MultiCare
International Health Plan

Your handbook and membership agreement

January 2024

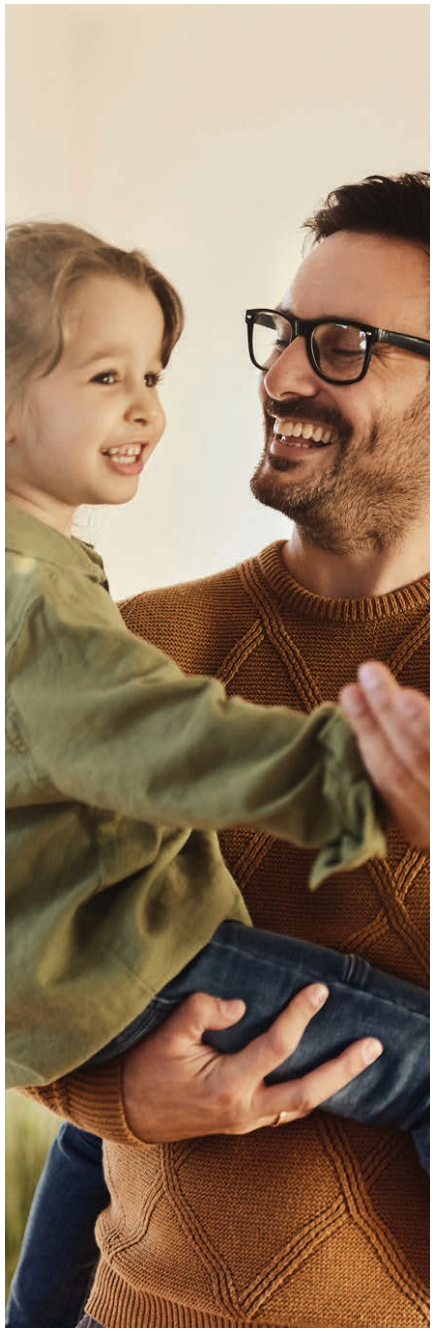
Insured by

UNIVERSAL LIFE

Supported by

AXA

Contents



01 Introduction

This handbook has been produced to set out all the features and benefits of the Universal Life Multicare International Health Plans which have been designed for residents of Cyprus. Universal Life is the insurer and is supported by AXA to provide these plans. Your membership statement will show the name of the plan which applies to you. The membership statement, the benefits table in this handbook relating to your plan and the handbook itself should be read together. This handbook also contains the membership agreement including definitions relevant to your plan. If there is anything you do not understand do not hesitate to call the Customer Support Centre of Universal Life.

Take a few moments to refresh your memory about your MultiCare International Health Plan, then relax and look forward to the highest standards of service from Universal Life. You can rest assured that we'll be there to support you.

Thank you for choosing Universal Life.

Signed for and on behalf of Universal Life Insurance Public Company Limited.

Stelios Sofroniou
Accident & Health Manager

02 Reasonable & customary charges

In your membership agreement we explain that we will not pay charges which are not fair and reasonable or that are higher than those customarily made. It is obviously important that we should only pay fees that are at the level normally charged.

We will only reimburse medical providers where their charges are reasonable and customary in accordance with standard and generally accepted medical procedures in a geographic area based on what providers in the area usually charge for the same or similar medical service. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

You can find out more about reasonable and customary charges on our website https://www.universallife.com.cy/schedule-of-procedures-and-fees1

Cyprus – 'Reasonable and customary' in Cyprus are considered to be the charges for medical treatment which do not exceed the general limit of fees that would be charged by other doctors and/or hospitals of similar specialisations for similar treatments to those concerning the claim. We therefore encourage you before any scheduled hospital treatment is undertaken, to ask for the estimated cost and then inform us accordingly so that we can let you know whether this amount is within the reasonable and customary charges.

UK and International – 'Reasonable and customary' is based on the average of the negotiated costs within our network in the area in which treatment is received. Where no network exists or in respect of independent medical practitioners and other healthcare professionals 'reasonable and customary' is defined as the average cost of the treatment for that country or region according to our records.

If you have U.S.A. (United States of America) cover – Before any treatment in the U.S.A., you must contact us for pre-authorisation of such treatment and services. Our adviser will confirm the member's entitlement to the benefit for the proposed treatment, help find a suitable medical network provider and arrange direct billing with them.

If you choose to have your treatment in the U.S.A. without our pre-authorisation, the eligible benefit may not be paid beyond 50% of reasonable and customary costs after deductible excess.

In the case of serious accident requiring immediate emergency in-patient treatment, you or your family member must contact us within 72 (seventy-two) hours of such accident. The benefit for eligible treatment is paid at reasonable and customary costs.

03 Making a claim

In patient or daycare treatment in Cyprus

If you have treatment at a provider in Cyprus, we can pay directly on your behalf, subject to the terms of your plan and providing that treatment has been pre-authorised by Universal Life. Please tell the provider that you are a MultiCare International Health Plan member when you are admitted. They will tell you if they can invoice us for your treatment directly or if they will invoice you. **You must contact us at least 10 days before admission.** Failure to inform us within this timeframe of any day-care or in-patient treatment may mean we are unable to make any direct settlement arrangements on your behalf. We will then advise you of whether direct settlement is possible, how much we will cover and for how long we will be able to pay for treatment.

It is your responsibility to ensure that pre-approval has been received before undergoing planned treatment.

Please note: We will not make or confirm direct settlement arrangements for treatment which is not eligible under your plan. We reserve the right to delay any such confirmation until we have established the eligibility of the condition that needs treatment.

In patient or daycare treatment within AXA Global Healthcare's network

If you have treatment at a provider listed in AXA Global Healthcare's network, we will pay directly on your behalf, subject to the terms of your plan and providing that treatment has been pre-authorised by Universal Life. **You must contact us at least 10 days before admission**. Failure to advise us within this timeframe of any day-care or in-patient treatment may mean we are unable to make any direct settlement arrangements on your behalf.

We will advise you of whether direct settlement is possible, how much we will cover and for how long we will be able to pay for treatment.

It is your responsibility to ensure that pre-approval has been received before undergoing planned treatment.

Please note: We will not make or confirm direct settlement arrangements for treatment which is not eligible under your plan. We reserve the right to delay any such confirmation until we have established the eligibility of the condition that needs treatment.

There are some hospitals that we won't pay for treatment. This is because they don't meet AXA Global Healthcare's billing criteria, or because we do not recognise them. You should check if we will pay the facility or hospital before you have your treatment. You can call us to check if we will pay a particular provider. We won't reimburse you for treatment you pay for yourself with one of these providers.

Further information can be found at ***https://select.axaglobalhealthcare.com/s/?expId=AXA_uni_03***

If you have treatment that you are covered for at a provider that is not in the AXA Global Healthcare network, we may still be able to pay reasonable & customary expenses directly.

Direct payment arrangements for diagnostic tests, procedures and treatment

The following diagnostic tests, procedures and treatment must be pre-approved by us whether taken on an in-patient, daycare or out-patient basis:

- MRI scans
- CT scans
- PET scans
- Gastroscopy
- Colonoscopy
- Physiotherapy

Emergency treatment

If the treatment is given as an emergency then you may not be able to contact us beforehand. Do however, ask somebody to contact us as soon as possible and make sure that, when you are admitted to hospital, the hospital is given your membership details and proof of identity so that they can contact us straight away.

Paying claims for out-patient treatment

If you have out-patient treatment, most providers will ask you to pay for your treatment and then make your claim to us. In this case, you will need to complete a claim form and return this to us along with a legally issued itemised invoice and receipt of payment.

We will make payment to you for the cost of any eligible treatment. If your treatment or part of it is deemed ineligible, we will not reimburse those costs.

The information required when you make a claim

When you want to make a claim let us know and we will send you a claim form, or you can download this from https://www.universallife.com.cy/useful_forms You must make sure the claim form is fully completed and signed by the attending physician and the Patient's declaration and consent (section 4) fully completed and signed by yourselves. If you fail to do so, we have the right not to process the claim until we receive your declaration and consent.

U connect - your easiest way to claim

You can also upload your claim documents through https://uconnect.unilife.com.cy/en/login. U connect is a web tool where our clients can create an account and upload their claims electronically anywhere at any time.

Please note: We only consider claims made within 90 days of treatment being received.

If we need more detailed information, we may request it in the following ways:

- We may need your medical practitioner to send us more details about your medical condition. Your medical practitioner may charge you for providing this information. This charge is not covered under your policy.
- We may have to ask a medical practitioner to advise us on the medical facts or examine you. In these cases, we will pay for the medical practitioner.

If you do not give us information we ask for, we may not be able to assess your claim and so may not be able to pay it.

Please note: We do not accept invoices from medical services agencies.

04 Second Medical Opinion

Upon being diagnosed as suffering from any medical condition, you may request a second medical opinion. We will then arrange for you to receive a second medical opinion from independent health consultants. The second medical opinion is for a reassessment of and to confirm your initial diagnosis and the treatment plan proposed. Please note that the second medical opinion is provided by a third party provider outside of Universal Life.

Universal Life is not responsible and/or liable for any claim, loss, damage directly or indirectly resulting from your use of this service. This service may be subject to geographical restrictions. Please call **+357 2222 0000** for more information.

05 International Emergency Medical Assistance

In addition to the private healthcare aspect of your plan, you may, depending on the benefits included, have access to Emergency Medical Assistance. This is a worldwide, 24 hours a day, 365 days a year emergency service providing medically necessary evacuation or repatriation services. If you need immediate in-patient treatment, where local facilities are unavailable or inadequate, a phone call to the International Assistance Company on **+44 1892 502 791** will alert the International Emergency Assistance service.

Please note that, for your own protection, calls may be recorded in case of subsequent query.

Entitlement to the evacuation service does not mean that your treatment following evacuation or repatriation will be eligible for benefit. Any such treatment will be subject to the terms of your plan.

We will cover the costs of emergency evacuation if:

- you are, or need to be, admitted as an emergency in-patient, and
- our appointed doctor and the treating doctor believe your current or nearest medical facilities are not able to provide the treatment you need.

We will cover the costs of repatriating you if we have agreed to cover your emergency evacuation. We will not cover the cost of evacuating or repatriating if you deside to travel elsewhere for treatment and we believe the nearest medical facilities are adequate for your treatment. This includes if you decide you want to travel back to the principal country of residence for your treatment.

How emergency evacuation and repatriation cover works

If you are admitted as an emergency in-patient and you or the treating doctor believe that the local medical facilities are not adequate to treat you, ask somebody to call our emergency number.

We will appoint a doctor who will be able to assess the medical facilities and the evacuation or repatriation service detailed at the beginning of this section will apply.

What costs we will cover

If the doctor we appoint decides that the medical facilities are not adequate to treat you, we will cover the reasonable costs of either:

- evacuating you to a suitable medical facility for treatment in the country you are in; or
- evacuating you to a suitable medical facility in a different country for treatment.

When you are discharged from the medical facility you were evacuated to, we will cover the costs of repatriating you to one of the following:

- the place where you normally live or your country of residence.
- a country that you hold a passport for.

We will cover these costs so long as we have agreed the method of transport to be used, and date and time of your evacuation or repatriation before it takes place.

We will also cover the cost of any necessary treatment given to you by our chosen evacuation agency while they are moving you.

Repatriation following death

If you die outside a country that you hold a passport for, we will cover the cost of transporting your body back to a port or airport in:

- your country of residence, or
- a country you hold a passport for.

The relevant exclusions for emergency evacuation and repatriation also apply to repatriation following death.

Will other members of your family or friends be able to travel with you?

If the member who needs to be evacuated or repatriated is under 18, we will cover the additional reasonable and necessary transport and accommodation costs for someone, aged 18 or over, to accompany them on their journey. If the member who needs to be evacuated or repatriated is over 18, we may agree to cover these costs if we believe it is medically appropriate.

Once our member reaches their evacuation destination, we will not cover the accompanying person's further costs.

What cover do I have if a family member is evacuated or repatriated?

Your cover depends on whether they are evacuated or repatriated either from the location where you both normally live or whether you are travelling together at the time.

If you are travelling away from home with a family member who is covered by a Universal Life policy and they are evacuated or repatriated, we will pay for your additional reasonable and necessary transport and accommodation costs that result from the evacuation or repatriation. We will do this if it is medically appropriate for you to travel with the family member.

If you are both at the location where you normally live and they have to be evacuated or repatriated from that location, we will pay for your additional reasonable and necessary transport costs that result from the evacuation or repatriation. We will do this if it is medically appropriate for you to travel with the family member. We will not cover your accommodation costs.

What will happen to my travel ticket?

