mammograms and non maternity ultrasounds) carried out in a ***medical facility*** covered under ***your plan***.
Radiology: Consultant fees	This ***benefit*** allows ***you*** to ***claim*** back some of the ***consultant's*** fee for radiology.
Orthotic insoles	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of orthotic insoles specified by a physiotherapist* or a podiatrist*.
Psycho-oncology counselling	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of psycho-oncology counselling (counselling received after ***in-patient*** or ***day-case*** chemotherapy) where it is carried out by a psychologist* and ***you*** have been referred to the psychologist* by ***your consultant***.
Emergency dental care	This ***benefit*** allows ***you*** to claim back some of the costs of dental ***treatments*** or ***procedures*** which are required as a result of an ***accident*** or ***injury*** and are required to alleviate pain or to treat an acute dental trauma which represents a serious threat to the member's general health. The patient must present to the dental practitioner within 48 hours following an ***accident*** or ***injury*** and receive treatment within 7 days of presenting to dental practitioner.
VO2 testing	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of VO2 testing.
Antenatal class	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of antenatal classes run by a midwife*. This ***benefit*** does not cover pregnancy yoga and pilates.
Baby massage	This ***benefit*** allows the parent or legal guardian of a child to ***claim*** back some of the costs of baby massage for that child. This ***benefit*** may not be ***claimed*** by more than one ***member*** in respect of the same baby massage session.

Manual Lymph Drainage (MLD)	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of ***treatment*** provided by a member of Manual Lymph Drainage Ireland or a member of the Irish Society of Chartered Physiotherapists. This ***benefit*** is only available where MLD is received to treat and manage the following conditions: • Lymphoedema • Oedema • Wounds and burns • Chronic inflammatory sinusitis • Arthritis This ***benefit*** will also cover the costs related to compression therapy and remedial and breathing exercises solely related to the above conditions. This ***benefit*** will not be covered when MLD is used in order to: • improve the appearance and texture of old scars • provide skin care and improve the hygiene of swollen limbs • treat traumatic bruising and swelling • treat acne & rosacea
Child speech and language	This ***benefit*** allows a child ***member*** to ***claim*** back some of the costs of their speech and language therapy provided by a speech and language therapist*. This ***benefit*** is only available to ***members*** who are under 18 years of age.
Home nursing	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of home nursing where it is received immediately after ***you*** have been discharged from an ***in-patient*** stay in a ***medical facility*** covered under ***your plan***, it is provided by a nurse* and ***your consultant*** has advised that the home nursing is ***medically necessary***.
Health screen at any centre	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of a health screen where it is carried out in an accredited ***medical facility***. This ***benefit*** only covers screening which consists of all the following: • lifestyle assessment • physical examination • blood count • urinalysis • written report
Health screening	This ***benefit*** allows you to ***claim*** back some of the costs of VO2 max testing, fertility assessment (Anti-mullerian hormone testing or semen analysis only) or sexual health screening. This ***benefit*** is only available where the fertility assessment or sexual health screening is carried out by a ***GP*** or in a fully accredited medical centre. You can only claim this ***benefit*** once during your ***policy year.***
Health screening (Optimise Gold & Platinum plans only)	If this ***benefit*** is covered under your plan, ***we*** will pay the providers directly for the Aviva Platinum Health Screening. You can only claim this ***benefit*** once per ***policy year***. The list of approved ***medical facilities*** where ***you*** can avail of this service is as follows: • Irish Healthcare at Blackrock Clinic, Co.Dublin • Hermitage Medical Clinic Lucan, Co,Dublin • Mater Private Hospital Dublin, Co.Dublin • Irish Healthcare at the Galway Clinic, Co.Galway • Mater Private Hospital Cork, Co.Cork
Sexual health screening	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of sexual health screening carried out by a ***GP*** or in a fully accredited medical centre.
Cardiac screening	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of cardiac screening carried out by a ***GP*** or a ***consultant*** where the cardiac screening involves all of the following tests: • An ECG • Fasting lipids • Random glucose • Blood Pressure • Cardiac risk factor assessment
Medical and surgical appliances	This ***benefit*** allows ***you*** to ***claim*** back the costs of the medical and surgical appliances set out on the List of Medical and Surgical Appliances up to the amount specified on that list.
Pre/post natal medical expenses	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of pre/post natal care provided by a ***consultant***, ***GP*** or a midwife* during and after ***your*** pregnancy. The following costs are included and can be claimed per pregnancy: • ***Out-patient consultant's*** fees (obstetrician and gynaecologist), • Maternity scans • Antenatal classes run by a midwife • Pre and post natal physiotherapist services provided by U Mamma** or by a chartered physiotherapist* with a specialty in women's health. This ***benefit*** covers pre/post natal care which is received between 9 months before and 3 months after ***your*** anticipated delivery date.
Vasectomy (GP only)	Under this ***benefit we*** will contribute up to a ***maximum of €360*** towards the cost of a vasectomy including any related consultations pre and post procedure. The vasectomy must be carried out by a ***GP*** who is registered with the Irish Medical Council. ***We*** will only accept one receipt, detailing the name of the procedure and date the procedure was performed and any related consultation dates. Vasectomy is only covered on selected plans, please contact Aviva or check your Table of Cover to see if you are covered.
How to claim	

* ***We*** will only cover the costs of visits to practitioners who have appropriate qualifications and registrations. Please see our Directory of Allied Health Professionals, Alternative (Complementary) and Other Practitioners in section 11.1 of this Membership Handbook for details of the qualifications and registrations which each practitioner must hold.

You need to pay the practitioner/***health care provider*** yourself and then ***claim*** the amount that is covered back from ***us*** in either of the following ways:

1. Throughout ***your policy year***: by scanning ***your*** original receipts and submitting them through our online claims tool (Aviva Online Claiming) on www.avivahealth.ie
2. At the end of ***your policy year***: by sending all ***your*** original receipts to ***us*** in an envelope with your name, address and membership number (see section 10 for details of where to send ***your*** receipts). ***You*** must submit original receipts. Photocopies, estimates, cash register receipts etc. will not be accepted, unless otherwise stated. ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.

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.

When claiming for prescription costs ***you*** must also submit the prescription claim form issued by ***your*** pharmacist. When claiming for the emergency dental care ***benefit you*** must also submit a dental report. When claiming the home nursing ***benefit you*** may also have to provide ***us*** with a medical report from ***your consultant*** confirming that the home nursing is ***medically necessary***.

When claiming the out of hours GP visits ***benefit*** the receipts ***you*** submit to us must show that ***you*** visited the ***GP*** in their capacity as an out of hours ***GP*** through the HSE's GP Out of Hours Service or that ***your GP*** visited ***you*** at home.

Benefit	**Description / Criteria**
Nurse on call	Nurse on call is a telephone based service that provides general, non-diagnostic information over the phone. Under this ***benefit you*** have access to the nurse on call service 24 hours a day 365 days a year.
How to claim	
Telephone: 1850 946 644	

Benefit	**Description / Criteria**
PET-CT Scans MRI Scans CT Scans Cardiac MRI Scans Cardiac CT Scans	Under this ***benefit we*** will cover or contribute towards the costs of ***your*** scan. The amount that is covered and how it is covered will depend on whether ***you*** have ***your*** scan carried out in a scan facility that is covered in the appropriate table for ***your*** scan type in ***your*** List of Medical Facilities on pages 33-35 (i.e. an approved centre) or in a scan facility that is not included in ***your*** List of Medical Facilities (i.e. a non-approved centre). The maximum amount that can be claimed for non-approved centres in ***your policy year*** may be limited. This will be shown on ***your*** Table of Cover. The following criteria must be satisfied before your scan will be covered: **MRI Scans** ***You*** must be referred by a ***consultant*** or ***GP***. For MRI scans in St James hospital ***you*** must be referred by an oncologist or other clinician working in St. James Hospital and the scan is required for the diagnosis, ***treatment*** or staging of a cancer. **CT Scans** ***You*** must be referred by a ***consultant***. For CT scans in St James hospital ***you*** must be referred by an oncologist or other clinician working in St. James Hospital and the scan is required for the diagnosis, ***treatment*** or staging of a cancer. **Cardiac MRI Scans** All cardiac MRI scans must be ***pre-authorised*** by ***us***. ***You*** must be referred by a ***consultant***. All cardiac MRI scans must be carried out in an approved cardiac scan facility (see the tables of MRI and CT facilities in section 12 of this Membership Handbook). **Cardiac CT Scans** All cardiac CT scans must be ***pre-authorised*** by ***us***. ***You*** must be referred by a consultant. All cardiac CT scans must be carried out in an approved cardiac scan facility list (see the tables of MRI and CT facilities in section 12 of this Membership Handbook) **CT Colonography Scans** All CT colonography scans must be ***pre-authorised*** by ***us***. ***You*** must be referred by a ***consultant***. **PET-CT Scans** All PET- CT scans must be ***pre-authorised*** by ***us***. ***You*** must be referred by a ***consultant***. In addition the ***clinical indicators*** which relate to ***your*** type of scan must be satisfied before it will be covered. The ***clinical indicators*** which must be satisfied before ***you*** will be covered for a cardiac MRI or cardiac CT scan are set out in the List of Clinical Indicators for Cardiac MRI and Cardiac CT Scans. The ***clinical indicators*** which must be satisfied before ***you*** will be covered for a MRI scan when referred by a ***GP*** are set out in the List of Clinical Indicators for GP Referrals for MRI Scans.
How to claim	
If ***your*** scan is carried out in an approved centre (i.e. a scan facility that is covered in the appropriate table for ***your*** scan type in ***your*** List of Medical Facilities), ***we*** will pay the scan facility directly. If ***your*** scan is carried out in a non-approved centre (i.e. a scan facility that is not covered in ***your*** List of Medical Facilities) ***you*** will have to pay for ***your*** scan yourself and ***claim*** the amount that is covered back from ***us***, if cover for non-approved centres is included in ***your plan***. You can do this by submitting ***your*** original receipt to ***us*** in an envelope with ***your*** name, address and ***membership number*** (see section 10 for details of where to send ***your*** receipts).	

Benefit	**Description and criteria**
babylon Health	Under this ***benefit*** we will cover the costs of consultations with a ***GP*** through the babylon Health app provided by Babylon Healthcare Services Limited**. If this ***benefit*** is available under ***your plan***, the maximum number of ***GP*** consultations ***you*** can receive in ***your policy year*** may be limited. This will be shown on ***your*** Table of Cover. Please note the babylon Health app is only available for download and use on iPhone or Android phones.
How to claim	
You will be provided with a babylon Health verification code on ***your*** Table of Cover. ***You*** will need to download the babylon Health app and register using ***your*** code. ***You*** will then be able to receive the number of online ***GP*** consultations that is shown in ***your*** Table of Cover, throughout ***your policy year***, without charge. ***We*** will pay Babylon Healthcare Services Limited* directly for ***your*** use of their service.	

* ***We*** will only cover the costs of visits to practitioners who have appropriate qualifications and registrations. Please see our Directory of Allied Health Professionals, Alternative (Complementary) and Other Practitioners in section 11.1 of this Membership Handbook for details of the qualifications and registrations which each practitioner must hold.

** The service providers named under these ***benefits*** may change from time to time.

How to calculate *your* cover under *your* Day-to-day Benefits and Out-patient 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. 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 Out-patient 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 Out-patient Benefits in ***your policy year***. So for example, where an ***excess*** applies to the Out-patient Benefits under ***your plan***, it applies to the total amount ***you*** are claiming for all ***your*** Out-patient 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*** Out-patient 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	

2.2 In-Patient Benefits

In-patient Benefits typically cover the fees charged by ***your*** hospital, treatment centre and ***health care provider*** whilst ***you*** are admitted to a hospital or treatment centre covered under ***your plan*** as an ***in-patient*** or ***day case*** patient.

Hospital costs

The fees charged by ***your*** hospital or treatment centre for ***your*** medical care whilst ***you*** are admitted are known as ***hospital costs***. They include the ***public hospital levy***, hospital accommodation costs, charges for the use of the operating theatres, charges for radiology and pathology, nursing charges, costs of prosthesis and charges for drugs administered for consumption whilst ***you*** are admitted. You can find the level of cover available for ***your hospital costs*** in a ***public hospital***, ***private hospital*** and high-tech hospital in ***your*** Table of Cover (see section entitled "Hospital Cover"). You can check whether ***your*** hospital is public, private or high-tech in the tables of ***medical facilities*** in section 12 of this Membership Handbook. Please note that some hospitals may be classed as a high-tech hospital for ***Level 1 plans*** and a ***private hospital*** for all other ***plans***. Treatment centres are not classed as public, private or high-tech. ***We*** will fully cover ***your hospital costs*** in the treatment centres covered in ***your*** Lists of Medical Facilities.

Medical facilities covered under *your plan*

The ***medical facilities*** covered under ***your plan*** are shown in ***your*** List of Medical Facilities. There are four 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 section 12 of this Membership Handbook.

Where ***you*** are admitted to a ***medical facility*** covered under ***your plan***, ***your hospital costs*** will be fully covered subject to any limitations specified in ***your*** Table of Cover, such as ***excesses***, shortfalls, co-payments, ***private rooms*** covered at semi-private rates etc. Where necessary, ***we*** have agreements with ***medical facilities*** to ensure that this is the case. However, ***medical facilities*** are free to end their arrangement with ***us*** at any time so ***we*** cannot guarantee that this will continue to be the case for all the ***medical facilities*** covered under ***your plan*** throughout ***your policy year***. Where this arrangement between ***us*** and a ***medical facility*** ends, the ***medical facility*** will no longer be covered by ***us*** and it will be removed from all the Lists of Medical Facilities. Similarly where ***we*** enter into new arrangements with ***medical facilities***, they will be added to one or more of the Lists of Medical Facilities. Such changes will affect ***your plan*** immediately. Up to date Lists of Medical Facilities are available on our website at **Avivahealth.ie.** ***We*** recommend that ***you*** always check whether ***your medical facility*** is covered before being admitted by reviewing ***your*** List of Medical Facilities on our website or contacting our call centre on **(021) 480 2040**.

Medical facilities not covered on *your plan*

We will not cover ***your hospital costs*** in a ***medical facility*** which is not covered in ***your*** List of Medical Facilities.

We have made every effort to ensure that all health services that are listed in the ***Minimum Benefit Regulations*** ("Prescribed Health Services") are available through at least one of the ***medical facilities*** covered in ***your*** List of Medical Facilities. In the unlikely event that a Prescribed Health Service is not available in one of those ***medical facilities***, ***we*** will cover the Prescribed Health Service in a ***medical facility*** that is not covered in ***your*** List of Medical Facilities as if it was covered under ***your plan*** (i.e. to the level of cover available under ***your*** In-patient Benefits). However, ***you*** must notify ***us*** in advance that ***you*** wish to receive such medical services in a ***medical facility*** that is not covered under ***your plan***. Please note that ***we*** will not cover ***you*** if ***you*** receive health services (other than ***emergency care***), which are not listed in the ***Minimum Benefit Regulations***, in a ***medical facility*** which is not covered under ***your plan***.

We will cover ***your stay*** in a ***public hospital*** that is not covered under ***your*** List of Medical Facilities whilst ***you*** are receiving ***emergency care***. ***You*** must have been admitted through the ***accident*** and emergency department. Any ***follow on care*** and/or ***elective treatments*** or

procedures will only be covered in a ***medical facility*** which is covered under ***your plan***. The only exception to this is if our ***medical advisers*** agree that ***you*** are not medically fit to travel, in which case ***we*** will cover ***your hospital costs*** in the same ***public hospital*** but this will need to be ***pre-authorised*** by ***us***.

How long are *your hospital costs* covered for?

You can ***claim hospital costs*** under ***your*** In-patient Benefits for a total of 180 days in a calendar year (the "Maximum Period"). This Maximum Period includes the number of days for which ***you*** can ***claim hospital costs*** as a psychiatric patient. The number of days that ***you*** can ***claim*** as a psychiatric patient is shown in the psychiatric ***treatment benefits*** in ***your*** Table of Cover.

Please note that the Maximum Period includes any days for which ***you*** have already ***claimed hospital costs*** (including ***hospital costs*** as a psychiatric patient) under another ***plan*** with ***us*** or with another health insurer in a calendar year.

