

Life Choice

Specified Illnesses Explained



Appendix A - Specified Illnesses

Important Note

The explanations under the headings “In Simpler Terms” in this document do not form part of the policy conditions and are provided solely for illustrative purposes. In the event of a claim under Specified Illness Benefit or Partial Payment Specified Illness Benefit on your Policy, the “Policy Definitions” will apply and your claim will be processed in accordance with the policy conditions.

1. Alzheimer’s Disease – resulting in permanent symptoms

Policy Definition

A definite diagnosis of Alzheimer’s disease by a Consultant Neurologist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

- Alzheimer’s Disease secondary to alcohol or drug misuse

In Simpler Terms

Alzheimer’s disease is a progressive and degenerative disease. The nerve cells in the brain deteriorate over time and the brain substance shrinks. The symptoms can include a severe loss of memory and concentration and there is an overall decline in all mental faculties.

A claim can be made if there is a definite diagnosis by a Consultant Neurologist or Geriatrician of Alzheimer’s disease where judgement, understanding and rational thought processes have been seriously and permanently affected.

2. Aorta Graft Surgery – for disease or traumatic injury

Policy Definition

The undergoing of surgery to the aorta with excision and surgical replacement of a portion of the aorta with a graft.

The term aorta means the thoracic and abdominal aorta but not its branches.

For the above definition, the following is not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair.

In Simpler Terms

The aorta is the main artery of the body and supplies blood rich with oxygen to all other arteries. The aorta may become narrowed, usually due to a build-up of fatty deposits on the wall of the artery, or it may become weakened because of an aneurysm (where the artery wall becomes thin and dilated). Surgery, as described in the above definition, to correct these conditions or repair for traumatic damage to the aorta with a graft is covered.

3. Aplastic Anaemia – of specified severity

Policy Definition

A definite diagnosis by a Consultant Haematologist of permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia and requires as a minimum one of the following treatments:

- Blood transfusion;
- Bone-marrow transplantation;
- Immunosuppressive agents;
- Marrow Stimulating agents.

All other forms of anaemia are specifically excluded.

In Simpler Terms

Aplastic anaemia is a disease of the bone marrow, which is the organ that produces the body's blood cells. The symptoms of aplastic anaemia are fatigue, bruising, infections and weakness. In patients with aplastic anaemia, the bone marrow goes into failure and stops producing, or produces too few red blood cells, white blood cells, and platelets. Without sufficient red blood cells, oxygen cannot reach organs and tissues throughout the body. A decrease in the number of white blood cells reduces the body's ability to fight infection. A decrease in platelets diminishes the body's clotting ability.

You can make a claim if a Consultant Haematologist diagnoses permanent bone marrow failure which is being treated by blood transfusion, agents to stimulate the bone marrow, immunosuppressive agents or a bone marrow transplant.

4. Bacterial Meningitis - resulting in permanent symptoms

Policy Definition

A definite diagnosis of bacterial meningitis by a Consultant Neurologist causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms*.

All other forms of meningitis including viral meningitis are not covered.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with

speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

Bacterial meningitis is a life-threatening illness that results from bacterial infection of the meninges (the layers of membrane that surround the brain and spinal cord). In many cases, it is possible to recover fully from bacterial meningitis with no lasting ill-effects. However, if there are permanent effects as outlined in the above definition, we would consider a claim. You can make a claim if a Consultant Neurologist confirms a diagnosis of bacterial meningitis which has resulted in permanent brain or nerve damage. All other forms of meningitis including viral meningitis are excluded.

5. Balloon Valvuloplasty

Policy Definition

The actual insertion, on the advice of a Consultant Cardiologist of a balloon catheter through the orifice of one of the valves of the heart and the inflation of the balloon to relieve valvular abnormalities.

In Simpler Terms

The valves of the heart open and close as part of the pumping action, which circulates blood around the body. When these valves become diseased, the ability of the heart to pump properly is reduced. It

is sometimes possible to open these valves with balloon valvuloplasty, where a small narrow tube containing a deflated balloon at its tip is advanced from a blood vessel in the groin through the aorta and into the heart. Once it is in place, the balloon is inflated until the flaps of the valve are opened.

6. Benign Brain Tumour - resulting in permanent symptoms or requiring surgery

Policy Definition

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms* The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Tumour in the pituitary gland
- Angiomas

The requirement for permanent neurological deficit will be waived if the benign brain tumour is removed by invasive surgery or treated by stereotactic radiosurgery.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor,

seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

A benign brain tumour is a non-cancerous abnormal growth of tissue. It can be very serious because the growth may be pressing on areas of the brain. These growths can be potentially life threatening and may have to be removed by surgery. Other conditions that are not usually life-threatening are specifically excluded. The pituitary is a small gland at the base of the brain, an angioma is a benign growth made up of small blood vessels.

You can make a claim if you are diagnosed as having a benign brain tumour of the brain and have had surgery to have it removed or are suffering from permanent neurological deficit as described in the above definition as a result of the tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. Neurological symptoms must be permanent. We do not cover tumours or lesions in the pituitary gland or angiomas.

7. Benign Spinal Cord Tumour - resulting in permanent symptoms or requiring surgery

Policy Definition

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and/or interfering with the function of the spinal cord which requires surgery or results in permanent neurological deficit with persisting clinical symptoms*.

The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Angiomas
- Prolapsed or herniated intervertebral disc

The requirement for permanent neurological deficit will be waived if the benign spinal cord tumour is removed by invasive surgery or treated by stereotactic radiosurgery.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal.

You can make a claim if you are diagnosed as having a benign spinal cord tumour and have had

surgery to have it removed or are suffering from permanent neurological deficit as described in the above definition as a result of the tumour. Angiomas are benign tumours that are made up of small blood vessels. They usually appear at or near the surface of the skin and are not covered. Prolapsed or herniated intervertebral discs are also not covered.

8. Blindness - permanent and irreversible

Policy Definition

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

In Simpler Terms

You can make a claim if you have suffered severe loss of sight in both eyes. The loss of sight must be to the extent that, even when tested with the use of visual aids such as glasses or contact lenses, the sight in your better eye is confirmed by a Consultant Ophthalmologist or Physician and to the satisfaction of our Company's Chief Medical Officer, as 3/60 or worse using the recognised sight test known as the Snellen eye chart. 3/60 is the measure when you can only see an object up to 3 feet away that a person with normal eyesight could see if it were 60 feet away. This condition must be permanent and irreversible. It is important to realise that this definition is very specific. It may be possible to be "registered blind" but still not be covered by the above definition.

9. Cancer - excluding less advanced cases

Policy Definition

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and

invasion of tissue.