Any unused portion of the travel tickets belonging to you or anyone that we evacuate with you will immediately become our property.You must give the tickets to us within 90 days.

Can I choose to travel to a particular country for treatment?

You can choose to go to a particular country for treatment, but we will not cover the cost of travelling to that country. Once you are in that country, the terms of your policy apply as normal.

Exclusions that apply to your cover for emergency evacuation and repatriation

You are not covered for emergency evacuation or repatriation if any of the following apply:

- the medical condition does not need immediate emergency in-patient treatment.
- the medical condition does not prevent you from travelling or working.
- the medical condition is directly or indirectly caused by a deliberately self-inflicted injury, suicide or an attempt at suicide.
- the medical condition is in any way connected with alcohol abuse, drug abuse or substance abuse.
- the medical condition is a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you only receive travel costs).
- the medical condition is a result of base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.
- the evacuation would involve moving you from a ship, oil-rig platform or similar off-shore location.
- we have not approved the evacuation or repatriation first.

- we have not been told about the medical condition within 30 days of the condition becoming an emergency (unless this was not reasonably possible).

- the medical condition is a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed.

- the emergency occurs when you are on a leisure trip to a destination to which the local relevant authority for foreign travel either advises against all travel, or advises against all travel on holiday or non-essential business.

Limits on our liability under your cover for emergency evacuation and repatriation

We will not be liable for:

- any failure or delay in providing emergency evacuation or repatriation.

- injury or death while you are being moved.

These limits do not apply if the failure or delay is caused by our negligence or the negligence of someone we have appointed to act for us.

06 Our position on pre-existing medical conditions

As you would expect private healthcare insurance is designed primarily to provide cover for new medical problems arising after joining. However certain conditions, which are unlikely to recur, may be covered.

If you have completed a medical history declaration your membership statement will indicate the specific medical conditions for which you are not covered.

Please contact our Customer Support Team in the first instance regarding any questions you may have on an existing medical condition.

07 Our position on routine treatment

As you would expect private healthcare insurance is designed to pay for treatment of unforeseen medical conditions arising after the inception of your plan. Routine care, while it is to be encouraged, cannot be paid for by the main benefits of your insurance policy as this is designed to cover the diagnosis and/or cure of an unforeseen condition. Therefore, eye tests, unless you have purchased the optional upgrade pack for Premiere Comprehensive plan, genetic testing, ECGs, blood tests, bone-density scanning, smear tests, mammograms and other such tests which may be carried out on a routine basis, as part of a screening programme or because a certain age has been reached, are not covered under your policy and no payment can be made. This includes any blood tests or other routine tests carried out to monitor a medical condition, including chronic conditions.

However, as your healthcare provider we wish to encourage you to be aware of your own health and wellbeing. Therefore plans Premiere, Value Plus and SmartStart include cover for an adult and children's screening, which will be available every membership/policy year.

08 Our position on preventative treatment

Health insurance is designed to cover problems that you are experiencing at the moment, so it generally doesn't cover preventative treatment, genetic tests or screening tests.
We do not pay for:

- preventative treatment, such as, but not limited to preventative mastectomy and hysterectomy; or

- routine preventative examinations and check-ups; or

- tests to check whether:
  - you have a medical condition when you have no symptoms; or
  - you have a risk of developing a medical condition in the future; or
  - there is a risk of you passing on a medical condition; or

- tests where the result of the test wouldn't change the course of the treatment that would be covered by your policy. This might be because the course of treatment for your symptoms will be the same regardless of what medical condition caused them; or

- preventative treatment or screening tests that are not conventional treatment or where they are used to direct treatment that is not established as being effective or is unproven; or

- any other preventative treatment to see whether you have a medical condition if you do not have any symptoms.

What is covered for genetic tests
We will pay for genetic testing when it is proven to help choose the best eligible treatment for your medical condition.
This means that it must be recommended in the drug license for a specific targeted therapy, such as HER2 testing for the use of Herceptin for breast cancer.

Please call us before you have any genetic tests to confirm that we will cover them. Your medical practitioner may want to do a variety of tests and they might not all be covered. The cost to you could be significant if the tests aren't covered under your plan.

09 Our position on continuing illness

In the membership agreement we explain that we do not pay benefit for medical conditions which are likely to continue or keep recurring; we pay only for the initial programme of diagnosis and treatment intended to improve or stabilise such conditions. We pay for illnesses that respond quickly to treatment in the short-term. Longterm control of illness is outside the scope of our agreement with you.
Where ongoing conditions are concerned we do, of course, try to be as helpful as we can. However, we have to bear in mind that what we charge our members has to cover the cost of claims and we cannot, if we are to treat our members equably, go on paying benefit for conditions which are likely to continue indefinitely or keep coming back. We therefore stop paying benefit as soon as it becomes apparent that the medical condition or episode of ill health is long-term or recurrent in nature.

Because of this we do not pay for routine follow-up consultations for the monitoring of medical conditions such as but not limited to diabetes mellitus, multiple sclerosis, thyroid disease or hypertension. However if such a condition should flare up and you require admission to hospital for treatment to bring it under control then benefit will be paid for the short period necessary to re-stabilise the condition.

Please note: Due to the nature of cancer, we cover it differently to other ongoing conditions. Please refer to the section 11 'Our position on cancer also see oncology treatment benefit 10.

In general terms, therefore, we pay only for diagnosis and treatment of conditions that respond quickly. We therefore stop paying benefit as soon as it becomes apparent that a medical condition is chronic in nature. In such a case, terms related to the condition and those

associated with it may be added to your policy immediately.

We reserve the right to determine when a condition has become chronic in nature. We will base that decision on a review of medical reports related to that condition.

10 Our position on unnecessary treatment

Like most health insurance, we only cover treatment that is medically necessary. We do not cover treatment that is not medically necessary, or that can be considered a personal choice.

11 Our position on cancer

Due to the nature of cancer, we cover it a little differently to other conditions. This section explains the differences. We will cover investigations and treatment of cancer.

We will cover active treatment of cancer for any new cancer that starts after you join. We will also cover that cancer if it comes back and you are still a member.

If you have exclusions to do with cancer because of your past medical history, we will not cover your treatment if this cancer comes back.

Remember that you have access to a Second Medical Opinion as part of your cover.

12 Our position on advanced therapies

There are a complex set of advanced therapies, including gene therapies and CAR-T treatment for cancer. They are known by different names across the world, for example Advanced therapy medicinal products (ATMPs), Cellular and gene therapy products (CGTPs) or Regenerative medicine advanced therapy (RMAT). We only cover a small number of ATMPs/CGTPs/RMATs under your policy, these are shown in the below table.

Therapy name	Where licensed and used within the terms of that license and in operation on 01 April 2023, we cover for:
Yescarta	Diffuse large B-cell lymphoma (DLBLC) and primary mediastinal large B-cell lymphoma (PMBCL) in adults
Kymriah	B-cell acute lymphoblastic leukaemia (ALL) in children and young adults and diffuse large B-cell lymphoma (DLBLC) in adults
Tecartus	Mantle cell lymphoma (MCL) in adults
Abecma	Multiple myeloma in adults
Imlygic	Malignant melanoma (a skin cancer) in adults
Alofisel	Complex perianal fistula problems in Crohn's disease in adults
Holocar	Limbal stem cell deficiency in adults following physical or chemical burns of the eye

By licensed, we mean granted marketing authorisation by the Medicines & Healthcare Products Regulatory Agency (MHRA) if the treatment is to be provided in the United Kingdom, the European Medicines Agency (EMA) if you are receiving treatment in Europe but outside of the United Kingdom or the Food and Drug Administration (FDA) if you are receiving treatment anywhere else in the world.

You must call us before you start your treatment to make sure its covered. We don't cover any ATMPs/CGTPs/RMATs that aren't on the list at the time you need the treatment, including any associated hospital or specialist costs. The list is subject to change so you should always check and call us before you start any treatment.

Your cancer cover

Place of Treatment	
Active treatment of cancer at a hospital	✓ Yes
Chemotherapy by intravenous drip at home	✓ Yes, when agreed by our clinical team, paid in full for up to 30 days per policy/ membership year.
Treatment at a hospice	X No
Diagnostic	
Fees for the medical practitioner treating your cancer	✓ Yes If the consultations are before your diagnosis they are covered as part of your overall out-patient limit. Consultations after your diagnosis are covered as part of your overall day-patient and in-patient limit.
Diagnostic tests relating to cancer	✓ Yes If the tests are before your diagnosis they are covered as part of your overall out-patient limit. Tests after your diagnosis are covered as part of your overall day-patient and in-patient limit.
Surgery as shown below under “Surgery”	✓ Yes
CT, MRI and PET scans	✓ Yes
Genetic testing proven to help choose the appropriate elitgible treatment.	✓ Yes
Genetic testing to work out whether you have a genetic risk of developing cancer	X No
Surgery	
Surgery for the treatment or diagnosis of cancer, so long as that treatment has been shown to be effective	✓ Yes
Experimental surgical procedures	Please contact us before having any new or experimental surgical procedures so that we can discuss the proposed procedure with you. We will write to tell you what we agree to pay for before your treatment starts. We will only pay up to the equivalent non-experimental surgical procedure as listed in the schedule of procedures and fees. To get a copy of the schedule, go to https://www.universallife.com.cy/schedule-of-procedures-and-fees1, or call our customer service team on: **+357 22 22 00 00**.
Complications that arise from new or experimental surgical procedure	X No - even if we agreed to cover the procedure itself

Preventative	
Preventative treatment, such as: Screening when you do not have symptoms of cancer. For example, if you had a screen that showed you have a genetic risk of breast cancer, we would not cover the screening or any treatment to reduce the chances of developing breast cancer in future (such as mastectomy).	X No
Vaccines to prevent cancer developing or coming back – such as vaccinations to prevent cervical cancer	✓ Yes Vaccines are covered as part and up to the limit of your health screening benefit if provided by your plan.
Drug therapy	
Drug treatment to kill cancer cells – including: • Biological therapies, such as Herceptin or Avastin • Chemotherapy	✓ Yes We will cover them if: • They have been licensed by the Medicines & Healthcare Products Regulatory Agency (MHRA) if the treatment is to be provided in the United Kingdom, the European Medicines Agency (EMA) if you are receiving treatment in Europe but outside of the United Kingdom or the Food and Drug Administration (FDA) if you are receiving treatment anywhere else in the world. • They are used according to their license. • They have been shown to be effective. The drugs we cover will change from time to time to reflect any changes in drug licenses. Please call us to find out the latest treatments that we cover.
Chemotherapy and/or biological drug treatment to prevent a recurrence of cancer or to maintain remission	✓ Yes
Experimental drugs	X No However if you take part in a randomised clinical trial that the appropriate ethics committee has approved, we will pay for your stay in hospital and specialist’s fees while you are receiving th experimental drug. You need to call us before treatment so we can agree costs and cover in writing. There may be information we need you to provide before we can agree costs. For example we will need you to provide us with a copy of your trial acceptance forms.

Drug therapy *continued*	
Other drugs. We cover: • Bone strengthening drugs such as bisphosphonates or Denosumab • Hormone therapy that is given by injection (for example goserelin, also known as Zoladex)	✓ Yes They are covered as long as you have them at the same time as you are having chemotherapy or biological therapy to kill cancer cells covered by your policy.
Drugs for treating conditions secondary to cancer, such as erythropoietin (EPO)	✓ Yes While you are having chemotherapy that is covered by your policy.
Out-patient drugs or other drugs that a medical practitioner could prescribe	✓ Yes Covered as part of your overall out-patient drugs and dressings cover.
Radiotherapy	
Radiotherapy including when it is used to relieve pain	✓ Yes
Proton beam therapy (PBT)	
A type of radiation therapy which uses protons rather than x-rays to treat cancer.	✓ Yes We will pay PBT for: • malignant solid cancers in members aged 21 and under • central nervous system (brain and spinal cord) cancer • chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • high naso-ethmoid, frontal and sphenoid tumours with base of skuill involvement • adenoid cystic carcinoma with perineural invasion • esthesioneuriblastoma • cancer of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) • conjunctival melanoma • choroidal haemangioma
Accelerated charged particle therapies	
A therapy where charged particles are targeted into the tumor tissue at an increased speed.	X No However, there is limited cover for Proton Beam Therapy in the circumstances shown above.
Advanced Therapy Medicinal Products (ATMPs), Cellular and Gene Therapy Products (CGTPs) and Regenerative Medicine Advanced Therapy (RMAPs)	
Advanced Therapy Medicinal Products (ATMPs), Cellular and Gene Therapy Products (CGTPs) and Regenerative Medicine Advanced Therapy (RMAPs)	Yes We cover a small number of approved ATMPs/CGTPs/RMATs. For the current list of ATMPs/CGTPs/RMATs that we cover, please see section 12.

