The health plan for everyone from

€12.38 a month

Helping you to cover the costs of everyday healthcare

Who is HSF Health Plan?

HSF Health Plan is the provider and underwriter of a health cash plan, committed to delivering simple and affordable ways to help you cover the cost of everyday healthcare such as dental, optical and physiotherapy, plus much more. With over 30 health benefits available, it provides an added security for you and your family's health.

HSF Assist provides unlimited access to a variety of assistance helplines and services which are available to all policyholders and their families. HSF Assist is currently provided for HSF Health Plan by Health Hero.

How does it work?

It's simple. You pay a premium for the scheme that suits you best, then you claim cash back for your treatments as and when you need it. And so your family doesn't feel left out, we also offer to cover the healthcare of your Spouse/Partner and children (up to age of 21) at no extra cost. The maximum payable is between all eligible named persons in any 12 consecutive calendar months.

What am I covered for?

Our Primary schemes FD1 to FD7 offer a wide range of health categories at affordable prices and we reimburse you up to 50% of your professional costs up to the maximum shown in the benefits table. With our Extra Cover Schemes FDA to FDC, we reimburse you up to 100%. There is a total limit on benefits calculated on a rolling balance over a 12 month basis with a further limit from the start of your policy on some hospital benefits. Please see Policy Terms & Conditions page 15 in this brochure.

All of our schemes include HSF Assist which provides: GP Advice Line, Virtual Doctor, Counselling / Emotional Wellbeing Service, Prescription service and Legal Advice.

Are there any restrictions?

There are pre-existing health restrictions on all benefits (see waiting periods and restrictions on pages 18 and 19) with the exception of Dental, Optical, General Practitioner (GP), Accident & Emergency, Prescription, Chiropody / Podiatry and Reflexology.

Apart from the Personal Accident category which has immediate cover there is a 3 month waiting time before any claims can be considered under the Consultation, Medical Tests, Practitioners (excluding Chiropody/Podiatry and Reflexology), Hospital, Day Case, Recuperation and Surgical Appliances categories and expenses incurred during the 3 months will not qualify for settlement. There is a longer waiting time of 10 months for Infertility or Birth and Adoption Grants and this time also applies to other categories if the claim is related to pregnancy.

A waiting period of 6 months applies to Eye Laser Treatment and Implantable Contact Lenses. Should you incur Dental, Optical, General Practitioner (GP), Prescription, Chiropody/ Podiatry or Reflexology expenses during the 3 month waiting time please keep the receipts and forward them to us after the 3 months has elapsed.

Making a claim

Claim forms can be downloaded from our website www.hsf.ie or mypolicy.hsf.ie alternatively by contacting our office on 0818 473 473 (for address see the back of this brochure). Original receipts must be sent with the claim form. Your payment will be made direct into your bank account (a current account in your name or joint names). **All claims must be submitted within six months of the date of treatment/purchase, accident taking place or discharge from a hospital.** Claims can only be considered if appropriate premiums have been paid.

Duration of the policy

Your policy is renewed automatically on a monthly basis unless your cover is cancelled or you allow it to lapse.

Can I cancel my policy?

When your application is accepted you will receive a "Welcome Pack" on receipt of this you have 14 days in which to write to us and change your mind; please see "Ceasing premiums" on page 19.

How to complain

Should you find it necessary to make a complaint,you should in the first instance contact our Customer Service department at our Ennis address. Details of our complaints procedure can be found at www.hsf.ie/faqs. A written acknowledgement will be issued within five business days of receipt of the complaint and this should include the name of the person appointed to be the point of contact in relation to the complaint, this will usually be a Senior Manager. If your complaint has not been resolved within 40 business days of receipt we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Services Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or call them on 01 567 7000.

HSF Health Plan and The Hospital Saturday Fund

In Ireland HSF Health Plan is authorised and regulated by the Central Bank of Ireland as a Third Country Branch. HSF Health Plan is the trading company of the registered charity The Hospital Saturday Fund.

All those who join HSF Health Plan, just by belonging, are making a contribution to the important work of the charity, not something which usually happens when an insurance policy is taken out.

HSF Health Plan Limited is an insurance undertaking, and all information is provided in order for applicants to choose the scheme to suit their personal circumstance as HSF Health Plan is not authorised to provide a professional recommendation.

Statement of demands and needs

This product meets the demands and needs of individuals and families who wish to manage their healthcare expenses such as dental and optical, hospital admissions, consultations and investigations, and personal accident. Advice is not available from HSF Health Plan and HSF Health Plan is not in a position to determine whether the product is appropriate for you. Applicants should choose the scheme to suit their personal circumstances and review in future whether this remains suitable.

To find out more information about HSF Health Plan, call us on

0818 473 473

email enquiries@hsf.ie

Benefit Summary

Choose between Primary Schemes which provide 50% benefit, or Extra Cover Schemes which provide up to 100% benefit.

One price: spouse/partner and children* covered at no extra cost!

Follow the arrow downwards to see amounts available for each category, under your chosen scheme.

	Primary Schemes							Extra Cover Schemes		
	FD1 €12.38 a Month	FD2 €18.71 a Month	FD3 €26.56 a Month	FD4 €33.80 a Month	FD5 €46.48 a Month	FD6 €59.16 a Month	FD7 €71.83 a Month	FDA €68.21 a Month	FDB €86.92 a Month	FDC €106.24 a Month
Dental & Optical										
50%	€80	€160	€260	€290	€360	€450	€550	100% €500	€650	€800
General Practitioner (GP) and Emergency Department (maximum of 10 grants per 12 months)										
Not Available on Schemes FC1, FC2 or FC3. However our GP Advice line is included on these schemes.				€13	€19	€25	€32	€19	€25	€32
Prescription - Amount per script - maximum of 6 grants per 12 months										
Not Available on Schemes FC1, FC2 or FC3.				€7	€10	€13	€16	€10	€13	€16
Practitioner - Physiotherapy, Physical Therapy, Osteopathy, Chiropractic										
50%	€65	€130	€195	€215	€260	€325	€390	100% €350	€500	€650
Wellbeing & Alternative Treatments - Acupuncture, Homeopathy, Chiropody / Podiatry, Reflexology										
50%	€65	€130	€195	€215	€260	€325	€390	100% €350	€500	€650
Consultations										
50%	€170	€330	€490	€510	€550	€640	€730	100% €680	€860	€1040
Medical Tests - Including Allergy Testing and Health Screening										
50%	€100	€200	€300	€340	€360	€420	€480	100% €440	€560	€680
Birth & Adoption										
Fixed Sum	€125	€250	€400	€440	€500	€650	€800	Fixed Sum €700	€850	€1000
Hospital (amounts per night, up to 40 nights per person)										
Fixed Sum	€20	€40	€64	€71	€84	€100	€120	Fixed Sum €80	€100	€120
Recuperation - After 7 Nights Stay in Hospital (Benefit available for 15 night stays, see benefit section for more details)										
Fixed Sum	€50	€100	€125	€140	€155	€190	€230	Fixed Sum €155	€190	€230
Day Case Surgery & Treatment (amounts per night, up to 8 day cases per person)										
Fixed Sum	€20	€40	€64	€71	€84	€100	€120	Fixed Sum €80	€100	€120
Surgical Appliances & Hearing Aids										
50%	€95	€150	€285	€330	€380	€475	€570	100% €550	€700	€850
Personal Accident - See page 8 for full details of benefits										
Permanent Disability up to	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	up to €15,000	€20,000	€25,000
Accidental Death Fixed Sum	€1,250	€2,500	€3,250	€3,500	€4,125	€5,000	€6,000	Fixed Sum €7,500	€10,000	€12,500
Dental Trauma	€125	€250	€325	€350	€420	€500	€600	€750	€1,000	€1,250
HSF Assist										
GP Advice Line, Virtual Doctor, Counselling / Emotional Wellbeing Service, Prescription Service and Legal Advice.										

*Dependent Children, living at the same address, up to age 21.

Our Schemes

HSF Health Plan's Family Scheme has been specially designed for individuals and families to claim up to a 50% cash refund on Primary Schemes and a 100% cash refund on Extra Cover schemes on many of their healthcare expenses. Dental, Optical, Physiotherapy, Consultations and Medical Tests and a number of complementary treatments are included. We also pay grants for General Practitioner (GP) visits and prescription charges.

Family Scheme choices

Our Primary Schemes FD1 to FD7 cover a wide range of health categories at an affordable price. With Primary Schemes we reimburse you 50% of your professional treatment costs up to the maximum amounts under the categories shown below.