Your *health care provider's* fees

Consultants

Your in-patient benefit for consultant's fees covers the professional fees of ***consultants*** who are registered with ***Aviva***, where they provide ***you*** with the ***treatments*** and ***procedures*** listed in the Schedule of Benefits. Your ***consultant's*** fees will only be covered where ***your procedure*** or ***treatment*** is performed in a ***medical facility*** covered under ***your plan***. However, there is a small number of ***treatments*** and ***procedures*** which will be covered when they are performed in ***your consultant's*** room. These are set out in the "non-hospital" section of the Schedule of Benefits.

Consultants **registered with *Aviva***

We will only cover ***consultants*** who are registered with ***Aviva***. Where ***your consultant*** is registered with ***us***, the extent to which their professional fees are covered will depend on whether they have chosen to be a participating consultant or standard rate ***consultant***.

- **Participating consultants**
  Participating consultants have agreed to accept payment from ***us*** in full settlement of their fees for performing the ***procedures*** and ***treatments*** in the Schedule of Benefits. This means that if ***your consultant*** is a participating consultant, ***you*** will be fully covered for the ***procedures*** and ***treatments*** listed in the Schedule of Benefits.

- **Standard rate consultants**
  Standard rate ***consultants*** (or part participating consultants) have not agreed to accept payment from ***us*** in full settlement of their fees. Only a small portion of the fees of standard rate ***consultants*** will be covered for performing the ***procedures*** and ***treatments*** in the Schedule of Benefits. Therefore, if ***your consultant*** is a standard rate ***consultant*** ***you*** will have to pay a large portion of their fees yourself. ***You*** will not be able to ***claim*** this back from ***us***.

Consultants **not registered with *Aviva***

Where ***your consultant*** is not registered with ***Aviva we*** will not cover their professional fees. The only exception to this is if ***your consultant's*** fees for performing ***your treatment*** or ***procedure*** are included in the ***Minimum Benefit Regulations***. If they are, ***you*** can ***claim*** the amount set out in the ***Minimum Benefit Regulations*** back from ***us*** at the end of ***your policy year***. It's important ***you*** know ***your consultant's*** fees are likely to be a lot more than the amount shown in the ***Minimum Benefit Regulations***. If this happens, ***you***'ll have to pay the difference.

Dentists/Oral surgeons/Periodontists

Your in-patient benefit for consultant's fees also covers a limited number of dental/oral ***surgical procedures*** where they are performed by a ***dentist***, ***oral surgeon*** or ***periodontist***. (This excludes dental visits and emergency dental care which are covered under our Day-to-day Benefits and Out-patient Benefits).

The dental/oral ***surgical procedures*** that are covered under our In-patient Benefits are listed in the "Periodontal/Oral/Dental Surgery Ground Rules" section of the Schedule of Benefits. These ***procedures*** will only be covered where they are performed by the specified type of dental practitioner (i.e. a ***dentist***, ***oral surgeon*** or ***periodontist***). Please note many dental/oral ***surgical procedures*** require ***pre-authorisation***. ***Your dentist/oral surgeon/periodontist's*** fees will only be covered where ***your*** oral/dental ***surgery*** is performed in a ***medical facility*** covered under ***your plan*** or in ***your dentist/oral surgeon/periodontist's*** room.

As with ***your consultant***, ***your dentist***, ***oral surgeon*** or ***periodontist*** must be registered with ***Aviva***. If they are not registered with ***us***, ***you*** will not be covered (subject to cover prescribed under the ***Minimum Benefit Regulations*** if applicable). The extent to which ***your oral surgeon/periodontist's*** professional fees are covered will also depend on whether they have chosen to be a participating or a standard rate ***oral surgeon/periodontist***. See the ***consultant*** section above for a full explanation on how ***your*** oral ***health care provider***'s status as participating or standard rate affects ***your*** cover. Please note that all ***dentists*** are classed as standard rate so ***we*** will only cover a limited portion of ***your dentist***'s fees for performing oral/dental ***surgery***.

GPs

We will cover ***your GPs*** fees for performing a limited number of ***treatments*** and ***procedures*** in their surgery. Such ***procedures*** and ***treatments*** are covered under your in-patient benefit for consultant's fees. Your ***GP***'s fees for a routine visit will be covered under our Day-to-day Benefits or Out-patient Benefits. The ***treatments*** and ***procedures*** that will be covered under ***your*** In-patient Benefits are set out in the GP Booklet. If ***your treatment*** or ***procedure*** is not listed in the GP Booklet, ***your GP***'s fees will not be covered. As with ***consultants*** and dental professionals, ***your GP*** must be registered with ***Aviva*** before they will be covered and the extent to which their fees are covered will depend on whether they are a participating ***GP*** or a standard rate ***GP***. Please see previous sections for a full explanation on the effect of ***your health care provider*** not being registered with ***Aviva*** and not participating with ***Aviva***.

Changes to the status of *your health care provider*

Health care providers are free to alter their arrangement with ***Aviva*** at any time. Therefore, by way of example, a participating ***health care provider*** may choose to become standard rate or to unregister with ***us*** at any time. Any changes to their status with ***us*** will affect how they are covered immediately. Therefore the level to which their fees are covered may change throughout ***your policy year***. ***We*** recommend that ***you*** always check whether ***your health care provider*** is registered with ***Aviva*** and whether they are participating or standard rate before undergoing any ***procedure*** or ***treatment*** or being admitted to a ***medical facility***. You can do this by visiting our website or contacting our call centre on **(021) 480 2040**.

Maternity *treatment*

In-patient benefits do not apply where ***you*** are admitted to a ***medical facility*** for the delivery of ***your*** baby (except for caesarean section deliveries). Whilst ***you*** are admitted for the delivery of ***your*** baby, ***you*** are a maternity patient and ***your*** Maternity Benefits apply. The level of cover available to ***you*** for ***your*** maternity care is set out in ***your*** Maternity Benefits on ***your*** Table of Cover. Where ***your*** maternity care ends, but ***you*** remain admitted for any ***medically necessary*** reason, ***your*** In-patient Benefits will apply and ***you*** will receive the level of cover available under the In-patient Benefits on ***your*** Table of Cover.

Psychiatric *treatment*

Where ***you*** are admitted to a psychiatric ***medical facility*** or a psychiatric unit in a ***medical facility***, ***your hospital costs*** and ***consultant's*** fees will be covered under ***your*** In-patient Benefits at the level shown in the Hospital Cover section of ***your*** Table of Cover. Your ***plan*** will also include psychiatric ***treatment benefits***. These ***benefits*** specify the maximum number of days for which ***you*** can ***claim your*** In-patient Benefits whilst ***you*** are a psychiatric patient.

How In-patient Benefits are *claimed*

In most cases, ***we'll*** pay the amount for which ***you*** are covered under ***your*** In-patient Benefits directly to ***your medical facility*** and ***health care providers***. They ***claim*** the amount for which ***you*** are covered from ***Aviva*** on ***your*** behalf and ***we*** pay this to them directly. This is known as ***direct settlement***. Please note that only the amount for which ***you*** are covered will be directly settled with ***your medical facility*** and ***health care provider***.

Direct settlement applies to all ***claim***s for professional fees for ***health care providers*** that are registered with ***us***. ***We*** will not directly settle any ***claim***s for the amounts shown in the ***Minimum Benefit Regulations*** for ***health care providers*** that are not registered with ***us***. ***Your*** List of Medical Facilities shows the ***medical facilities*** that ***we*** will pay through ***direct settlement***. Whether ***direct settlement*** is available for a particular ***medical facility*** may change from time to time. ***You*** should always check the most up to date Lists of Medical Facilities before being admitted to any ***medical facility*** to see whether ***direct settlement*** applies or whether ***you*** will have to pay the ***medical facility*** and ***claim*** it back from ***us***.

Where ***direct settlement*** applies, ***your medical facility*** or ***health care provider*** will submit ***your*** claim form to ***us*** on ***your*** behalf. It is important to remember that they are only making the ***claim*** on ***your*** behalf and that ***you*** are responsible for ensuring that all aspects of the ***claim*** are correct. If ***your*** claim form contains any inaccurate information, ***we*** may treat ***your claim*** as fraudulent, decline the ***claim*** and possibly cancel ***your plan*** or ***policy*** (see section 7 of this Membership Handbook for further information on our fraud ***policy***). ***You*** will need to sign ***your*** claim form before ***your medical facility*** or ***health care provider*** submits it to ***us***. ***Your medical facility*** and ***health care providers*** should always specify the ***medical care you*** received on ***your*** claim form before ***you*** are asked to sign it. ***You*** should check this information very carefully to ensure that it is accurate. By signing this form ***you*** are confirming that ***you*** have received the ***medical care*** specified in the form and that all information contained in ***your*** claim form is true and accurate. When we've paid ***your claims***, ***we'll*** send ***you*** a statement confirming payment and outlining the amounts paid on ***your*** behalf.

Where ***direct settlement*** is not available, ***you*** will have to pay ***your medical facility*** and ***your health care provider*** yourself and ***claim*** the amount that is covered back from ***us***. ***You*** will need to submit a ***claim*** form to ***us*** specifying the ***medical care you*** received which is signed by all relevant ***health care providers*** and ***your medical facility*** together with all ***your*** receipts. ***Your medical facility*** and ***health care providers*** will be able to provide these for ***you***. The completed ***claim*** form and receipts should be sent to our ***claim***s team (see section 10 of this Membership Handbook).

Please note *we* reserve the right to:

- refuse payment in respect of In-patient Benefits where ***you*** stayed in a ***medical facility*** overnight but our ***medical advisers*** determine that ***you*** should have been a ***day case***
- refuse payment in respect of day-case ***benefits*** where our ***medical advisers*** have determined that ***you*** should have been an ***out-patient***
- only pay the amount that would have been covered, if ***your treatment*** or ***procedure*** had been carried out in the manner deemed appropriate by our ***medical advisers***

Shortfall

In some cases ***your benefit*** may not cover all ***your*** medical costs and ***you*** will need to pay a proportion of such costs yourself. This is known as a shortfall. For instance, if ***your hospital costs*** are subject to 90% cover, ***you*** will be required to pay the remaining 10% yourself. ***You*** can see if a shortfall applies and if so, how much it is, in ***your*** Table of Cover.

In-patient or *day case excess*

In some cases ***you*** may be required to pay an amount of ***your*** bill before ***your*** cover begins. This is known as an ***excess***. 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***.
- ***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.

Colorectal cancer screening

Please note that In-patient Benefits only cover the costs of colorectal cancer screening (colonoscopy, FIT or CT colon) where ***you*** have:

- a family history of polyposis coli;
- a family history of hereditary non polyposis coli;
- a ***first degree relative*** diagnosed with colorectal cancer before the age of 60 years; or
- two ***first degree relatives*** who have been diagnosed with colorectal cancer.

Where ***you*** satisfy the above criteria, ***your*** colorectal cancer screening will be covered under ***your*** In-patient Benefits once every five years from when:

- ***you*** reach the age of 40 years; or
- ***you*** reach an age which is 10 years younger than the age at which ***your first degree relative*** was first diagnosed with colorectal cancer.

Listed cardiac *procedures* and listed special *procedures benefits*

In most cases these ***benefits*** provide enhanced cover for ***your hospital costs*** in a high-tech hospital when ***you*** are undergoing the ***procedures*** specified in the List of Cardiac Procedures or the List of Special Procedures. This is because the ***excesses*** that apply to these ***benefits*** are generally lower than those that apply to ***your*** general ***hospital costs*** in a high-tech hospital. ***You*** can see if these ***benefits*** are available under ***your plan*** in the high-tech hospital section of ***your*** In-patient Benefits on ***your*** Table of Cover.

2.3 Maternity Benefits

Maternity Benefits can be categorised as In-patient Maternity Benefits, Out-patient Maternity Benefits and other Maternity Benefits, depending on how they are ***claimed***. In-patient Maternity Benefits cover ***your hospital costs*** and some of ***your consultant's*** fees when ***you*** are admitted to a ***medical facility*** covered under ***your plan*** as a maternity patient for the delivery of ***your*** baby. The costs of ***your*** pre and post natal care are not covered under ***your*** In-patient Maternity Benefits but may be covered under ***your*** Out-patient Benefits or Other Benefits.

In-patient Maternity Benefits	
Benefit	**Description and criteria**
Public hospital cover for maternity	Under this ***benefit we*** will either: a) Cover ***your hospital costs*** for up to 3 nights where ***you*** are admitted to a ***public hospital***. The type of hospital accommodation that will be covered under this ***benefit*** is the same as that covered under ***your public hospitals*** cover in ***your*** In-patient Benefits. However, please note that ***you*** will only be able to avail of a ***private room*** or ***semi private room*** where you have opted to be a private or semi private patient with the ***public hospital***. The private or semi private fee imposed by the ***public hospital*** is not covered under this ***benefit*** but ***you*** may be able to ***claim*** back some of that fee under our pre/post natal medical expenses ***benefit*** if this ***benefit*** is available on ***your plan***.; or b) Pay the contribution specified in ***your*** Table of Cover towards ***your hospital costs***. The type of cover available to ***you*** will depend on ***your plan*** and is set out in ***your*** Table of Cover. This ***benefit*** is only available where ***you*** have been admitted to a ***public hospital*** covered on ***your plan*** to give birth. Where ***your plan*** covers ***you*** for "up to 3 nights' accommodation" but it is ***medically necessary*** for ***you*** to remain for more than 3 nights, the remainder of ***your*** stay in hospital will be covered under ***your*** In-patient Benefits. Please note that caesarean section deliveries are covered under ***your*** In-patient Benefits and not under this ***benefit***.
In-patient maternity consultant fees	Under this ***benefit we*** will either: • Cover the professional fees of ***your*** baby's paediatrician; • Cover ***your*** anaesthetist's and pathologist's professional fees; and • Cover ***your consultant's*** professional fees for a routine delivery (***procedure*** 2206) up to the amount set out in the Schedule of Benefits. (Please note that if ***your consultant*** charges more than this amount for delivering ***your*** baby ***you*** will be required to pay the balance yourself). Or: • Pay the contribution specified in the Table of Cover towards ***your consultants***' professional fees. The type of cover available under ***your plan*** is set out in ***your*** Table of Cover. Please note that where ***you*** are attending a ***public hospital*** this ***benefit*** is only available where ***you*** have opted to be a private or semi-private patient.
Grant-in-aid amount	This ***benefit*** allows ***you*** to ***claim*** back some of ***your hospital costs*** for maternity care in a private maternity hospital covered under ***your plan***. If this ***benefit*** is available under ***your plan***, the maximum amount which ***we*** will cover is set out in ***your*** Table of Cover. Please note that where you are attending a ***public hospital*** this benefit is only available where you have opted to be a private or semi-private patient. Please note that where ***you*** are attending a ***public hospital*** this ***benefit*** is only available where ***you*** have opted to be a private or semi-private patient for ***your*** out-patient visits throughout your pregnancy or where the ***public hospital*** deems it ***medically necessary*** for ***you*** to be treated by a ***consultant***.
How to claim	
Where the ***benefit*** covers a contribution towards the costs of ***your*** maternity care, the maximum amount that ***we*** will contribute will be set out in ***your*** Table of Cover. If ***your*** medical expenses exceed this amount, ***we*** will pay the maximum contribution to ***your medical facility*** or ***health care provider*** and ***you*** will need to pay them the balance. Please see section 2.2 of this Membership Handbook for details of how In-patient Benefits are ***claimed*** and paid.	