Palliative	
Care to relieve pain or symptoms rather than cure the cancer.	✓ Yes We will provide cover and support throughout your cancer treatment even if it becomes incurable. We cover radiotherapy, chemotherapy and surgery (such as draining fluid or inserting a stent) to relieve pain.
End of life care	
End of life care	✓ Yes We will cover treatment to relieve symptoms during the end stages of life.
Monitoring	
Follow ups Cover for follow up consultations and reviews for cancer	✓ Yes As long as you are still a member and have a policy that covers this. This is paid from your cover for out-patient treatment.
Limits	
Time limits on cancer treatment. Your policy covers you while you are having treatment to kill cancer cells and for monitoring	There is a limit of 180 days per in-patient admission on this policy.
Other cover	
Stem cell or bone marrow treatment If you plan to donate tissue as a live donor or receive tissue from a live donor, please call us so we can tell you what support we offer. We do not cover any related administration costs. For example, we will not cover transport costs or the cost of finding a donor.	✓ Yes

13 Our position on Learning and Developmental disorders

We cover eligible treatment, investigations, assessment or grading, excluding occupational therapy, to do with:

- Learning disorders
- Educational problems
- Behavioural problems
- Physical development
- Psychological development
- Speech delay

Cover is limited for any one of the above disorders/problems once in a child's lifetime and up to three months following diagnosis as long as the child is below the age of 14 years old.

14 Our position on physiotherapy

All physiotherapy must follow referral by a medical practitioner. Additionally physiotherapy is limited to a maximum of 6 sessions. We will consider a further 6 sessions with the submission of an updated doctor's prescription. If further physiotherapy is needed we will need an updated medical report from the attending medical practitioner.

15 Your additional services

My Digital Doctor

Most patients google their symptoms, visit hospital emergency departments, or schedule a clinic appointment when they are not feeling well. Data reports show that 70% of the time, these kinds of choices are the wrong ones, whether they be clinically unsafe, unstructured, unnecessarily expensive, or inconvenient.

As a member, you will have access to My Digital Doctor, our online AI-based virtual medical assistant to evaluate your symptoms, receive recommendations on what to do next and a pre-diagnosis in less than 3 minutes.

My Digital Doctor is available through our customer service portal U connect.
Easy to use in any browser, My Digital Doctor is the tool for the modern patient.

Specialized Call Center for prompt customer service

As a member you have access to a Specialized Call Center for a more efficient and prompt support.

Through the Call Center, you can:
Receive information about the Preferred Providers' Network of Universal Life, arrange appointments with private doctors of your choice who are part of the Preferred Providers' Network and learn about Hospitals, Doctors and Referral Procedures to Emergency Units. You can contact the new Call Center at **+357 22 41 95 55.** Working hours: Monday-Friday 8:00am - 21:00pm.

During after hours, weekends and holidays, only calls for emergency cases and referrals to Emergency Units will be answered.

The Call Center provides support on appointments and inquiries related to the Preferred Providers' Network; It's not related to issues that concern benefits and features of the MultiCare Health policies. The Call Center provides support related to the Preferred Providers Network in Cyprus.

Case Management

Our Case Managers offer a friendly and professional service to assist members going through treatment. The Case Managers have the knowledge and skills to provide emotional support and administrative assistance from diagnosis through to the end of treatment.

If you are diagnosed with a complex medical condition and need to make a claim, we'll assign you with your own Case Manager. The Case Manager will work with your treating specialist to manage your claim and be a dedicated point of contact throughout treatment. The Case Manager can help you find a local treatment facility, pre-approve treatments, and sort paperwork and invoices, leaving you with one less thing to think about.

The Case Managers offer truly personalised support, so you will feel reassured that there's a trusted professional supporting you and your claim throughout your treatment journey.

Expert health information

As a member you will have access to an expert health information helpline by calling **+44 (0) 1892 556 753.**

We want to support you whenever you need to talk to a medical expert – not just when you need to claim.

Get the latest information on vaccinations or health precautions before travelling, check on symptoms that are worrying you, understand the facts on a health condition or simply call for support and reassurance.

Nurses, midwives, pharmacists and counsellors are standing by, ready to talk to you. Midwives and pharmacists are available Monday to Friday from 08:00 to 20:00 GMT; Saturday and UK public holidays from 08:00 to 16:00 GMT; and Sunday 08:00 to 12:00 GMT

This service is completely confidential and completely separate from our claims service. You can choose to remain anonymous with no record of your call. Or you can ask to make a note of your call in case you want to call again.

The team can't diagnose medical conditions or prescribe medicine, but they can give the latest information about specific illnesses and conditions, treatments and medicine, as well as provide guidance and support.

16 Managing your policy

Adding a family member

You can apply to add the following family members to your policy:

- Your partner in marriage, a civil partnership, or when living together permanently in a similar relationship.
- Any of your children or your partner's children.
- A new baby.

Adding a new born baby

You can add new born babies who are born to you after you have joined, from their date of birth. We will require you to complete a new application form for each new born baby to be added to your policy. Provided this is done within 90 days of the birth, we will not normally require their medical history and cover will commence from the date of birth. In all other cases a full medical history will be required. We will tell you in writing the date the cover starts and any special terms which apply to it.

We do not however allow this concession if any of the following apply:

- either parent has had any kind of fertility treatment and the babies are a multiple birth; or
- the babies are a multiple birth and were born after assisted reproduction; or
- you have adopted the baby.

We explain these limits in the following paragraphs.

Babies born after fertility treatment, or following assisted reproduction, or who you have adopted

You can add a baby born after fertility treatment, or following assisted reproduction (such as IVF), or who you've adopted, to your policy. As with most health insurance, our cover for treatment has a few limits in these situations.

If you have adopted a baby, or if you have a multiple birth after fertility treatment or following assisted reproduction:

- we may ask for more details of the baby's medical history.

- we will not cover treatment in a Special Care Baby Unit or paediatric intensive care immediately after the birth.

- we may add other conditions to the baby's cover. For example, we may limit their cover for pre-existing conditions.

We count fertility treatment as either parent taking any prescription or nonprescription drug or other treatment to increase fertility.

Transferring to another plan

You may apply to change your plan at your policy anniversary. We reserve the right to apply medical underwriting exclusions to the new plan you have chosen based upon your medical history at the time of change. We reserve the right to refuse to change your plan.

Transferring from a group

If you are leaving a group policy and wish to transfer to an individual policy we may offer two options;

i) you may request us to exclude all medical conditions existing or known about at the time of transfer. In this event you will pay the published premium for your age and plan.

ii) you may request us to continue your cover which may include conditions developed whilst on your group policy. In this event, we may offer a higher premium than that published. The loading thus applied, which is a percentage of the published premium for your age and plan, will apply throughout the life of your policy. We reserve the right to refuse such a request.

Paying your premium

You can pay your premium in any of the following ways:

- Yearly or monthly by Direct Debit.

- Yearly by cheque/banker's draft.

It is important that you pay your premium when it is due. If you miss a payment, we will cancel your policy and we will not pay any claim for treatment that you had after the payment was due.

If you have stopped paying for your policy, or you have missed or think you will miss a payment, please call us on **+357 22 220 000**. We will talk to you about your payment options or alternative cover options.

Changing your frequency of payment

If you wish to change the way you pay for your policy please contact us. Such changes can only be effected at your policy anniversary.

Changing the terms of your policy

We have the right to change all or any part of your policy from any renewal date. However we will make changes only to reflect any past or foreseeable changes in medical practice and procedures and the nature and extent of claims made or likely to be made generally under the plan. The purpose of such changes will be to seek, so far as possible, to maintain substantially the same level and type of cover in place while ensuring that the plan remains affordable. We may also increase the premium if costs, taxation or regulations require us to do so. In the case of changes in taxation or legislation, we may increase premiums or make other changes with immediate effect if required by law, to do so.

We will tell you about any changes with a minimum of 10 days notice.

If you do not agree with such changes, you have the right to terminate your policy. Please contact us in this instance.

Changing your principal country of residence

If you move away from your country of residence and would still like to be covered, please give the Universal Life Customer Support Team a call on **+357 22 220 000**. They will advise you of the options available to you.

Cancelling your policy during the cooling off period

You have the right to cancel up to 30 days from the day that your policy has been issued or the day that you receive the full policy terms and conditions, whichever comes later. This is known as the cooling off period. If you cancel during this period, you will not have to pay anything, as long as you have not made a claim within that period.

If we pay for treatment during the cooling off period, and the member cancels the policy, we will deduct the claim amount paid for the treatment from the premium to be returned, and you shall have an obligation to return to us any claim amount in excess of the premiums paid. If you do not cancel your policy within the cooling-off period your policy will continue for a year as long as you continue paying your premiums.

Changes of your personal details

If any of your personal details change, It's important that you let us know as soon as possible. If you are unsure whether the change is important, it's best to tell us and we can explain if it affects your policy.

You must tell us if there's a change to your country of residence.

We are not able to provide insurance for anyone residing in any country other than Cyprus (except students studying abroad).

If you are a student studying abroad, we are not able to provide insurance in some countries, so it's your responsibility to check that your cover is still valid if you move.

There are some countries where we will not be able to renew your policy at the end of the policy year. If you move to one of these countries, you will only have cover under your policy until your renewal date. We will write to you to let you know when your cover will end.

Why premiums change

There are a number of reasons why the cost of your healthcare insurance could increase from time to time. We review premiums each year and make calculations based on a number of factors. Two of the most common reasons are because:

- Your premium will tend to rise as you get older. This is because, unfortunately, as we get older we all tend to suffer more health issues.

- The cost of medical treatment tends to rise too, as new and better ways of diagnosing and treating diseases are developed. We regularly review our plans to keep them up to date and to include new tests and treatments where we can.

Your premium will only change at renewal or if something changes, such as adding a new baby, during the year. We will tell you about any changes to your premium with a minimum of 10 days notice.

Complaints procedure

Our full Complaints Management Policy and Procedure is available and regularly updated on our website https://www.universallife.com.cy/complaints_management

The policyholder or member must follow this process, step by step, to ensure that any concerns are dealt with as swiftly as possible and to protect the member's rights.

We strongly recommend that you make any formal complaint in writing to protect your interests.This will support our objective of ensuring any complaints received are dealt with fairly, promptly, efficiently and in confidence.

With the best will in the world, concerns about some aspects of our service can occasionally arise. Our staff has wide authority to deal with and settle issues immediately where possible. We will do everything we can to help.

Your first point of contact should be your Insurance Intermediary or our Customer Support team.

If you find it necessary to pursue the matter further, please proceed with a formal written complaint to:

Complaints Management Officer
Universal Life
P.O Box 21270
1505 Nicosia
Cyprus
email: complaints@unilife.com.cy

who will investigate the matter independently.

For a quicker review of your complaint, we encourage you to submit any supporting documentation along with your complaint.

We will send you an acknowledgment of receipt of your complaint within 2 business days from the date of receipt.

Your complaint will be evaluated, and a reply provided to you within 15 business days from the date we have received this. Should we require further time to prepare our reply, we will inform you accordingly, and any additional time required shall not exceed a total of 45 business days from the date of receipt of the complaint.

Having received a reply from the Complaints Management Officer, if you are still not happy with the way in which a complaint has been handled, you may then write to:

General Manager/Chief Operating Officer
Universal Life
P.O. Box 21270
1505, Nicosia
Cyprus

If you remain dissatisfied, you may then, without prejudice to your right to take legal action against us, refer your complaint to the Financial Ombudsman at the below details:

Financial Ombudsman
www.financialombudsman.gov.cy
Contact Number: 22848900
Address: Kyrpanoros 15, 1061 Nicosia
P.O.Box 26722,1647 Nicosia

Notes:
Further information about our complaints process can be found at

None of the above affects your right to take legal action against us for any grievance you may have with regard to this Policy.

Please remember to quote your membership number on all correspondence.

17 Our service to you

Courtesy
Your requirements will always be dealt with promptly, considerately and courteously. No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance
Our insurance intermediaries and staff will help you, if you have any doubts, to understand the terms of your contract and any other factors which affect your cover. They will help you to make proper use of your cover should you need to make a claim.

Confidential handling of your personal details and affairs
Any medical details we require will usually be requested via yourself and will be kept confidential. We will adhere, at all times, to our obligations under the relevant law.

Advance notification of change in cover
Essential changes to the terms of the cover (including benefits, premiums and your membership agreement) will be notified to you, in writing, in advance of the date from which the changes take effect, usually your annual renewal.

We will tell you about any changes with a minimum of 10 days notice.
If you do not agree with such changes, you have the right to terminate your policy. Please contact us in this instance.