Our Extra Cover Schemes FDA to FDC are for those who want to pay a little more in order to get higher benefits in return. With Extra Cover Schemes, we reimburse you 100% of your professional treatment costs up to the higher maximum amounts under the categories shown below.

All of our schemes include HSF Assist. This provides a GP Advice Line, Virtual Doctor and Prescription Service. It also includes Emotional Wellbeing, Counselling and Legal Helplines.

Pre-existing conditions and health problems

If you have a pre-existing health condition there will be a waiting time before cover for certain claims will start. The waiting time will be 5 years from when you are first registered for cover. In addition, for later increases in cover the waiting time before the increased cover takes effect will be 2 years at the time of the increase (see "Waiting periods" and "Restrictions" on pages 18 and 19 for full details and concessions for previous cover).

You may start making claims three months after your policy start date, unless otherwise stated. Reimbursement for most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim. See page 19 for full details.

Monthly costs (net of partial Standard Rate Tax Relief)

Primary

Monthly Cost	FD1	FD2	FD3	FD4	FD5	FD6	FD7
	€12.38	€18.71	€26.56	€33.80	€46.48	€59.16	€71.83

Extra Cover

Monthly Cost	FDA	FDB	FDC
	€68.21	€86.92	€106.24

Dental and Optical

Help towards the cost of all dental treatment including check-ups, and the cost of a sight test and optical appliances, up to the maximum shown. This benefit may be used flexibly according to requirements for both categories. It is payable between all eligible named persons in any 12 consecutive calendar months. The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments are included in Scheme FD3 onwards and the Extra Cover Schemes, but claims for this particular treatment can only be accepted for claims incurred at least 6 months after the policy start date.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€80	€160	€260	€290	€360	€450	€550

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€500	€650	€800

Whole cost up to the maximum

General Practitioner (GP) and Emergency Department

An amount payable towards the cost of a visit to a General Practitioner (GP) (Family Doctor) or an attendance at an Accident and Emergency Department in a public or private hospital/ clinic. Limited to 10 visits in any 12 consecutive calendar months, regardless of which eligible insured person is the patient.

The maximum repaid per visit is as shown or actual charges if less.

Primary

Not Available on Schemes FD1, FD2 or FD3. However our GP Advice line is included on these schemes.	FD4	FD5	FD6	FD7
	€13	€19	€25	€32

Extra Cover

FDA	FDB	FDC
€19	€25	€32

Prescription

An amount payable towards prescription charges. Limited to 6 prescriptions in any 12 consecutive calendar months, regardless of which eligible insured person is the patient.

The maximum repaid per prescription is as shown or actual charges if less.

Primary

Not Available on Schemes FD1, FD2 or FD3.	FD4	FD5	FD6	FD7
	€7	€10	€13	€16

Extra Cover

FDA	FDB	FDC
€10	€13	€16

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

Help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner in the categories above up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€65	€130	€195	€215	€260	€325	€390

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€350	€500	€650

Whole cost up to the maximum

Wellbeing & Alternative Treatments: Acupuncture, Homeopathy, Chiropody / Podiatry, Reflexology

Help towards the cost of consultation and treatment not including medication (apart from Homeopathy) or appliances by a qualified and registered practitioner in the categories above up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€65	€130	€195	€215	€260	€325	€390

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€350	€500	€650

Whole cost up to the maximum

Consultations

Help towards the cost of specialists' consultation fees listed on page 16, **all undertaken on an outpatient basis**, up to the maximum shown (consultations carried out as an A&E visit are not covered). Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€170	€330	€490	€510	€550	€640	€730

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€680	€860	€1,040

Whole cost up to the maximum

Medical Tests

Help towards the cost of medical tests including, initial allergy testing, vaccinations, health screening, pathology tests, x-rays, scans, electrocardiograms and other investigations listed on page 16, **all undertaken on an outpatient basis**, up to the maximum shown (medical tests carried out as an A&E visit are not covered). Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€100	€200	€300	€340	€360	€420	€480

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€440	€560	€680

Whole cost up to the maximum

Birth and Adoption Grant

Payable to the policyholder, whether the mother or father of the baby, for each registered birth in hospital or at home. Hospital benefit is payable for the mother in addition to the birth grant from the sixth night onwards. The grant is also payable for a registered adoption up to the age of 10. **Claims for this benefit can only be accepted at least 10 months after policy start date.**

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€125	€250	€400	€440	€500	€650	€800

Extra Cover

FDA	FDB	FDC
€700	€850	€1,000

Hospital

General and Hospice: For an inpatient admission to a hospital or hospice to receive medical treatment. Payable to each eligible insured person for up to 40 nights in any 12 consecutive calendar months. (See pages 16 and 17 for full details).

Accident: For an inpatient admission to a hospital immediately following an accident. Payable to each eligible named person for up to 40 nights in any 12 consecutive calendar months. (See pages 16 and 17 for full details). No waiting period, if the admission is related to an Accident.

Elderly, Mental Illness and Addiction: For an inpatient admission to a hospital for elderly medical care / long stay / rehabilitation / respite for a mental illness, or for admission to a hospital for addictions. Payable to each eligible named person for up to 50 nights elderly and 50 nights mental illness from first registration, but not for more than 40 nights in a 12 month period. (See pages 16 and 17 for full details). **All amounts shown are per night.**

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€20	€40	€64	€71	€84	€100	€120

Extra Cover

FDA	FDB	FDC
€80	€100	€120

Recuperation

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 7 nights, a recuperation grant is payable for each eligible insured person.

Primary

Recuperation Grant after 7 nights

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€50	€100	€125	€140	€155	€190	€230

or

Recuperation Grant after 15 nights

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€75	€150	€185	€210	€230	€280	€340

Extra Cover

Recuperation Grant after 7 nights

FDA	FDB	FDC
€155	€190	€230

or

Recuperation Grant after 15 nights

FDA	FDB	FDC
€230	€280	€340

Day Case Surgery and Treatment

For a planned admission to occupy a bed for a day in a public or private hospital to undergo surgery, treatment or a procedure. Limited to 8 occasions within any 12 consecutive calendar months for each eligible insured person.

All amounts shown are per day.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€20	€40	€64	€71	€84	€100	€120

Extra Cover

FDA	FDB	FDC
€80	€100	€120

Surgical Appliances and Hearing Aids

An amount payable towards the cost of purchasing a surgical appliance or hearing aid, prescribed or recommended by a doctor (or a practitioner, eg. a physiotherapist, who has treated the policyholder or dependant, and the appliance forms part of that treatment), up to the maximum shown. Payable between all eligible insured persons in any 12 consecutive calendar months. A full list of surgical appliances covered can be found on page 17.

Primary

FD1	FD2	FD3	FD4	FD5	FD6	FD7
€95	€150	€285	€330	€380	€475	€570

Half the cost up to the maximum

Extra Cover

FDA	FDB	FDC
€550	€700	€850

Whole cost up to the maximum

Personal Accident Benefit

All claims must be submitted within 6 months of the accident occurring.

If an Accident results in Permanent Disability or death, the financial consequences can be enormous. Even less serious injuries can result in a lengthy period off work, or confinement to the house. Whilst you may be able to cope in the short term, a longer period of disability can put severe pressure on your finances.

Lump sum cash payments (shown opposite) when they are needed most could ease the financial burden. Policyholders are covered 24 hours a day, every day of the year, whether at work, at home or at play.

Permanent Disability: A lump sum cash benefit depending upon the type and degree of Permanent Disability following an Accident.

Facial Disfigurement: A lump sum payment for Permanent facial disfigurement as a result of an Accident.

Accidental Death: A lump sum payment if the Accident is fatal.

Dental Trauma: A lump sum payment for dental treatment required as a direct result of a blow to the head.

Temporary Disability: A weekly sum payable (normally by direct credit, monthly in arrears) if following an Accident, you are:

a) unable to take up your normal paid occupation or any other paid employment; or
b) confined to the home (applicable only if you are not in paid employment at the time of the Accident) as certified by a qualified medical practitioner.

Payable from the 31st day of your disability for up to 52 weeks. Odd days will be paid at 1/7th of the weekly rate.

Although there is no waiting period under this section, the Temporary Disability benefit is not payable for the first 30 days (Deferment Period) of each period of temporary disablement.

Fracture Benefit: A lump sum payment for a fracture or fractures to one or more bones of the arm or leg following an Accident.