Out-patient Maternity Benefits	
Benefit	**Description and criteria**
Home birth	This ***benefit*** allows ***you*** to ***claim*** back some of the medical costs involved in having a home birth, where such costs are directly associated with the delivery of ***your*** child. If this ***benefit*** is available under ***your plan*** the maximum amount that ***we*** will contribute is set out in ***your*** Table of Cover.
Antenatal benefit	Under this ***benefit Aviva*** will contribute towards an antenatal course with a midwife. If this ***benefit*** is available under ***your plan*** the maximum amount that ***we*** will contribute per day and the maximum number of days for which it can be ***claimed*** is set out in ***your*** Table of Cover.
Post-natal counselling	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of post-natal counselling where it is received within 12 months of ***your*** baby being born and is carried out by a person belonging to one of the following societies/associations: • The Irish Psychological Society (PSI) • The Irish Association of Counsellors and Psychotherapists (IACP) • The British Association of Counsellors and Psychotherapy (BACP) • Family Therapy Association of Ireland (FTAI) • The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) The contribution under this ***benefit*** is payable up to a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan***, the maximum amount which ***we*** will cover per day and the maximum number of days for which it can be ***claimed*** is set out in ***your*** Table of Cover.
Breastfeeding consultancy	This ***benefit*** allows ***you*** to ***claim*** back some of the costs of a consultation with a qualified breastfeeding ***consultant***. The contribution under this ***benefit*** is payable for a limited number of breastfeeding consultancy sessions in ***your policy year***. If this ***benefit*** is available under ***your plan***, the maximum amount which ***we*** will cover per session and the maximum number of session for which it can be ***claimed*** is set out in ***your*** Table of Cover.
Cord blood stem cell preservation	This ***benefit*** allows ***you*** to ***claim*** back: • €600 on the cost of cord blood stem cell preservation where the umbilical cord is being harvested after the birth of a single child or identical twins or • €900 on the cost of cord blood stem cell preservation where the umbilical cord is being harvested after the birth of non-identical twins. The ***benefit*** is only available where the cord blood stem cell preservation is provided by Medicare Health & Living Limited (Medicare).* Telephone: 01-2014900. Website: www.medicare.ie
Partner benefit	This ***benefit*** allows ***you*** to ***claim*** back some of the following costs where ***you*** have to travel to be with ***your*** partner when they are admitted to a ***medical facility*** to give birth to ***your*** child: • Costs of ***your*** hotel or bed and breakfast accommodation; • ***Your*** travel costs to and from ***your*** home to the ***medical facility***; • The costs of a child minder whilst ***you*** are visiting ***your*** partner in a ***medical facility***. The contribution under this ***benefit*** is payable for the reasonable costs incurred within a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan***, the maximum amount that ***we*** will contribute per day and the number of days for which it can be ***claimed*** is set out in ***your*** Table of Cover. The contribution can only be ***claimed*** for costs incurred on the day ***your*** baby is born, on the day before ***your*** baby is born or on the day after ***your*** baby is born and can only be ***claimed*** for consecutive days.
Post Natal Night Nurse Care	This ***benefit*** allows ***you*** to ***claim*** back some of the costs towards the services of a paediatric nurse* at home after ***you*** have your baby. This ***benefit*** must be ***claimed*** within 26 weeks of the date on which ***your*** child was born. The contribution under this ***benefit*** is payable for paediatric home nursing costs which are incurred up to a specified number of days/nights in ***your policy year***. If this ***benefit*** is available under ***your plan*** the maximum amount that ***we*** will contribute per day and the maximum number of days/nights for which can be ***claimed*** will be set out in ***your*** Table of Cover.

How to claim

These ***benefits*** are ***claimed*** as Out-patient Benefits. At the end of ***your policy year***, ***you*** must send all ***your*** original receipts to ***us*** in an envelope with ***your*** name, address and ***membership number*** to ensure that ***we*** can reimburse ***you*** for all eligible ***treatment*** (see 'Your Contacts'). ***You*** can also ***claim*** throughout ***your policy year*** by scanning ***your*** original receipts and submitting them through our online claims tool (Aviva Online Claiming) on www.avivahealth.ie.

Please ensure that all original receipts state:
- The amount paid
- The full name of the ***member*** receiving ***treatment***/service and their date of birth;
- The type of ***treatment***/service received;
- The date the ***treatment***/service was received;
- The signature and contact details for the treating ***consultant*** and the hospital or treatment centre where ***you*** were treated (if applicable).

We will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.

Other Maternity Benefits	
Benefit	**Description and criteria**
Early discharge maternity benefit	Under this ***benefit you*** can ***claim*** a cash payment where ***you*** have given birth in a ***medical facility*** covered under ***your plan*** and are discharged after only one night. This ***benefit*** only applies where ***you*** were a private ***in-patient*** in a ***public hospital*** and ***your consultant*** has approved ***your*** discharge after only one night's stay as an ***in-patient***. This ***benefit*** cannot be ***claimed*** in conjunction with the post-natal home help ***benefit*** or the alternative amount to post-natal home help ***benefit***. If this ***benefit*** is available under ***your plan***, the maximum amount that ***we*** will contribute is set out in ***your*** Table of Cover.

How to claim
You will need to provide ***us*** with a letter from the ***medical facility*** from which ***you*** were discharged showing the dates on which ***you*** were admitted and discharged. ***You*** may also need to provide ***us*** with evidence that ***your consultant*** has consented to ***your*** discharge after only one night's stay as an ***in-patient***.

Benefit	Description and criteria
Post-natal home help (PNHH)	Under this ***benefit we*** will cover the cost of domestic home help provided by Brown Flower Limited* after ***your*** baby is born. If this ***benefit*** is available under ***your plan***, the number of days of home help that will be covered is set out in ***your*** Table of Cover. ***You*** will normally be covered for up to 2 days of domestic home help under this ***benefit***. The maximum number of hours of home help that will be provided on each day is four hours. ***You*** must call ***us*** to request the service within 20 weeks of the date on which ***your*** child was born and ***you*** must receive the domestic home help within 26 weeks of the date on which ***your*** child was born. This ***benefit*** is not available where Brown Flower Limited is unable to provide the domestic home help service for any reason including where they are fully booked or where ***your*** home is not in an area serviced by Brown Flower Limited. When the domestic home help will be provided is subject to Brown Flower Limited's availability and their operating hours. The receipt of domestic home help is subject to Brown Flower Limited's terms and conditions and outside the control of ***Aviva***. This ***benefit*** cannot be ***claimed*** in conjunction with the following ***benefits***: • the alternative amount for post natal home help ***benefit***; • the early discharge maternity ***benefit***; • the rebate towards the costs of a birthing package under the Doula Ireland ***benefit***. If ***you*** wish to cancel a booking with Brown Flower Limited, ***you*** must contact them directly to do so. You must give Brown Flower Limited more than 24 hours' notice of any cancellation. If ***you*** fail to do so, this ***benefit*** will be exhausted and ***you*** will continue to be prevented from claiming the alternative amount for post natal home help ***benefit,*** the early maternity discharge ***benefit*** and the rebate towards the costs of a birthing package under the Doula Ireland ***benefit***. Either ***you*** or a family member/friend who is 18 years old or older must be present in ***your*** home at all times when the domestic home help assistant is in attendance. This ***benefit*** may only be ***claimed*** by one ***member*** (either parent) in respect of each birth.
How to claim	
Call ***us*** on **(021) 480 2040** between 9.00am and 7.00pm Monday to Friday. ***We*** will take ***your*** details and pass these on to Brown Flower Limited who will contact ***you*** to arrange the service. When ***you*** contact ***us***, ***you*** will need to provide ***us*** with evidence of ***your*** baby's birth – this may be either the birth certificate or a note confirming the birth from a ***GP***, ***consultant*** or district nurse.	
Benefit	**Description and criteria**
Alternative amount for post natal home help	This ***benefit*** allows ***you*** to ***claim*** €120 towards the costs of domestic home help after ***you*** have ***your*** baby. This ***benefit*** must be ***claimed*** within 26 weeks of the date on which ***your*** child was born. This ***benefit*** cannot be ***claimed*** in conjunction with the following: • the post natal home help ***benefit***; • the early discharge maternity ***benefit***; • the rebate towards the costs of a birthing package under the Doula ***Ireland benefit***.
Newborn free until next renewal	Under this ***benefit, you*** may add your ***newborn*** to ***your policy*** without charge within 13 weeks of the date of his/her birth. Where ***you*** do so, he/she will be covered under the same ***plan*** as ***you*** until ***your*** next ***renewal date***.
How to claim	
Please call ***us*** to let ***us*** know that ***you*** wish to ***claim*** these ***benefits***. ***You*** will need to provide ***us*** with evidence of ***your*** baby's birth – this may be either the birth certificate or a note confirming the birth from a ***GP***, ***consultant*** or district nurse.	

Benefit	Description and criteria
Doula Ireland	Under this ***benefit you*** can ***claim*** a discount on a birthing package through Doula Ireland. If this ***benefit*** is available under ***your plan***, the discount that is available will be set out in ***your*** Table of Cover. If ***you*** do not ***claim*** the post-natal home help ***benefit*** or the alternative amount for post-natal home help ***benefit***, ***you*** may ***claim*** a rebate towards the amount ***you*** paid Doula Ireland for ***your*** birthing package. This is available in conjunction with the discount. If this ***benefit*** is available under ***your plan***, the amount of rebate that can be claimed is set out in ***your*** Table of Cover.
How to claim	
Discount to be ***claimed*** from Doula Ireland at point of sale. In addition, if ***you*** do not wish to claim the post natal home help ***benefit*** or the alternative amount for post natal home help ***benefit, you*** can claim the additional rebate. In order to do so, ***you*** should send your original receipt to ***us***.	

* The service providers named under these ***benefits*** may change from time to time.

2.4 Other Benefits

Other Benefits provide cover that complements our In-patient Benefits, Out-patient Benefits and Maternity Benefits.

Other Benefits	
Benefit	**Description and criteria**
Public hospital levy (also known as the Public Statutory In-patient Charge)	***Public hospitals*** charge ***in-patients*** a daily charge for a maximum of 10 days each calendar year. This is known as the ***public hospital levy***. Under this ***benefit we*** will cover the ***public hospital levy*** for a maximum of 10 days in a calendar year.
How to claim	
Where the ***public hospital*** in question is covered under ***your plan***, ***we*** will pay this charge directly to the ***public hospital***. See section 2.2 of this Membership Handbook for information on how ***direct settlement*** operates. If the ***public hospital*** in question is not covered under ***your plan***, ***you*** will have to pay ***your public hospital levy*** to the ***public hospital*** and ***claim*** this back from ***us***. This ***benefit*** is subject to €1 ***excess*** which will be refunded to ***you***.	

Benefit	**Description and criteria**
Post-operative home help	Under this ***benefit we*** will cover the cost of domestic home help where ***you*** have undergone a ***treatment*** or ***procedure*** which is set out in the List of Post-Operative Home Help (POHH) Procedures in a ***medical facility*** covered under ***your plan***. This ***benefit*** is only available where the domestic home help is provided by Brown Flower Limited*. ***You*** must call ***us*** to request the service within 3 weeks of the date of ***your*** discharge from the ***medical facility*** in which ***you*** received the ***treatment*** or ***procedure***. ***You*** must receive the domestic home help within 4 weeks of ***your*** discharge from the ***medical facility*** in which ***you*** received the ***treatment*** or ***procedure***. If this ***benefit*** is available under ***your plan*** the number of days of home help that will be covered is set out in ***your*** Table of Cover. The maximum number of hours of home help that will be provided on each day is four hours. This ***benefit*** is not available where Brown Flower Limited is unable to provide the domestic home help service for any reason including where they are fully booked or where ***your*** home is not in an area serviced by Brown Flower Limited. When the domestic home help will be provided is subject to Brown Flower Limited's availability and their operating hours. The receipt of domestic home help is subject to Brown Flower Limited's terms and conditions and outside the control of ***Aviva***. This ***benefit*** cannot be ***claimed*** in conjunction with the alternative amount for post-operative home help ***benefit***. If ***you*** wish to cancel a booking with Brown Flower Limited, ***you*** must contact them directly to do so. ***You*** must give Brown Flower Limited more than 24 hours' notice of any cancellation. If ***you*** fail to do so this ***benefit*** will be exhausted and ***you*** will continue to be prevented from claiming the alternative amount for post-operative home help ***benefit***. Either ***you*** or a family member/friend who is 18 years old or older must be present in ***your*** home at all times when the domestic home help assistant is in attendance.
How to claim	
Call ***us*** on **(021) 480 2040**. ***We*** will take ***your*** details and pass these on to Brown Flower Limited who will contact ***you*** to arrange the service. ***You*** must provide a letter from ***your*** treating ***consultant*** confirming the dates of ***your treatment*** and ***procedure*** and the ***treatment*** and ***procedure*** code.	
Benefit	**Description and criteria**
Alternative amount for post-operative home help	This ***benefit*** allows ***you*** to ***claim*** €120 towards the costs of domestic home help after ***you*** have undergone a ***procedure*** that is listed on the List of Post-Operative Home Help (POHH) Procedures. This ***benefit*** cannot be ***claimed*** in conjunction with the post-operative home help ***benefit***. This ***benefit*** must be ***claimed*** within 4 weeks of the date of ***your*** discharge. This ***benefit*** cannot be ***claimed*** in conjunction with the post-operative home help ***benefit***.
How to claim	
Please call ***us*** to let ***us*** know if ***you*** wish to ***claim*** this ***benefit***. ***You*** must provide a letter from ***your*** treating ***consultant*** or ***your medical facility*** confirming the date of ***your treatment*** and ***procedure*** and the ***treatment*** and ***procedure*** code.	

Benefit	**Description and criteria**
Oncotype dx	Under this ***benefit we*** will cover the cost of genomic testing for HER positive node negative breast cancer to indicate the recurrence score for breast cancer returning in a 10 year time period. This ***benefit*** is only available where the genomic testing has been ***pre-authorised*** by ***Aviva***.
Day-case procedure for rheumatology & chemotherapy	Under this ***benefit we*** will cover the cost of rheumatology and chemotherapy provided by Point of Care Health Services Limited* on a ***day case*** basis.
Vasectomy (in Clane Hospital)*	Under this ***benefit*** we will cover your hospital costs and ***consultant's*** fees where you have a vasectomy carried out in Clane Hospital subject to €125 excess. This ***benefit*** is only available on Family Focus and Hospital Focus plans.
How to claim	
These ***benefits*** are ***claimed*** in the same way as In-patient Benefits. Please see section 2.2 of this Membership Handbook for details of how In-patient Benefits are ***claimed*** directly by ***medical facilities*** and ***health care providers***.	

Benefit	Description and criteria
Convalescence benefit	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of a stay in a ***convalescence home*** for a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan***, the maximum amount that ***we*** will contribute per day and the maximum number of days for which this can be ***claimed*** is set out in ***your*** Table of Cover. This ***benefit*** is only available in respect of a stay in a ***convalescence home*** where ***you*** entered such ***convalescence home*** immediately after ***you*** were an ***in-patient*** in a ***medical facility*** covered under ***your plan*** for the purpose of receiving a ***medically necessary treatment*** or ***procedure***
Home nursing	This ***benefit*** allows ***you*** to ***claim*** back some of the cost of home nursing immediately after ***you*** have been discharged from an ***in-patient*** stay in a ***medical facility*** covered under ***your plan***. The home nursing must be provided by a nurse** and ***your consultant*** must have advised that the home nursing is ***medically necessary***. The contribution under this ***benefit*** is payable for home nursing costs which are incurred up to specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan***, the maximum amount that ***we*** will contribute per day and the maximum number of days for which can be ***claimed*** will be set out in ***your*** Table of Cover.
Child home nursing	Under this ***benefit we*** will contribute towards the costs of home nursing by a paediatric nurse**. The child home nursing must be received immediately after the ***member*** has been an ***in-patient*** for at least 5 days in a ***medical facility*** covered under their ***plan***. The ***member's consultant*** must have advised that the home nursing care is ***medically necessary***. The contribution under this ***benefit*** is payable for child home nursing costs which are incurred up to a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan*** the maximum amount that ***we*** will contribute per day and the maximum number of days for which can be ***claimed*** will be set out in ***your*** Table of Cover.
Parent accompanying child	Under this ***benefit we*** will contribute towards the following costs where ***your*** child is an ***in-patient*** for more than 3 days and ***you*** have to travel to be with them: • costs of ***your*** hotel or bed and breakfast accommodation • ***your*** travel costs to and from the ***medical facility*** • the costs of food and drink consumed whilst ***you*** are visiting ***your*** child The contribution under this ***benefit*** is payable for reasonable costs incurred by ***you*** up to a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan*** the maximum amount which ***we*** will cover per day and the maximum number of days for which it can be ***claimed*** is set out in ***your*** Table of Cover. The contribution can only be ***claimed*** for costs incurred after ***your*** child has been an ***in-patient*** for 3 consecutive days i.e. the contribution can only be ***claimed*** for the costs ***you*** incur from the 4th day ***your*** child remains an ***in-patient***. For the purposes of this ***benefit*** "child" means a child of 14 years of age or under.
In-patient support benefit	Under this ***benefit we*** will contribute towards the following costs where ***you*** have to travel more than 50 kilometres from ***your*** home to receive an ***in-patient treatment*** or ***procedure*** in a ***public hospital***: • fuel costs to get to and from the ***public hospital*** (petrol or diesel) • public transport costs to get to and from the ***public hospital*** The contribution under this ***benefit*** is payable for reasonable costs incurred by ***you*** up to a specified number of days in ***your policy year***. If this ***benefit*** is available under ***your plan*** the maximum amount which ***we*** will cover per day and the maximum number of days for which it can be ***claimed*** is set out in ***your*** Table of Cover. This ***benefit*** is only available for travel costs to and from a ***public hospital*** and only where the hospital in question is the nearest ***public hospital*** in which ***you*** can receive the ***treatment*** or ***procedure***.
Cancer support benefit	Under this ***benefit we*** will contribute towards the costs of hotel or bed and breakfast accommodation where ***you*** have to stay in a hotel or bed and breakfast to enable ***you*** to receive chemotherapy or radiotherapy in a ***public*** or ***private hospital***. This ***benefit*** is only available where ***you*** have to travel more than 50 kilometres from ***your*** home to receive chemotherapy or radiotherapy in the ***public*** or ***private hospital***. This ***benefit*** is only available for the costs of a hotel or bed and breakfast on the night before and the night after ***you*** receive the chemotherapy or radiotherapy. If this ***benefit*** is available under ***your plan*** the maximum amount that ***we*** will contribute per day and per ***policy year*** is set out in ***your*** Table of Cover.
Medical and surgical appliances	Under this ***benefit we*** will contribute towards the costs of the medical and surgical appliances set out on the List of Medical and Surgical Appliances up to the amount specified on that list.