Professional and efficient service
All requests for assistance and any claims you submit will be considered impartially (without any bias or preference) in accordance with the benefits and membership agreement of your plan.

18 How we manage your personal data

Protecting your information
Universal Life Insurance Public Company Limited and any party that has a contractual agreement with Universal Life Insurance Public Company Limited will deal with all personal information you supply in the strictest confidence. We will comply with all the provisions of the European Union Regulation 2016/679 on the protection of natural persons with regards to the processing of Personal Data, General Data Protection Regulation.

How we will use your information
We will process information about you that may be supplied by you, the family members who are covered and healthcare providers.

We may contact healthcare providers for further information, for example to clarify an invoice, discuss an extension to a stay in hospital, or to get copy of medical records. If we need your consent to do this, we will get it from you first.

Your data will be used to:

- provide the services set out under the terms of this policy.
- administer your policy.
- develop customer relationships and services.
- comply with any legal obligations we may have.

Information about family members

When you give us information about family members, we will take this as confirmation that you have their consent to do so. We will send most correspondence about the policy, including claims correspondence to the policyholder. We do this because the policyholder is the legal holder of the insurance policy.If any family member over 18 does not want us to do this, they should apply for their own policy.

Your data and fraudulent claims and other crimes

If we, or others, suspect that fraudulent claims have been made or other crimes have been committed, we are legally required to disclose information to the relevant law enforcement agencies.

Recording of telephone calls

We may record telephone calls for training, security and quality control purposes.

Contacting you about other products and services

Provided that you have given us your explicit consent, we may contact you to tell you about other products and services such as special offers and healthcare information. These contacts may be by letter, phone, email or mobile message.

You can tell us that you don't wish to receive this information at any time.

Your Data Protection Rights

You have the right at any time, to request access to your data, and to ask us to correct, erase or restrict the processing (under certain circumstances) of your personal data. You may also object to the use of your personal information and ask us to electronically transfer information you have made available to us (the right of portability). In addition, you have the right to withdraw your consent for the processing of your personal data, although should you choose to withdraw your consent for the processing of data concerning your health, we note that this will impact our ability to administer the Policy and evaluate your claims.
To exercise any of these rights please contact us in writing at the email address: **personaldata@unilife.com.cy**.
You also have the right to submit a complaint about the use of your personal information by us to our Data Protection Officer at the above email address and/or to the Office of the Commissioner for Personal Data Protection.

Our Privacy Notice

Further information as to how we use your data, how we collect and share such information, and for how long we retain your data, can be found in our full Privacy Notice available at https://www.universallife.com.cy/complaints_management

19 Benefits table

Some words and phrases have special meanings. When we use these terms they are in bold print and they are defined under the definitions section of this handbook.

What You're Covered For – MultiCare International Health Plan

Please refer to the column showing the benefits table applicable to your plan. Your latest membership statement will show which plan is applicable to you and give other details which are relevant to you.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
Areas of cover		**Area 1** or **Area 2**	**Area 1** or **Area 2**	**Area 1** or **Area 2**	**Area 1** or **Area 2**
Level of cover	Benefits applicable to **your plan**. Standard benefits are highlighted.	Standard: Benefits 1-19, 27 & 32 Comprehensive: Benefits 1-32	Standard: Benefits 1-19, 27 & 32 Comprehensive: Benefits 1-32 (excluding 29 & 30)	Comprehensive: Benefits 1-22, 27 & 32 (excluding 5, 8, 11, 12, 13, 15, 16, 18, 19, 23 - 26, 28 - 31)	Standard: Benefits 1-23, 27 & 32 (excluding 5, 11, 12, 13, 15, 16, 18 & 19) Comprehensive: Benefits 1-32 (excluding 5, 11, 12, 13, 15, 16, 18, 19, 24 - 26, 28 - 31)
Yearly maximum	**We** will pay up to the maximum shown each **year** foreach **member**.	€3,000,000	€500,000	€100,000	€100,000
Annual **excess** payable	The **excess** payable for each **member** each **year.**	No **excess** or optional: €1,000 / €2,500 / €5,000	€85 each **year** or optional*: €1,000 / €2,500 / €5,000 *Optional **excess**: €1,000 (total mandatory + optional = €1,085) €2,500 (total mandatory + optional = €2,585) €5,000 (total mandatory + optional = €5,085)	No **excess**	Option 1: No **excess** Option 2: €85 each **year** Option 3: €170 each **year**
In-patient and daycare treatment					
1 **Hospital** charges	a) Accommodation charges inclusive of routine nursing and special nursing when approved; drugs and dressings used for in-patient or daycare **treatment** for **surgical** or non-surgical related admissions. b) Operating theatre fees (including eligible appliances), recovery room fees, **surgical** drugs and dressings used for in-patient or daycare **treatment**.	Paid in full up to the limit shown in **your plan**. (see also benefit 16)	Paid in full up to the limit shown in **your plan**. (see also benefit 16)	Paid in full up to the limit shown on **your plan**. This benefit includes **treatment** for Oncology, heart conditions, stroke, **treatment** as a result of external trauma (provided that appropriate **treatment** begins within 48 hours of the initial trauma). The above **treatment** may be delivered on an in-patient or day care basis.	Paid in full up to the limit shown in **your plan** when **you** have **treatment** in **your principal country of residence** or within **your area of cover.**
2 Surgeons' and Anaesthetists' charges	For each operation this includes pre and post-operative consultations while an in-patient or daycare patient. Related out-patient consultations are payable under benefit 20.				

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
3 Physicians' charges	Physicians' charges for in-patient and daycare **treatment**. This includes intensive care.	Paid in full up to the limit shown in **your plan**. (see also benefit 16)	Paid in full up to the limit shown in **your plan**. (see also benefit 16)	Paid in full up to the limit shown on **your plan**. This benefit includes **treatment** for Oncology, heart conditions, stroke, **treatment** as a result of external trauma (provided that appropriate **treatment** begins within 48 hours of the initial trauma). The above **treatment** may be delivered on an in-patient or day care basis.	Paid in full up to the limit shown in **your plan** when **you** have **treatment** in **your principal country of residence** or within **your area of cover**
4 Consultations diagnostic procedures and physiotherapy	Out-patient consultations, diagnostic procedures and physiotherapy are payable under benefits 20 and/or 21 even if they are related to in-patient or daycare **treatment** either before admission or after discharge.				
5 Additional accommodation	a) Charges for one adult relative staying in the same **hospital** as a child **member** who is under 18 **years** of age. This is paid from the child's benefit. b) Benefit is also payable for charges for a child being breast fed to stay in the same **hospital** with his or her nursing mother who is herself a **member**. This is payable from the mothers benefit.			No benefit	No benefit
6 Cash benefit	Cash benefit for each night the **member** receives free **treatment**. **We** will pay this benefit only if the **treatment** the **member** receives would have been eligible for benefit privately under this **policy**. ***This benefit counts against the overall maximum limit of your plan.***	€200 per night. Up to 30 nights per policy **year**.	€180 per night. Up to 30 nights per policy **year**.	€80 per night. Up to 30 nights per policy **year**	€150 per night. Up to 30 nights per policy **year**.
7 In-patient Rehabilitation (medically necessary)	Please note this benefit is subject to preauthorisation (refer to page 50 for more information).	We will pay up to 28 days per event.	We will pay up to 28 days per event.	We will pay up to 28 days per event.	We will pay up to 28 days per event.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
Other treatment					
8 Out-patient **surgical procedures**	**Surgical procedures** received as an out-patient. ***Pre and post-operative out-patient consultations and diagnostics are payable out of benefits 20 and/or 21 on Comprehensive cover. Please note, there is no out-patient benefit on Standard cover.***	Paid in full up to the limit shown in **your plan**.	Paid in full up to the limit shown in **your plan**.	No benefit	Paid in full up to the limit shown in **your plan**.
9 In-patient CT, MRI and PET scanning	Computerised tomography including magnetic resonance imaging (brain and body scanning) received as an in-patient or daycare patient only when referred by a **medical practitioner**.			Paid in full up to the limit shown in **your plan**.	
10 Oncology **Treatment** Radiotherapy/ chemotherapy	Radiotherapy, chemotherapy and oncology related tests, drugs and **medical practitioner** fees for **treatment** received as an in-patient, out-patient or daycare patient during a course of oncology **treatment**. ***By course we mean a course of six cycles of chemotherapy or six weeks of radiotherapy. Up to a maximum of two courses in a year. A 'cycle' of chemotherapy is determined by the number of sessions for which the drug used is licensed***.				
11 Day patient and outpatient radiotherapy and chemotherapy cash benefit*	Cash benefit for each radiotherapy and/or chemotherapy session for which the **member** receives free **treatment**. We will pay this benefit only if the **treatment** the **member** receives would have been eligible for benefit privately under this policy. This benefit counts against the overall maximum limit of **your** plan	€50 per session up to €1,000 a **year**	€50 per session up to €1,000 a **year**	No benefit	No benefit

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
12 Pregnancy	Benefits only become available and eligible **claims** payable for expenses incurred after the **member** (the mother) has been continuously covered under the **plan** for 12 consecutive months for Premiere and 24 consecutive months for Value Plus and has effected the annual renewal of that **plan** for the coming **policy year**. a) **Your** normal pregnancy and childbirth including in-patient or out-patient antenatal and postnatal consultations and delivery. b) Charges for **your treatment** related to complications incurred during pregnancy including caesarean section.	Up to €4,000 for each female **member** per pregnancy	Up to €3,000 for each female **member** per pregnancy	No benefit	No benefit
13 Childbirth cash benefit	**We** will make a single cash payment per pregnancy when the mother has received free **treatment** under the General Health System which would have been eligible on their **plan**. The allowance will be paid only if the pregnant mother has been insured under this policy for 12 consecutive months for Premiere and 24 consecutive months for Value Plus. This benefit is only payable if **you** have not claimed for the same pregnancy under **your** current Cash Benefit (Benefit 6 on **your** handbook and membership agreement) or Pregnancy Benefit including any pregnancy complications (Benefit 12 on **your** handbook and membership agreement). This benefit counts against the overall maximum limit of this policy and is payable upon presentation of a legal birth certificate.	Premiere Comprehensive €1,300 for each female **member** per pregnancy. Premiere Standard €1,000 for each female **member** per pregnancy.	Value Plus Comprehensive €1,000 for each female **member** per pregnancy. Value Plus Standard €600 for each female **member** per pregnancy.	No benefit	No benefit