If you or any other eligible person (Insured Person) suffer Bodily Injury as a direct result of an Accident which within 24 months of the Accident results in Permanent Disability, Facial Disfigurement or Death the following will be paid:

	Primary							Extra Cover		
	FD1	FD2	FD3	FD4	FD5	FD6	FD7	FDA	FDB	FDC
Permanent Disability	up to	up to	up to	up to	up to	up to	up to	up to	up to	up to
A proportion of this sum will be paid depending upon the degree of permanent disability in accordance with the following scale:	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
Permanent Total Disablement	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
Loss of Sight in one or both eyes	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
Loss of hearing in both ears	€1,875	€3,750	€4,875	€5,250	€6,200	€7,500	€9,000	€11,250	€15,000	€18,750
Loss of hearing in one ear	€375	€750	€975	€1,050	€1,250	€1,500	€1,800	€2,250	€3,000	€3,750
Loss of the use of:										
a) an arm, hand or leg above the knee	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
b) a leg below the knee or a foot	€1,250	€2,500	€3,250	€3,500	€4,125	€5,000	€6,000	€7,500	€10,000	€12,500
c) a shoulder or elbow	€625	€1,250	€1,625	€1,750	€2,100	€2,500	€3,000	€3,750	€5,000	€6,250
d) a hip, knee, ankle or wrist	€500	€1,000	€1,300	€1,400	€1,650	€2,000	€2,400	€3,000	€4,000	€5,000
e) a thumb	€500	€1,000	€1,300	€1,400	€1,650	€2,000	€2,400	€3,000	€4,000	€5,000
f) any finger or big toe	€250	€500	€650	€700	€825	€1,000	€1,200	€1,500	€2,000	€2,500
g) any other toe	€125	€250	€325	€350	€420	€500	€600	€750	€1,000	€1,250
Facial Disfigurement	N/A	N/A	€250	€280	€400	€500	€600	€700	€800	€900
Accidental Death	€1,250	€2,500	€3,250	€3,500	€4,125	€5,000	€6,000	€7,500	€10,000	€12,500
Dental Trauma	€125	€250	€325	€350	€420	€500	€600	€750	€1,000	€1,250

In addition there are the following payments for Temporary Disability and a Fracture of the specified bone or bones listed below:

Temporary Disability	N/A	N/A	€25 per week	€30 per week	€40 per week	€50 per week	€60 per week	€70 per week	€80 per week	€90 per week
Fracture Grant - Only payable for these specified bones:										
Leg – ankle, tibia and fibula, kneecap, femur and hip	N/A	N/A	€125	€140	€200	€250	€300	€350	€400	€450
Arm – wrist, radius and ulna humerus and shoulder.	N/A	N/A	€60	€70	€100	€130	€160	€190	€220	€250
Fractured fingers/thumbs/toes or hand/foot bones NOT covered										
Overall limit per Accident	N/A	N/A	€320	€380	€500	€630	€760	€890	€1,020	€1,150

All claims must be submitted within 6 months of the accident occurring.
See pages 17 and 18 for Definitions and Exclusions.

HSF Assist

HSF Assist provides unlimited access to a variety of assistance helplines and services which are available to all policyholders. The services available are:

GP Advice Line - 24 hour access to a doctor

Virtual Doctor - a webcam based face-to-face consultation service with a doctor

Prescription Service - if appropriate, the GP can offer a prescription for medication.

Counselling / Emotional Wellbeing Service - a telephone and, if needs be, a face-to-face counselling service

Legal Support - telephone access to legally trained staff.

You can use any part of the HSF Assist service as many times as you need.
HSF Assist is currently provided for HSF Health Plan by Health Hero.

HSF Assist calls are made to a freephone 1800 number.
Please check with your service provider for the costs on using these numbers.
HSF health plan cannot be responsible or liable for any call charges.

GP Advice Line

This service is available 24 hours a day, 7 days a week and the telephone number will be given to you in your welcome pack. The service allows you to speak with a qualified practising GP free of charge and at a convenient time. After making the initial call the doctor will telephone you. Every call is confidential and your details will not be passed on to anyone without your prior consent.

You can ask about all sorts of things including:

- an ache or pain that won't go away
- sensitive or confidential concerns
- explanations of diagnosis or treatment you may have been prescribed
- possible after-effects of surgery
- side-effects of any medication you are taking
- vaccinations you may need when you are travelling abroad and other health precautions relevant to your own personal medical history

Important Note

This is not an emergency service; in an emergency you should always contact your own GP or the emergency services so as not to delay any necessary treatment. Nor can it be used if you are, or might be, pregnant, for any health related condition, whether or not it is related to pregnancy.
In such cases you should always consult your own doctor.
The GP telephone consultation service is not intended to replace the personal care offered by your own doctor and cannot be used to obtain referral for treatment.
The GP telephone consultation service is provided via a freephone number to UK based qualified, experienced, practising General Practitioners (GPs) under the jurisdiction of the Irish Medical Council, General Medical Council and the English courts.

Virtual Doctor

HSF Assist provides you with the next generation in GP services: Virtual Doctor - an online doctor to see you at a time to suit you.

Now you don't need to leave home or work to see a qualified GP. With HSF Virtual Doctor, Ireland's first online webcam GP consultation service, you can arrange an online face-to-face consultation at a time that fits with your busy life, 7 days a week, 8am to 10pm (telephone consultations are available 24/7).

- At home – you don't need to wait days for an appointment and travel to a busy surgery and wait for your appointment.
- At work – imagine your own company doctor service without having to leave the office.

The Virtual Doctor Service is further enhanced by using state of the art explanatory 3D medical images and health information enabling you, the patient, to have a more complete understanding of your condition.

Prescription Service

When you consult with one of our GPs, either on the telephone or by using the Virtual Doctor, if the GP feels it is appropriate, they can offer you a prescription for medication. This prescription will be faxed to a pharmacy you nominate so you can obtain your medication. This service is available 7 days a week, from 8am to 10pm (excluding Bank Holidays). You will need to allow up to 4 hours for the prescription to be received at the pharmacy. If a prescription is offered after these times, it will be available the next working day.

Counselling / Emotional Wellbeing Service
Our team of experienced, professionally trained counsellors are available to support you 24 hours a day, 7 days a week.

You can call the service as often as you need to. There is no charge for this service; you only pay the cost of your telephone call. With HSF Assist, if appropriate, you can receive up to 6 counselling sessions. These can be over the telephone, video link or face-to-face.

We cannot consider any face-to-face counselling claims that have been organised independently by you. All face-to-face counselling must follow helpline counselling sessions undertaken via HSF Assist and be on their recommendation. *(Please note that there is a maximum of 6 sessions for the lifetime of your policy). There is no pre-existing condition rule applicable to HSF Assist including the face-to-face counselling.*

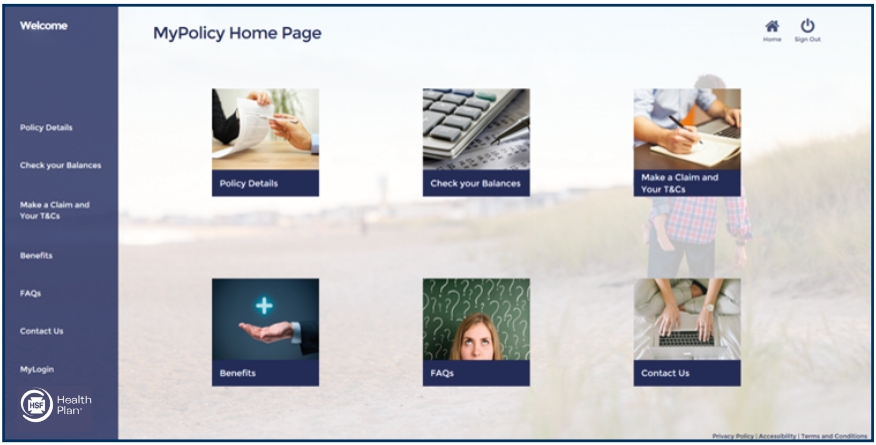
Legal Support

The Legal and Information team provide ‘Citizens Information Board’ type information around topics such as: consumer, debt management, relationships, family and care, as well as signposting to additional resources.

They can provide support for issues such as: disability, bullying, flexible working, problems with neighbours, consumer rights, child and elderly care, among many others.

Legal advice is available 8am - 8pm, Monday to Friday. If you call outside these times, we will arrange to call you back.