How to claim

These ***benefits*** are ***claimed*** in the same way as Out-patient Benefits

You must settle the bill directly with the provider of the goods or services. At the end of ***your policy year***, ***you*** must send all original receipts to ***us*** in an envelope with ***your*** name, address and ***membership number*** (see 'Your Contacts'). ***You*** can also claim throughout ***your policy year*** by scanning ***your*** original receipts and submitting them through our online claims tool (Aviva Online Claiming) on www.avivahealth.ie.

Please ensure that all original receipts state:

- The amount paid;
- The full name of the ***member*** receiving ***treatment***/service and their date or birth;
- The type of ***treatment***/service received;
- The date the ***treatment***/service was received;
- The signature and contact details for the treating ***consultant*** and the hospital or treatment centre where ***you*** were treated (if applicable).

We will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.

When claiming for the convalescence benefit, home nursing benefit or child home nursing benefit ***you*** may also have to provide ***us*** with a medical report from ***your consultant*** confirming that the stay in a ***convalescence home*** or the home nursing is ***medically necessary***.

Benefit	Description and criteria
Stress management telephone line	Under this ***benefit members*** have access to a stress management telephone service 7 days a week, 365 day a year.
How to claim	
Telephone : 1850 718 888	

Benefit	**Description and criteria**
Medicall ambulance costs	Under this ***benefit we*** will cover the cost of an ambulance where it is required to transfer ***you*** between ***medical facilities*** or between a ***medical facility*** and a ***convalescence home***. The ***benefit*** is only available where the ambulance is provided by Medicall Ambulance Limited* and where it is ***medically necessary***. This ***benefit*** is only available where ***you*** were, or will be, a private patient in the ***medical facility*** covered under ***your plan*** to which ***you*** are being transferred from or to.
How to claim	
We will pay Medicall Ambulance Limited* directly but ***you*** must sign the forms provided by Medicall Ambulance Limited to allow them to ***claim*** the costs of the service on ***your*** behalf.	

Benefit	**Description and criteria**
Employment Assistance Program (EAP)	Where this ***benefit*** is available on ***your plan***, ***you*** will have access to a dedicated telephone counselling service. This telephone counselling service is available 24 hours a day, 365 days a year. 6 face to face counselling sessions per ***policy year*** are also available on some ***plans***. The type of cover available is set out in ***your*** Table of Cover. This ***benefit*** is only available to ***members*** who are 18 years old and over. All counselling must be provided by EAP Consultants Limited*.
How to claim	
Telephone counselling To ***claim*** this ***benefit*** please call the dedicated EAP phone line on 1850 718 888. EAP will take ***your*** details and organise for a counsellor to contact ***you*** Face to face counselling If ***your*** telephone counsellor considers it necessary they will refer ***you*** to a counsellor for face to face counselling.	

Benefit	**Description and criteria**
Health in the Home (HITH)	Under this ***benefit we*** will cover the costs of a home nursing service, provided by TCP Homecare Limited*, where ***you*** require ***medically necessary treatment*** but ***you*** wish to be discharged and continue ***your treatment*** at home. The home nursing is limited to administering ***your*** prescribed ***treatments***. ***Your consultant*** must have approved ***your*** early discharge and consented to ***your treatment*** being continued at home. This ***benefit*** is only available for home nursing immediately following a ***medically necessary in-patient*** stay in a ***medical facility*** covered under ***your plan***. This ***benefit*** is not available where TCP Homecare Limited* cannot provide the home nursing service for any reason including where they are fully booked or where ***your*** home is not in an area serviced by TCP Homecare Limited*. The receipt of the home nursing service operated by TCP Homecare Limited* is subject to TCP Homecare Limited's* terms and conditions and is outside the control of ***Aviva***. This ***benefit*** must be ***pre-authorised*** by ***Aviva***.
How to claim	
We will pay TCP Homecare Limited* directly.	
Benefit	**Description and criteria**
Asthma care programme	Under this ***benefit you*** receive a discount on the asthma care programme run by Asthma Care Ireland*. The discount cannot be used in conjunction with any other offer or promotion run by Asthma Care Ireland and cannot be redeemed online.
How to claim	
This is a point of sale discount which ***you*** can ***claim*** from Asthma Care Ireland at time of purchase on production of ***your Aviva*** membership card.	

* The service providers named under these ***benefits*** may change from time to time.

** Please see our Directory of Allied Health Professionals, Alternative (Complementary) and Other Practitioners in section 11.1 of this Membership Handbook for details of the qualifications and registrations that must be held by the practitioner.

2.5 Overseas benefits

We have two types of overseas ***benefits*** available on our ***plans***; A&E Abroad ***benefits*** and Elective Overseas Referral ***benefits***.

A&E Abroad

Our A&E Abroad ***benefits*** cover ***your*** medical costs and the costs of repatriation for ***you*** and ***your*** companion where ***you*** require ***emergency care*** outside ***Ireland***. The table below explains all our A&E Abroad ***benefits*** but ***you*** should check ***your*** Table of Cover to see which of these ***benefits*** apply to ***you***.

Our A&E Abroad ***benefits*** are not a substitute for travel insurance. ***We*** recommend that ***you*** purchase travel insurance prior to travelling outside ***Ireland*** and obtain a European Health Insurance Card before ***you*** travel (see www.ehic.ie).

All ***claim***s will be assessed and settled in euro. ***Aviva*** will use the foreign exchange rate which applies at the date of ***your*** discharge from the ***medical facility*** abroad or at the time of purchase, as appropriate.

A&E Abroad	
Benefit	**Description and criteria**
Hospital bill for in-patient treatment	Under this ***benefit we*** will cover ***your*** medical costs for ***emergency care*** in a ***medical facility*** abroad where: • The ***emergency care*** is ***medically necessary***; • The ***emergency care*** is ***pre-authorised*** and arranged by ***Aviva***; • ***You*** began ***your emergency care*** abroad within 31 days of ***your*** departure from ***Ireland***; • ***You*** receive the ***emergency care*** in an ***internationally recognised hospital***; • ***You*** have not travelled against medical advice; • ***You*** were not suffering from a ***terminal illness*** when ***you*** left ***Ireland***; and • ***You*** did not suspect when ***you*** left ***Ireland*** that ***you*** might require any ***medical care*** when ***you*** were abroad and a reasonable person in ***your*** position would not have suspected that ***you*** would require any ***medical care*** when ***you*** were abroad. There is a maximum amount that can be claimed under this ***benefit*** on ***your plan***. This will be shown in ***your*** Table of Cover. ***We*** will not cover: • non-medical expenses; • ***medical care*** that has not been ***pre-authorised*** and arranged by ***us***; • ***elective treatments*** or ***procedures*** or ***follow on care***, regardless of whether this is related to ***your emergency care***; • ***medical care*** that could be delayed until ***your*** return to ***Ireland***.
How to claim	
You should call our international assistance number 00353 148 17840 in advance of receiving ***your emergency care*** to have ***your medical care pre-authorised*** and arranged by ***us***. ***You*** must provide ***us*** with details of ***your*** travel insurance and ***your*** European Health Insurance Card. If ***you*** are unable to contact our international assistance number, a third party may do so on ***your*** behalf. In most cases, where ***we*** have ***pre-authorised*** and arranged ***your emergency care*** in advance, ***we*** will pay ***your medical facility*** and ***health care providers*** directly (by ***direct settlement***). However, some ***medical facilities*** and ***health care providers*** abroad may not accept payment from ***us*** by ***direct settlement***. Where this occurs, ***you*** must pay the ***medical facility*** and ***health care providers*** yourself and ***claim*** the amount covered under this ***benefit*** back from ***us***. ***You*** will need to submit ***your*** original receipts to ***us*** to do so. ***You*** should send all receipts to ***us*** in an envelope with ***your*** name, address and ***membership number***. ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.	

Benefit	**Description and criteria**
Repatriation expenses	Under this ***benefit we*** will arrange and cover the costs (up to a specified amount) of ***your*** transport back to ***Ireland*** where ***you*** are unable to use ***your*** return transport to return to ***Ireland*** for medical reasons. ***You*** must be willing to travel as soon as ***you*** are medically fit to do so. If ***you*** fail to accept the transport ***we*** offer ***you*** this ***benefit*** will be exhausted. All repatriation travel must be arranged by ***us***. ***We*** will not cover the cost of any travel that has not been arranged by ***us***. The maximum amount that ***we*** will cover under this ***benefit*** is set out in ***your*** Table of Cover. This ***benefit*** is only available in conjunction with our 'hospital bill for in-patient treatment' ***benefit***.
How to claim	
Please call our international assistance number 00353 148 17840 and ***we*** will arrange ***your*** transport back to ***Ireland***. ***You*** may be required to provide ***us*** with a medical certificate confirming ***you*** are fit to travel before ***we*** can arrange and cover the costs of ***your*** transport back to ***Ireland***. ***We*** will pay the transport providers directly where possible. If ***we*** are unable to pay ***your*** transport provider directly for any reason ***you*** will have to pay them yourself and ***claim*** this back from ***us***. ***You*** will need to submit ***your*** original receipts to ***us*** to do so. ***You*** should send all receipts to ***us*** in an envelope with ***your*** name, address and ***membership number***. ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.	

Benefit	**Description and criteria**
Companion repatriation expenses	This ***benefit*** allows ***you*** to ***claim*** back the transport costs incurred by ***your*** companion to return to ***Ireland*** where they have missed their return mode of transport as a result of remaining with ***you*** whilst ***you*** were receiving ***your emergency care***. The maximum amount that ***we*** will contribute under this ***benefit*** is set out in ***your*** Table of Cover. This ***benefit*** is only available in conjunction with our 'hospital bill for in-patient treatment' ***benefit***.

How to claim
Your companion must arrange and pay for their transport back to ***Ireland***. ***You*** can ***claim*** the contribution under this ***benefit*** from ***us*** by sending ***us*** their receipts. ***You*** must send all original receipts to ***us*** in an envelope with ***your*** name, address and ***membership number***. ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.

Benefit	Description and criteria
Expenses for companion who remains with you	This ***benefit*** allows ***you*** to ***claim*** back reasonable accommodation, local transport and food costs incurred by ***your*** companion as a result of such companion remaining with ***you*** whilst ***you*** are receiving ***your emergency care***. The maximum amount that ***Aviva*** will contribute under this ***benefit*** is set out in ***your*** Table of Cover. This ***benefit*** is only available in conjunction with our hospital 'bill for in-patient treatment' ***benefit***.
How to claim	
Your companion must pay the providers of the goods and services and keep their receipts. ***You*** can ***claim*** the contribution under this ***benefit*** from ***us*** by sending ***us*** their receipts. ***You*** must send all original receipts to ***us*** in an envelope with ***your*** name, address and ***membership number***. ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.	

Benefit	Description and criteria
24 hour telephone assistance	Under this ***benefit you*** have access to a 24 hour telephone assistance line whilst ***you*** are abroad. This ***benefit*** is only available in conjunction with our 'hospital bill for in-patient treatment' ***benefit***.
How to claim	
Please call 00353 148 17840	

Please note that our A&E Abroad ***benefits*** will not apply where ***your emergency care*** is required:

- for a nervous, mental or psychiatric condition;
- for conditions and/or ***injuries*** arising from excessive alcohol consumption;
- for conditions and/or ***injuries*** arising from ***substance abuse***;
- for conditions and/or ***injuries*** arising from deliberately injuring yourself;
- for conditions and/or ***injuries*** arising from ***your*** own negligence;
- for conditions and/or ***injuries*** arising from ***hazardous sports***;
- for conditions and/or ***injuries*** arising from breaking the law;
- for conditions and/or ***injuries*** arising from air travel unless as a passenger on a licensed aircraft operated by a commercial airline;
- in a country in which the Irish Department of Foreign Affairs has recommended that ***you*** should exercise extreme caution, avoid non-essential travel or not travel; and
- for giving birth where ***you*** travelled abroad intending to give birth abroad or it could reasonably have been expected at the time of ***your*** departure that ***you*** would give birth abroad.

Elective Overseas Referrals

Our Elective Overseas Referral ***benefits*** cover some of the cost of having a ***surgical procedure*** performed abroad. ***We*** provide two ***benefits*** under our Elective Overseas Referral ***benefits***; (A) 'benefit abroad for surgical procedures that are available in Ireland' and (B) 'benefit abroad for surgical procedures that are not available in Ireland'. The table below explains both our 'Elective Overseas Referral' ***benefits*** but ***you*** should check ***your*** Table of Cover to see if these ***benefits*** are covered under ***your plan***.

All elective ***medical care*** received abroad must be ***pre-authorised*** by ***Aviva.*** See the "How to Claim" section of the table below for details of how to have ***your*** elective overseas ***medical care pre-authorised*** by ***us***.

Please note *you* will only be covered up to the amount *pre-authorised* by *us*. *Your* overseas *medical facility* and *health care providers* may charge more than this amount. If they do, *you* will be responsible for paying the balance. In addition *we* do not pay overseas *medical facilities* and *health care providers* directly. *You* will need to pay your entire bill to the *medical facility* and/or *health care providers* yourself. *You* can then *claim* the *pre-authorised* amount from *us* by submitting *your* receipts.

When ***you*** submit an Aviva Overseas Pre-Approval Form to ***us***, our ***medical advisers*** will decide whether the ***surgical procedure you*** require abroad is available in Ireland. This can require a complex medical assessment of the ***treatments*** and ***procedures you*** wish to receive abroad and the ***treatments*** and ***procedures*** available in ***Ireland*** to treat ***your*** condition. The decision of our ***medical advisers*** is final. In addition, their assessment is based entirely on the information ***you*** provide in advance of ***your*** undergoing ***your procedure*** (in ***your*** Aviva Overseas Pre-Approval Form). The amount ***pre-authorised*** by ***us*** cannot be reassessed following ***your treatment*** regardless of whether the ***treatment you*** receive differs from that anticipated in ***your*** Aviva Overseas Pre-Approval Form or otherwise.

Please note that the following conditions apply to Elective Overseas Referrals:

- The ***surgical procedure*** must be performed within 31 days from when ***you*** leave ***Ireland***;
- ***You*** must have been referred for the ***surgical procedure*** abroad by a participating ***consultant*** in ***Ireland***;
- The ***surgical procedure*** must be performed before ***your pre-authorisation*** expires. ***Your pre-authorisation*** will end either 6 months from when it is granted, or at the end of the ***policy year***;
- The ***surgical procedure*** must be ***medically necessary*** and our ***medical advisers*** must agree that the ***surgical procedure*** will result in a reasonably favourable medical prognosis;
- The proposed ***surgical procedure you*** require abroad must be related to and have the same objective as a ***procedure*** or ***treatment*** that ***you*** are covered for in ***Ireland***; and
- The ***surgical procedure*** or, where the ***surgical procedure*** is not available in ***Ireland***, the most similar ***surgical procedure*** available in ***Ireland***, must not be controlled by a national register of waiting lists for ***transplants*** or other complex ***procedures***.