The term malignant tumour includes leukaemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
 - pre-malignant
 - non-invasive
 - cancer in situ
 - having either borderline malignancy; or
 - having low malignant potential.
 - All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
 - Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
 - Any skin cancer other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).
 - Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0

In the event of a claim for bladder cancer, the amount of any Life Insured's Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Early Stage Urinary Bladder Cancer – of specified advancement (number 10 of Appendix B).

In Simpler Terms

The term 'cancer' is used to refer to all types of malignant tumours. A malignant tumour usually grows quickly, usually invades surrounding tissue

as it expands, and can spread via the bloodstream or lymphatic system to form more growths in other parts of the body.

A claim can be made if you are diagnosed as suffering from a malignant tumour that has invaded surrounding tissue, unless the type of cancer is specifically excluded. Your claim must be supported by a microscopic examination of a sample of the relevant cells. This is known as 'histology' and would usually be carried out as part of a normal hospital investigation.

Leukaemia (a cancer of white blood cells) and lymphoma (a cancer of the lymphatic system, a vital part of the body's immune system) including non-Hodgkin's disease are covered.

Malignant melanoma (a serious form of skin cancer) is the only form of skin cancer that is covered. This is because most other forms of skin cancer are relatively easy to treat and are rarely life threatening.

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. The Gleason score which is a method of measuring differentiation in cells is specifically designed to help evaluate the prognosis of those who have been diagnosed with prostate cancer scoring patients between 2 and 10, with 10 having the worst prognosis. Cancers with a Gleason score less than or equal to 6 are less aggressive, less likely to spread and have a better prognosis. The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason

score of greater than 6 (i.e. a Gleason score of 7 or above) or it has progressed to at least clinical TNM classification of T2N0M0.

Many forms of bladder cancer have a slow course over many years and are managed by surgery or diathermy (the generation of local heat in body tissues by high frequency electromagnetic currents). The prognosis for patients with early stage superficial bladder cancer is very good. We will not pay a claim for bladder cancer under this cancer definition unless the tumour has progressed to at least clinical TNM classification of T2N0M0.

As part of this definition, we do not cover 'non-invasive cancer' or 'cancer in situ', which means that the cancer is in its early stages and has not spread to neighbouring tissue or is of a type that is contained and will not tend to spread. As these cancers have been detected at an early stage, they are unlikely to be life threatening.

10. Cardiac Arrest – with insertion of a defibrillator

Policy Definition

Sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable Cardioverter-Defibrillator (ICD), or
- Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

For the above definition the following is not covered:

- Insertion of a pacemaker
- Insertion of a defibrillator without cardiac arrest
- Cardiac arrest secondary to alcohol or drug misuse

In Simpler Terms

Cardiac arrest is where the heart suddenly stops beating, sometimes because of abnormal heart rhythm (arrhythmia) or coronary heart disease, resulting in an interruption to the blood circulating around the body. This in turn prevents the delivery of oxygen around the body resulting in unconsciousness.

An ICD is a small battery powered device which is implanted in patients who are at risk of sudden cardiac arrest to detect abnormal heart rhythm (arrhythmia) and correct it by delivering an electrical shock.

CRT-D involves using a specialised defibrillator to re-coordinate the action of the right and left ventricles of the heart.

You can make a claim if you have suffered a cardiac arrest and gone on to have either an ICD or CRT-D implanted. A cardiac arrest secondary to alcohol or drug misuse is not covered.

11. Cardiomyopathy – of specified severity

Policy Definition

A definite diagnosis by a Consultant Cardiologist of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least 6 months when stabilised on therapy advised by the Consultant.

The diagnosis must also be evidenced by:

- electrocardiographic changes; and
- echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy.

For the above definition, the following are not covered:

- all other forms of heart disease and/or heart enlargement;

- myocarditis; and
- cardiomyopathy secondary to alcohol or drug misuse.

In Simpler Terms

Cardiomyopathies are a group of disorders of the heart muscle, often of unknown cause, which can lead to sudden death and heart failure. The heart muscle can no longer effectively receive or pump blood throughout the body. The symptoms of cardiomyopathy include shortness of breath on moderate exercise, chest pain, and fainting.

You can make a claim if you are diagnosed by a Consultant Cardiologist with cardiomyopathy which significantly hinders normal everyday activities and results in permanently impaired ventricular function as described in the above definition.

12. Chronic Lung Disease – of specified severity

Policy Definition

Confirmation by a Consultant Physician of chronic lung disease which is evidenced by all of the following:

- The need for continuous daily oxygen therapy on a permanent basis;
- Evidence that oxygen therapy has been required for a minimum period of six months;
- FEV1 being less than 40% of normal;
- Vital Capacity less than 50% of normal.

In Simpler Terms

You can make a claim if confirmation is provided by a Consultant Physician that you are suffering from severe and restrictive chronic lung disease which significantly hinders everyday activities and is evidenced by all the criteria described in the above definition.

13. Coma - resulting in permanent symptoms

Policy Definition

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems for a continuous period of at least 96 hours;

and

- results in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug misuse.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

A coma is a state where a person is unconscious and cannot be brought round. Someone in a coma

will have little or no response to any form of physical stimulation and will not have control of their bodily functions. Comas are caused by brain damage, most commonly arising from a head injury, a stroke or lack of oxygen.

14. Coronary Artery By-pass Grafts - with surgery to divide the breastbone

Policy Definition

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

For the above definition, the following are not covered:

- balloon angioplasty;
- atherectomy;
- rotablation;
- insertion of stents;
- laser treatment.

In Simpler Terms

A coronary artery by-pass operation involving open heart surgery is one of the main methods of treating coronary artery disease, especially when a person suffers recurrent attacks of angina (heart related chest pain). The operation is necessary if one or more arteries, which supply blood to the heart, are narrowed or blocked. The surgery involves taking a blood vessel, often from a limb, and using it to direct blood past the diseased or blocked artery. This is a major operation, involving the actual opening up of the chest wall to reach the heart inside.

15. Creutzfeld-Jacob Disease - resulting in permanent symptoms

Policy Definition

A definite diagnosis of Creutzfeld-Jacob disease by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

*Permanent neurological deficit with persisting clinical symptoms" is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

Creutzfeldt- Jakob Disease (CJD) is a degenerative condition of the brain. As the disease progresses, muscular co-ordination diminishes, the intellect and personality deteriorate and blindness may develop. There is no treatment and death usually occurs within 6-18 months of the onset of symptoms. A claim can be made if there is a definite diagnosis by a Consultant Neurologist that you are suffering from this disease.