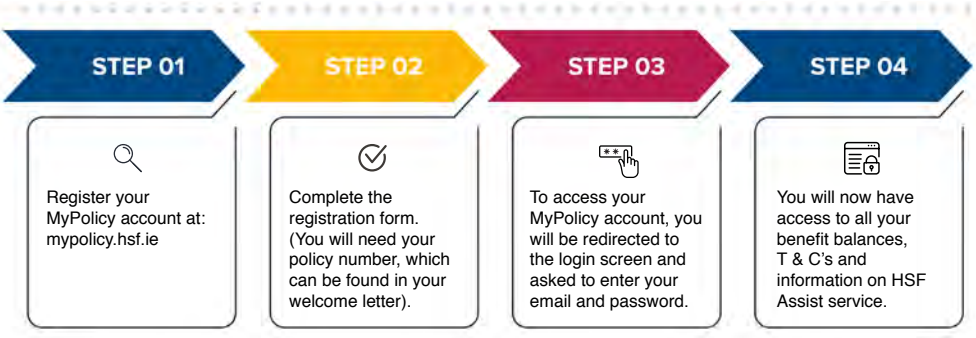
Access your policy anytime with MyPolicy



MyPolicy - your personal online account manager
We want you to make the most of your cover, and with MyPolicy, using your HSF Health Plan becomes easier and gives you the freedom to access your policy information any time of the day or night.

With MyPolicy, you can check your benefit balances, download a claim form, check claims paid against any category, access your terms and conditions and information on your HSF Assist® services.

Once your policy is issued, you can activate your MyPolicy account by visiting the website link provided below and entering your policy details.



If you have any queries in regards to MyPolicy, contact us at:
ContactUsMyPolicy@hsf.ie
or call us on
0818 473 473

Policy Terms & Conditions - Please read carefully

About the HSF Health Plan

HSF Health Plan is the provider and underwriter of a health cash plan. The schemes in this brochure provide cover for you against the everyday costs of such things as a visit to the dentist, optician and various practitioners, and make grants for hospital admissions and the birth of a baby.

Some amounts relate to the cost of the services you have received which are payable when you send in your paid receipts. Other amounts are a fixed rate, for example a fixed amount for each night spent in hospital or for the birth of a baby, or bodily injury from an accident. The amounts provided by the various schemes are explained in this brochure. A number of conditions apply with the main ones being (and explained fully in the relevant section of the 'Rules and further explanations of categories' or 'General terms and conditions'):

- There is a total limit on payments calculated on a rolling balance over a 12 month period basis with a further limit from registration on some hospital benefits. See 'Claims' on pages 19 and 20 and 'Hospital' on pages 16 and 17.
- Claims cannot be accepted until at least three months after your policy start date, unless otherwise stated.
- Pre-existing health conditions and health problems present when you join or increase premiums, are not covered for an initial period under many scheme categories. See 'Waiting periods', 'Restrictions' and 'Changing Schemes' on pages 18 and 19.
- Switching between schemes is allowed. See 'Changing Schemes' and 'Ceasing premiums' on page 19 for the terms.

Full policy terms and conditions, and the cover provided, are shown in this brochure.

Paying premiums and changing your mind

Details of the prices of each scheme are shown in this brochure. Payment can be made by direct debit or credit/debit card. When your application is accepted you will receive a welcome pack. This will include details of any restrictions which are in place if you have any existing medical conditions. On receiving confirmation of your policy, you have 14 days in which to change your mind and withdraw your application (telephone or write to the HSF Health Plan office in Ennis – details on page 24). If any premiums have been paid you will receive a full refund providing no claims have been settled. See 'Ceasing premiums' on page 19 for cancelling after this period.

Duration of cover in the plan

Cover is provided continuously from month-to-month, beginning with your policy start date, until it is cancelled or otherwise comes to an end. It is automatically renewed.

Making a claim

At the conclusion of three months after the start date of the policy or another stated period, you may start claiming. Claim forms are provided on request by telephoning 0818 473 473, or writing to HSF Health Plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare, or by downloading from our website www.hsf.ie. If you log on to MyPolicy, telephone or write, you may enquire about how much you may receive. Please quote your policy number. Original receipts must be sent with the claim form. Your payment will be made direct into your bank account (a current account in your name or joint names).

Dental and Optical

The dentist or optician must be suitably qualified and registered with the Comhairle Fiaclóireachta, The Dental Council or The Health & Social Care Professionals Council (H&SCPC). Sundry items purchased at Dental Surgeries and Opticians premises, eg. solutions, cleaners, contact lens removers, floss, are not covered and prescription charges for any kind of medication are not covered under this category. Claims cannot be accepted for the purchase of spectacles or contact lenses supplied without prescription or for any dental treatment (including teeth whitening) not carried out at a dental surgeon's practice (eg. if undertaken at a cosmetic/retail outlet).

Consultations with Consultant Oral Surgeons, Consultant Facio-Maxillary Surgeons, Consultant Orthodontic Surgeons and Consultant Ophthalmic Surgeons are not covered under this category. These should be claimed under the Consultations category. The cost of treatment or operative procedures undertaken by these Consultants is not included in any category. If Eye Laser Treatment or a permanent contact lens implant (to correct long or short sightedness) is carried out by a Consultant Ophthalmic Surgeon or undertaken in hospital as a day case patient or an inpatient, claims cannot be accepted for Consultations, Medical Tests or for Hospital or Day Case, in addition to the Optical category.

The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments is included in Scheme FD3 onwards, but claims for this particular treatment can only be accepted at **least 6 months** after registration.

Rules concerning pre-existing conditions do not apply to this particular category.

General Practitioner (GP) and Emergency Department

The amount is repaid up to the maximum (but if the actual charge is less, only this amount will be refunded) on the production of a paid receipt supplied by a General Practitioner (GP), clinic or a hospital indicating attendance at an Accident and Emergency Department which includes public, private or injury clinics.. The stated amount is paid for attendances by any eligible named person up to an overall limit of 10 visits (regardless of which eligible named person is the patient) within a 12 month period. Any procedures carried out during the visit are covered by this benefit and may not be claimed for separately under this or any other category.

Rules concerning pre-existing conditions do not apply to this particular category.

Prescription

The amount is repaid up to the maximum (but if the actual charge is less, only this amount will be refunded) on the production of a paid receipt supplied by a Pharmacy (Dispensing Chemist), indicating that a prescription has been dispensed. Only one amount is payable on each receipt regardless of the number of items. The stated amount is paid up to an overall limit of 6 prescriptions within a 12 month consecutive period regardless of which eligible named person is the patient.

Rules concerning pre-existing conditions do not apply to this

particular category.

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

The maximum payable is between the above four headings. It is not, for example, on Scheme FDA €350 for each of the four. Claims will only be accepted with paid receipts from qualified practitioners. Policyholders, in their own interests, should only consult properly qualified practitioners who are registered with professional organisations which maintain high standards. Benefit does not include the cost of any medication or any surgical appliances supplied or prescribed by the practitioners. Claims cannot be accepted for prophylactic treatments or sports massage/therapy.

Wellbeing & Alternative Treatments: Acupuncture, Homeopathy, Chiropody / Podiatry, Reflexology

The maximum payable is between the above four headings. It is not, for example, on Scheme FDA €350 for each of the four. Claims will only be accepted with paid receipts from qualified practitioners. Policyholders in their own interests, should only consult properly qualified practitioners who are registered with professional organisations which maintain high standards. Benefit does not include the cost of any medication (apart from Homeopathy) or any surgical appliances supplied or prescribed by the practitioners. Consultations with Consultant Podiatric Surgeons (of hospital consultant status) are not covered in this category. These should be claimed under the Consultations category. The cost of treatment or operative procedures undertaken by these consultants is not included in any category.
Rules concerning pre-existing conditions do not apply to Chiropody/Podiatry or Reflexology.

Consultations & Medical Tests

Claims must be for consultations in a hospital or clinic on an outpatient basis only and carried out by a doctor of consultant status. Treatment (including radiotherapy) and operative procedures (including delivery of a baby) are not covered, neither is any radiography during such treatment/ procedures. Reimbursement is only on the initial consultation with a Consultant Psychiatrist. Claims cannot be accepted for examinations / investigations carried out while an inpatient or as a day case or for medico-legal reports, possible legal evidence (including paternity testing), or for insurance, employment, fitness/occupational assessments or immigration/emigration purposes.

The following are covered under Medical Tests:
Any investigations undertaken, on an outpatient basis only, in a hospital x-ray, MRI/CT scanning, pathology or nuclear medicine / medical physics department (or its equivalent elsewhere); electrocardiogram (ECG),
electroencephalogram (EEG); electromyogram (EMG); audiogram and orthoptic investigations. Minor invasive investigations carried out at the same time as an out-patient consultation, and not requiring the use of a separate treatment room, are also covered. Claims are accepted for visits to health screening clinics and for the cost of a vaccination adminstered at a GP surgery or clinic or the issue of prescriptions for a vaccination. Medical screening carried out in a GP surgery will be assessed under the GP category.
For allergy testing the initial consultation and diagnosis of problems by a qualified practitioner with a personal consultation in a clinical environment (not a retail outlet or tests carried out in a homeopothy environment.) is covered but not any subsequent consultation, therapy or treatment.