Elective Overseas Referral	
Benefit	**Description and criteria**
Benefit abroad for surgical procedures that are available in Ireland	Under this ***benefit we*** will cover the following: • ***Hospital costs***: ***We*** will cover ***your hospital costs*** in a ***medical facility*** abroad up to the amount that would be covered under ***your*** In-patient Benefits if ***you*** were to be admitted to a ***medical facility*** in ***Ireland*** to have the ***surgical procedure*** performed. Our ***medical advisers*** will base their assessment on the ***hospital costs*** that would be covered in the ***medical facility*** in ***Ireland***, which, in their opinion, would have been most suitable for ***you***. • ***Consultant's*** fees: ***Consultants*** practicing overseas are treated as standard rate ***consultants***. Under this ***benefit Aviva*** will cover ***your consultant's*** fees to the same level as would be covered under ***your plan*** if ***you*** were treated by a standard rate ***consultant*** whilst admitted to a ***medical facility*** in ***Ireland*** to receive ***your surgical procedure***. Please see section 2.2 of this Membership Handbook for information on how the professional fees of standard rate ***consultants*** are covered. Our ***medical advisers*** will decide the ***hospital costs*** and the ***consultant's*** fees that would have been covered if ***you*** were admitted to a ***medical facility*** in ***Ireland*** to undergo the ***surgical procedure you*** wish to receive abroad. The decision of our ***medical advisers*** is final. The costs of traveling to and from the country in which ***you*** wish to receive ***your surgical procedure*** will not be covered. ***We*** will confirm the amount that ***we*** will cover under this ***benefit*** when ***we pre-authorise*** your overseas ***surgical procedure***.
Benefit abroad for surgical procedures that are not available in Ireland	Under this ***benefit we*** will cover the following: • ***Hospital costs***: ***We*** will cover ***your hospital costs*** in a ***medical facility*** abroad up to the amount that would be covered under ***your*** In-patient Benefits if ***you*** were to be admitted to a ***medical facility*** in ***Ireland*** to receive the most similar ***surgical procedure*** available in ***Ireland***. Our ***medical advisers*** will base their assessment on the ***hospital costs*** that would be covered in the ***medical facility*** in ***Ireland***, which, in their opinion, would have been most suitable for ***you***. • ***Consultant's*** fees: ***Consultants*** practicing overseas are treated as standard rate ***consultants***. Under this ***benefit Aviva*** will cover ***your consultant's*** fees to the same level as would have been covered under ***your plan*** if ***you*** were treated by a standard rate ***consultant*** whilst admitted to a ***medical facility*** in ***Ireland*** to receive ***your surgical procedure***. Please see section 2.2 of this Membership Handbook for information on how the professional fees of standard rate ***consultants*** are covered. Our ***medical advisers*** will decide the ***hospital costs*** and the ***consultant's*** fees that would be covered if ***you*** were admitted to a ***medical facility*** in ***Ireland*** to undergo a ***surgical procedure*** to treat the medical condition/ conditions specified in your Aviva Overseas Pre-Approval Form. Our ***medical advisers*** must believe that the ***surgical procedure*** that ***you*** wish to undergo abroad is medically proven to be a more effective method of ***treatment*** than the ***treatments*** and ***procedures*** available in ***Ireland*** to treat the condition/conditions specified in your Aviva Overseas Pre-Approval Form. The decisions of our ***medical advisers*** are final. The costs of traveling to and from the country in which ***you*** wish to receive ***your surgical procedure*** will not be covered.
How to claim	
If ***you*** wish to ***claim*** either of these ***benefits you*** must have all ***your medical care*** abroad ***pre-authorised*** by ***us***. To obtain ***pre-authorisation you*** will need to complete the Aviva Overseas Pre-Approval Form which is available on our website. Part 3 of the Aviva Overseas Pre-Approval Form must be completed by ***your GP*** or ***Consultant***. Where our ***medical advisers*** deem it necessary, ***you*** may also be required to provide ***us*** with additional information (including a detailed medical report) from ***your GP*** or ***consultant*** in ***Ireland*** and/or your treating ***consultant*** abroad. ***We*** will assess your ***pre-authorisation*** request within 15 working days and confirm the amount for which ***you*** are covered. ***You*** will need to pay ***your*** overseas ***medical facility*** and ***health care providers*** directly for ***your medical care***. ***You*** can then claim the amount ***we*** have ***pre-authorised*** back from ***us*** by submitting ***your*** original receipts to ***us*** in an envelope with ***your*** name, address and membership number (see section 10 for details of where to send your receipts). ***We*** will not return ***your*** original receipts unless ***you*** ask ***us*** to do so at the time ***you*** submit them to ***us***.	

2.6 Aviva Member Benefits

As an ***Aviva member***, ***you*** are eligible to receive discounts on certain health related products or services. These are known as Aviva Member Benefits and are explained in the table below. To ***claim your*** Aviva Member Benefits, ***you*** will need to prove that ***you*** are an ***Aviva member*** at the time of purchasing the products or booking/receiving the service. ***You*** can do this by showing ***your Aviva*** membership card. The companies providing the products and services and the discounts that are available may change from time to time so ***you*** should check the most up to date information on our website before ***you*** try to ***claim***.

Aviva Member Benefits		
Benefit	**Provider contact details**	**Description/Criteria**
Health screening	**Charter Medical Group*** Telephone: 01 657 9000 **Employment Health Advisers*** Telephone: 021 453 6000	Charter Medical Group and Employment Health Advisers provide ***Aviva members*** with a point of sale discount on health screening. This offer may not be used in conjunction with any other offer or promotion run by Charter Medical Group and Employment Health Advisers. This discount can be ***claimed*** once per ***policy year***. In addition to the discount, ***you*** may also be able to ***claim*** a contribution from ***us*** on the amount that ***you*** have paid to Charter Medical Group or Employment Health Advisers for ***your*** health screening. To ***claim*** the contribution from ***us you*** need to settle the bill directly with Charter Medical Group or Employment Health Advisers and send ***your*** receipt to ***us*** at the end of ***your policy year*** (see section 10 of this Membership Handbook for contact details for our claims team).

Smoking Cessation	**Allen Carr's Easyway to Stop Smoking Programme*** Telephone: 1890 379 929 or 01 4999010 Website: www.easyway.ie or www.allencarr.ie	Allen Carr's Easyway to Stop Smoking Programme provide ***Aviva members*** with a point of sale discount on its smoking cessation programme. This offer may not be used in conjunction with any other offer or promotion run by Allen Carr's Easyway to Stop Smoking Programme.
Dental Access Package	**Smiles Town and Dental** Telephone: 1850 323 323 Website: www.smiles.ie	Smiles Town and Dental provide ***Aviva members*** with a point of sale discount on a number of dental ***treatments***. This discount cannot be used in conjunction with any other offer or promotion run by Smiles Town and Dental facilities. Where the ***treatment*** or ***procedure*** is not supplied for the entire mouth, the discount shall be applied on a ***pro rata*** basis.
Asthma care programme	**Asthma Care Ireland*** Telephone: 1800 931 935 or 091 756229 Email: info@asthmacare.ie Website: www.asthmacare.ie or www.buteykochildren.com	Asthma Care Ireland provide ***Aviva members*** with a point of sale discount on its asthma care programme. The discount cannot be used in conjunction with any other offer or promotion run by Asthma Care Ireland and cannot be redeemed online.
Laser eye surgery	**Optical Express*** Telephone: 1800 818 543 Website: www.opticalexpress.com/ie	Optical Express provide ***Aviva members*** with a point of sale discount on LASIK or LASEK ***treatments***. Where the ***treatment*** is not supplied for both eyes, the discount shall be applied on a ***pro rata*** basis. This offer may not be used in conjunction with any other offer or promotion run by Optical Express.
Fitsquad	**2012 FITSQUAD LIMITED*** Website: www.fitsquad.ie	2012 Fitsquad Limited provide ***Aviva members*** with a point of sale discount on its fitsquad outdoor fitness programme. This offer may not be used in conjunction with any other offer or promotion run by 2012 Fitsquad Limited.
U Mamma	**U Mamma*** Telephone: 01 2014900 Website: www.umamma.ie	U Mamma provide ***Aviva members*** with a point of sale discount on pre and post natal ***treatments***. This offer may not be used in conjunction with any other offer or promotion run by U Mamma.
4d scans	**Ultrasound Dimensions*** 21 Main Street, Blackrock, Co. Dublin Telephone: 01 210 0232 Email: info@ultrasound.ie	Ultrasound Dimensions provide ***Aviva members*** with a point of sale discount on 4D maternity scans. This offer may not be used in conjunction with any other offer or promotion run by Ultrasound Dimensions.
Elvery's Sports	**Elvery's Sports*** Stores nationwide	Elvery's Sports provide ***Aviva members*** with a point of sale discount on certain products and a free gift with purchases over a specified amount. This offer may not be used in conjunction with any other offer or promotion run by Elvery's Sports. In addition ***we*** will contribute towards the cost running shoes purchased from Elvery's Sports. One contribution can be ***claimed*** per ***member*** per ***policy year***. To ***claim*** the contribution from ***us*** ***you*** need to settle the bill directly with Elvery's Sports and send ***your*** receipt to ***us*** at the end of ***your policy year*** (see section 10 of this Membership Handbook for contact details for our claims team). This Aviva Member Benefit is available on certain ***plans*** only. Please refer to your Table of Cover to see if it's applicable to ***your plan***.
Back up	**Health & Case Management Limited (HCML)***	Health & Case Management Limited provide ***Aviva members*** with advice on back and neck pain and where required physiotherapy for a once off nominal fee. Please call ***us*** on **(021) 480 2040** and provide ***us*** with some initial details. ***We*** will put ***you*** in contact with a clinical case manager from HCML. ***Your*** clinical case manager will assess ***your*** requirements and provide ***you*** with advice and information on exercises or other things ***you*** can do to improve ***your*** condition. Where HCML considers it necessary, they will refer ***you*** to one of their associated physiotherapists. ***You*** must attend the physiotherapist recommended by HCML. ***You'll*** be entitled to two physiotherapy ***treatment*** programmes in ***policy year*** for a nominal fee of €50 per ***treatment*** programme. This fee should be paid to ***your*** physiotherapist at the first session of ***your treatment*** programme. Each ***treatment*** programme is limited to 8 physiotherapy sessions. Each ***treatment*** programme must be completed within 6 months from the date it is begun. A second ***treatment*** programme can only be started 4 months after the preceding one finishes. Additional physiotherapy session within a ***treatment*** programme will require ***pre-authorisation***. This is only available to ***members*** who are 18 years old and over. Further information on Back Up is available on our website at Avivahealth.ie/back-up.
babylon Health	**Babylon Healthcare Services Limited***	***Members*** can ***claim*** a discount on the cost of subscribing to the babylon Health app. The babylon Health app allows ***you*** to have a consultation with a ***GP*** through ***your*** mobile device. Please note the babylon Health app is only available for download and use on iPhone or Android phones. This offer may not be used in conjunction with any other offer or promotion run by Babylon Healthcare Services Limited*.

* The service providers named under these ***benefits*** may change from time to time. Please also note that ***we*** are not responsible for the content of the websites of these service providers.

3. Exclusions from Your Cover

We do not cover the following (subject to compliance with the ***Minimum Benefit Regulations***):

- Any costs that are not covered under a ***benefit*** listed on ***your*** Table of Cover;
- Any costs incurred whilst a waiting period applies;
- The cost of any ***medical care*** that our ***medical advisers*** believe is not ***medically necessary***;
- Any costs that our ***medical advisers*** believe are not ***reasonable and customary costs***;
- The cost of any ***medical care*** that our ***medical advisers*** believe is not an ***established treatment***;
- Any costs incurred in a ***medical facility*** that is not covered under ***your plan***;
- The cost of any ***treatment*** or ***procedure*** provided by a ***health care provider*** who is not registered with ***Aviva***;
- Any costs associated with ***treatments*** and ***procedures*** that are not listed in the Schedule of Benefits;
- Preventative or maintenance ***treatments*** and ***procedures*** unless listed in the Schedule of Benefits;
- ***Cosmetic surgery*** unless this is ***medically necessary*** to restore a ***member's*** appearance due to: (i) an ***accident***,(ii) a genetic disfigurement at birth or (iii) a significant disfigurement caused by disease;
- Any costs arising from or related to ***medical care*** not covered by ***Aviva***, including subsequent ***treatments***, ***procedures*** or medical care which are required as a result of such ***medical care***;
- Gender reassignment ***treatments*** or ***procedures***;
- Any costs that relate in any way to ***transplants*** including any subsequent ***treatments***, ***procedures*** or ***medical care;***
- Any nursing home care and convalescence care that is not covered under our convalescence ***benefit***;
- Ambulance costs except those covered under our Medicall ambulance costs ***benefit***;
- The costs of any form of vaccination except that covered under our vaccination ***benefit*** as a Day-to-day Benefit or an Out-patient Benefit;
- Any costs associated with family planning or contraceptive measures, including any form of infertility ***treatment***, investigations into infertility, the reversal of infertility ***treatment*** and assisted reproduction, except where such costs are covered under ***our*** vasectomy ***benefit***, prescription ***benefit*** or the fertility assessment in ***our*** health screening ***benefit***;
- Any ***treatment*** programmes for weight related disorders or eating disorders that are not provided by a ***consultant*** psychiatrist in a ***medical facility*** covered under ***your plan***;
- Any costs relating to participation in clinical studies or trials;
- Any costs arising from or related to ***injury*** or illness caused by virtue of war, chemical, biological or nuclear disasters, civil disobedience or any act of terrorism;
- The cost of any ***medical care*** or other goods or services provided by a ***member*** of the insured's ***immediate family*** unless this is ***pre-authorised*** by ***Aviva***;
- Expenses for which ***you*** are not liable;
- The cost of any ***medical care*** or other goods or services which were not received by ***you***;
- Any costs not incurred during ***your policy year***;
- Any costs of associated with the ***treatment*** of symptoms which are not due to any underlying disease, illness or ***injury***;
- Nursery fees;
- The cost of ophthalmic ***procedures*** for correction of short-sightedness, long-sightedness or astigmatism where the ***procedure*** is being performed to avoid wearing glasses or contact lenses;
- The cost of any ***medical care*** which is performed by, or under the direction of, a ***consultant*** who is not registered with the Irish Medical Council as a specialist in the area in question;
- The cost of health screening except where the costs are covered under our health screening ***benefit***, sexual health screening ***benefit***, health screening at any centre ***benefit*** or where a contribution is available on health screening under our Aviva Member Benefits;
- Any penalty charge in lieu of Health Act contributions;
- Any psychologists fees other than those covered under the psycho-oncology counselling ***benefit*** and the child counselling ***benefit***;
- The cost of prophylactic ***procedures*** to remove organs or glands that shows no sign of cancer in an attempt to prevent the development of cancer of the organ or gland in question, unless the ***procedure*** is listed in the Schedule of Benefits and it provides that it can be performed for that purpose;
- The cost of drugs or medication unless they are covered under a Day-to-day Benefit or an Out-patient Benefit or are provided to ***you*** as part of ***your hospital costs*** whilst ***you*** are an ***in-patient*** or a ***day case*** patient in a ***medical facility*** covered under ***your plan***;
- The cost of a drug which is over and above the cost of a drug which is, in the opinion of our ***medical advisers***, an alternative, generic or bio similar drug;
- The cost of drugs not recommended for cover by the National Centre for Pharmacoeconomics;
- The costs of drugs where they are used for a purpose which is different from that for which they were licensed by the Health Products Regulatory Authority;
- The cost of ***rehabilitation*** services;
- The costs of a robotic ***surgical procedure*** which are over and above the costs that would have been incurred had the ***surgical procedure*** been performed using traditional methods;
- Any costs, legal or otherwise, incurred by a ***member*** as a result of making a ***claim*** or taking legal action against any person/ company/public body;
- Medical expenses imposed for non-attendance or late cancellation of an appointment;
- The costs of medical certificates, medical records / reports, or the costs associated with obtaining details of medical history;
- Differences in foreign exchange rates, bank charges or other charges applied to foreign exchange

4. Your Policy

Joining *Aviva*

Your plan/policy lasts for one year which means that ***your policy/plan*** will run until the ***renewal date*** shown on ***your*** membership certificate unless cancelled by the ***policyholder*** or by ***us*** for the reasons outlined in this Membership Handbook. As soon as ***we*** receive ***your*** first premium, ***you*** will be covered from ***your*** chosen commencement date subject to the terms and conditions of ***your policy***. When ***you***'ve joined, ***you*** will have access to the secure membership area of our website where ***you*** can make changes to ***your*** cover and to ***your*** personal details. Please note that if ***you*** are a ***group scheme member you*** may not be able to make changes to ***your plan*** via the secure membership area of our website. Please see section 8 for further details on ***group schemes***.