16. Crohn's Disease – of specified severity

Policy Definition

A definite diagnosis of Crohn's disease by a Consultant Gastroenterologist with fistula formation and intestinal strictures. There must have been two or more resections of the small or large intestine on separate occasions.

There must also be evidence of continued inflammation with ongoing symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

In the event of a claim for this illness, the amount of any Life Insured's Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Crohn's Disease – treated with surgical intestinal resection (number 7 of Appendix B).

In Simpler Terms

Crohn's disease is an inflammatory bowel disease. It causes inflammation of the lining of the digestive tract, which can lead to abdominal pain, severe diarrhoea and even malnutrition. Inflammation associated with Crohn's disease can involve different areas of the digestive tract in different people. Crohn's disease can be both painful and debilitating, and sometimes may lead to life-threatening complications.

While there's no known cure for Crohn's disease, therapies can greatly reduce the signs and symptoms and even bring about long-term remission. With treatment, many people with Crohn's disease are able to function well.

A claim can be made if there is a definite diagnosis by a Consultant Gastroenterologist of Crohn's disease and the condition is as severe as described in the above definition.

17. Deafness - permanent and irreversible

Policy Definition

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

In Simpler Terms

Deafness means a profound loss of hearing (as defined in the above definition) in both ears where the condition cannot be cured and is permanent, with no chance of recovery. It may be possible to be "registered deaf" but still not be covered by the above definition.

18. Dementia - resulting in permanent symptoms

Policy Definition

A definite diagnosis of dementia by a Consultant Neurologist or Geriatrician. There must be progressive and permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

- Dementia secondary to alcohol or drug misuse.

In Simpler Terms

Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive functioning, intellect, and behavioural changes. Areas of cognition affected may be memory, concentration, language and problem solving.

A claim can be made if there is a definite diagnosis by a Consultant Neurologist or Geriatrician of dementia where judgement, understanding and rational thought processes have been seriously and permanently affected.

Dementia secondary to alcohol or drug misuse is not covered.

19. Devic's Disease – with persisting symptoms

Policy Definition

A definite diagnosis of Devic's disease by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

In Simpler Terms

Devic's disease, also known as neuromyelitis optica is an autoimmune disorder in which the immune system attacks the protective covering (myelin) of the nerve fibres in the spinal cord and/or optic nerves. The condition causes symptoms similar to those in multiple sclerosis (MS) which is also an autoimmune disorder but Devic's disease is a distinct disease and requires different treatment than MS.

20. Encephalitis - resulting in permanent symptoms

Policy Definition

A definite diagnosis of encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

Under the above definition Myalgic Encephalomyelitis (ME) is not covered.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system

that are present on clinical examination and expected to last throughout the insured person's life.

- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

Encephalitis means inflammation of the brain. There are a number of causes which include infections (especially viral) and post-infectious autoimmune processes where the immune system attacks the brain in error. However, the causes of many cases of encephalitis remain unidentified. Encephalitis can be a life-threatening condition and can leave people with permanent neurological problems.

You can make a claim if you have a diagnosis of encephalitis confirmed by a Consultant Neurologist and where there are permanent neurological symptoms as described in the above definition.

21. Heart Attack - of specified severity

Policy Definition

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- Typical clinical symptoms (for example,

characteristic chest pain).

- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher; Troponin T >1.0ng/mL, AccuTnI >0.5ng/mL or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following is not covered:

- Other acute coronary syndromes including but not limited to angina.

In Simpler Terms

If the blood supply to the heart is interrupted, this can cause a portion of the heart muscle to die. Doctors call this sudden death of heart muscle an acute myocardial infarction, but the condition is widely known as a heart attack.

A heart attack is usually caused by a blocked artery (coronary occlusion) or a blood clot (coronary thrombosis) and causes permanent damage to the part of the heart muscle affected. This damage can be detected using an ECG machine which traces the heart beat. As a result of cell death chemicals such as cardiac enzymes and troponins are released into the blood stream and these are usually present for several days after the event and can be detected by a blood test.

In order for a claim to be valid, you must have suffered a heart attack and be supported by an episode of typical chest pain, increase in cardiac enzymes or troponins as described in the above definition that are typical of a heart attack and new ECG changes that are typical of a heart attack.

22. Heart Structural Repair

Policy Definition

The undergoing of heart surgery requiring thoracotomy on the advice of a Consultant Cardiologist to correct any structural abnormality of the heart.

In Simpler Terms

Structural abnormalities of the heart can take many forms including for example abnormal openings in the dividing wall separating the left and right chambers of the heart. Having abnormalities of the heart corrected is covered if the procedure is done via a thoracotomy (which involves a surgical incision into the chest wall).

23. Heart Valve Replacement or Repair - with surgery to divide the breastbone

Policy Definition

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

In Simpler Terms

When a heart valve is not working properly because it has become narrowed or is leaking, an operation may be required to repair or replace the valve. Having a defective heart valve replaced or repaired is covered if the procedure is done using open-heart surgery involving the surgical division of the breastbone.

24. HIV infection

Policy Definition

HIV infection – contracted in any of the Approved Territories from a blood transfusion, a physical assault or at work.

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment; or
- a physical assault; or
- artificial insemination or in-vitro fertilisation given as part of medical treatment; or
- an incident occurring during the course of performing normal duties of employment

after the start of the policy and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is contracted through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug misuse.

In Simpler Terms

Human immunodeficiency virus is generally recognised as the virus that causes acquired immune deficiency syndrome (AIDS). The virus can be passed on in several ways including through contaminated blood, bloodstained bodily fluids and infected needles. This benefit is designed to cover people who are in special danger of acquiring HIV or AIDS through their work or who have become infected as a result of a blood transfusion in the European Union, Australia, Canada, New Zealand, Norway, Switzerland or the United States of America . The infection must happen after

the policy start date and must be appropriately reported and investigated in accordance with established procedures as described in the above definition.

25. Intensive Care – requiring mechanical ventilation for 10 consecutive days

Policy Definition

Any sickness or injury resulting in the Life Insured requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in a Major Hospital.

For the above definition the following are not covered:

- sickness or injury as a result of drug or alcohol misuse or other self inflicted means
- children under the age of 90 days

In Simpler Terms

Mechanical ventilation by means of tracheal intubation is where a tube is inserted into the windpipe and a machine pumps air in and out of the lungs to keep a patient alive.

You can make a claim if you have undergone this procedure in an intensive care unit for ten consecutive days.

26. Kidney Failure - requiring ongoing dialysis

Policy Definition

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

For the above definition, the following is not covered:

- Kidney failure secondary to alcohol or drug misuse.