The following are NOT covered
Invasive investigations, such as endoscopies, carried out with some form of anaesthetic, and requiring the use of an out-patient treatment room (for which the hospital or clinic charges an additional fee) or occupancy of a bed on a day stay basis. The Day Case benefit may be claimed in these circumstances if applicable.

Birth Grant and Adoption Grant

The period of at least 10 months before claims can be accepted in this category also relates to inpatient treatment and all other categories for consultation, investigation and treatment associated with the pregnancy. The Birth Grant is also paid for a still birth if an official certificate is submitted. Adoption is included in this category, however, a claim under this category may not be submitted until HSF Health Plan cover has been of at least 10 months' duration. The adoption certificate should be dated after the end of this 10 months' period and before the child's 10th birthday. Claims for overseas births and adoptions are not covered, but may be considered at our discretion.

Hospital

The hospital or hospice must be in Ireland or the United Kingdom and its name and admission and discharge dates should be clearly stated on the claim form. Benefit is payable for up to 40 nights as a patient in any consecutive 12 calendar months. The amount payable is the stated grant and no direct costs (e.g. Consultants' fees, room charges, medication/dressings involved with the hospital admission) are covered. Stays in nursing homes, convalescent homes , district hospitals and/or centres providing addiction treatment and/or rehabilitation services are not covered.
Benefit is restricted to 50 nights in total in a period of continuous cover, regardless of scheme, for admissions to hospital or hospice for mental illness, geriatric care and substance abuse (admissions to centres providing addiction treatment and/or rehabilitation services without a hospital status are not covered). These 50 nights are counted as part of and not in addition to the ruling in the sentence above eg. within a 12 month period the number of nights for which benefit is payable will not exceed 40 regardless of the reason for admission.
In accordance with the usual practice, the date of admission is counted as the first night but the date of discharge is not counted. Time spent within an Accident and Emergency Department (A&E) is not considered as part of an admission unless the hospital declares it to be so in accordance with their records. Claims must be submitted after each discharge from hospital. Weekend leave or longer periods of home leave do not count as a discharge, although no amounts will be paid for nights spent at home. Transfers from one hospital to another without a period at home in between are counted as a continuous period in hospital.
In cases of long stay admissions a claim may be submitted after 40 nights and an amount will be paid up to the number of nights due within the rules. Recuperation only, as appropriate, will be payable upon discharge. However, if an admission extends beyond 12 months a further claim may be submitted. There are special rules for these unusual circumstances. If, on the date of admission to hospital, the benefit limit is shown to have been reached in the preceding

12 months then no payment is made for that admission at all unless the current admission is of a duration which takes it past the anniversary of the discharge date 12 months earlier. In these cases the balance of nights due will be paid.

Recuperation

This grant is paid automatically, subject to qualifying for the appropriate number of nights in the hospital categories and actually having been discharged. There is no requirement to make an additional claim. If re-admissions occur after less than seven nights following discharge, and the second or subsequent admissions by virtue of their length would also qualify for a grant, only one such grant will be paid at the rate set for the longest of the admissions. The grant is not payable when the patient dies in hospital or if an admission includes a confinement and qualifies for the Birth Grant.

Day Case Surgery and Treatment

The claim form must be signed by an official at the hospital and bear the official stamp to verify the information given by the policyholder. Policyholders admitted overnight following a Day Case attendance will be entitled to the Hospital and not the Day Case benefit. The following are not included: Geriatric, psychiatric or rehabilitation day hospitals or units; an unplanned day or period spent in an Accident and Emergency or Casualty Department; minor surgery, treatment or procedures undertaken in outpatient or similar departments. The amount payable is the stated grant and no direct costs, e.g. Consultants' fees, room charges, medication/ dressings involved with the hospital admission are covered.

Surgical Appliances and Hearing Aids

The types of appliances will be restricted to those that are worn and do not include anything disposable or hired and include the following:

- Anti-embolic stockings following surgery
- Apnoea Alarm
- Artificial Eye
- Artifical Limb
- BiPAP or CPAP machine
- Cardiac/Blood Pressure Monitor
- Compression Garments
- Customised Orthotic Shoes (excluding shoes or trainers purchased in a retail store or online)
- Glucometer (excluding regent strips)
- Hearing Aids
- Nebulizer Machines (excluding drugs)
- Orthotic Devices such as Splints, Calipers, Belts and Air Cast boots
- Peak Flow Meter
- Post Mastecomy Prosthesis
- Shoe Insole Orthotics (excluding shoes or trainers unless customised)
- Post Surgical Bras (limited to 2 following surgery only)
- Trusses or Abdominal Binder
- Wigs or Hair Pieces following Chemo or Radiotheraphy.

Personal Accident

1. Payment for any Permanent Disability not shown in the table on page 9 will be based on a medical assessment of the disability in relation to the table and not in relation to the Insured Person's ability to work.
2. If the Insured Person was already disabled before an Accident or already had a condition which is gradually deteriorating, the payment will be reduced. The reduced payment will be based on a medical assessment of the difference between:

   a) the Permanent Disability after the Accident; and

   b) the extent to which the Permanent Disability is affected by the disability or condition before the Accident.
3. If the Insured Person claims for loss of limb, he / she cannot also claim for parts of that limb.
4. The most an Insured Person can receive for Permanent Disability resulting from any one Accident is the amount specified for Permanent Total Disablement.

Definitions

1. **Accident** means a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly. This does not include death or injuries sustained due to a medical condition such as cardiac arrest etc.
2. **Bodily Injury** means injury to an Insured Person which solely and independently of any other cause results in the Insured Person's Death, Permanent Disability, Temporary Disability, fracture of a specified bone or bones, or Dental Trauma. Bodily Injury excludes any condition resulting from any gradually operating cause or degenerative process.
3. **Permanent Disability** means disablement which has lasted for at least 12 months and from which it is believed the Insured Person will never recover.
4. **Permanent Total Disablement** means disablement caused other than by loss of limb or Sight which, having lasted for at least 12 months, will in all probability entirely prevent the Insured Person from engaging in or giving attention to a profession or occupation of any and every kind for the remainder of his / her life. Where payment has been made for the entire or partial loss of the use of a limb, no further payments will apply for the loss of the use of other areas of that limb; shoulder, elbow, wrist, hand, fingers/thumb, hip, knee, ankle, foot or toes.
5. **Loss of Sight** means total and irrecoverable loss of sight when an Insured Person's name has been added to the Register of Blind Persons or when the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.
6. **Dental Trauma** means Bodily Injury resulting from an Accident which is as a direct result of a blow to the head. Payments will be made only for Dental Treatment required following the Accident. Payment will be up to the amount shown in the Dental Trauma benefit for the scheme chosen. In any case the amount will not exceed 5% of the Permanent Disability Benefit of the cover selected. The Maximum for this on Scheme FDA is €750. The benefit will only be paid in respect of treatment an Insured Person receives within 12 months of the date of the Accident. This benefit covers dental treatment directly relating to an Accident such as a sports injury or a fall and includes anaesthetic fees, Dental crowns, bridges and white fillings, Dental veneers and Replacement dentures or repairs. It is a condition of this policy that the dentist confirms on each receipt that the treatment is only to repair the damage to the Insured Person's teeth as a direct result from a blow to the head. In addition to the

Exclusions stated under Personal Accident the following exclusions also apply to this benefit:

1. Cancellation charges made by the dentist (for example, for missed appointments).
2. Damage to dentures when not being worn.
3. Dental consumables (for example, toothbrushes, mouthwash and dental floss).
4. Dental prescription charges.
5. Dental insurance, premiums and joining fees for a practice's dental plan.
6. Any treatment an Insured Person receives 12 months or more after the date of the accident.
7. Dental treatment an Insured Person receives for an accident which happened before joining the plan.
8. Bodily Injury caused by eating and drinking.

7. **Permanent facial disfigurement** means to the extent of not less than one square centimetre of scar tissue or a scar of not less than two centimetres in length in each case in the area from the hairline to and including the lower jaw and ears.
8. **Temporary Disability** means disablement which prevents the Insured Person from engaging in or giving attention to his / her normal, gainful occupation or which confines the Insured Person to his / her home on medical grounds.
9. **Benefit Period** means the total period (but not necessarily consecutive period) for which the Temporary Disability Benefit is payable in respect of any one Accident to any Insured Person. Note: Odd days will be paid at

   1/7th of the specified weekly rate.
10. **Deferment Period** means a period of temporary disablement during which the Temporary Disability Benefit shall not be payable.