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment.**

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
14 Ambulance Transport (when **medically** essential)	This is to pay for a road ambulance for **emergency** transportation to or between **hospitals** or when the **medical practitioner** says **you** need to have medical supervision whilst **you** are being transported.	Up to €600 for each **member** each **year**	Up to €500 for each **member** each **year**	Up to €200 for each **member** each **year**	Up to €500 for each **member** each **year**
15 **Emergency Treatment**- Outpatient first aid following an accident	**We** will cover the costs of **emergency treatment** - outpatient first aid following an accident, offered in a recognised **emergency** unit at a **hospital**	Paid in full up to the limit shown in **your plan**	Paid in full up to the limit shown in **your plan**	No benefit	No benefit
16 Outside **area of cover** (This benefit is payable when **members** are travelling for business or pleasure only)	This is to cover **emergency treatment** or **treatment** of a **medical condition** which arises suddenly whilst outside the **member's area of cover**.	Not required for **Area** 1 cover. For **Area** 2 benefit for the USA, Canada and Switzerland is payable in respect of six weeks travel each **year** and is limited to a maximum of €75,000 each **year**	Not required for **Area** 1 cover. For **Area** 2 benefit for the USA, Canada and Switzerland is payable in respect of six weeks travel each **year** and is limited to a maximum of €60,000 each **year**	No benefit	No benefit
17 International **Emergency** Medical Assistance	**We** will cover the costs of **emergency** evacuation if **you** are, or need to be, admitted as an **emergency** in-patient, and our appointed doctor and the treating doctor believe **your** current or nearest medical facilities are not able to provide the **treatment you** need. This service also covers the costs If **you** die outside a country that **you** hold a passport for. **We** will cover the cost of transporting **your** body back to a port or airport in **your** country of residence, or a country **you** hold a passport for. For full details please refer to pages 8-10. ***Please note that the optional excess is not applicable to this benefit.***	Paid in full up to the limit shown in **your plan**.	Paid in full up to the limit shown in **your plan**.	Paid in full up to the limit shown in **your plan**.	Paid in full up to the limit shown in **your plan**.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
18 Women's health & wellbeing cover	Pap smear & mammography This benefit is available to **members** each **year** after the **member** has been continuously covered for 12 consecutive months and every renewal thereafter.	€150 for each female **member** each **year**	€150 for each female **member** each **year**	No benefit	No benefit
19 Men's health & wellbeing cover	Prostate Specific Antigen (PSA) test	€20 for each male **member** each **year**	€20 for each male **member** each **year**	No benefit	No benefit
Out-patient treatment					
20 **Medical practitioner** charges and **prescription** drugs	a) **Medical Practitioner** charges b) **Prescription** drugs	The overall limit for benefits 20-26 is €5,000 each **year**. Additionally, benefit 23 is limited to €500 and this counts against the overall limit.	The overall limit for benefits 20-26 is €1,000 each **year**. Additionally, benefit 23 is limited to €500 and this counts against the overall limit.	The following only applies to benefits 20-22. The overall limit for **your** out-patient pack is €500 each **year**. Within this **you** may **claim**, up to a maximum value of €100 each **year**, without a **medical practitioner's** referral for Health Screening including but not limited to cervical smears, testicular screening, blood tests, screening for sexually transmitted diseases including HIV/AIDS. Also **you** may **claim** for non-professional **sports** injuries, up to 6 physiotherapy **visits** each **year**, **medical practitioner** consultations up to 3 **visits** each **year** and **prescription** medicine if prescribed by a **medical practitioner.**	The overall limit for benefits 20-23 is €2,000 each **year**. Additionally, benefit 23 is limited to €500 and this counts against the overall limit.
21 **Medical practitioner** consultations, diagnostic procedures and physiotherapy	**Medical practitioner** charges for consultations and **treatment**, diagnostic procedures (even if they are related to in-patient daycare or physiotherapy **treatment**). ***Please note that all physiotherapy must follow referral by a medical practitioner. Additionally physiotherapy is limited to a maximum of 6 sessions. We will consider a further 6 sessions with the submission of an updated doctor's prescription. If further physiotherapy is needed we will need an updated medical report from the attending medical practitioner.***				
22 Out-patient CT, MRI and PET scanning	Computerised tomography including magnetic resonance imaging and positron emission tomography (brain and body scanning) received as an out-patient only when referred by a **medical practitioner**.				
23 Alternative **treatment**	Out-patient **chiropractic treatment**, **homeopathy** and **osteopathy** given by a **medical practitioner** who is registered to practice as a **chiropractor**, **acupuncturist**, **homeopath** or **osteopath** where the **treatment** is given. **Podiatric** consultations only.			No benefit	

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
24 Accidental damage to teeth	Initial **treatment** required immediately following accidental damage to natural teeth and given by a **medical practitioner** within 48 hours of the incident.	The overall limit for benefits 20-26 is €5,000 each **year**	The overall limit for benefits 20-26 is €1,000 each **year**	No benefit	No benefit
25 Psychiatry	Out-patient **treatment** of psychiatric illness. Benefit is payable for **treatment** given by a psychiatrist or by a psychotherapist or psychologist when under the control of a psychiatrist. Page 49, (bb) psychiatric illness of the **membership** agreement applies to this benefit.	**We** will pay for a period of 3 months per **year**	**We** will pay for a period of 3 months per **year**		
26 Nursing-at-home	Nursing at home when arranged by a **medical practitioner** (with **our** prior approval) out of medical necessity for a **member** who needs a **registered nurse** immediately following in-patient or daycare **treatment**.	**We** will pay up to 30 days a **year**	**We** will pay up to 30 days a **year**		
Other Benefits					
27 **Second Medical Opinion**	**You** have access to a second **medical** opinion on **your** first diagnosis via external international **medical** experts. This service may be subject to geographical restrictions	Unlimited access during policy **year**	Unlimited access during policy **year**	Unlimited access during policy **year**	Unlimited access during policy **year**
28 Health Screen*	This benefit is available to **members** each **year** after the **member** has been continuously covered for 12 consecutive months and every renewal thereafter. The benefit may be claimed at a properly registered healthscreening **provider**. **Members** may have whatever **medical** tests they wish up to the annual limit detailed in the benefit table. This benefit is to cover annual health screen and is not limited to: ***stress ecg, prostate and lipid test, general health checks and vaccinations.***	€100 each **year** for each adult **member** €75 each year, for each child **member**	€100 each **year** for each adult **member** €75 each year, for each child **member**	No benefit	No benefit

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02.
Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Benefits		Premiere	Value Plus	Smart Start (not available for groups)	StudentCare (not available for groups)
29 Teeth Cleaning	Routine dental teeth cleaning	€30 each **year**	No benefit	No benefit	No benefit
30 Non-routine dental care. Major restorative dental **treatments**.	This benefit covers the fees of a dental practitioner and associated costs for the **treatment** of the following specified procedures: removal of impacted, buried, or unerupted teeth, removal of roots, removal of solid odontomas, apicectomy, new or repair of bridge work, new or repair of crowns, root canal **treatment**, new or repair of upper or lower dentures, and removal of wisdom teeth (whether performed in **hospital** or in dental surgery, whether performed by a dental practitioner, specialist or an oral or maxillofacial surgeon). This benefit excludes orthodontic **treatment**, routine **treatment** and dental implants. This benefit is available to **members** each **year** after the **member** has been continuously covered for 12 consecutive. months and every renewal thereafter.	70% up to €300 per **year**	No benefit	No benefit	No benefit
31 Children vaccinations and administration by a **medical practitioner** or **nurse.***	This benefit is available to **members** each **year** after the **member** has been continuously covered for 12 consecutive months and every renewal thereafter.	€100 per child per policy **year**	€100 per child per policy **year**	No benefit	No benefit
32 Travel allowance.*	This benefit is available in case **you** have a pre-approved scheduled in-hospital **treatment** in **Cyprus**, at one of **our** network **hospitals** which is in a city different than the one of **your** residence.	Up to €200 for each **member** each **year**	Up to €200 for each **member** each **year**	Up to €200 for each **member** each **year**	Up to €200 for each **member** each **year**

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) – see page 5 paragraph 02. Reasonable and customary will apply in any event. If in doubt please contact **us** before receiving **treatment**.

*The annual **excess** does not apply for this benefit.

Optional covers

Your membership statement will show if you have added any of the following optional covers.

Out-patient add-on pack

Benefits		Limit
Yearly Maximum	**We** will pay up to the maximum shown each **year** for each **member**.	€500
GP **visits** & **medical practitioner** consultations	**We** will pay for consultations and **treatment** with a **medical practitioner**.	Up to €200 per insured person per membership **year** (max €25 per **visit**)
Prescription Drugs	**We** will pay for drugs prescribed by a **medical practitioner.**	Up to €150 per insured person per membership **year**.
Diagnostic Tests	Diagnostic tests received as an out-patient only when referred by a **medical practitioner**.	Up to €200 per insured person per membership **year**.
Physiotherapy and Alternative **treatments**	When referred by a **medical practitioner we** will pay up to the annual limit for all eligible medical conditions for Outpatient alternative **treatments**, **chiropractic treatment**, **homeopathy** and **osteopathy** given by a **medical practitioner** who is registered to practice as a **chiropractor**, **acupuncturist**, **homeopath** or **osteopath** where the **treatment** is given	Up to €200 per insured person per membership **year** (max €25 per session)
Psychiatric **treatment**	Out-patient **treatment** of a psychiatric illness. Benefit is payable for **treatment** given by a psychiatrist or by psychotherapist or a psychologist only when under the control of a psychiatrist.	Up to €200 per insured person per membership **year**

The above benefits cannot be purchased separately, and if added to the **policy**, will apply to all insured **members**.

Optional Upgrade Pack for Premiere Plan – Comprehensive

Benefits		Limit
Dental	Cover for extraction, cleaning, composite filling, root canal **treatment**, bridges and crowns, panoramic X-rays, gingivitis **treatment** and surgical extraction.	Overall limit €500 each **year**. Extraction €30 per tooth; Cleaning €40 each **year**; Composite filling €30 per tooth; Root canal **treatment** €50 per tooth; Bridges and crowns €80 per tooth; Panoramic X-rays €15 per x-ray; Gingivitis **treatment** €60 each **year**; Surgical extraction €80 per tooth.
Optical	Costs for eye tests, **prescription** glasses and contact lenses. **We** will pay this so long as the glasses or lenses are used to correct **your** vision. **We** accept prescriptions from Opticians as well as Opthalmologists.	Overall limit €100 each **year**.
Chronic conditions	Cover for drugs and diagnostic tests related to new **chronic** conditions. ***Please note that pre-existing chronic conditions are not covered under this benefit.***	Overall limit €300 each **year**.
Health screen	Health screening cover as per benefit 28 (page 38). Please note – this upgrade will be in addition to benefit 28. ***Please note that a waiting period of 12 months is applicable from the effective date of the Optional Upgrade Pack.***	Adults €300 each **year**. Children €200 each **year**.

The above benefits cannot be purchased separately, and if added to the **policy**, will apply to all insured **members**.

20 What we pay for

This **policy** insures the **members** against the reasonable and customary cost of necessary **treatment** and diagnostics carried out by a **medical practitioner**.

We will pay:

i) for charges actually incurred for items listed in **your benefits table**. These are subject to the limits shown there. Note: if **you** incur costs in **excess** of the limits **you** will have to pay the difference;

ii) for **treatment** of an **acute medical condition** and for the short term **treatment** of an **acute** episode of a **chronic** condition intended to stabilise and bring under control the **chronic medical condition**. See **(e) chronic** illness. When the **medical condition** has been stabilised **we** will stop making payments. **We** will never pay for more than 180 days **treatment** for any **medical condition** in a **year** in accordance with **(pp)** "**Time Limit**" shown on page 52. For cancer **treatment** see '11 Our position on cancer';

iii) if the charges made by the **medical practitioner** are fair and reasonable and/or at the level customarily charged by **medical practitioners** in accordance with **our** definitions of reasonable and customary charges on page 5 in this handbook and on each page of the **benefits table**. If necessary **we** can delay paying the **claim** until **we** are satisfied that the charges are appropriate. If the charges made by the **medical practitioner** are not reasonable and customary and/or are higher **we** will only pay the amount which is customarily charged and the **member** will have to pay the rest;

iv) for **treatment** by a **medical practitioner** or **acupuncturist**, **chiropractor**, **homeopath**, **osteopath**, **physiotherapist** and **podiatrist** or for the services of a **nurse** or any other **treatment** or additional benefit if the **plan** covers it and then only as allowed by the **benefits table**;

v) provided the costs are not for something excluded by the terms of the **member's policy**;

vi) for costs incurred during a period for which the premium has been paid.

21 What we do not pay for

Exclusions and Limitations:
(Please note titles are for ease of use only)

***Please note**: exclusions are shown in **black** text and where possible, positive amendments are shown in **green** text*.

We do not pay benefit for the following (subject to some limited cover being available as shown):

(a) appliances

the costs of providing or fitting any external prosthesis or appliance such as, but not limited to, boots, gauzes, crutches, joint supports, orthotics, spectacles, contact lenses, hearing aids, dentures and scoliosis brace;

(b) artificial life maintenance

We do not cover artificial life maintenance for more than 60 continuous days if **you** are in a persistent vegetative state and only being kept alive by medical intervention such as mechanical ventilation.

(c) ATMP's

There are a complex set of advanced **therapies**, including gene **therapies** and CAR-T **treatment** for cancer. They are known by different names across the world, for example Advanced **Therapy** Medicinal Products (ATMPs), Cellular and Gene **Therapy** Products (CGTPs) or Regenerative Medicine Advanced **Therapy** (RMAT). In Section 12 you will find a list of the ATMPs/CGTPs/RMATs that **we** cover.

We do not cover any ATMPs/CGTPs/RMATs that aren't on the list at the time **you** need the **treatment**, including any associated **hospital** or specialist costs. The list is subject to change so **you** should always check and call **us** before **you** start any **treatment**.

We cover a small number of ATMPs/CGTPs/RMATs under the **plan**. **You** must call **us** before **you** start **your treatment** to make sure its covered. For more information and for the current list of the ATMPs/CGTPs/RMATs **we** cover, please see section 12.

(d) breast reduction

We do not cover either male or female breast reduction.

(e) **chronic** illness

i) non-surgical **treatment** of a **medical condition** or episode of ill health which persists for a long period or is recurrent (please also see pages 11-12);

ii) the monitoring of a **medical condition** once it has been stabilised;

iii) any **treatment** which offers only temporary relief of symptoms rather than dealing with the underlying **medical condition**. Please note that **we** will cover drugs and diagnostic tests related to chronic conditions if **you** are covered under the Optional Upgrade Pack;

(f) Congenital deformities and/or conditions

any charges related to the **treatment** and/ or correction and/or **treatment** of any condition that is caused or results directly or indirectly from congenital deformities and/or conditions, whether or not **you** were aware of them or experience symptoms.