In Simpler Terms

The kidneys act as filters that remove waste materials from the blood. When the kidneys do not function properly, a build-up of waste products in the blood can lead to life threatening problems. The body can function with only one kidney because the remaining kidney can take over the work of the damaged kidney. However, if both kidneys fail completely and irreversibly, and regular dialysis (a process using a machine to perform the functions of the kidneys) or a kidney transplant is required then a claim can be made.

27. Liver Failure - irreversible and end stage

Policy Definition

Chronic liver disease, being end stage and irreversible liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice,
- ascites; and
- hepatic encephalopathy.

For the above definition, the following is not covered:

- Liver Failure secondary to alcohol or drug misuse.

In Simpler Terms

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function. Liver failure occurs when a large portion of the liver is damaged. You can make a claim if you are diagnosed by a Consultant Physician as having incurable end stage liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discoloration of the skin and whites of the eyes due to abnormally high levels of bilirubin (bile pigment) in the blood stream. This jaundice must be a permanent feature. Ascites is a fluid build up in the abdomen caused by fluid leaks

from the surface of the liver and intestines. It can occur if the blood or lymphatic flow through the liver is blocked. Encephalopathy caused by liver failure is the deterioration of brain function due to toxic substances building up in the blood which are normally removed by the liver.

Liver Failure secondary to alcohol or drug misuse is not covered.

28. Loss of one Limb - permanent physical severance

Policy Definition

Permanent loss of a hand from above the wrist or a foot from above the ankle joint. Permanent loss does not include loss of use or function only. It means having a hand or foot completely severed.

If a Life Insured loses a limb as a result of their own deliberate act, or a penalty imposed by a court of law, we will not pay you any benefit under the policy.

In Simpler Terms

You can make a claim if you have lost one limb, where the limb has been permanently severed above the wrist in the case of a hand or above the ankle in the case of a foot.

29. Loss of Speech - permanent and irreversible

Policy Definition

Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

In Simpler Terms

You can make a claim if you suffer from total and permanent loss of speech as a result of physical injury or disease.

30. Major Organ Transplantation - specified organs

Policy Definition

The undergoing as a recipient of a transplant of bone marrow or a complete heart, kidney, liver, lung, or pancreas, or a lobe of liver, or a lobe of lung, or inclusion on the official programme waiting list of a Major Hospital in Ireland or the United Kingdom for such a procedure.

For the above definition, the following are not covered:

- Transplant of any other organs, parts of organs, tissues or cells.
- Major organ transplant secondary to alcohol or drug misuse.

In Simpler Terms

Serious disease or injury can severely damage the heart, lungs, kidneys, liver or pancreas. The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason a patient could be on a waiting list for a long period waiting for a suitable organ. Bone marrow transplant is also covered.

You can make a claim if you have had a transplant of any of the organs listed above or are on an official programme waiting list of a major Irish or United Kingdom Hospital for such a procedure.

31. Motor Neurone Disease - resulting in permanent symptoms

Policy Definition

A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

In Simpler Terms

Motor neurone disease is a rare progressive

degenerative disorder, which affects the central nervous system that controls muscular activity. As the nerves degenerate the muscles weaken and deteriorate. The cause is unknown and there is no known treatment.

You can make a claim if there is a definite diagnosis by a Consultant Neurologist that you are suffering from this disease.

32. Multiple Sclerosis - with persisting symptoms

Policy Definition

A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

In Simpler Terms

Multiple sclerosis is an autoimmune disorder in which the immune system attacks the protective covering (myelin) of the nerve fibres in the brain and spinal cord. The symptoms depend on which areas of the brain or spinal cord have been affected. They include temporary blindness, double vision, loss of balance and lack of co-ordination.

The diagnosis must be confirmed by a Consultant Neurologist.

33. Multiple System Atrophy – resulting in permanent symptoms

Policy Definition

A definite diagnosis of multiple system atrophy by a Consultant Neurologist. There must be evidence of permanent clinical impairment of either:

- motor function with associated rigidity of movement; or
- the ability to coordinate muscle movement; or
- bladder control and postural hypotension

In Simpler Terms

Multiple system atrophy is a progressive neurological disorder of unknown cause which affects nerve cells in specific areas of the brain.

This results in problems with various bodily functions such as movement, balance and bladder control.

You can make a claim if you have been unequivocally diagnosed with this condition by a Consultant Neurologist and evidenced by the symptoms described in the above definition.

34. Muscular Dystrophy - resulting in permanent symptoms

Policy Definition

A definite diagnosis of muscular dystrophy by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

*Permanent neurological deficit with persistent clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

Muscular dystrophy is a group of hereditary diseases in which certain muscles degenerate over time. Although in many cases the person can live with the disease for a long time, muscular weakness usually leads to problems with, for example, mobility.

There are a number of forms of muscular dystrophy which affect different muscles to varying degrees. You can make a claim if the diagnosis of muscular dystrophy is confirmed by a Consultant Neurologist and leads to permanent neurological deficit with persistent clinical symptoms as described in the above definition.

35. Paralysis of one Limb - total and irreversible

Policy Definition

Total and irreversible loss of muscle function to the whole of any one limb.

In Simpler Terms

You can make a claim if you totally and irreversibly lose the ability to move or use any one limb.

36. Parkinson's Disease (idiopathic) - resulting in permanent symptoms

Policy Definition

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must also be permanent clinical impairment that includes bradykinesia (slowness of movement) and at least one of the following:

- tremor; or
- muscle rigidity; or
- postural instability

For the above definition, the following is not covered:

-
- Parkinson's disease secondary to alcohol or drug misuse

In Simpler Terms

Parkinson's disease is a progressive degenerative disorder of the brain that affects the central nervous system. This is characterised by uncontrollable shuffling, tremors in the limbs, slow movement, rigid facial expression and unstable gait. The progression of the disease is slow and there is no known cure.

The term "idiopathic" means that the cause of the disease is not known, so any form of Parkinson's disease brought on by a known cause such as drugs, toxic chemicals or alcohol is not covered.

You can make a claim if you have been diagnosed with idiopathic Parkinson's disease by a Consultant Neurologist and evidenced by the symptoms described in the above definition.

37. Peripheral Vascular Disease – with bypass surgery

Policy Definition

A definite diagnosis of peripheral vascular disease by a Consultant Cardiologist or Vascular Surgeon, due to atherosclerosis or Buerger's disease, with objective evidence from an ultrasound of obstruction in the arteries which results in by-pass graft surgery to an artery of the legs.

For the above definition, the following is not covered:

- Angioplasty

In the event of a claim for this illness, the amount of any Life Insured's Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Peripheral Vascular Disease - treated by angioplasty (number 12 of Appendix B).