Exclusions

No Benefits will be payable:

1. If the Bodily Injury is caused by: war or any act of war; the Insured Person serving full-time in the armed forces of any country or international organisation; suicide, attempted suicide or deliberate self-inflicted injury by the Insured Person (even if they are insane); the Insured Person taking part in air sport or air travel, unless as a passenger; a sickness or disease; Repetitive Stress (Strain) Injury or Syndrome or any other condition or injury which develops over a period of time.
2. For any disabilities caused by or arising from Post Traumatic Stress Disorder or related syndromes or any psychological or psychiatric condition.

HSF Assist®

There are no additional charges to use the services in HSF Assist (except for the cost of the phone call to the service). There is no limit on how many times you use the services (except for any structured counselling sessions if they are provided). If you are advised by the telephone counselling service that you would benefit from structured counselling sessions, they can arrange for you to have a session or sessions with a local counsellor. HSF Assist will cover up to 6 sessions with the counsellor within the lifetime of your policy.

Becoming a Policyholder

Anyone aged 18 or over may join and cover will continue for life, if the policyholder so wishes, and if

a) your premium payments are kept up to date via Direct Debit or Debit/Credit card directly to HSF Health Plan
and
b) the rules and conditions are adhered to.

Cover is provided continuously from month to month until it is cancelled or otherwise comes to an end. You will not receive renewal documentation unless we change the terms and conditions of your policy. When your application is processed you will receive a welcome pack. Upon its receipt you have 14 days in which to change your mind (telephone 0818 473 473 or write to HSF Health Plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare).

If any premiums have been paid you will receive a full refund providing that no claims have been settled during this period.

One registration also covers a spouse / adult dependant and children under 21, permanently residing at the same address.

The named policyholder or spouse / adult dependant must be a parent of the stated children under 21 or be the legal guardian of them. Children in a fostering arrangement are not eligible for inclusion.

An "adult dependant" is an adult living at the same address as the policyholder whose relationship with the policyholder is similar to that of a spouse. The term does not refer to any other adult who may be dependent on the policyholder for any care or financial support.

Couples in a relationship may each have a separate policy under a Primary Scheme only.

Waiting periods

Claims may be submitted as soon as three months have elapsed from your policy start date, unless stated otherwise. There is a longer period of 10 months for the Birth and Adoption Grant and this time also applies to other categories if the claim is related to infertility or pregnancy. There is a waiting period of 6 months for Eye Laser Treatment and Implantable Contact Lenses. Any restrictions, which are temporary (see paragraph below), include any conditions which existed or for which symptoms were present before your cover began; any development of existing conditions; any recurrence of conditions which have existed in the past; any hereditary, congenital or perinatal conditions which may already exist but which manifest symptoms only after cover commences and any which previously existed but were not disclosed. Until waiting periods have been served, it may also be necessary to refuse claims relating to a particular area or structure of the body where there has been a problem in the past unless medical advice indicates that there is no connection.

The above restrictions for pre-existing conditions are removed after set waiting periods from first registration or from the date of any increase in cover.

The set waiting periods are:

a) On first registration: **5 years.**
and
b) For increases: **2 years.**

The set waiting period may be reduced for cover from registration (but not increases) where;

i) Immediately prior to cover on this policy starting, you were covered for the pre-existing condition under an HSF Health Plan policy in which case the previous level of cover will be maintained or

ii) Within 3 months prior to this policy starting, you were

covered by a policy from an insurer authorised by the Health Insurance Authority in which case the set waiting period will be reduced by the premium paying period with that insurer before cover for the pre-existing condition will be provided at the previous level of cover.

iii) At the time of making a claim using above you should request a reduction in the set waiting period. You will need to supply original written evidence regarding the nature, level and residual waiting period from your previous insurer.

Any claim for any benefit that relates to an accident can be made immediately once your policy has been issued. Should you need to claim during the Waiting Period as a result of an accident, you will need to include with your claim submission, details of the accident and any substantiating evidence that the treatment you received for which you are claiming for, was a result of that accident.
Any Pre-existing health conditions will be taken into account as to the injuries sustained.
An accident is defined in our Personal Accident benefit.

Restrictions

Claims cannot be accepted for anything related to plastic surgery and consultations / treatment for cosmetic reasons; self harm or self inflicted injuries; Infertility treatment. Conditions which begin during the three month period after cover commences should be notified in writing and you will then be advised if any restrictions apply. Optical, Dental, Chiropody/Podiatry, Reflexology, General Practitioner (GP) / Emergency Department, Prescription, Personal Accident and HSF Assist are the only categories not subject to the pre-existing condition rules, although some Personal Accident benefits may be limited if a disability or medical condition existed before the Accident.

No policyholder may be covered in more than a single scheme. These rules are based on the insurance principle of not being able to make a profit from the reimbursement of any expenditure.

Change of address

Any change of address must be notified in writing or by email to HSF Health Plan so that our records remain up-to-date.

Death of a policyholder

When a policyholder dies, any outstanding claims at the time of death will be settled as appropriate, payments being made on production of the required proof of entitlement.

Payment of premiums

Policyholders should check that payments have commenced in order that they are received regularly by HSF Health Plan. Policyholders who fall into arrears for more than six months will be required to rejoin under the usual conditions of enrolment.

Changing Schemes

Any existing policyholder is able to apply to change to a different scheme by completing an application form providing cover under the current scheme is 12 months or longer.
Acceptance may be subject to a proviso or restriction and a waiting period for any new health condition which may have arisen. In transfers to any scheme, the periods before claims may be submitted are waived in all categories except the following: Birth and Adoption Grants; all other categories if the claim is associated with pregnancy; Eye Laser Treatment in the Dental and Optical category only when transferring from a Primary Scheme to an Extra Cover Scheme.
Claims related to medical conditions existing at the time of increasing or linked to previous medical conditions will be paid at the appropriate former scheme rate. There may be circumstances where categories are grouped together for flexibility (eg. Practitioners) when it is necessary to settle claims at a former scheme rate for all categories in that group.

Ceasing premiums

Policyholders who wish to cease premiums should provide written notification to HSF Health Plan. Past premiums will not be refunded. Entitlement to claim will continue throughout any period of time covered by premiums. Any errors in premium payments must be notified to HSF Health Plan within two years of the occurrence for refunding to be possible.

Claims

Claims will not be paid unless the appropriate premiums are up-to-date. Claims must be made within six months from the date of the treatment/purchase or discharge from hospital or the accident taking place. All claims are subject to premium checks and it may be necessary to ask you for additional medical or supporting information in connection with any claims. Please see payment of premiums. All payments are tax free and easy to claim with claim forms provided on request by telephoning 0818 473 473 or writing to HSF Health Plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare or by downloading from our website www.hsf.ie

Reimbursement of most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim (not from your joining or scheme increase date or from a calendar year).

For example: an FDA policyholder, after serving the waiting period, who has up to €500.00 to claim for dental/optical expenses in any 12 consecutive months, could have the following claim record:

Date Claim Paid	*Claim Paid Amount*	*Remaining Balance in the Scheme FDA Dental/Optical Category*
17 June 2023	€400.00	A balance of €100.00 remains.
5 October 2023	€100.00	Now a nil balance is left. The next available amount will be €400.00 on 17 June 2024.
11 August 2024	€250.00	A balance of €150 remains

Within any consecutive 12 month period, the claim paid amount has not exceeded €500.00. After each claim is paid the amount becomes available again 12 months later. Balances available in each category can be checked on MyPolicy at mypolicy.hsf.eu.com or by telephoning the claims department who will give guidance on when to submit a claim.
Claims will only be accepted where accumulated receipts total €7 or more. Benefit payments which relate to amounts paid for a service provided will be up to 50% of the cost in the Primary Schemes and up to 100% of the cost in the

Extra Cover Schemes, depending on the maximum shown in the brochure. Payment will be by direct credit into your own bank account.

The receipts must:

a) be originals, not photocopies/scanned;
b) include the practitioner's stamp / name, qualifications and date of issue;
c) include the patient's full name and address;
d) state the type of service and items provided;
e) be for a service for which payment has been met directly by the person named under the cover;
f) be for a service covered by the HSF Health Plan categories only and not for any insurance premiums paid to cover that service. We cannot accept statements or summaries.

In circumstances where part or all of of the amount stated on the receipt has been met by another organisation or insurance company, HSF Health Plan will not consider that amount in the assessment of the claim, to ensure that a policyholder does not receive more than the amount paid as to do so would be an illegal act.