Changing *your policy*

The ***policyholder*** can make changes to their ***policy*** or any of the ***plans*** listed on their ***policy*** at any time by logging onto the membership area on our website (**Avivahealth.ie/members/manage-my-plan**) or by contacting ***us*** (or their broker) directly. Changes can affect the premium that is payable. If a change is made to the ***policy***, ***we*** will issue new ***policy*** documents to the ***policyholder*** as soon as the change is completed. Please be aware that an upgrade waiting period may apply where there is an upgrade in cover (please see section 6 for further details on upgrade waiting periods). ***We*** cannot take instructions to make changes to the ***policy*** or any of the ***plans*** listed on the ***policy*** from a ***member***. However, the ***policyholder*** can nominate a person to act on their behalf to make changes to the ***policy*** or any of the ***plans***. If ***you*** wish to nominate someone, please call or write to ***us*** and let ***us*** know if they have authority to act on the entire ***policy*** or just specific ***plans***.

Where a ***plan*** is altered prior to the end of the ***policy year***, the Day-to-day Benefits and Out-patient Benefits will be applied on a ***pro rata*** basis.

Renewing *your plan*

To renew ***your*** membership:

- If ***you*** pay in monthly installments by direct debit, simply continue to make ***your*** direct debit payments. ***We*** will automatically renew ***your policy***.
- If ***you*** pay ***your*** annual premium in advance by cheque or credit card, please contact ***us*** to arrange payment and renew ***your policy*** (see section 10 of this Membership Handbook for our contact details).

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 Aviva

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 ***claim***s 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 ***claim***s 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 this 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

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.

Paying *your* premiums

All premiums must be paid in euro. ***We*** accept payment by debit card, direct debit, credit card or cheque. Please note credit card and debit card payments will only be accepted in three circumstances:

- as payment for the first monthly premium while the direct debit is being set up;
- to pay a monthly premium which is late;
- to pay the yearly premium in advance.

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***.

5. General Terms & Conditions

General rules

- ***Your policy*** is governed at all times by the laws of ***Ireland*** and the exclusive jurisdiction of the courts of ***Ireland***;
- All ***policy*** documents and communications to ***members*** will be in English. ***We*** can provide ***policy*** documents and/or communications in braille or large print if requested;
- All ***members*** must be resident in ***Ireland***;
- ***You*** may be required to validate the information contained in ***your*** claim form. ***We*** may contact ***you*** during the claims process for this purpose;
- Where the amount that can be ***claimed*** under a ***benefit*** is greater than the amount ***you*** have been charged for the goods or services that are covered under that ***benefit***, ***we*** will only cover the amount that ***you*** have been charged subject to any ***excess***, shortfall or co-payment which may apply;
- The availability of beds in a ***semi-private room*** or ***private room*** is determined by the ***medical facilities*** and is outside the control of ***Aviva***;
- Where ***we*** cover the cost of goods or services that ***you*** have received as a result of an ***accident*** or ***injury*** for which another person/company/public body may be liable and ***you*** make a ***claim*** or take legal action against such other person/company/public body, ***you*** must include the cost of the goods or services covered by ***us*** in the damages ***you*** seek to recover from the person/company/public body. If ***you*** successfully recover some or all of the costs covered by ***Aviva***, by whatever means, ***you*** must reimburse ***us*** as soon as possible. ***We*** will not contribute towards the costs of pursuing such a ***claim*** or legal action;
- Where ***you*** (or any other person for whom ***you*** are seeking health insurance) hold any form of health insurance with another company ***you*** must let ***us*** know at the inception of ***your policy***. Where the costs of the goods or services which are covered under ***your plan*** with ***Aviva*** are also insured by another insurer, such costs will be allocated between ***us*** and ***your*** other insurer on a ***pro rata*** basis when you make a ***claim;***
- ***You*** will be covered under the ***benefits*** available in the ***plan you*** hold on the date ***your medical care*** (or other service) commences or on the date ***you*** receive goods, subject to any waiting periods that may apply. If ***you*** reduce the level of cover on ***your plan***, this lower level of cover becomes effective immediately;
- ***You*** must provide details of ***your*** membership with ***us*** to ***your medical facility*** and ***health care providers*** before undergoing ***your procedure*** or ***treatment*** or being admitted to a ***medical facility***;
- ***We*** will not return any documents ***you*** send to ***us*** unless ***you*** ask ***us*** to when ***you*** send them to ***us***;
- ***We*** will not pay ***your claim*** where ***you*** have failed to comply with any of the terms of ***our*** contractual documents;
- ***We*** have absolute discretion whether or not to exercise our legal rights. Failure to exercise our legal rights shall not prevent ***us*** from doing so in the future;
- ***Aviva*** and our agents reserve the right to review any information which relates to the ***medical care***, goods or services that ***you*** are claiming for (including ***your*** medical records) where ***we*** are of the opinion that access to such information is required to process ***your claim*** and/or detect or prevent fraud. ***You*** must provide ***your medical facility*** and ***health care providers*** with any consents which they require to allow them to release such information to ***Aviva*** and our agents. ***We*** will not pay ***your claim*** where ***we*** are unable to gain access to any information which ***we*** believe is necessary to enable ***us*** to process the ***claim*** or detect fraud;
- If any provision of this Membership Handbook is found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, the invalidity or unenforceability of such provision shall not affect the other provisions of this Membership Handbook and all provisions not affected by such invalidity or unenforceability shall remain in full force and effect.
- In the event that ***Aviva*** disagrees with the classification of a ***member*** as a public or a private patient by a ***medical facility*** or a ***health care provider***, ***our*** decision shall prevail and be final.
- Any dispute between ***you*** and ***us*** (about our liability over a ***claim*** or the amount to be paid, where the amount of the ***claim*** is €5,000 or more) must be referred (within 12 months of the dispute arising) to an arbitrator appointed jointly by ***you*** and ***us***. If ***we*** cannot agree on an arbitrator, the President of the Law Society of Ireland will decide on the arbitrator and the decision of that arbitrator will be final. ***We*** may not refer the dispute to arbitration without ***your*** consent where the amount of the ***claim*** is less than €5,000. If ***you*** do not refer such a dispute to arbitration within 12 months, ***we*** will treat the ***claim*** as abandoned.

6. 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***. 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 13 weeks or more. ***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 ***Aviva.*** These waiting periods will apply from the date ***you*** took out health insurance with ***Aviva*** or another insurer for the first time, or, from the date ***you*** took out health insurance with ***Aviva*** or another insurer after ***your*** health insurance had lapsed for 13 weeks or more.

Initial Waiting Periods

Benefit	Under 55 years old	55 years and older
All In-Patient Benefits Medical Ambulance Cost Health In the Home PET CT Scans Oncotype Dx Day-case for Rheumatology and Chemo Public Hospital Levy	26 weeks	
All Maternity Benefits	52 weeks	
All Day to Day Benefits Post Operative Home Help Alternative amount for post-operative home help Convalescence Benefit Home Nursing Parent Accompanying Child In- Patient Support Benefit Cancer Support Benefit Medical & Surgical Appliances	None	26 weeks
All Out Patient Benefits Asthma Care Programme Employment Assistance Programme Stress Management Telephone Line	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 13 weeks or more.

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

Pre-Existing Condition Waiting Periods

Benefit	Under 55 years old	55 years and older
All In-Patient Benefits Day-case for Rheumatology and Chemo PET-CT Scans Medical & Surgical Appliances Health In the Home	5 years	
All Maternity Benefits	52 weeks	
All Day to Day Benefits All Out Patient Benefits Asthma Care Programme Stress Management Telephone Line Medical Ambulance Cost Employment Assistance Programme Convalescence Benefit Home Nursing Child Home Nursing Parent Accompanying Child In- Patient Support Benefit Cancer Support Benefit Public Hospital Levy Post Operative Home Help Alternative amount for post-operative home help Oncotype Dx	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 ***Aviva*** from another health insurer. Where an upgrade waiting period applies, ***we*** will cover ***you*** to the level that was available under the ***benefit*** that ***you*** are claiming on your previous ***plan***. Where the ***benefit you*** are claiming was not available on ***your*** previous ***plan***, ***you*** will not be covered. The one exception to this is where ***you*** are claiming under ***your*** In-Patient Benefits. ***We*** will only apply an upgrade waiting period to ***claims*** made under ***your*** In-Patient Benefits where ***your claim*** relates to an ailment, illness or condition that existed before ***you*** upgraded. In these circumstances, ***you*** will be covered to the level of cover that was available under the In-Patient Benefits on the ***plan*** that ***you*** held at the time the ailment, illness or condition commenced. 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 ***Aviva.*** 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 Medical Ambulance Cost Health In the Home Day-case for Rheumatology and Chemo PET CT Scans	2 years	
All Maternity Benefits	52 weeks	
Post Operative Home Help Alternative amount for post-operative home help Oncotype Dx Convalescence Benefit Home Nursing Parent Accompanying Child In- Patient Support Benefit Cancer Support Benefit Medical & Surgical Appliances	None	52 weeks
All Day to Day Benefits	None	26 weeks
All Out Patient Benefits Asthma Care Programme Employment Assistance Programme Stress Management Telephone Line Public Hospital Levy	None	
Child Home Nursing	None	N/A

7. Fraud Policy

We operate a fraud ***policy*** in respect of all ***claim***s made by ***you*** or on ***your*** behalf. ***We*** do regular audits of all ***claim***s. In all instances where fraud is suspected, ***we*** will carry out a full and comprehensive investigation. If a ***claim*** submitted by ***you*** or on ***your*** behalf is found to be fraudulent or dishonest in any way, the ***claim*** will be declined in its entirety, ***benefits*** under the ***policy*** will be forfeited and the ***policy*** and/or any ***plans*** listed on the ***policy*** may be cancelled. ***We*** reserve the right to refer the matter and details of the fraudulent ***claim*** to the appropriate authorities for prosecution.

8. Group Schemes

If ***your plan*** was started as part of a ***group scheme*** arrangement and the ***group scheme sponsor*** is acting on ***your*** behalf, ***you*** agree that the ***group scheme sponsor*** will have the following powers and responsibilities for the ***policy***:

- The ***group scheme sponsor*** may instruct ***us*** to start and cancel the ***policy***;
- The ***group scheme sponsor*** may instruct ***us*** to change ***your plan*** or level of cover;
- The ***group scheme sponsor*** may instruct ***us*** to add or reduce the number of ***members*** on the ***policy***;
- The ***group scheme sponsor*** may amend or cancel any or all of the ***plans*** listed under the ***policy***;
- The ***group scheme sponsor*** must ensure that all premiums are paid on time as unpaid premiums may impact whether ***claim***s are paid;
- The ***group scheme sponsor*** must ensure that all adequate consents from ***members*** are obtained prior to the ***policy*** entering into force, including consents from ***members*** for the processing of their personal data.

Members who are part of a ***group scheme*** arrangement may require the permission of the ***group scheme sponsor*** to amend their cover. In such circumstances, the ***members*** may be required to pay additional premium for such amended cover.

If ***your policy*** was arranged through a ***group scheme sponsor***, ***your*** cover will continue as long as ***you*** fulfil the conditions for participation in the ***group scheme*** and the ***group scheme sponsor*** continues to pay ***your*** premium.

9. Premium Changes

We may change the premium payable for our ***plans*** from time to time. These changes will not affect ***you*** until ***your*** next ***renewal date*** unless you change your plan during your policy year. Please note that ***we*** deduct ***your tax relief*** from ***your*** premium so ***you*** don't have to ***claim*** it back from the Revenue Commissioners. The level of ***tax relief*** is set by the Government and may be changed at any time which is outside our control. ***We*** are legally obliged to apply tax changes immediately and this may result in a change to the amount that ***you*** are required to pay to ***us*** for the ***plans*** listed in ***your policy***.

10. Your Contacts

When contacting our numbers below, please quote ***your membership number*** which is detailed on ***your*** membership card.

Aviva customer service team

Contact ***us*** should ***you*** have any queries or in order to obtain ***pre-authorisation***.
Address: Customer Care Team, ***Aviva*** Health Insurance ***Ireland*** Limited, PO Box 764, Togher, Cork
E-mail: support@Avivahealth.ie
Telephone: (021) 480 2040

Corporate enquiries

E-mail: corporate.enquiries@Avivahealth.ie
Telephone: 1890 721 721

Claims submission

Claims Team, ***Aviva*** Health Insurance ***Ireland*** Limited, PO Box 764, Togher, Cork

Appeals

Should ***you*** wish to appeal a claim decision, ***you*** can contact the Customer Care Team:

- By phone on (021) 480 2040
- By email: support@Avivahealth.ie
- By post at: Claims Support Team, P.O Box, 764, Freepost, Togher, Cork

If ***you*** remain dissatisfied with the appeal decision, ***you*** may refer ***your*** appeal to the Financial Services Ombudsman Bureau at the following address:

Financial Services Ombudsman's Bureau
3rd Floor, Lincoln House, Lincoln Place, Dublin 2.
Lo call: 1890 88 20 90
Fax: 01 6620890
Email: enquiries@financialombudsman.ie

International assistance number

You must call this number in advance of receiving any ***emergency care*** outside ***Ireland***.
Telephone: 00353 148 17840

Nurse-on-call

All ***Aviva members*** have unlimited access to a team of qualified nurses for non-emergency medical information. Nurse-on-call is a telephone based service that provides general, non-diagnostic information over the phone. All calls will remain fully confidential.
Telephone: 1850 946 644

Complaints

We aim to give excellent service to all our ***members***; however, ***we*** recognise that things may occasionally go wrong. ***We*** will do our best to deal with ***your*** complaint as effectively and quickly as possible.

If ***you*** arranged ***your*** cover through broker initially then ***you*** should direct ***your*** complaint to the broker through whom ***you*** arranged ***your*** cover.

Alternatively ***you*** can contact the Complaints Team:

- By phone on (021) 480 2040
- By email: support@Avivahealth.ie
- By post at: The Complaints Team, P.O Box, 764, Freepost, Togher, Cork

If ***you*** remain dissatisfied with ***Aviva***, ***you*** may refer ***your*** complaint to the Financial Services Ombudsman Bureau at the following address:
Financial Services Ombudsman's Bureau
3rd Floor, Lincoln House, Lincoln Place, Dublin 2.
Lo call: 1890 88 20 90
Fax: 01 6620890
Email: enquiries@financialombudsman.ie

11. Definitions

Aviva
Aviva Health Insurance Ireland Limited

Accident
An incident that happens unexpectedly and unintentionally, resulting in ***injury***.

Acute
Short and sharp onset and which requires immediate medical attention.

Benefit
Benefits are the individual pieces of cover that make up ***your plan***. Each ***benefit*** covers a different type of medical expense or associated cost.

Claim
Where a ***member*** (or a ***medical facility*** or a ***health care provider*** on their behalf) requests payment from ***Aviva*** of the costs that are covered by a ***benefit*** available under their ***plan***.

Clinical indicators
The medical criteria that must be satisfied in order for a ***treatment*** or ***procedure*** to be deemed to be ***medically necessary*** by our ***medical advisers***.

Consultant
Consultant means a medical practitioner who:

- is engaged in hospital practice;
- holds all necessary qualifications to act as a ***consultant*** in the Republic of ***Ireland***;
- by reason of his/her training, skill and experience in a designated specialty (including appropriate specialist training) is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his or her care, or that aspect of care on which he or she has been consulted, without supervision in professional matters by any other person and;
- holds a current full registration as a specialist with the Medical Council of Ireland and is listed on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council of ***Ireland***.

In relation to ***treatments*** and ***procedures*** which are performed outside ***Ireland***, a ***consultant*** is a surgeon, physician or anaesthetist who is legally qualified and recognised to provide the ***treatment*** or ***procedure*** in that country on a tertiary referral basis.