In Simpler Terms

Symptoms of peripheral vascular disease arise when there is significant narrowing of arteries in the legs. Symptoms vary from feeling pain in your calf when exercising (intermittent claudication) to pain when resting, skin ulceration, and gangrene.

Atherosclerosis is caused when fatty deposits build up along the inner walls of an artery.

Buerger's disease (thromboangiitis obliterans) is caused by inflammation of the blood vessels (vasculitis). The blood vessels tighten and can become totally blocked. Bypass surgery is carried out by taking a healthy blood vessel and using it to direct blood past the narrowed or blocked artery.

You are not covered under this definition for any other intervention techniques such as angioplasty.

38. Pneumonectomy – removal of a complete lung

Policy Definition

The undergoing of surgery on the advice of a Consultant Physician to remove an entire lung for disease or traumatic injury.

For the above definition, the following are not covered:

- removal of a lobe of the lungs (lobectomy);
- lung resection or incision

In Simpler Terms

You can make a claim if you have had an entire lung removed as a result of injury or disease.

Removal of only a part of a lung is not covered under this definition.

39. Primary Pulmonary Hypertension - of specified severity

Policy Definition

A definite diagnosis of primary pulmonary hypertension by a Consultant Cardiologist. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classifications of functional capacity*.

* NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

In Simpler Terms

Pulmonary hypertension is when the blood pressure in the pulmonary artery (the major artery connecting the heart to the lungs) is higher than normal. There is no apparent cause. This means that the heart is under pressure when pumping blood into the lungs and typical symptoms include the shortness of breath, fatigue and fainting. These and other symptoms appear much more severely when exercising. Over time the heart muscle weakens.

You can make a claim if you have been diagnosed with primary pulmonary hypertension by a Consultant Cardiologist and which results in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity. The NYHA Function Classification is a measure used to classify the severity of heart failure.

40. Progressive Supra-nuclear palsy - resulting in permanent symptoms

Policy Definition

A definite diagnosis of progressive supra-nuclear palsy by a Consultant Neurologist. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

In Simpler Terms

Progressive supra-nuclear palsy (PSP) is a degenerative disease causing gradual deterioration and death of specific areas of the brain. The exact cause is unknown but there is evidence in some cases to suggest it may run in families. The disease affects the part of the brain above the nuclei ("supranuclear"), which are pea-sized structures in the part of the nervous system that controls eye movements. The symptoms of PSP usually appear slowly but get progressively worse. These symptoms include impairment of motor function, eye movement disorder and postural instability.

You can make a claim if there has been a definite diagnosis by a Consultant Neurologist that you are suffering with this disease.

41. Pulmonary Artery Graft Surgery - with surgery to divide the breast bone

Policy Definition

The actual undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

In Simpler Terms

Pulmonary artery surgery may be carried out for some disorders of the pulmonary artery including pulmonary atresia and aneurysm.

You can make a claim if you have undergone

open-heart surgery involving the surgical division of the breastbone on the advice of a Consultant Cardiothoracic Surgeon to replace the diseased pulmonary artery with a graft.

42. Rheumatoid Arthritis – of specified severity

Policy Definition

A definite diagnosis of chronic rheumatoid arthritis by a Consultant Rheumatologist resulting in all of the following:

- the condition must be diagnosed, established and treated for a period of at least 12 months;
- there must be morning stiffness in the affected joints of at least one-hour duration;
- there must be arthritis of at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a rheumatologist;
- the arthritis must involve at least one or more of the following sites:
 - wrists or ankles;
 - hands and fingers;
 - feet and toes;
- the arthritis must affect both sides of the body;
- presence of rheumatoid factor or anti CCP (anticyclic citrullin-ated protein) antibodies, unless all other criteria are met;
- there must be subcutaneous nodules (nodular swelling beneath the skin);
- there must be radiographic changes typical of active rheumatoid arthritis.

In Simpler Terms

Rheumatoid arthritis is a chronic disease involving inflammation of the joints and their surrounding tissue. This inflammatory process can result in the progressive destruction and deformity of the

affected joints. The joints commonly affected are the wrists, ankles, hands, fingers, feet and toes.

Before a claim can be made, the disease must have progressed to such severity that it satisfies all of the detailed conditions listed in the above definition.

43. Stroke - resulting in permanent symptoms

Policy Definition

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.

*Permanent neurological deficit with persistent clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

A stroke is caused by an interruption to the flow of blood to the brain. This can be due either to a blocked artery which prevents blood reaching the brain or a burst blood vessel in the brain. In either case, a claim will be valid if it causes ongoing clinical symptoms of a stroke which are expected to be permanent.

The policy does not cover 'transient ischaemic attacks' (known as mini-strokes) because there is only a short term interruption of the blood supply to the brain. This does not result in permanent damage to the brain. The symptoms may initially be similar to those of a stroke but patients normally recover within 24 hours.

44. Systemic Lupus Erythematosus - of specified severity

Policy Definition

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms*, or
- Permanent impairment of kidney function tests as follows:
 - Glomerular Filtration Rate (GFR) below 30ml/min.
 - Abnormal urinalysis showing proteinuria or haematuria.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness,

dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

For the purposes of this definition, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin will not be accepted as evidence of permanent deficit of the neurological system.

In Simpler Terms

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease that develops slowly causing inflammation in joints and blood vessels, often with a rash on the skin. It can affect many systems of the body, including the kidneys, heart, skin, and central nervous system. Discoid lupus is generally restricted to the skin, is not life threatening and is not covered by this definition.

A claim can be made if a definite diagnosis of SLE, to the severity specified in the above definition, is made by a Consultant Rheumatologist.

45. Third Degree Burns - covering 20% of the body's surface area

Policy Definition

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or at least 25% surface area of the face which for the purpose of this definition includes the forehead and the ears.

In Simpler Terms

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into

the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You can make a claim if you have suffered third-degree burns covering 20% or more of the surface area of your body or at least 25% surface area of the face.

46. Total and Permanent Disability

Policy Definition

1. Total and Permanent Disability before age 65 means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed medication and then be unable to perform the task on their own.

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability Benefit arises.

The 6 activities are:

- Walking – the ability (using a walking stick for balance or confidence if necessary) to walk 200 meters on the flat without stopping or severe discomfort .
- Mobility – the ability to bend or kneel down to pick up something from the floor and straighten up again.
- Lifting – lifting a 1 kilogram weight from table height with either hand and carrying it for 5 meters.
- Manual Dexterity – using a pen, pencil or keyboard with either hand.
- Communication – the ability to answer a telephone and reliably take a message.
- Climbing – the ability to climb up and then

down a flight of 12 stairs with the use of a handrail if needed.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from:

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following is not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse

2. Total and Permanent Disability at age 65 or over means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed medication and then be unable to perform the task on their own, even with the use of appropriate assistive aids and appliances (e.g. a handrail to help getting into and out of the bath or shower).