Claims cannot be accepted for treatment or services provided outside Ireland and the United Kingdom. There are no such location restrictions under the Personal Accident categories. Should any overpayment be made in respect of any of the benefits, the amount in question will be set against any future claims, or a repayment may be requested. Any fee paid by a policyholder to a practitioner for any type of medical statement or to a hospital for a statement concerning admission /attendance cannot be reimbursed by HSF Health Plan. Claims cannot be accepted from service providers who are related to the insured person.

Payment for personal accident claims

Any money due will be paid to the policyholder, if living, otherwise to his/her personal representative/s within 21 days of the claim being submitted to the satisfaction of HSF Health Plan.

Any receipt which the policyholder or anyone acting on the policyholder's behalf, or his/her representative(s) may give to HSF Health Plan for benefits payable, shall be deemed final and complete discharge of all liability of HSF Health Plan in respect of such benefits.

How to claim

Claims must be made within 6 months of the date of treatment, purchase, discharge from hospital or date of accident. To claim, scan and email claim form, as an attachment, with your receipt to claims@hsf.ie or post the original receipt with an HSF claim form to our Ireland office, 5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare. Claims are paid within 10 working days into your personal bank account. HSF Health Plan do NOT send back any original receipts.

General Conditions

Regardless of any amendments, the Birth and Adoption Grants will remain available to policyholders in the form outlined in the brochure for a minimum of 13 calendar months from the date of joining or changing schemes. This applies to all existing policyholders.

In the interest of the majority of the policyholders, the Board of Directors of HSF Health Plan reserve the right at renewal to:

a) vary the premium rates by giving at least 28 days' notice to the policyholder's last known home address;
b) vary the range and rates of benefits and the conditions and terms relating thereto;
c) make amendments to these rules with such changes applying at the next renewal date;

At other times the Board of Directors reserve the right to:

d) refuse to settle the claim of any policyholder who is in breach of the rules and conditions, or has been unwilling to cooperate in the process of considering a claim;
e) take legal action against anyone who makes a fraudulent claim and terminate cover immediately;
f) take legal action against anyone who makes, or is associated with, a fraudulent claim and terminate cover immediately;
g) use information provided on application and claim forms for the prevention and detection of crime.

Regulatory Information

Regulation and Compensation

HSF Health Plan Limited is approved in Ireland by the Department of Health and Children and registered with the Health Insurance Authority. It is registered as a Third Country Branch No 904935 by the Companies Registration Office in Ireland. It is authorised and regulated by the Central Bank of Ireland Institution Code C185821. The UK details of HSF Health Plan may be checked on the Financial Services Register on the Financial Conduct Authority website.

Advice and Reviews

HSF Health Plan is not authorised to provide advice and our Account Executives are only allowed to provide factual information on our products. They are not in a position to determine whether the product is appropriate for you.
Applicants should carefully consider the schemes available to them and choose the scheme to suit their personal circumstances. Policyholders should regularly review their policy documents to ensure the scheme remains suitable for their circumstances.

Remuneration of our Account Executives

Our Account Executives receive a salary and also receive a bonus based on sales and on meeting certain quality thresholds.

Compliments and Complaints

We endeavour to provide a high standard of service to our Policyholders and welcome comments and suggestions. Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at our Ennis address. Any complaint that is not resolved within 40 business days of receipt may be referred to the Financiall Services Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or call them on 01 567 7000. Full details of our complaints procedures are automatically sent on receipt of a complaint and at each stage relevant addresses are provided. Such details are available on request at all times. These procedures do not prevent you from taking legal action.

Governing Law

Cover in your scheme within this HSF Health Plan will be governed by and interpreted in accordance with Irish Law. All terms and conditions and communications will be in English.

Annual Premium Calculator

Below are the annual premiums for the HSF Health Plan schemes.

Primary Schemes	Extra Cover Schemes
FD1 €148.56	FDA €818.52
FD2 €224.55	FDB €1,043.06
FD3 €318.71	FDC €1,274.86
FD4 €405.64	
FD5 €557.75	
FD6 €709.86	
FD7 €861.98	

Data protection laws that affect you

This section informs you of the information we record about you. It sets out the conditions under which we may process any information that we collect from you, or that you provide to us. It covers information that could identify you ("personal information") and information that could not. In the context of the law and this notice, "process" means collect, store, transfer, use or otherwise act on information. We take seriously the protection of your privacy and confidentiality.

Our policy complies with the EU General Data Protection Regulation (GDPR).
The law requires us to tell you about your rights and our obligations to you in regards to the processing and control of your personal data.

Data Privacy Policy
What is GDPR?
The General Data Protection Regulation (GDPR) is an EU regulation. This piece of legislation replaces the Data Protection Act 1998 and places a greater accountability on organisations when using personal information and in turn give customers more rights. The GDPR applies to all organisations that offer products or services to customers that reside in the EU as well as those that collect data from customers based in the EU.

What does this mean to you?
Under the GDPR, we have a legal duty to protect any information we collect from you. We use leading technologies to safeguard your data, and keep strict security standards to prevent any unauthorised access to it. Upon the demonstration of satisfactory identification evidence, you may request a copy of the information we hold about you.

What information do we collect?
Health cash plan applications
If you make an application for a health cash plan. We collect three types of information: your personal details (including those of your partner and any dependants - if applicable), your medical details (including those of your partner and any dependants - if applicable) and payment details.

Personal details
The personal details we collect are: your personal and contact details including name, address, date of birth, company name and address (if applicable), email address and telephone numbers. We also collect the name and date of birth of your partner (if applicable) and any dependants (if applicable).

Medical details
The medical details we collect are: any conditions or illness you, your partner and any dependants may have had (or have) and the date any of the symptoms began. The medical details we collect are: any conditions or illness you, your partner and any dependants may have had (or have) and the date any symptoms began. A copy of this information is kept securely by HSF Health Plan and our technology suppliers, Microsoft Azure.

Payment details
The payment details we collect are Direct Debit or Credit Card information. Direct Debit or Credit Card information will be used for automatic payments to be made from the account you provide. Confirmation of premium deductions from your employer (where applicable). A copy of this information may be kept securely by HSF Health Plan (and temporarily by our technology suppliers Microsoft Azure).

Information about your Direct Debit
When you agree to set up a Direct Debit arrangement, the information you give to us is passed to our own bank Allied Irish Bank for processing according to our instructions. We do keep a copy.

Sending a message to our support team
When you contact us, whether by telephone, through our website or by e-mail, we collect the data you have given to us in order to reply with the information you need.
We record your request and our reply in order to increase the efficiency of our business.

How we use your information and the legal basis
When you make an application for a Health Cash Plan or otherwise agree to our terms and conditions, a contract is formed between you and us.
In order to carry out our obligations under that contract we must process the information you give us. Some of this

information may be personal information.
We may use it in order to:

- verify your identity for security purposes
- sell products to you
- provide you with our services
- provide you with suggestions and advice on products, services and how to obtain the most from using our website.

We process this information on the basis there is a contract between us, or that you have requested we use the information before we enter into a legal contract.
Additionally, we may aggregate this information in a general way and use it to provide class information, for example to monitor our performance with respect to a particular service we provide. If we use it for this purpose, you as an individual will not be personally identifiable.

Who we share your information with
HSF Health Plan may share your data with regulatory bodies when it is a legal requirement to do so for the purpose of monitoring and enforcing compliances:

- Financial Ombudsman Services
- Data Protection Commissioner
- Fraud Prevention Agencies

We may also share aspects of your information on occasion with organisations to enable continuity of service; these include:

- Organisations that pay premiums on your behalf in line with the policy contract (if applicable).
- IT Support

We may pass information to our service providers to assist in the continuity and provision of benefits. At the time of writing, Health Hero is a provider, however this is subject to change.

How long we hold your data for?
Except as otherwise mentioned in this privacy notice, we keep your personal information only for as long as required by us:

- to provide you with the services you have requested;
- to comply with other law, including for the period demanded by our tax authorities;
- to support a claim or defence in court.

In line with our current retention policy we retain your personal data for at least 6 years but no more than 7 years after the health plan policy has ceased.

Where is your information stored?
All of your data is located in the EU.

Implications of not providing data
If you do not provide information we may not be able to:

- provide requested services to you;
- continue to provide and/or renew existing products or services

We will tell you when we ask for information which is not a contractual requirement or is not needed to comply with our legal obligations.

How to exercise your information rights including the right to object
Access to your Data
You have the right to request a copy of all information about you held by HSF Health Plan.

Data Portability
You have the right to exercise your right to data portability in certain circumstances.