Convalescence home
A nursing home registered pursuant to the Health (Nursing Homes) Act1990 which is approved by the Health Information and Quality Authority and retains a current registration with that body. A link to the Health Information and Quality Authority's list of registered convalescence/nursing homes can be found at **Avivahealth.ie.**

Cosmetic surgery
Treatments or ***procedures*** or part of a ***treatment*** or ***procedure*** which are purely aesthetic and are intended to improve the ***member's*** appearance for psychological or personal reasons and which are not ***medically necessary***.

Day case
A patient who is admitted to a ***medical facility*** but who does not stay overnight. This includes patients who are admitted to a ***medical facility*** to receive ***side room procedures***.

Dentist
A dental practitioner, who:

- holds a current full registration with the Irish Dental Council,
- is on the Register of ***Dentists***,
- is qualified to practice as a primary medical care physician,
- holds a primary medical qualification

Direct settlement
Where ***we*** settle ***your*** bill with ***your medical facility*** or ***health care providers*** directly so ***you*** don't have to pay them and ***claim*** it back from ***us***.

Elective treatments or procedures
Any ***treatment*** or ***procedure*** that is scheduled in advance because it does not involve ***emergency care***.

Emergency care
Medical care required to treat a sudden, unexpected, ***acute*** medical or surgical condition that without ***medical care*** within 48 hours of onset would result in death or cause serious impairment of critical bodily functions.

Established treatment
A ***treatment*** or ***procedure*** that is, in the opinion of our ***medical advisers***, an established clinical practice for the purpose for which it has been prescribed, is supported by publication in Irish or international peer reviewed journals, and is proven and not experimental.

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

First degree relative
A blood related parent, brother, sister, son or daughter of a ***member***.

Follow on care
Medical care received after ***emergency care*** ends including convalescence or ***rehabilitation***.

General practitioner / GP
A medical practitioner who holds all necessary qualifications to act as a general practitioner in ***Ireland***, holds a current full registration with the Irish Medical Council and is registered with ***Aviva***.

Government levy
A stamp duty which health insurers must pay to the Revenue Commissioners on each health insurance ***plan*** sold. The ***government levy*** is paid into a central fund and is redistributed by the government to maintain a health insurance system where a person's age or health does not determine the level of premium they pay. The ***government levy*** is included in ***your*** premium for each of the ***plans*** listed in ***your policy***. Where ***your*** premiums are being paid monthly, ***we*** disburse the cost of the ***government levy*** evenly across ***your*** payments. Details of the amount of the ***government levy*** are set out in ***your*** membership certificate.

Group scheme
A collection of ***members*** who are insured by ***Aviva*** as a group under the instructions of a ***group scheme sponsor***

Group scheme sponsor
A ***group scheme sponsor*** is a natural or legal person whether an employer, association, professional body or otherwise who arranges or facilitates for a group of persons to receive health insurance cover from ***Aviva*** as a ***group scheme***.

Hazardous sports
Any dangerous sporting activity including, but not limited to: hunting, shooting, mountaineering, rock climbing, motor sports including motor cycle sport, quad-biking, aviation other than as a fare paying passenger, ballooning, bungee jumping, hang gliding, microlighting, parachuting, paragliding or parascending, potholing or caving, power boat racing, water rafting, competitive yachting or sailing, bobsleighing, off-piste skiing, competitive canoeing or kayaking, boxing, wrestling, karate, judo or martial arts, scuba diving, any professional sporting activity, or extreme sports such as free diving, base jumping and ice climbing.

Health care provider
A ***consultant***, ***GP***, ***dentist***, ***oral surgeon*** or ***periodontist***.

Immediate family
Your parent, child, sibling, spouse and partner.

Injury
A wound or trauma inflicted on the body by an external force.

In-patient
A patient who is admitted to a ***medical facility*** and who occupies a bed overnight or for longer for ***medically necessary*** reasons.

Hospital costs
Charges imposed by a ***medical facility*** on an ***in-patient*** for ***medically necessary*** services provided by such ***medical facility*** to such ***in-patient***, excluding the costs of take home drugs and the costs of telephone calls made whilst the patient was admitted. The professional fees of ***consultants*** are not part of ***your hospital costs***.

Internationally recognised hospital
An institution that is, in the opinion of our ***medical advisers***, legally licensed as a medical or surgical hospital under the laws of the country in which it is situated.

Ireland
The Republic of Ireland excluding Northern Ireland.

Level 1 plans
These are: Access ***Plan*** Level 1, Aviva Select and Aviva Select Starter, Day2Day Focus, Level 1 Everyday, Level 1 Everyday Nurses, Level 1 Everyday Teachers, Health Starter, Hospital Nurses ***Plan*** Level 1, Hospital Teachers ***Plan*** Level 1, I ***Plan*** Level 1, Level 1 Hospital, ***Level 1 Plan***, Me ***Plan*** Level 1, Daily Level 1, Health Level 1, Value Focus, ***We Plan*** Level 1.

Medical adviser
A fully qualified ***GP***, ***consultant*** or nurse who holds all the necessary registrations to practice in ***Ireland*** and who provides medical advice to ***Aviva***.

Medical care
Care relating to the science or practice of medicine.

Medical facility
A hospital, scan centre, or treatment centre.

Medically necessary
Medical care which is prescribed by a ***consultant***, ***GP***, ***dentist***, ***oral surgeon*** or ***periodontist***, and which, in the opinion of our ***medical advisers***, is generally accepted as appropriate with regard to good standards or medical practice and:
i) is consistent with the ***member's*** symptoms or diagnosis or ***treatment***;
ii) is necessary for such a diagnosis or ***treatment***;
iii) is not provided primarily for the convenience of the ***member***, the ***medical facility*** or ***health care provider*** or at the request of the ***member***;
iv) is furnished at the most appropriate level, which can be safely and effectively provided to the ***member***;
v) is for ***procedures*** and investigations that are medically proven and appropriate;
vi) does not include extended convalescence or palliative care.

Member
A person named on a ***policyholder's policy***. Each ***member*** will be covered to the level of ***benefits*** available under the ***plan*** assigned to him/her by the ***policyholder***.

Membership number
The number assigned by ***us*** to a ***member***. Each person named on the ***policy*** has a separate ***membership number***, as set out in the membership certificate.

Minimum Benefit Regulations
The Health Insurance Act 1994 S.I. 83/1996 (Minimum ***Benefit***) Regulations, 1996 made pursuant to the Health Insurance Act 1994 as amended. The ***Minimum Benefit Regulations*** set out the minimum payments that all health insurers must make in respect of health services that are listed in those regulations. These health services are known as prescribed health services. ***You*** are guaranteed to receive cover to the level set out in the ***Minimum Benefit Regulations*** in respect of prescribed health services.

Newborn
A child under 13 weeks of age who is born to or adopted by a ***member.***

Oral surgeon
A ***dentist*** who is on the Specialist Register of Oral ***Consultants*** maintained by the Dental Council of ***Ireland*** and who is registered with ***Aviva***.

Out-patient
A patient who receives a ***procedure***, ***treatment*** or medical service without being an ***in-patient*** or ***day case***.

Periodontist
A ***dentist*** who has completed a 3 year post graduate training course which is, or is recognised as, equivalent to training courses accredited by the European Federation of Periodontists.

Plan
A package of health insurance ***benefits***. ***Policyholder***s choose the ***plans*** which apply to each ***member*** named on their ***policy*** when they take out their ***policy***.

Policy
The health insurance contract between the ***policyholder*** and ***Aviva*** under which the ***policyholder*** and ***members*** (if applicable) are insured by ***Aviva***.

Policyholder
The person who holds a contract of insurance with ***Aviva*** for the ***benefit*** of themselves and the ***members*** named on their ***policy***. The ***policyholder*** is responsible for paying the premiums for all the ***plans*** listed in that ***policy***.

Policy year
The period for which a ***policyholder*** and ***members*** are insured under a ***policy***. All ***policies*** run for a period of one year.

Pre-authorisation / pre-authorised / pre-authorise
Aviva must agree in advance before certain ***treatments*** and ***procedures*** will be covered. This consent is known as ***pre-authorisation***. The Schedule of Benefits and the GP Booklet set out the ***treatments*** and ***procedures*** that require ***pre-authorisation***.

Pre-existing condition
Any disease, illness, condition or ***injury*** that existed before ***you*** started ***your*** first health insurance ***plan*** with any health insurer. A ***pre-existing*** condition is determined from the date the condition commences rather than the date upon which ***you*** become aware of the condition. A ***pre-existing*** condition may therefore be present before giving rise to any symptoms or being diagnosed by a doctor.

Private hospital
A hospital categorised as a ***private hospital*** in the tables of ***medical facilities*** in section 12 of this Membership Handbook.

Private room
- A room in a ***private hospital*** which contains only one bed, or
- A room in a ***public hospital*** which contains only one bed

Procedure
A medical process or course of action. Use of the term '***procedure***' will include ***surgical procedures***, where appropriate.

Pro-rata
In proportion, proportional or proportionally as appropriate.

Public hospital
A publicly funded hospital other than a nursing home which provides services to a person pursuant to his or her entitlements under Chapter 11 of Part IV of the Irish Health Act 1970 and is categorised as a ***public hospital*** in the tables of ***medical facilities*** in section 12 of this Membership Handbook.

Public hospital levy
The public hospital levy is a daily charge imposed by public hospitals on in-patients and day case patients. The public hospital levy will be charged for a maximum of 10 days in any period of 12 consecutive months.

Reasonable and customary costs
Medical expenses that are of a similar level to those ***claimed*** by the majority of our ***members*** for similar medical care carried out in ***Ireland***.

Rehabilitation
Long term, sub-acute ***treatment*** that aims to restore a person's maximum physical or mental capabilities after a disabling illness or ***injury*** that cannot normally be restored by medical care.

Renewal date
The day after the final day of a ***policy year***. The ***policyholder's*** next ***renewal date*** is shown on the ***policyholder's*** membership certificate.

Semi-private room
- A room in a ***private hospital*** which contains not more than five beds, or
- A room in a ***public hospital*** which contains not more than five beds

Side room procedure
A ***treatment*** or ***procedure*** which is classified as a ***side room procedure*** in the Schedule of Benefits or the GP Booklet.

Surgical procedure/Surgery
The ***treatment*** of disease, ***injury*** or deformity by instrumental intervention.

Substance abuse
A mental or physical condition caused directly or indirectly by taking any chemical substance or solvent unless a general practitioner or ***consultant*** has prescribed it.

Tax relief
Tax relief on health insurance payments. Everybody is entitled to ***tax relief*** on some or all of the premium they pay for health insurance. ***Tax relief*** on health insurance premiums is applied at source. This means that ***we claim your tax relief*** from the Revenue Commissioners on ***your*** behalf and automatically reduce the premium ***you*** pay ***us*** for the ***plans*** listed on ***your policy*** by this amount.

Terminal illness
An incurable disease, which, in the opinion of our ***medical advisers*** or an attending ***consultant***, will result in a life expectancy of less than one year.

Transplants
The transfer of tissue or organ(s) from its original position to a new position(s) necessary to treat irreversible end stage failure of the relevant tissue or organ(s) including heart, combined heart and lung, lung (single and bilateral), simultaneous pancreas and kidney, liver, small bowel, kidney, simultaneous small bowel and liver, bone marrow or stem cells and which are subject to the National Waiting List for Organ Transplants.

Treatment
Any health service a person needs for the medical investigation, cure, or alleviation of the symptoms of illness or ***injury***.

We, us
Aviva Health Insurance ***Ireland*** Limited.

Working day
Monday to Friday excluding bank holidays.

You, your
The ***policyholder*** and any ***member***(s) named under a ***policy***.

11.1 Directory of Allied Health Professionals, Alternative (Complementary) and Other Practitioners

Allied Health Professionals	
Breastfeeding consultant	A registered midwife who is also a member of the ALCI (Association of Lactation Consultants in Ireland and who holds International Board Certified Lactation Consultant (IBCLC) membership.
Chiropodist	A member of one of the following Societies: • The Society for Chiropodists/Podiatrists • Society of Chiropodists and Podiatrists in Ireland • Institute of Chiropodists and Podiatrists in Ireland • Irish branch of the British Chiropody and Podiatry Association • The Irish Chiropodists/Podiatrists Organisation Ltd
Dietician	A member of the Irish Nutrition & Dietetic Institute.
Midwife	A person who is registered as a midwife with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).
Nurse (also including paediatric nurse)	A nurse who is registered with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).
Occupational therapist	A member of the Association of Occupational therapists of Ireland.
Physiotherapist	A chartered physiotherapist, who is a member of the Irish Society of Chartered Physiotherapists or a member of the Chartered Society of Physiotherapists.
Podiatrist	A member of one of the following Societies: • The Society for Chiropodists/Podiatrists • Society of Chiropodists and Podiatrists in Ireland • Institute of Chiropodists and Podiatrists in Ireland • Irish branch of the British Chiropody and Podiatry Association • The Irish Chiropodists/Podiatrists Organisation Ltd.
Speech and language therapist	A member of the Irish Association of Speech and language therapists

Alternative (Complementary) and Other Practitioners	
Acupuncturist	A person who is on the professional register of one of the following bodies: • The Acupuncture Council of Ireland (TCMCI Ltd) • The Acupuncture Foundation Professional Association • The Professional Register of Traditional Chinese Medicine
Baby massage therapist	A member of Baby Massage Ireland,(BMI) the Irish chapter of International Association of Infant Massage
Chiropractor	A member of one of the following Associations: • The Chiropractic Association of Ireland • Mc Timony Chiropractic Association of Ireland
Homeopath	A person who is on the professional register of one of the following Societies: • The Irish Society of Homeopaths • The Irish Medical Homeopathic Society
Massage therapist	A member of the Irish Massage therapists Association.
Medical herbalist	A member of the Irish Institute of Medical herbalists (IIMH).
Osteopath	A member of The Osteopathic Council of Ireland.
Physical therapist (Sports rehabilitation therapist)	A member of one of the following Associations: • Irish Association of Physical therapists • Registered Physical therapists of Ireland • Association of Neuromuscular Therapists • Irish Institute of Physical therapists • A member of the British Association of Sports Rehabilitators and Trainers
Psychologist	A member of the Irish Association for Counselling & Psychotherapy, a member of the Psychological Society of Ireland.
Reflexologist	A member of the National Register of Reflexologists (Ireland), Irish Reflexologists' Institute.

12. Lists of Medical Facilities

Please refer to ***your*** Table of Cover to check whether list 1, 2, 3 or 4 applies to your ***plan***.