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability Benefit arises.

The 6 activities are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other

means.

- Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
- Feeding – The ability to feed one's self once food has been prepared and made available.
- Toileting – the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.
- Mobility – the ability to move indoors from room to room on level surfaces.
- Transferring – The ability to move from bed to an upright chair or wheelchair and vice versa.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following is not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse.

In Simpler Terms

This definition is not linked to any particular specified illness. It is based on your permanent inability to carry out a variety of activities or mental incapacities as listed in the above definition. It is intended to provide more extensive cover for

events or conditions which may radically change your life.

47. Traumatic Head Injury - resulting in permanent symptoms

Policy Definition

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be confirmed by a Consultant Neurologist and agreed by our Chief Medical Officer.

For the above definition, the following is not covered:

- Traumatic Head Injury secondary to alcohol or drug misuse.

* Permanent neurological deficit with persistent clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

In Simpler Terms

A head injury caused by trauma can leave an individual with permanent brain or nerve damage. You can make a claim if a Consultant Neurologist confirms that you have permanent neurological deficit with persisting clinical symptoms as described in the above definition, as a direct result of a head injury.

Appendix B -

Partial Payment Specified Illnesses

Important Note

The explanations under the headings “In Simpler Terms” in this document do not form part of the policy conditions and are provided solely for illustrative purposes. In the event of a claim under Specified Illness Benefit or Partial Payment Specified Illness Benefit on your Policy, the “Policy Definitions” will apply and your claim will be processed in accordance with the policy conditions.

1. Angioplasty for Coronary Artery Disease – of specified severity

Policy Definition

Undergoing of treatment for severe coronary artery disease, of any of the following:

- balloon angioplasty
- atherectomy
- rotablation
- laser treatment
- and / or insertion of stent(s)

to treat the narrowing or blockage in a Main Coronary Artery. This procedure must have been carried out on the advice of a Consultant Cardiologist.

Angiographic evidence to support the necessity for the procedure will be required. The intervention must be to treat at least 70% diameter narrowing in a Main Coronary Artery.

Provided the above requirements are met, we will make a payment of €5,000 on completion of balloon angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s), to correct at least 70% diameter narrowing in one Main Coronary Artery.

We will make a second payment on the completion of balloon angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s) to

correct at least 70% diameter narrowing of one of the other Main Coronary Arteries. The second payment is the balance of the Partial Payment Specified Illness Benefit for Angioplasty for Coronary Artery Disease set out in Section C, for Condition 2.1.3

For the purposes of this definition Main Coronary Arteries are defined as being:

- Right Coronary Artery
- Left Main Stem
- Left Anterior Descending
- Circumflex

Procedures to any of the branches of the above Main Coronary Arteries are specifically excluded.

In Simpler Terms

There are several procedures involving the use of coronary catheters (flexible plastic tubes). One of these is balloon angioplasty, which involves the insertion of a catheter into the body; the catheter is then inflated to force the narrowed or blocked artery apart.

A stent is a small permanent metal tube that acts as an internal support to the artery. Stenting is often used in conjunction with balloon angioplasty.

Atherectomy and laser treatment are other techniques that involve the insertion of a catheter into a blocked artery to help clear it. Rotablation is when a small device is used to drill through the blockage in the coronary arteries.

If you require balloon angioplasty, atherectomy, rotablation, laser treatment and or insertion of stent(s), a claim of €5,000 can only be made if the treatment is to correct at least 70% diameter narrowing of one main coronary artery.

You can make a second claim on the completion of balloon angioplasty, atherectomy, rotablation, laser treatment and or insertion of stent(s) to correct at least 70% diameter narrowing of one of the other main coronary arteries.

2. Brain Abscess drained via craniotomy

Policy Definition

Undergoing of surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

In Simpler Terms

A brain abscess results from an infection in the brain. Swelling and inflammation develop in response to the infection. Infected brain cells, white blood cells and organisms collect in an area of the brain, a membrane forms and creates the abscess. While this immune response can protect the brain from the infection, an abscess may put pressure on delicate brain tissue.

A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain.

You can make a claim if you are diagnosed, with supporting CT or MRI evidence, as having an intracerebral abscess and where this abscess is removed through a craniotomy by a Consultant Neurosurgeon.

3. Carcinoma in Situ - Oesophagus, treated by specific surgery

Policy Definition

A definite diagnosis of a carcinoma in situ of the oesophagus by a Consultant Physician, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

For the above definition, the following is not covered:

- Treatment by any other method is specifically excluded.

In Simpler Terms

The oesophagus is a muscular tube through which food passes from the mouth to the stomach.

Carcinoma in situ is an early form of carcinoma which affects only the cells in which it originated and has not yet begun to spread to other cells (i.e. it is non-invasive).

You can make a claim if you have been diagnosed as having carcinoma in situ of the oesophagus and where this has been treated by the removal or partial removal of the oesophagus.

4. Carotid Artery Stenosis - treated by endarterectomy or angioplasty

Policy Definition

Undergoing of endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

In Simpler Terms

The carotid artery is the artery that supplies blood to the head and neck. This artery can narrow or become partially blocked by deposits of plaque (fatty tissue). These deposits are dangerous because if this material travelled to the brain it could cause a stroke.

Carotid stenosis can be corrected by procedures such as carotid endarterectomy (where the surgeon opens up the artery and removes the plaque) or angioplasty with or without stents (where the surgeon uses a balloon to expand the artery).

You can make a claim if you have undergone one of these procedures to correct carotid artery stenosis where the artery was at least 70% narrowed. Your doctor will need to provide angiographic evidence for a claim to be valid.

You cannot make a claim for other treatments for

carotid artery stenosis.

5. Cerebral Aneurysm - treated by craniotomy, stereotactic radiosurgery or endovascular repair

Policy Definition

Undergoing of treatment for a cerebral aneurysm by a Consultant Neurosurgeon or Radiologist via craniotomy, or stereotactic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral aneurysm.

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation

In Simpler Terms

A cerebral aneurysm is a weakness in the wall of a cerebral artery or vein resulting in a swelling of the blood vessel. A cerebral aneurysm can rupture and bleed into surrounding tissue. Some cerebral aneurysms, particularly those that are very small, do not bleed or cause any problems.