However, in the case of new born children added to a **policy** under the terms of clause page 56, Addition of Children and where the parent's **policy** (either parent's) to which the child is being added has been in force for at least 12 months prior to birth, **we** will pay up to €200,000 in the child member's lifetime. Congenital deformities and/or conditions in the case of children resulting from any method of assisted conception (except artificial insemination) or if adopted will not be covered under any circumstances;

(g) cosmetic **treatment**

cosmetic **treatment** or cosmetic surgery; or

i) **treatment** that is connected to previous cosmetic **treatment** or cosmetic surgery; or

ii) **treatment** that is connected with the use of cosmetic (beauty) products or is needed as a result of using a cosmetic (beauty) product, whether it is needed for medical or psychological reasons.

iii) the removal of fat or surplus tissue from any part of the body whether or not it

is needed for medical or psychological reasons; including but not limited to breast reduction.

iv) any fees for any kind of bariatric (weight loss) surgery or weight loss **treatment** regardless of why the surgery or **treatment** is needed. This includes fitting a gastric band, creating a gastric sleeve, or other **treatment**.

(h) dentistry

i) orthodontics, periodontics, endodontics, preventative dentistry and general dental care including fillings no matter who gives the **treatment** unless **you** are covered under the Optional Upgrade Pack;

ii) any dental procedure except as indicated by your **benefits table**. Please note that no **surgical procedures** for dental purposes are covered under **your plan** unless under the terms applicable to Benefit 24 accidental damage to teeth;

We do not cover **treatment** needed following damage caused by any of the following:

- normal wear
- eating or drinking something, even if it contains a foreign body
- boxing or playing rugby (except tag rugby) without wearing suitable mouth protection
- brushing **your** teeth or any other oral hygiene procedure.

(i) developmental delay

treatment directed towards developmental delay in children under 14 years old whether physical or psychological or learning difficulties for more than the first 3 months following diagnosis and only once in the **member's lifetime**;

(j) donor organs

We do not pay for:

i) the cost of collecting donor organs or tissue; or

ii) any related administration costs – for example, the cost of searching for a donor; or

iii) any costs towards organ or tissue transplant that is not done in line with appropriate regulatory guidelines.

(k) drugs & dressings

We will pay for the use of drugs that have been established as being effective. This means the drug must be licensed for use by either:

- the Medicines and Healthcare products Regulatory Agency (MHRA) if the **treatment** is to be provided in the **United Kingdom**; or
- the European Medicines Agency (EMA) if the **treatment** is to be provided in Europe, but outside of the **United Kingdom**; or
- the US Food and Drug Administration (FDA) or another appropriate medical authority if the **treatment** is to be provided outside of Europe and the **United Kingdom**. The drug must be used within the terms of its licence.
- the **Cyprus** Ministry of Health's Pharmaceutical Services.

Please note that **we** do not pay for standard toiletries such as, but not limited to, shampoos, soaps, toothpastes, personal hygiene items, contraceptives, proprietary headache and cold cures, dietary medicines, herbal products, cosmetic creams, weight control medicines etc. with or without prescription, nor do **we** pay for telephone calls. **We** do not cover any supplements or substances that are available naturally, such as oral vitamins, minerals and organic substances. **We** will cover the cost of vitamins to be administered by injection or infusion in case of a confirmed vitamin deficiency that requires medical management.

(l) end of life/terminal stages of illness

costs associated with end of life care or the costs associated with the terminal stages of illness however **we** will cover **treatment** to relieve symptoms during the end stages of life.

(m) excess/deductible

any **claim** or part of a **claim** in respect of which **you** have to pay an **excess/ deductible**. In this case **we** will only pay the balance of the **claim** after **we** have deducted the **excess/ deductible** amount. Any **excess/ deductible** that applies will be shown in **your benefits table**;

(n) experimental or unproven **treatment**

your plan covers **you** for established medical **treatments**, which **we** call **conventional treatment. Conventional treatment** does not cost more than an equivalent **treatment** that delivers similar therapeutic or diagnostic outcome. Such **conventional treatment** must not be provided or used primarily for the convenience or financial or other advantage of **you** or **your medical practitioner** or health professional. For a **surgical procedure** to be covered it must be listed in **our Schedule of Procedures and Fees**.

There is no cover for any **treatment** or procedure that is unconventional, experimental or that has not been established as being effective.

In some cases, **we** may cover **treatment** that is not licensed but has been shown to be effective through an appropriate clinical trial and assessment, with the results published in authoritative medical journals or if **you** choose to receive unconventional **treatment** (which refers to any **treatment** or procedure outside the definition of **conventional treatment**), even though a **conventional treatment** for **your** diagnosis is available, **you** must contact **us** before the **treatment** begins. **We** will only consider such unconventional, unproven, or experimental **treatment** if **we** are able to agree and approve the **treatment** is a suitable equivalent to a **conventional treatment** and the fees are reasonable with **your medical practitioner** and **hospital** before **you** start the **treatment**. If the unproven or experimental **treatment** is more expensive, **we** reserve the right to pay the **claim** up to the equivalent **conventional treatment** cost. However, if the **treatment** is not recognised in the country where **you** have the **treatment**, **we** shall not be able to cover it. **You** are not covered for complications that arise as a result of authorise or unauthorised unconventional, unproven, or experimental **treatment**.

(o) fibroids

any **treatment** or **surgical procedure** for fibroids of any kind, unless the **member** has been insured by **us** under this **policy** for a continuous period of six months prior to symptoms becoming apparent that lead to the **treatment** or **surgical procedure**. All such **treatment** or **surgical procedures** must be pre-authorised by **us**;

(p) health spas/hydros

any charges from health hydros, spas, nature cure clinics or any similar place, even if it is registered as a **hospital**;

(q) hernia

any **treatment** or **surgical procedure** for hernia of any kind, as a result of accident or illness, including but not limited to intervertebral disc herniation, unless the **member** has been insured by **us** under this **policy** for a continuous period of six months prior to symptoms becoming apparent that lead to the **treatment** or **surgical procedure**. All such **treatment** or **surgical procedures** must be preauthorised by **us**;

(r) H.R.T.

hormone replacement therapy except when it is medically indicated following related surgery by a qualified **medical practitioner** (rather than for the relief of physiological symptoms) when **we** will pay for the consultations and for the cost of the implants or patches (but not tablets).

We will only pay benefits for a maximum of two **years** from the date of first consultation;

(s) illegal and criminal activity

we do not cover **treatment** you need as a result of **your** active involvement in illegal or criminal activity;

(t) impotence

treatment of impotence or sexual disfunction or any consequences of them;

(u) kidney failure

regular or long term kidney dialysis in the case of **chronic** kidney failure. **We** do pay for dialysis for up to six weeks during preparation for a kidney transplant;

(v) medical reports

we will not pay for medical reports or for the completion of **claim** or application forms or any part of them and other administration fees.

(w) meniscus

any **treatment** or **surgical procedure** for **meniscus** of any kind, as a result of accident or illness, unless the **member** has been insured by **us** under this **policy** for a continuous period of six months prior to symptoms becoming apparent that lead to the **treatment** or **surgical procedure**. All such **treatment** or **surgical procedures** must be preauthorised by **us**;

(x) occupational **therapy**

We do not pay occupational **therapy** unless it follows hand surgery or fractures. Also **we** do not pay occupational **therapy** for developmental delay or to facilitate the fitting of a splint.

(y) organ or tissue donation

We do not pay if **you** plan to donate an organ or tissue as a live donor.

(z) pre-existing conditions

treatment of any **medical condition** which the **member** already had when he or she joined and which the **subscriber** should have told **us** about but did not tell **us** at all or did not tell **us** everything unless **we** had agreed otherwise in writing that there was no need for **you** to tell **us**. This includes any physical defect or **medical condition** or symptoms whether or not being treated and any previous **medical condition** which recurs or which the **member** should reasonably have known about even if he or she has not consulted a **medical practitioner**;

(aa) pregnancy, childbirth and infertility

i) Any **treatment** for **your** pregnancy or childbirth unless;

- It is allowed for **you** by **your plan** and;
- It is complicated by a **medical** condition **you** need **treatment** for, during and/or after pregnancy or childbirth. Examples of **medical conditions** related to pregnancy and childbirth that **we** cover are:
  - ectopic pregnancy (pregnancy where the embryo or foetus grows outside the womb)
  - hydatidiform mole (abnormal cell growth in the womb)
  - retained placenta (afterbirth retained in the womb)
  - eclampsia (a coma or seizure during pregnancy and following pre eclampsia)
  - post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
  - miscarriage requiring immediate surgical **treatment**, and;
- The pregnant **member** has been insured by **us** under this **policy** for a continuous period as shown on **your benefits table** and membership statement.

ii) termination of **your** pregnancy or any consequences of it;

iii) fetal surgery which is surgery performed on an unborn child or medical **treatment** in connection with such surgery whether undergone by the mother or the unborn child;

iv) investigations into and complications arising from the **treatment** of **your** infertility, contraception, assisted reproduction, sterilisation (or its reversal) or of any **treatment** for them (except **treatment** for complications of **your** pregnancy resulting from artificial insemination) or of any **treatment** for them including post-natal care of the mother, child or children. However **we** will pay for initial investigations into the cause of infertility provided that **you** and **your** partner have been insured by **us** under this **policy** for a continuous period of two **years** at the start of these investigations and were unaware of **your** infertility or inability to conceive before **your** insurance under this **policy** began. Please note all such **treatment** will be taken from the pregnancy benefit number 12;

(bb) psychiatric illness

the **treatment** of psychiatric illness except for out-patient **treatment** as allowed for by **your benefits table** nor will **we** pay for psychiatric home nursing;

(cc) **quarantine**

We do not cover costs where **you** are required to quarantine but have no

medical need for **treatment** or care as an in-patient. This includes state mandated quarantine, even if it takes place in a **hospital**.

(dd) reconstructive surgery

we do not cover **treatment** that is connected to previous reconstructive surgery or any cosmetic operation.

We will cover **your** first reconstructive surgery following an accident or surgery for a **medical condition** that was covered by the **plan**. **We** will do this so long as:

- you have been continuously covered by a private medical insurance **plan** since before the accident or surgery happened; and
- **we** agree the cost of the **treatment** in writing beforehand

Reconstructive surgery following breast cancer.

we do not cover **treatment** that is connected to previous reconstructive surgery or any cosmetic operation to a reconstructed breast.

In the case of breast cancer **we** will cover the first reconstructive surgery, this means:

- one planned surgery to reconstruct the diseased breast
- one further planned surgery to the other breast, when it has not been operated on, to improve symmetry
- nipple tattooing, up to 2 sessions
- one planned surgery to reconstruct the nipple.

After the completion of **your** first reconstructive surgery, **we** will also cover:

- Two planned fat transfer surgeries. The fat must be taken from another part of **your** body and cannot be donated by anyone else. Fat transfer operations must take place within three **years** of first reconstructive surgery.
- One planned surgery to remove and exchange implants damaged by radiotherapy **treatment** for breast cancer. The removal and exchange must take place within five **years** of **you** completing **your** radiotherapy **treatment**.

We will only pay for each of these operations once (or two fat transfer surgeries), regardless of how long **you** remain a **member** of the **plan**.

(ee) rehabilitation

We will cover in-patient rehabilitation for up to 28 days per event, so long as:

- it follows an **acute** brain injury, such as a stroke; and
- it is part of a **treatment** that is covered by the **plan**; and
- it takes place in a **hospital** or unit that specialises in rehabilitation; and
- a **medical practitioner** who specialises in rehabilitation is overseeing **treatment**; and
- **we** have agreed the costs before **you** start rehabilitation; and
- the **treatment** could not be carried out on an out-patient basis.

If **you** have severe central nervous system damage following external trauma or accident, **we** will extend this cover to up to 180 days of in-patient rehabilitation.

(ff) routine & preventative care

preventative (ie: prophylactic) **treatment** and tests including, but not restricted to, eye tests, hearing tests, routine screening, genetic testing, vaccinations and routine and preventative medical examinations including routine follow-up consultations except as allowed by **your plan** and/or that **you** are covered for under the Optional Upgrade Pack;

(gg) self inflicted

treatment which arises from or is directly or indirectly caused by a deliberately self-inflicted injury and/or condition, an attempt at suicide, or affray. In respect of affray **we** will only consider **claims** where there is clear evidence in an official police report that the **member** was not the aggressor;

(hh) self-transplant

We do not pay for self-transplant, except for bone marrow transplant.

(ii) gender reassignment or gender confirmation

We do not cover gender reassignment operations, other surgical **treatment**, psychotherapy, or any other **treatment** relating to gender reassignment.