A. Hospitals	Location	Direct settlement	Hospital type	List 1	List 2	List 3	List 4
Cavan							
Cavan General Hospital	Cavan	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Cork							
Bantry General Hospital	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Bon Secours Hospital	Cork	Yes	***Private hospital***	Covered			
Cork University Hospital	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Cork University Maternity	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Mallow General Hospital	Cork	Yes	***Public hospital***	Covered			
Mater Private Hospital Cork	Cork	Yes	***Private hospital***	Covered	Covered	Covered	
Mercy University Hospital, Grenville Place	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
South Infirmary / Victoria University Hospital	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
St. Finbarr's Hospital	Cork	Yes	***Public hospital***	Covered			
St. Patrick's (Marymount Hospice)	Cork	Yes	***Public hospital*** (hospice)	Covered	Covered		
Clare							
Cahercalla Community Hospital, Ennis	Clare	Yes	***Private hospital***	Covered	Covered	Covered	
Midwestern Regional Hospital, Ennis	Clare	Yes	***Public hospital***	Covered			
Donegal							
Letterkenny General Hospital	Donegal	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Dublin							
Beacon Hospital, Sandyford, D18	Dublin	Yes	High-tech hospital	Covered	Covered	Covered	
Beaumont Hospital, Santry, D9	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Blackrock Clinic, Co.Dublin	Dublin	Yes	High-tech hospital	Covered			
Blackrock Hospice (part only), Co.Dublin	Dublin	Yes	***Public hospital*** (hospice)	Covered	Covered		
Bon Secours Hospital, Glasnevin, D9	Dublin	Yes	***Private hospital***	Covered	Covered	Covered	
Cappagh National Orthopaedic Hospital, Finglas, D11	Dublin	Yes	***Public hospital***	Covered	Covered		
Children's University Hospital, Temple St.	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Connolly Hospital	Dublin	Yes	***Public hospital***	Covered			
Coombe Women's and Infant's University Hospital	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Hampstead Acute Unit, Dublin 9	Dublin	Yes	***Private hospital***	Covered	Covered		
Hermitage Medical Clinic Lucan	Dublin	Yes	***Private hospital*** High Tech Hospital for ***Level 1 plans****	Covered	Covered	Covered	
Highfield Private hospital, Whitehall, D9	Dublin	Yes	***Private hospital***	Covered	Covered		
Incorporated Orthopaedic Hospital of Ireland, Clontarf, D3	Dublin	Yes	***Public hospital***	Covered			
La Ginesa - St John of God	Dublin	Yes	***Private hospital***	Covered	Covered		
Mater Misericordiae University Hospital, D7	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Mater Private hospital, D7	Dublin	Yes	High-tech hospital	Covered			
National Maternity Hospital, Holles St, D2	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Our Lady's Hospice, Harold's Cross (part only), Dublin 6W	Dublin	Yes	***Public hospital*** (hospice)	Covered	Covered		
Our Lady's Hospital for Sick Children, Crumlin, D12	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Peamount Hospital, Newcastle, Co.Dublin	Dublin	Yes	***Public hospital***	Covered			
Rotunda Hospital, D1	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Royal Victoria Eye and Ear Hospital, D2	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Sports Surgery Clinic, Santry, D9	Dublin	Yes	***Private hospital***	Covered	Covered	Covered	
St. Columcille's Hospital, Loughlingstown, Co.Dublin	Dublin	Yes	***Public hospital***	Covered			
St. Edmundsbury Private hospital, Lucan, Co.Dublin	Dublin	Yes	***Private hospital***	Covered			
St. James's Hospital, D8	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
St. John of God Hospital, Stillorgan, Co.Dublin	Dublin	Yes	***Private hospital***	Covered	Covered		
St. Joseph's, Raheny, D5	Dublin	Yes	***Public hospital***	Covered			

A. Hospitals	Location	Direct settlement	Hospital type	List 1	List 2	List 3	List 4
St. Luke's Hospital, Rathgar, D6	Dublin	Yes	*Public hospital*	Covered			
St. Michael's Hospital, Dun Laoghaire, Co.Dublin	Dublin	Yes	*Public hospital*	Covered			
St. Patrick's University Hospital, D8	Dublin	Yes	*Private hospital*	Covered			
St. Vincent's Hospital, Fairview, D3	Dublin	Yes	*Public hospital*	Covered	Covered	Covered	Covered
St. Vincent's Private Hospital, D4	Dublin	Yes	*Private hospital*	Covered	Covered	Covered	
St. Vincent's University Hospital, D4	Dublin	Yes	*Public hospital*	Covered	Covered	Covered	Covered
The Adelaide and Meath Hospital incorporating The National Children's Hospital, Tallaght, D24 (Tallaght Hospital)	Dublin	Yes	*Public hospital*	Covered	Covered	Covered	Covered
UPMC Cancer Centre, Beacon Hospital, D18	Dublin	Yes	*Private hospital*	Covered	Covered	Covered	
Galway							
Merlin Park Regional Hospital	Galway	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Bon Secours Hospital, Renmore	Galway	Yes	*Private hospital*	Covered			
Galway Clinic	Galway	Yes	*Private hospital* High Tech Hospital for *Level 1 plans**	Covered	Covered	Covered	
Portiuncula Hospital	Galway	Yes	*Public hospital*	Covered	Covered	Covered	Covered
University College Hospital	Galway	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Kerry							
Bon Secours Hospital, Tralee	Kerry	Yes	*Private hospital*	Covered			
Kerry General Hospital	Kerry	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Kildare							
Clane General Hospital	Kildare	Yes	*Private hospital*	Covered	Covered	Covered	
Naas General Hospital	Kildare	Yes	*Public hospital*	Covered			
Kilkenny							
Aut Even Hospital	Kilkenny	Yes	*Private hospital*	Covered	Covered	Covered	
Lourdes Orthopaedic Hospital, Kilcreene	Kilkenny	Yes	*Public hospital*	Covered	Covered		
St. Luke's General Hospital	Kilkenny	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Laois							
Midland Regional Hospital (Portlaoise)	Laois	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Leitrim							
Our Lady's Hospital (Manorhamilton)	Leitrim	Yes	*Public hospital*	Covered			
Limerick							
Barrington's Hospital	Limerick	Yes	*Private hospital*	Covered	Covered	Covered	
University Hospital Limerick (Mid-Western Regional Hospital)	Limerick	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Mid-Western Regional Maternity Hospital	Limerick	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Mid-Western Regional Orthopaedic Hospital	Limerick	Yes	*Public hospital*	Covered	Covered		
Mid-Western Radiation Oncology Unit	Limerick	Yes	*Public hospital*	Covered	Covered	Covered	
Milford Care Centre	Limerick	Yes	*Public hospital*	Covered	Covered	Covered	Covered
St. John's Hospital	Limerick	Yes	*Public hospital*	Covered			
Louth							
Louth County Hospital, Dundalk	Louth	Yes	*Public hospital*	Covered			
Our Lady of Lourdes Hospital, Drogheda	Louth	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Mayo							
Mayo General Hospital (Castlebar)	Mayo	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Meath							
Our Lady's Hospital (Navan)	Meath	Yes	*Public hospital*	Covered			
Monaghan							
Monaghan General Hospital	Monaghan	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Offaly							
Midland Regional Hospital (Tullamore)	Offaly	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Roscommon							
Roscommon County Hospital	Roscommon	Yes	*Public hospital*	Covered			

A. Hospitals	Location	Direct settlement	Hospital type	List 1	List 2	List 3	List 4
Sligo							
Kingsbridge Private Hospital (Garden Hill)	Sligo	Yes	*Private hospital*	Covered	Covered	Covered	
Sligo General Hospital	Sligo	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Tipperary							
Mid-Western Regional Hospital Nenagh (St. Joseph's)	Tipperary	Yes	*Public hospital*	Covered			
South Tipperary General Hospital (Clonmel)	Tipperary	Yes	*Public hospital*	Covered			
Waterford							
Whitfield Clinic, Butlerstown North	Waterford	Yes	Private	Covered	Covered	Covered	
Waterford Regional Hospital	Waterford	Yes	*Public hospital*	Covered	Covered	Covered	Covered
Westmeath							
Midland Regional Hospital (Mullingar)	Westmeath	Yes	*Public hospital*	Covered	Covered	Covered	
St. Francis Private Hospital (Mullingar)	Westmeath	Yes	*Private hospital*	Covered	Covered	Covered	
Wexford							
Ely Hospital, Ferrybank	Wexford	Yes	*Public hospital*	Covered			
Wexford General Hospital	Wexford	Yes	*Public hospital*	Covered	Covered	Covered	
Northern Ireland							
Antrim							
Royal Victoria Hospital (Belfast)	Antrim	Yes	*Private hospital*	Covered			
Ulster Independent Clinic (Belfast)	Antrim	Yes	*Private hospital*	Covered			
Derry							
Altnagelvin Area Hospital	Derry	Yes	*Private hospital*	Covered			
North West Independent Hospital (Ballykelly)	Derry	Yes	*Private hospital*	Covered			
Down							
Daisy Hill Hospital (Newry)	Down	Yes	*Private hospital*	Covered			

B. Treatment Centres	Location	Direct settlement	Hospital type	List 1	List 2	List 3	List 4
Bushypark Treatment Centre, Ennis	Clare	Yes	Addiction centre	Covered			
Cork Clinic, Western Road (limited to hysteroscopy and cystoscopy only)	Cork	Yes	Treatment Centre	Covered	Covered	Covered	
Cuan Mhuire (Farnanes)	Cork	Yes	Addiction centre	Covered	Covered	Covered	
Tabor Lodge, Belgooly	Cork	Yes	Addiction centre	Covered	Covered	Covered	
Eccles Clinic, Dublin 7	Dublin	Yes	Treatment Centre	Covered	Covered	Covered	
M.S. Care Centre, Rathgar, D6	Dublin	Yes	Respite Care	Covered	Covered		
Park West Clinic, Nangor Rd., D12	Dublin	Yes	Treatment Centre	Covered	Covered	Covered	
Rutland Centre, Knocklyon, D16	Dublin	Yes	Addiction centre	Covered	Covered		
White Oaks Treatment Centre	Donegal	Yes	Addiction centre	Covered	Covered	Covered	
Cuan Mhuire, Coolarne	Galway	Yes	Addiction centre	Covered	Covered	Covered	
Talbot Grove Centre, Castleisland	Kerry	Yes	Addiction centre	Covered			
Cuan Mhuire, Athy	Kildare	Yes	Addiction centre	Covered	Covered	Covered	
Aislinn Treatment Centre, Ballyragget	Kilkenny	Yes	Addiction centre	Covered			
Gulladoo Treatment Centre	Leitrim	Yes	Addiction centre	Covered	Covered	Covered	
Cuan Mhuire (Bruree)	Limerick	Yes	Addiction centre	Covered	Covered	Covered	
Hope House (Foxford)	Mayo	Yes	Addiction centre	Covered			
Aiséirí Centre (Cahir)	Tipperary	Yes	Addiction centre	Covered			
Aiséirí Centre (Roxborough)	Wexford	Yes	Addiction Centre	Covered			

C. Scan Facilities: Approved MRI Facilities	Location	Direct settlement	Facility type	Approved Cardiac Scan Facilities	List 1	List 2	List 3	List 4
Bon Secours Hospital	Cork	Yes	*Private hospital*	No	Covered			
Alliance Medical at Cork University Hospital	Cork	Yes	*Public hospital*	No	Covered	Covered	Covered	Covered
Alliance Medical Mater Private Cork	Cork	Yes	Scan centre	No	Covered	Covered	Covered	

C. Scan Facilities: Approved MRI Facilities	Location	Direct settlement	Facility type	Approved Cardiac Scan Facilities	List 1	List 2	List 3	List 4
Affidea Cork, The Elysian	Cork	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Mercy University Hospital	Cork	Yes	***Public hospital***	Yes	Covered	Covered	Covered	Covered
Trans Specialists at South Infirmary / Victoria University Hospital	Cork	Yes	***Public hospital***	No	Covered	Covered	Covered	Covered
Letterkenny General Hospital	Donegal	Yes	***Public hospital***	No	Covered	Covered	Covered	Covered
Beacon Hospital, Sandyford, Dublin 18	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Blackrock Clinic, Co. Dublin	Dublin	Yes	***Private hospital***	Yes	Covered			
Bon Secours Hospital (Glasnevin), Dublin 9	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Alliance Medical at Charter Medical Group	Dublin	Yes	Scan centre	Yes	Covered	Covered	Covered	Covered
Affidea Dundrum, Rockfield Medical Campus, Balally, Dublin 16	Dublin	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Affidea at The Meath Primary Care Centre, Dublin 8	Dublin	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Affidea Northwood, Santry, Dublin 9	Dublin	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Hermitage Clinic Lucan	Dublin	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans ****	Yes	Covered	Covered	Covered	
Mater Private hospital, Dublin 7	Dublin	Yes	***Private hospital***	No	Covered			
Sports Surgery Clinic, Santry, Dublin 9	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
St. James' Hospital, Dublin 8	Dublin	Yes	***Public hospital***	No	Covered**	Covered**	Covered**	Covered**
St. Vincent's Private hospital, Dublin 4	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Bon Secours Hospital, Renmore	Galway	Yes	***Private hospital***	No	Covered			
Galway Clinic	Galway	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans ****	No	Covered	Covered	Covered	
Alliance Medical at Merlin Park	Galway	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical Portiuncula	Galway	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Bon Secours Tralee	Kerry	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Clane General Hospital	Kildare	Yes	Scan centre	No	Covered	Covered	Covered	
Affidea at Vista Primary Care Centre	Kildare	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Aut Even Hospital	Kilkenny	Yes	***Private hospital***	No	Covered	Covered	Covered	
Affidea, Dean Street Clinic, Kilkenny	Kilkenny	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Barringtons Hospital	Limerick	Yes	Scan centre	Yes	Covered	Covered	Covered	Covered
Limerick Clinic, City Gate House, Raheen Business Park	Limerick	Yes	Scan centre	No	Covered	Covered	Covered	
Alliance Medical at Our Lady Of Lourdes Hospital, Drogheda	Louth	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Tullamore Regional Hospital	Offaly	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Affidea at Sligo General Hospital	Sligo	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Whitfield Clinic, Butlerstown North	Waterford	Yes	***Private hospital***	No	Covered	Covered	Covered	
Alliance Medical at North West Independent Hospital (Ballykelly)	Derry	Yes	Scan centre	No	Covered			

C. Scan Facilities: Approved CT Facilities	Location	Direct settlement	Facility type	Approved Cardiac Scan Facilities	List 1	List 2	List 3	List 4
Affidea Cork, The Elysian	Cork	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Mater Private Cork	Cork	Yes	Scan centre	No	Covered	Covered	Covered	
Beacon Hospital, Sandyford, Dublin 18	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Beaumont Consultants Private Clinic, Santry, Dublin 9	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Blackrock Clinic, Co. Dublin	Dublin	Yes	***Private hospital***	Yes	Covered			
Bon Secours Hospital, Glasnevin Dublin 9	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	

C. Scan Facilities: Approved CT Facilities	Location	Direct settlement	Facility type	Approved Cardiac Scan Facilities	List 1	List 2	List 3	List 4
Alliance Medical at Charter Medical	Dublin	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Affidea Dundrum, Rockfield Medical Campus, Balally, Dublin 16	Dublin	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Hermitage Clinic Lucan	Dublin	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans*** *	Yes	Covered	Covered	Covered	
Mater Private hospital, Dublin 7	Dublin	Yes	***Private hospital***	No	Covered			
St. James' Hospital, Dublin 8	Dublin	Yes	***Public hospital***	No	Covered**	Covered**	Covered**	Covered**
St. Vincent's Private hospital, Dublin 4	Dublin	Yes	***Private hospital***	No	Covered	Covered	Covered	
Bon Secours Hospital, Renmore	Galway	Yes	***Private hospital***	No	Covered			
Galway Clinic	Galway	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans*** *	Yes	Covered	Covered	Covered	
Alliance Medical at Merlin Park	Galway	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Alliance Medical at Clane General Hospital	Kildare	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Affidea - Vista Primary Care (Naas)	Kildare	Yes	Scan centre	No	Covered	Covered	Covered	Covered
Barringtons Hospital	Limerick	Yes	Scan centre	Yes	Covered	Covered	Covered	Covered
Limerick Clinic, City Gate House, Raheen Business Park	Limerick	Yes	Scan centre	No	Covered	Covered	Covered	
UPMC Whitfield, Butlerstown North	Waterford	Yes	***Private hospital***	No	Covered	Covered	Covered	
St. Francis Private hospital (Mullingar)	Westmeath	Yes	***Private hospital***	No	Covered	Covered	Covered	

C. Scan Facilities: Approved PET-CT Facilities	Location	Direct settlement	Facility type	List 1	List 2	List 3	List 4
Alliance Medical at Cork University Hospital	Cork	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Beacon Hospital, Sandyford, Dublin 18	Dublin	Yes	***Private hospital***	Covered	Covered	Covered	
Blackrock Clinic, Co. Dublin	Dublin	Yes	***Private hospital***	Covered			
Hermitage Clinic Lucan	Dublin	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans*** *	Covered	Covered	Covered	
Mater Private hospital, Dublin 7	Dublin	Yes	***Private hospital***	Covered			
St. James's Hospital, Dublin 8	Dublin	Yes	***Public hospital***	Covered	Covered	Covered	Covered
Galway Clinic	Galway	Yes	***Private hospital*** High-tech hospital for ***Level 1 plans*** *	Covered	Covered	Covered	
UPMC Cancer Centre Whitfield Clinic	Waterford	Yes	***Private hospital***	Covered	Covered	Covered	

*__Level 1 plans__ are: Access __Plan__ Level 1, Aviva Select & Aviva Select Starter, Day2Day Focus, Level 1 Everyday, Level 1 Everyday Nurses, Level 1 Everyday Teachers, Health Starter, Hospital Nurses __Plan__ Level 1, Hospital Teachers __Plan__ Level 1, I __Plan__ Level 1, Level 1 Hospital, __Level 1 Plan__, Me __Plan__ Level 1, Daily Level 1, Health Level 1, Value Focus, __We Plan__ Level 1.

**Referrals must be made by an oncologist or other clinician at St. James Hospital and must be related to the diagnosis, treatment or staging of a cancer.

These lists are subject to change and are correct at time of going to print, March 1st 2016. For the most up-to-date lists, visit Avivahealth.ie

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