A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain. Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment is where the surgeon accesses the brain via arteries using catheters, balloons, coils and stents.

You can claim if you have a craniotomy, stereotactic radiosurgery, or endovascular treatment using coils under the care of a Consultant Neurologist or Radiologist, as appropriate, to treat a cerebral aneurysm.

6. Cerebral Arteriovenous Malformation - treated by craniotomy, stereotactic radiosurgery or endovascular repair

Policy Definition

Undergoing of treatment of a cerebral arteriovenous fistula or malformation by a Consultant Neurosurgeon or Radiologist via craniotomy, or stereotactic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral arteriovenous fistula or malformation.

For the above definition, the following is not covered:

- Intracranial aneurysm

In Simpler Terms

Cerebral arteriovenous malformation is a condition whereby there is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An arteriovenous fistula (AV fistula) is one such abnormal connection. When this is present, blood flows directly from an artery into a vein bypassing the capillaries. This can cause a problem if oxygenated blood has not reached its intended destination within the brain.

The most common symptoms include headaches and seizures. In more serious cases blood vessels may rupture and there will be haemorrhaging within the brain.

A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain. Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment is where the surgeon accesses the brain via arteries using catheters, balloons, coils and stents.

You can claim if you have a craniotomy, stereotactic radiosurgery, or endovascular treatment using coils under the care of a Consultant Neurologist or Radiologist, as appropriate, to treat a cerebral arteriovenous fistula or malformation.

7. Crohn's Disease – treated with surgical intestinal resection

Policy Definition

A definite diagnosis of Crohn's disease by a Consultant Gastroenterologist and where the Life Insured has undergone surgery to remove part of the small or large intestine.

The removed part of the small or large intestine must show histological confirmation of Crohn's disease.

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Intestinal biopsy

The amount of any Accelerated or Standalone Specified Illness Benefit to be paid for Crohn's Disease – of specified severity (number 16 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Crohn's Disease – treated with surgical intestinal resection.

In Simpler Terms

Crohn's disease is a chronic inflammatory bowel disease. It causes inflammation of the lining of the digestive tract, which can lead to abdominal pain, severe diarrhoea and even malnutrition. Inflammation associated with Crohn's disease can involve different areas of the digestive tract in different people. Crohn's disease can be both painful and debilitating, and sometimes may lead to life-threatening complications.

While there's no known cure for Crohn's disease, therapies can greatly reduce the signs and symptoms and even bring about long-term remission. With treatment, many people with Crohn's disease are able to function well.

A claim can be made if there is a definite diagnosis by a Consultant Gastroenterologist of Crohn's

disease, and as a result of this condition, you have had surgery to remove part of the small or large intestine as described in the above definition.

8. Ductal Carcinoma in Situ - Breast, treated by surgery

Policy Definition

A definite diagnosis of a ductal carcinoma in situ of the breast, which has been removed surgically by mastectomy, partial mastectomy, segmentectomy or lumpectomy. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

In Simpler Terms

Ductal carcinoma in situ is a term used to describe an early form of carcinoma which affects only the cells in which it originated and has not yet begun to spread to other cells (i.e. it is non-invasive).

Ductal means that these malignant cells develop within the milk ducts of the breast so ductal carcinoma in situ means that the carcinoma has not moved outside of these cells and into the surrounding breast tissue or other parts of the body.

A claim can be made if you have been diagnosed with having ductal carcinoma in situ of the breast and where this has been treated by the removal or partial removal of the breast or surgical removal of the tumour itself.

9. Early Stage Prostate Cancer with Gleason score between 2 and 6 - and with specific treatment

Policy Definition

A definite diagnosis of prostate cancer by a Consultant which has been histologically classified as having a Gleason score between 2 and 6 provided:

- The tumour has progressed to at least clinical TNM classification T1N0M0; and
- The Life Insured has undergone treatment by prostatectomy, external beam or interstitial implant radiotherapy.

For the above definition, the following is not covered:

- Treatment with cryotherapy, transurethral resection of the prostate, 'experimental' treatments or hormone therapy.

In Simpler Terms

The Gleason score which is a method of measuring differentiation in cells is specifically designed to help evaluate the prognosis of those who have been diagnosed with prostate cancer scoring patients between 2 and 10, with 10 having the worst prognosis. Cancers with a Gleason score less than or equal to 6 are less aggressive, less likely to spread and have a better prognosis.

The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another.

You can make a claim if you have been diagnosed with prostate cancer by an appropriate Consultant with a Gleason score between 2 and 6 and where the tumour has progressed to at least clinical TNM classification T1N0M0 and have also undergone treatment as described in the above definition.

10. Early Stage Urinary Bladder Cancer - of specified advancement

Policy Definition

A definite diagnosis by a Consultant of urinary bladder cancer which has been histologically classified as having progressed to either:

- stage Tis - Carcinoma in situ – diffuse 'flat' non-papillary tumour; or
- stage T1N0M0 - Carcinoma which has invaded the sub-epithelial connective tissue

For the above definition, the following is not covered:

- Any urinary bladder tumour which has been histologically classified as stage Ta (non-invasive papillary carcinoma).

The amount of any Accelerated or Standalone Specified Illness Benefit to be paid for bladder cancer (covered under Cancer, number 9 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Early Stage Urinary Bladder Cancer – of specified advancement.

In Simpler Terms

The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another.

You can make a claim if you have been diagnosed with bladder cancer by an appropriate Consultant where the tumour has progressed to at least clinical TNM classification of Tis or T1N0M0.

We do not cover Ta tumours as they generally have a better prognosis and are easily treatable.

11. Implantable Cardioverter Defibrillator (ICD) – for primary prevention of sudden cardiac death

Policy Definition

Undergoing of the insertion of an Implantable Cardioverter-Defibrillator (ICD) on the advice of a Consultant Cardiologist for primary prevention of sudden cardiac death.

For the above definition, the following is not covered:

- Insertion of a pacemaker

In Simpler Terms

An implantable cardioverter defibrillator (ICD) is a small battery-powered electrical device that is implanted in patients who are at risk of sudden cardiac death due to life-threatening, irregular heart rhythms. The device is programmed to detect cardiac arrhythmia (abnormal heart rhythm) and correct it by delivering a jolt of electricity.

We do not cover insertion of a pacemaker as this is a different device and is used to treat conditions that are generally less serious.

12. Peripheral Vascular Disease – treated by angioplasty

Policy Definition

Undergoing of balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist or Vascular Surgeon to correct at least 70% narrowing or blockage to an artery of the legs. Angiographic evidence will be required.