What if you want us to stop using your personal information?
You have the right to object to our use of your personal information, or to ask us to delete, remove, or stop using your personal information if there is no need for us to keep it. Please note our policy is to only keep personal information for as long as is reasonably required for the purpose(s) for which it was collected. We are required to keep certain transactional records – which does include personal information – for more extended periods to meet legal, regulatory, tax or accounting needs. We are also required to retain an accurate record of dealings with us for at least six years after your last interaction with us, so we can respond to any complaints or challenges you or others might raise later.
We may sometimes be able to restrict the use of your data. This means that it can only be used for certain things; if this is the case we would not use or share your information in other ways whilst it is restricted. You can ask us to restrict the use of your personal information if:

- It has been used unlawfully but you don't want us to delete it.
- You have already asked us to stop using your data but you are waiting for us to tell you if we can keep on using it.

If you wish to exercise any of your above rights you can do so by contacting the Data Protection Officer.

Verification of your information
When we receive any request to access, edit or delete personal identifiable information we shall first take reasonable steps to verify your identity before granting you access or otherwise taking any action. This is important to safeguard your information.

Right to complain
Should you not be happy with the way we handle your personal data, you have the right to complain. You can do so by contacting the Data Protection Officer.
If your complaint reasonably requires us to contact a third party, we may decide to give to that third party some of the information contained in your complaint. We do this as infrequently as possible, however it is a matter for our sole discretion as to whether we do give information, and if we do, what that information is.
You also have a right to lodge a complaint with the supervisory:
Data Protection Commissioner.

Data Protection Officer contact details
The Data Controller is HSF Health Plan.
You can contact the Data Protection Officer of HSF health plan by telephone on 0818 473 473 or in writing at:
HSF Health Plan,
5 Westgate Business Park,
Kilrush Road,
Ennis,
Co. Clare.

Visit www.hsf.ie to see full details.

Your Questions Answered

Q Can I join at any age?

A Anyone aged 18 or over may join.

Q Can I get cover for others in my family?

A Yes. Give details of your spouse / adult dependant and children on your application form and they will be included.

Q Can I increase to a higher scheme at any time?

A Schemes may be changed providing cover on the current scheme is in place for at least 12 months.

Q Do I have to have a medical to join?

A No. You need only complete and sign the health declaration on the application form.

Q Why do you need medical information?

A In order to explain the cover you will receive, and any restrictions which may apply.

Q Do older people pay higher premiums?

A No, all ages pay the same rates.

Q How do I pay?

A By Direct Debit, Credit Card or Debit Card.

Q Are benefits taxable?

A No. You keep all you receive from HSF Health Plan.

Q When can I make a claim?

A For most benefits claims will be accepted after 3 months, any exceptions are clearly indicated in the brochure.

Q How do I make a claim?

A Claim forms are available on request by telephoning the number indicated on the reverse of your certificate of cover or from our website.

Q How do I receive my money?

A By direct credit into your bank account.

Q When would my cover begin?

A Cover begins on the date printed on your certificate of cover.

How to join

1: Select the scheme which best suits your needs.
2: Complete the application form from page 25, remembering to include the names and dates of birth of everyone to be included.
3: Write all the medical information requested concerning yourself and everyone else included on page 26. (This will help us to explain the cover you receive, but failure to do so will not affect your registration).
4: Complete the Direct Debit form on pages 27.
5: Send all completed forms to the Ennis address – we will do the rest.

A welcome pack will be sent to your home address and the date stated on the certificate will denote when your cover began.

Ireland Office
5 Westgate Business Park,
Kilrush Road, Ennis, Co. Clare
Tel: 0818 473 473
Email: enquiries@hsf.ie
www.hsf.ie

Head Office
24 Upper Ground, London SE1 9PD
Tel: 0044 (0)20 7928 6662

Application to join HSF Health Plan

HSF Health Plan AE Code

Date Received – HSF Health Plan use	Policy No. – HSF Health Plan use

THIS PART MUST BE COMPLETED IN ALL CASES

I apply to join HSF Health Plan at the monthly rate indicated (net of partial Standard Rate Tax Relief at source) (PLEASE TICK)

Scheme FD1	Scheme FD2	Scheme FD3	Scheme FD4	Scheme FD5	Scheme FD6	Scheme FD7	Scheme FDA	Scheme FDB	Scheme FDC
€12.38	€18.71	€26.56	€33.80	€46.48	€59.16	€71.83	€68.21	€86.92	€106.24

Surname

Forename(s) Other Initials Mr/Mrs/Miss/Ms/Other

Address

Eircode

Email Tel: Work

Date of birth Policyholder Day Month Year Tel: Home

Date of birth Spouse/Adult Dependant Day Month Year Mobile

PPS Number

Spouse/Adult Dependant's Surname

Spouse/Adult Dependant's Forename(s)

If already covered by HSF please state:	
Premium	Policy No. (if known)

Children (children must be under 21 years of age)

Child's Surname	Child's Forename(s)	Sex	Date of Birth

HSF Health Plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF Health Plan services and those of the Hospital Saturday Fund.

By completing health information on the reverse of this form you will assist us in the administration of your policy. Failure to do so will not affect the registration.

TEAR ALONG PERFORATION

Declaration

This application is made on behalf of myself (the policyholder) and any adult and child dependants listed above.
I confirm that no advice has been received regarding this application from HSF Health Plan. I agree to HSF Health Plan holding data relevant to my scheme registration. I agree to abide by HSF Health Plan rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or premiums if deemed necessary, with notice. I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary I understand that HSF Health Plan may need to impose some restrictions on my cover.

Signature X	Date

Medical information

Your cover has to be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and / or treatments could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. To give false information could be considered to be a fraudulent act and lead to termination of cover.

Please tick the boxes below for any long term / chronic / congenital conditions even if at present under control. If any condition is not listed please complete the 'Other' section, stating conditions in full and avoiding abbreviations.

If you DO NOT have any conditions to declare, please leave the boxes below blank and sign the signature box below.

☐ Transferring from another insurer? PLEASE SUPPLY DETAILS	

Name	Condition/Illness	Date symptoms began
	☐ Arthritis PLEASE STATE PART(S) OF BODY AFFECTED BELOW …….. ☐ Asthma/Chest problems ☐ Diabetes ☐ Epilepsy ☐ Kidney disease ☐ Liver disease ☐ Raised blood pressure/Angina ☐ Congenital (conditions from birth) PLEASE STATE …….. ☐ Clinical Obesity	

Please list other illnesses / operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition / illness requiring the treatment.

Name	Any other Condition/Illness	Date symptoms began

Declaration

This declaration is made on behalf of myself (the policyholder). I agree to HSF Health Plan holding data relevant to my scheme registration. I declare that all the information I have given on this application form is true and complete to my knowledge.

Signature **X** Date

TEAR ALONG PERFORATION

SEPA Direct Debit Mandate

Unique Mandate Reference Policy Number (HSF USE)

Health Plan

Creditor Identifier: IE71ZZZ302170

Legal Text: By signing this mandate form, you authorise HSF Health Plan Limited to send instructions to your bank to debit your account and your bank to debit your account in accordance with the instruction from HSF Health Plan Limited. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.
Your rights are explained in a statement that you can obtain from your bank.
Please complete all the fields below marked *
Return the form to HSF Health Plan, FREEPOST, 5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare.

*Your Name:

*Your Address:

Address Line 1 _____

Address Line 2 _____

*City/Eircode:

*Country:

*Account number (IBAN):

*Swift BIC:

Creditor's Name: **HSF Health Plan Limited**
Creditor's Address: **5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare.**
Country: **Ireland.**

*Type of payment Recurrent ☐ **or** One-Off Payment ☐ (Please tick ✓)

*Preferred Frequency Monthly ☐ Quarterly ☐ 6 Month ☐ Annually ☐

*Preferred date 5th ☐ **or** 20th ☐ (Please tick ✓)
(Please tick ✓)

*Signature(s):

*Date of signing:

TEAR ALONG PERFORATION

HSF Health Plan Ltd is the trading company of The Hospital Saturday Fund, a Registered Charity in the UK No 1123381 and in Ireland Registered Charity No 20104528. In Ireland HSF Health Plan Ltd is authorised and regulated as a Third Country Branch by the Central Bank of Ireland. Registered as Company no 904935, their registered office is at 5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare. In the UK HSF Health Plan Ltd is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Registered as Company in England No 30869, their registered office is at 24 Upper Ground London SE1 9PD.

Ireland Office
5 Westgate Business Park,
Kilrush Road, Ennis, Co. Clare
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HSF Health Plan

November 2023 CM022 ROI Family Direct Scheme