(jj) short/long – sightedness and causes

any **treatment** to correct problems of vision such as but not limited to long/ short sightedness and astigmatism;

(kk) social, domestic and other costs unrelated to **treatment**

we do not cover the costs that **you** pay for social or domestic reasons, such as but not limited to travel or home help costs. This includes if **your** in-patient stay is extended for a reason not related to **your treatment** and **you** could have that **treatment** as an out-patient, including pre-admissions into a facility where there is no medical necessity.
We do not cover the costs of home **visits** unless a home **visit** is necessary because of the sudden onset of an **acute** condition that means **you**'re not able to have **your treatment** or consultation in a medical clinic or consulting room.

(ll) special nursing

special nursing in **hospital** unless **we** have agreed beforehand that it is necessary and appropriate;

(mm) special terms

any special terms, restrictions, exclusions or **treatment** specifically excluded, or any terms added to **your policy** as shown on **your** membership statement. This may include additional underwriting terms when a pre-existing or **chronic** condition was not declared in **your** application form and is later discovered. This can be done and applied at any time within **your policy year**.

(nn) sports

Treatment of injuries sustained from playing **professional sport** or from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 meters, trekking to a height of over 2,500 meters, bungee jumping, canyoning, hangliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter **sports** activity carried out off piste;

(oo) substance abuse

treatment which arises from or is in any way connected with alcohol abuse or drug or substance abuse whether or not relating to psychiatric disorders;

(pp) time limit

treatment for any **member** for a total of more than 180 days in any **year** whether for out-patient **treatment**, in-patient **treatment**, daycare **treatment** or home nursing or any combination of them;

(qq) time limit for claims

any **treatment** if **we** have not received a properly completed **claim** form, original legally issued numbered invoices and test results (where required) within 90 days of the **treatment** being given;

(rr) travelling abroad

if the **member** leaves their **principal country of residence** for more than 180 days in any **year**. **We** will not pay benefits and reserve the right to cancel the **member's policy**;

(ss) **treatment** abroad

in respect of a **member** who has travelled outside the **area of cover** to get **treatment** (whether or not that was the only reason) or travelled against medical advice. **Emergency treatment** or **treatment** of a **medical condition** which arises suddenly while outside the **member's area of cover** is limited as shown on **your benefits table**;

(tt) TVT

any **treatment** or **surgical procedure** in respect of Tension Free Vaginal Taping (TVT) or stress incontinence of any kind, unless the **member** has been insured by **us** under this **policy** for a continuous period of six months prior to symptoms becoming apparent that lead to the **treatment** or **surgical procedure**. All such **treatment** or **surgical procedures** must be pre authorised by **us**;

(uu) unreasonable charges

charges which are unreasonable or excessive. In respect of in-patient **hospital** charges **we** will pay only for the basic cost of a single room with bathroom as the accommodation charge associated with the **treatment** given. Please see **our** definition of reasonable and customary charges on page 5 and under each page of the **benefits table**;
You can find more information related to this topic here:
https://www.universallife.com.cy/schedule-of-procedures-and-fees1

(vv) war & like risks, nuclear, biological or chemical contamination

We do not cover **treatment you** need as a result of nuclear, biological or chemical contamination.

We do not cover **treatment you** need as a result of **your** active involvement in war (declared or not), an act of a foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any similar event.

We do not cover **treatment you** need because **you** have put yourself in needless peril, such as going to a place of unrest as an onlooker.

We do cover **treatment** due to a terrorist act so long as the act does not cause nuclear, biological or chemical contamination.

(ww) Varicose veins

We do cover **treatment** of varicose veins, but only in certain circumstances.

What is covered?

We will cover one **surgical procedure** per leg to treat varicose veins. This may be foam injection (sclerotherapy), ablation or other surgery.

We will cover one follow up consultation with **your medical practitioner** and one simple injection sclerotherapy per leg to treat residual or remaining veins when it is carried out in the 6 months after **you**'ve had the main **surgical procedure**.

What's not covered?

We do not cover more than one **surgical procedure** per leg, regardless of how long **you** stay a **member** on a **policy** arranged by Universal Life.

There is no cover for the **treatment** of recurrent varicose veins under **your policy**.

There is no cover for the **treatment** of thread veins or superficial veins.

22 How we manage your **claim**

We will assess all **claims** for eligibility against the benefits of **your plan**. In respect of **claims** for **medical conditions** for which symptoms might reasonably have become apparent prior to inception of **your policy we** may also refer to **AXA** for a ruling on eligibility. **We** may require **you** to provide additional medical information, at **your** cost, in such cases. Please refer to page 6 for details of how to make a **claim**.

Pre-authorisation

The **member** should tell **us** before he or she undergoes in-patient, daycare **treatment**, **physiotherapy** or the scans shown on page 26-43.

You must pre-authorise any **treatment** shown in the **benefits table** as being subject to pre-authorization and benefit will only be paid if such **treatment** has been pre-authorised by **us**. In cases of medical **emergency** special arrangements will apply, see pages 26-43.

Supplying full information

Before **we** can consider a **claim you** must ensure that:

- the **member** sends **us** a completed **claim** form as soon as they can and no later than 90 days from the date the **treatment** starts; and
- **we** receive numbered invoices, accompanied by any appropriate numbered fiscal receipt where applicable, for **treatment** costs; and
- the **member** promptly gives **us** all the information **we** may request including:
  - diagnostic test results; and
  - any reports **we** may ask for from any third party including any information from a **medical practitioner**. This is provided at the **member's** expense.

Other insurance and our right of recovery

The **member** must tell **us** on the **claim** form if any of the cost can be claimed from anyone else or under another insurance policy. If so then:

- if another insurance policy is involved **we** will only pay **our** proper share; or
- if benefits are claimed for **treatment** to a **member** whose injury or **medical condition** was caused by some other person (the "third party"), **we** will pay those benefits the **member** can **claim** under the **policy** (unless they are covered by another insurance policy, when **we** will only pay **our** proper share of the benefits) however in paying those benefits **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party.
- **You** must tell **us** as quickly as possible if **you** believe someone else or something (ie a third party) contributed to or caused the need for **your treatment**, such as a road traffic accident, an injury or potential clinical negligence.

Where **you** bring a **claim** against a third party (a "Third Party Claim"), **you** or **your** representatives must:

- include all amounts paid by **us** for the **treatment** relating to **your** Third Party Claim (our "Outlay") against the third party;
- include interest on **our** Outlay at 8% p.a;
- keep **us** fully informed on the progress of **your** Third Party Claim and any action against the third party or any pre-action matters;
- agree any proposed reduction to **our** Outlay and interest with **us** prior to settlement. If no such agreement has been sought **we** retain the right to recover 100% of **our** Outlay and interest directly from **you**;
- repay any recovery of **our** Outlay and interest from the third party directly to **us** within 21 days of settlement;
- provide **us** with details of any settlement in full.

In the event **you** recover **our** Outlay and interest and do not repay **us** this recovered amount in full **we** will be entitled to recover from **you** what **you** owe **us** and **your plan** may be cancelled.

Even if **you** decide not to make a claim against a third party for the recovery of damages **we** retain the right (at **our** own expense) to make a claim in **your** name against the third party for **our** Outlay and interest. **You** must co-operate with all reasonable requests in this respect.

Appointment of independent medical practitioners

We can appoint and pay for an independent **medical practitioner** to advise **us** on the medical issues relating to any **claim**. If required by **us** the independent **medical practitioner** will also medically examine the **member** making the **claim** and provide **us** with a report. The **member** must co-operate with the independent **medical practitioner** otherwise **we** will not pay the **claim**.

Dishonesty/false claims

If a **member** makes a **claim** which is in any way dishonest:

- **we** will not pay any benefits for that **claim**; and
- if **we** have already paid benefits for that **claim** before **we** discovered the dishonesty **we** can recover those benefits from **you**; and
- **we** can take any of the actions listed in paragraph **Our** options if **you** break the terms of **your policy**

Paying claims in currencies other than Euro

If **we** agree to pay benefits in a local currency other than the Euro, the currency will be converted using the closing midpoint exchange rate currently published in the ICE foreign exchange rates when **we** assess the **claim**. All payments will be subject to any exchange control regulations that may be in force at the time of payment.

Ex-gratia payments

Any benefit payments made by **us** which are made on an "ex gratia" basis and to which, therefore, **you** are not entitled shall count against any maximum annual limits applicable in respect of any benefit. Any ex-gratia payment that **we** make does not, in any event, establish a precedent for the payment of future **claims** even if such **claims** are for **treatment** of any of the original conditions for which the ex-gratia payment was made.

To whom we pay

We will pay benefits to **you** unless **you** have notified **us** otherwise in writing.

23 Joining, renewing & adding children

When cover starts

We will tell **you** in writing the date **your policy** starts and any special terms which apply to it. Please note that this is subject to **our** receiving and accepting **your** premium. However, **policy** inception may occur after **we** have accepted **your** premium. **You** will only be able to **claim** benefits for that **treatment** received after the inception date on **your** membership statement whether or not **your** premium has been paid in advance. **We** can refuse to give cover and will tell **you** if **we** do.

Policy Period

Your policy is for one **year**. At the end of that time, provided the **plan you** are on is still available, **you** can renew it on the terms and conditions applicable at that time which **we** will notify to **you**. However, **we** reserve the right to refuse to accept **you** as a customer or to renew **your policy** at any **policy** anniversary. **We** will not exercise this right as the result of a **member's claims** experience or altered state of health.

Policy period for additions and deletions

Benefits for any **member** who is added to a **policy** during the **year** will cease at the next renewal and a new **policy year** will begin for that **member** at the next renewal. Benefits for any **member** whose membership is terminated for any reason during the **year** will cease with effect from the date of termination. (See also paragraph **Our** options if **you** break the terms of **your policy**).

Notice of cancellation at anniversary date

Unless **we** and/or **you** have agreed before the end of the **year** to renew the **policy**, cover will cease on the anniversary date. This will happen whether or not written notice of cancellation has been given by **us** to **you**.

Addition of children

If a child is born during a **policy year** and **you** wish that child to qualify as a **member**, without providing evidence of health, **you** must ask **us** for this in writing within 90 days of the birth. Children born as the result of any method of assisted conception (except artificial insemination) or adopted children will have to provide evidence of health. Please also see page 19.

Termination of cover for children on a parent's policy

Cover for a **dependant** child will stop at the end of the **year** following that child's marriage or the child's moving out of **your** home or that of the child's other parent. Once a **dependant** child reaches the age of 21 **years** he/she will no longer be eligible for cover under a parent's **policy**. Thus cover under the parent's **policy** will cease for that child at the **policy** anniversary immediately following the child's 21st birthday. The child may apply, at that time, for a **policy** of his/her own on the basis of continuing personal medical exclusions. This means that the medical exclusions (special terms) applying to that child will be transferred to his/her new **policy** and will apply as they did under the parent's **policy**. Please refer to the section ***Notifying us of a change of residence for our rules on dependant children studying abroad***.

Full time students

We provide cover for full time students, up to the age of 30, either studying in **Cyprus** or abroad. Proof of fulltime education must be provided on application and at each subsequent renewal. Students intending to reside outside **Cyprus** for more than 180 days in a **year** will be required to complete an application form and to transfer cover to a StudentCare **plan**.

24 What we expect from you

Giving full information

You must make sure that, whenever **you** are required to give **us** information, all the information **you** give is true, accurate and complete. If it is not then **we** can cancel the **policy** or apply different terms of cover or any of the terms of paragraph ***Our options if you break the terms of your policy***, page 57.

Notifying us of a change of residence

This **policy** is available to persons whose **principal country of residence** is **Cyprus**. **You** must tell **us** if a **member** will be outside their **principal country of residence** for more than 180 days in a **year** or if they intend to change their **principal country of residence** even if they are staying in the same **area**. If **you** don't tell **us we** can refuse to pay benefits. Students (up to the age of 30) normally resident in **Cyprus**, but who are in full-time education abroad, may reside outside **Cyprus** for more than 180 days in a **year**.

Payment of the premiums

You must pay **your** premium when it is due. **We** will decide the amount at start of each **year** and tell **you** how much it is. **You** can pay it in the way **you** have agreed with **us**. **We** can change the amount of **your** premium during a **year** to reflect any change in legislation, and/or insurance premium tax or other taxes but **we** will tell **you** of the change. As **your policy** runs for a **year**, **you** must pay **your** premium for the whole **year** no matter the frequency it is paid. If **your** premium payments are not up to date **your policy** will end.

Notifying us of a change of address

You must write and tell **us** if you change **your** address. **You** are acting on behalf of any **member** covered by **your policy** so **we** will send all correspondence about the **policy** to **your** address.