The amount of any Accelerated or Standalone Specified Illness Benefit to be paid for Peripheral Vascular Disease – with bypass surgery (number 37 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Peripheral Vascular Disease - treated by angioplasty.

In Simpler Terms

Symptoms of peripheral vascular disease arise when there is significant narrowing of arteries in the legs. Symptoms vary from feeling pain in your calf when exercising (intermittent claudication) to pain when resting, skin ulceration, and gangrene.

Balloon angioplasty involves the insertion of a catheter (flexible plastic tubes) into a narrowed artery; the catheter is then inflated to force the narrowed or blocked artery apart.

A stent is a small permanent metal tube that acts as an internal support to the artery. Stenting is often used in conjunction with balloon angioplasty.

Atherectomy and laser treatment are other techniques that involve the insertion of a catheter into a blocked artery to help clear it.

You can make a claim if you require balloon angioplasty, atherectomy, laser treatment and or insertion of stent(s), if the treatment is to correct at least 70% narrowing or blockage of an artery of the legs.

Under this definition, we do not cover peripheral vascular disease treated by any other method.

13. Pituitary Tumour – resulting in permanent symptoms or surgery

Policy Definition

A definite diagnosis of a non-malignant tumour in the pituitary gland by a Consultant Neurologist or Neurosurgeon resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms*; or
- Treatment of the tumour by surgery or stereotactic radiosurgery

*Permanent neurological deficit with persistent clinical symptoms is defined as:

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected

to last throughout the insured person's life.

- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

For the above definition, the following are not covered:

- Where symptoms of pituitary tumour are absent with on-going medical treatment
- Tumours in the brain

In Simpler Terms

The pituitary gland makes hormones that control many other glands in the body. A pituitary tumour is a growth of abnormal cells in the pituitary gland. Most tumours of the pituitary gland are benign and slow-growing, however, they can cause a variety of symptoms including headache, loss of vision, and infertility. Treatment may include surgery, radiation therapy and drug therapy.

We do not cover pituitary tumours where symptoms are controlled by ongoing medication only.

14. Serious Accident Cover - resulting in at least 28 consecutive days in hospital

Policy Definition

A serious accident resulting in severe physical

injury where the Life Insured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

For the purposes of this definition only, a hospital stay also includes treatment in an inpatient rehabilitation centre, if the Life Insured is transferred directly from hospital to the rehabilitation centre for continuous treatment.

Severe physical injury means injury resulting solely and directly from unforeseen, external, violent and visible means and independent of any other causes.

Only one Partial Payment Specified Illness Benefit will be paid for Partial Payment Specified Illnesses resulting from the same accident. Any Accelerated or Standalone Specified Illness Benefit to be paid will be reduced by any Partial Payment Specified Illness Benefit paid where the Accelerated or Standalone Specified Illness results from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days
- Serious accident injury secondary to alcohol or drug misuse

In Simpler Terms

You can make a claim if you have a serious accident and are hospitalised for at least 28 consecutive days to receive medical treatment for your injuries. The 28 consecutive days can include time spent in a rehabilitation centre if you are transferred there directly from the hospital to continue your treatment. You can only make one claim for Partial Payment Specified Illness Benefit resulting from the same accident.

Serious accident injury secondary to alcohol or drug misuse is not covered.

15. Significant Visual Impairment - permanent and irreversible

Policy Definition

Permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/36 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lens.

In Simpler Terms

You can make a claim if you have suffered severe loss of sight in both eyes. The loss of sight must be to the extent that, even when tested with the use of visual aids such as glasses or contact lenses, the sight in your better eye is confirmed by an Consultant Ophthalmologist or Physician and to the satisfaction of our Company's Chief Medical Officer, as 6/36 or worse using the recognised sight test known as the Snellen eye chart. 6/36 is the measure when you can only see an object up to 6 feet away that a person with perfect eyesight could see if it were 36 feet away. This condition must be permanent and irreversible. It is important to realise that this definition is very specific. It may be possible to be "registered blind" but still not be covered by the above definition.

16. Single Lobectomy - the removal of a complete lobe of a lung

Policy Definition

The undergoing of medically essential surgery to remove a complete lobe of a lung for disease or traumatic injury

For the above definition the following are not covered:

- Partial removal of a lobe of the lungs (segmental or wedge resection)
- Any other form of lung surgery

In Simpler Terms

The human lungs are divided into sections called lobes. The left lung has two lobes and the right lung has three. The lobes of the lungs are further divided into segments.

You can make a claim if you have an operation to remove an entire lobe from the lung because of disease or injury. The operation to remove the entire lobe must be deemed medically essential by our Company's Chief Medical Officer.

You will not be able to claim if only a segment of the lobe is removed, or for any other type of lung surgery.

17. Surgical Removal of One Eye

Policy Definition

Surgical removal of a complete eyeball for disease or trauma.

In Simpler Terms

You can make a claim if you have had an entire eyeball removed as a result of disease or injury.

18. Syringomyelia or Syringobulbia – treated by surgery

Policy Definition

A definite diagnosis of Syringomyelia or Syringobulbia by a Consultant Neurologist, which has been surgically treated. This includes surgical insertion of a permanent drainage shunt.

In Simpler Terms

Syringomyelia is a term referring to a disorder in which a cyst or cavity forms within the spinal cord. Syringobulbia is a related disorder of the brainstem. This cyst, called a syrinx, can expand and elongate over time, destroying the spinal cord and/or brain stem. The damage may result in pain, paralysis, weakness and stiffness in the back, shoulders, and extremities. Syringomyelia may also cause a loss of the ability to feel extremes of hot or cold, especially in the hands.

You can make a claim if you have been diagnosed with either of these conditions by a Consultant Neurologist and have undergone surgical treatment for the condition.

19. Third Degree Burns covering at least 5% of the body's surface

Policy Definition

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area.

In Simpler Terms

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You can make a claim if you have suffered third-degree burns covering at least 5% and less than 20% of the surface area of your body.

In Simpler Terms

Ulcerative colitis is a chronic inflammatory bowel disease that affects the large intestine (colon) and the rectum. There is inflammation and ulceration of the innermost lining of the intestine. Common symptoms include diarrhoea, rectal bleeding and abdominal pain. If ulcerative colitis does not respond to medical treatment, surgery may be required.

You can make a claim if you have had a total colectomy (removal on the entire colon) to treat ulcerative colitis.

We do not cover ulcerative colitis if treated by medication only and/or partial removal of the colon.

20. Ulcerative Colitis – treated with total colectomy

Policy Definition

A definite diagnosis by a Consultant Gastroenterologist of ulcerative colitis which is treated by removal of the entire colon (large bowel).

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Partial removal of the colon



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