Complaints procedure

If there is a dispute between **you** and **us we** have a complaints procedure set out on pages 21-22 of this handbook which **you** must follow so that **we** can resolve it.

Courtesy

Our staff are highly trained to treat all of **our** customers with consideration and courtesy. **We** request that **you** similarly treat **us** with the same consideration. Any threats, verbal or otherwise made to **our** staff will be taken extremely seriously. Any such action on the part of a **member** may result in the immediate cancellation of **your policy**. **We** reserve the right to record all telephone calls and interactions between **our** staff and **members**, be they face-to-face or written. Such recordings will primarily be used for quality and training purposes but may also be used as evidence of unwarranted abuse. **We** reserve the right to act on such evidence; such action may include immediate termination of a **policy** and/or referral to the authorities.

25 General

Changing the terms of the policy

We can change all or any part of the **policy**, including the **benefits table** or these terms, only for the reasons set out in clause ***Changing the Terms of your Policy***, page 20. **We** will give you 10 days' notice of the changes and will send details of them to the address **we** have for **you** on **our** records. The changes will take effect when stated in **our** handbook, even if, for any reason, **you** don't receive details of them. In the event of a **chronic** condition becoming apparent during the **year** or any breach in accordance with **our** clause ***Our options if you break the terms of your policy***, page 57, **we** reserve the right to apply terms to **your policy** with immediate effect. **You** have a right to cancel **your policy**, in accordance with the terms of this handbook, should **you** not agree with any changes made to the **Policy**.

Our options if you break the terms of your policy

If any **member** breaks any of the terms of the **policy** or makes, or attempts to make, any dishonest **claim we** can:

- refuse to make any payment; and
- refuse to renew **your policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- end **your policy** and all cover under it immediately; or
- in the case of non-disclosure of a pre-existing **medical condition**, declare **your policy** null and void and recover any benefits paid.

Cypriot jurisdiction

This **policy** is deemed to be a Cypriot contract and will be governed by and in accordance with the laws of **Cyprus**.

What happens if we make a payment to you in error

If **we** transfer money to you in error or accidentally overpay **you**, **you** must return it to **us** immediately. If **you** become aware of an accidental payment or overpayment, **you** must let **us** know straight away so that **we** can arrange for the money to be returned to **us**.

Written authorisation

The terms of **your policy** cannot be changed nor **claims** confirmation given by verbal communication between **you** and by **us**. Any changes, approvals or other statements relating to **your policy** must be confirmed in writing by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in writing.

Waiver of terms

If **we** do not at any time apply or enforce any of the terms of this **policy** this will not prevent **us** from doing so at a later date.

International economic sanctions

We will not do business with any individual or organisation that appears on an economic sanctions list or is subject to similar restrictions from any other law or regulation. This includes sanction lists, laws and regulations of the Government of **Cyprus**, European Union, **United Kingdom**, United States of America, or under a United Nations resolution.
If **you** or any **family members** are directly or indirectly subject to economic sanctions, including sanctions against **your** country of residence, **we** reserve the right to do any of the following:

- immediately end cover (even if **you** have permission from a relevant authority to continue cover or pay premiums)
- stop paying **claims** on the **policy** (even if **you** have permission from a relevant authority to continue cover or pay premiums)
- cancel the **policy** or remove a **family member** immediately without notice.

We will tell **you** if **we** do any of these. If **you** know that **you** or a **family member** are on a sanctions list, or subject to similar restrictions, **you** must let **us** know within seven days of finding this out.

26 Definitions

(a) acupuncturist
a person who is qualified, licensed and registered by a recognised, relevant authority to practice as an **acupuncturist** where **treatment** is given and is recognised by **us**. **We** will advise **you** as to whether **we** recognise the **acupuncturist you** intend to use if **you** ask **us**.

(b) acute
a **medical condition** or episode of ill health which is of short duration and which has a definite end point as determined by **us**.

(c) area/area of cover
one of the following:
area 1: worldwide

area 2: worldwide excluding U.S.A, Canada and Switzerland.

(d) AXA Global healthcare's network
a regularly updated list available on **our** website www.universallife.com.cy/eng which displays the **hospitals/providers** where direct settlement and discounts can be arranged.
i) In **Cyprus you** may use any **hospital/ provider**.
ii) outside **Cyprus you** should use **AXA Global Healthcare (UK)** global **medical provider network** except in the case of an **emergency** where this may not be possible.
iii) in the **UK you** may use any **hospital/ provider** however, if a **hospital/ provider** outside **AXA Global healthcare's network** is used, benefit will be payable up to a level that would have been charged for the **treatment** within **AXA Global healthcare's** local **network**.

(e) benefits table
the table applicable to **your plan** showing the maximum benefits **we** will pay for

(f) chiropractor
a person who is qualified, licensed and registered by a recognised, relevant authority to practice as a **chiropractor** where **treatment** is given and is recognised by **us**. **We** will advise **you** as to whether **we** recognise the **chiropractor you** intend to use if **you** ask **us**.

(g) chronic
a **medical condition** or episode of ill health which persists for a long period, persists indefinitely, recurs or is incurable. Please also see Page 12.

(h) claim
the benefits **you** ask **us** to pay in respect of an episode of **treatment**.

(i) conventional treatment
We define **conventional treatment** as **treatment** that:
- is established as best medical practice in the country where the **treatment** is taking place; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility where the **treatment** is provided; and
- has been proven to be effective and safe for the **treatment** of **your medical condition** through high quality clinical trial evidence (full criteria available on request).

(j) Cyprus
the island of **Cyprus** excluding areas occupied by the Turkish military forces.

(k) dependant/family member
the **subscriber's** partner and unmarried children (or those of the **subscriber's** partner) up to the age of 21, living with the **subscriber** or their other parent when the **policy** is taken out or when it is renewed. By partner **we** mean the husband or wife or the person with whom the **subscriber** lives permanently in a similar relationship. Please also see page 56 in respect of students.

(l) emergency
we reserve the right to determine whether **treatment** given is a result of an **emergency**. Normally this will be **treatment** received in the accident and **emergency** department of a **hospital** or requiring immediate **hospital** admission.

(m) excess/deductible
the amount **you** must pay, as shown in the **benefits table** for **your plan**, which will be deducted from the amount payable for eligible **treatment** under **your plan**. Any annual **excess** payable is applied each **policy year** even if **treatment** is continuous from one **year** to the next.

(n) group
when the person or entity paying the premium for the **policy** is not a **member** benefiting from cover under the **plan**, and is not a **family member**. Normally this will be the **subscriber's** employer or sponsor.

(o) homeopath
a person who is qualified, licensed and registered by a recognised, relevant authority to practice as a **homeopath** where **treatment** is given and is recognised by **us**.

(p) hospital
a state or private **hospital** or a daycare medical clinic licensed or registered to provide medical, **surgical** or psychiatric **treatment** under the laws of **Cyprus** or the equivalent duly licensed or registered in the country, state or other government jurisdiction in which it is situated and where there is constant support by a **medical practitioner**. In the **United Kingdom** the **hospital** must be an establishment listed in **AXA Global healthcare's network**.

(q) lifetime
the period in which the **member** is alive. This does not refer to the life of the **policy**.

(r) living abroad
remaining outside **Cyprus** for 180 days or more, in a **year**.

(s) medical condition
any disease, illness or injury, including psychiatric illness not excluded under the terms of **your policy**.

(t) medical practitioner
Definition for **treatment** in **Cyprus** and outside the **UK**: a person who has primary degrees in the practice of medicine and **surgery** from a medical school that is listed in the World Health Organisation's World Directory of Medical Schools and who is licensed to practice medicine by the relevant licensing authority where **treatment** is given and properly licensed and qualified to provide the **treatment**.
Definition for **treatment** within the **UK**: a **medical practitioner** who meets all of the following conditions:

- is fully registered under the Medical Acts.
- specialises in at least one of the following: **acupuncture**, **osteopathy** or **chiropractic.**
- is registered under the relevant Act.
- is recognised by us as a complementary practitioner for out-patient **treatment**. In the **UK**, the definition of a recognised specialist for out-patient **treatment** only is widened to include those who meet all of the following conditions:
- specialise in psychosexual medicine, musculoskeletal or sports medicine, podiatric **surgery**.
- is fully registered under the Medical Acts.
- is recognised by **us** as a specialist.

The full criteria we use when recognising specialists are available on request.

(u) member
you as the **subscriber** and/or any **dependant/family member** included in **your policy**.

(v) nurse/registered nurse
a qualified **nurse** who is registered to practice as such where the **treatment** is given and is recognised by **us**.

(w) osteopath
a person who is qualified, licensed and registered by a recognised, relevant authority to practice as an **osteopath** where **treatment** is given and is recognised by **us**. **We** will advise **you** as to whether **we** recognise the **osteopath you** intend to use if **you** ask **us**.

(x) physiotherapist
a person who is qualified, licensed and registered by a recognised, relevant, authority to practice as a **physiotherapist** where **treatment** is given and is recognised by **us**. **We** will advise **you** as to whether **we** recognise the **physiotherapist you** intend to use if **you** ask **us**.

(y) plan
your plan the name of which is shown on **your** latest membership statement.

(z) podiatrist
a person who is qualified, licensed and registered by a recognised, relevant authority to practice as a **podiatrist** where **treatment** is given and is recognised by **us**. **We** will advise **you** as to whether **we** recognise the **podiatrist you** intend to use if you ask **us**.

(aa) policy
the insurance contract between **you** and **us**. Its full terms are set out in the current versions of the following documents as sent to **you** from time to time:

- any application form **we** ask **you** to fill in which forms the basis of this contract.
- these terms and the **benefits table** setting out the cover under **your plan**.
- **your** membership statement.
- any additional terms applied to **your plan** such as but not limited to special terms applied to **chronic** or pre-existing conditions. Changes to these terms must be confirmed in writing and **we** will write to **you** to confirm any changes, undertakings or promises that **we** make.

(bb) prescription
out-patient drugs and diagnostics as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** which are relevant to that condition and are covered by the **member's policy**.

(cc) principal country of residence
the country where **you** live for 180 days, or more, in a **year**.

(dd) professional sports
a sport where **you**:

- are paid
- receive a grant or sponsorship (**we** do not count travel costs in this), or
- are competing for prize money

(ee) schedule of procedures and fees
an internal list of **surgical procedures we** maintain and regularly update which classifies **surgical procedures** according

to their complexity. It is recommended that **you** contact **us** before undergoing any **surgical procedure** to ensure that it is recognised by **us**, is conventional **treatment** and is covered under **your plan**. The eligibility of **your treatment** is not dependent upon the **schedule of procedures and fees**. To check the **schedule of procedures and fees** applicable to **Cyprus** please visit www.universallife.com.cy/eng

(ff) subscriber
the **member** with whom **we** have made this Agreement for the provision of cover for the **member** and/or **dependant/ family member** or, for **group** schemes, the employee.

(gg) Surgical procedure
an operation or other invasive **surgical** intervention listed in the **schedule of procedures and fees.**

(hh) treatment
a **surgical** or **medical procedure** which must be carried out by a **medical practitioner** except where **your benefit table** specifically allows otherwise. This includes:

- diagnostic procedures – consultations and investigations needed to establish a diagnosis.
- in-patient **treatment** – **treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights.
- daycare **treatment** – **treatment** at a **hospital** or out-patient clinic where the **member** is admitted to a **hospital** bed and requires a period of supervised recovery but does not stay overnight.
- out-patient **treatment** – **treatment** at an out-patient clinic, a **medical practitioner's** consulting rooms, in a **hospital** where the **member** is not admitted to a bed or when the **member** is visited for the purpose of receiving **treatment**.

Please note: **We** reserve the right to determine whether the **treatment** and/or diagnostics or tests are both necessary and appropriate to the condition for which the **member** is making a **claim**. **Our** decision will prevail in any event.

(ii) United Kingdom/UK
Great Britain and Northern Ireland including the Channel Islands and the Isle of Man.

(jj) visit
each separate occasion that the **member** meets with a **medical practitioner** and receives a consultation and/or **treatment** for a **medical condition**.

(kk) we/us/our
Universal Life Insurance Public Company Limited and any other companies **we** are affiliated with.

(ll) year
twelve Gregorian calendar months from when **your policy** began or was last renewed.

(mm) you/your
the **subscriber** and/or the **member** named on **your** membership statement.

Note: this handbook forms part of **your** contract of insurance with **us** and must be read in conjunction with the **benefits table** applicable to **your plan** and **your** latest membership statement.

Contact us:

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Email customersupport@unilife.com.cy or through our Customer service portal U connect

https://uconnect.unilife.com.cy/en/login

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