Private Medical Insurance

CyprusCHOICE

Member Guide

COSMOS insurance

Always by your side.

Welcome to CyprusCHOICE

This member guide outlines how to use **your** plan and should be read in conjunction with **your Table of Benefits** and **your Certificate of Insurance** which highlight the **benefits** applicable to **your cover**.

Please read these documents carefully to ensure **you** are aware of all the **benefits**, and the **terms** and conditions that are applicable to the **cover** provided.

If **you** have any queries regarding any of the **covers** provided, if **you** require more details about this **policy**, or if **you** have any changes in **your** personal circumstances or information, please contact **us**. Contact details are available in section one of this document.

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Important Information

Throughout this member guide certain words and phrases appear in **bold** type. This indicates that they have a special medical or legal meaning. Please refer to section 06 ‘definitions’.

01

Contacting us

Contacting us

We understand that there may be times when **you** need to contact **us** for information. **Your** queries may involve clarification of the **cover you** have, whether a particular **medical condition** is covered under the **policy**, how to make a claim or obtain **pre-authorisation** for **your treatment**, or to understand the status of **your** claim. Below are the key contact information and information about **your** digital membership card.

For claims within Cyprus and for international claims assistance:

T: +357 22796015
E: medicalclaims@cosmosinsurance.com.cy

Key contact information and your digital membership card

All **your** key contact information and **your** digital membership card is available in via the mobile application and **your** member portal.

You can download our application by visiting the AppStore for iOS or Google Play for Android.

For general queries relating to your policy:

Cosmos Insurance Company Public Ltd
T: +357 77 77 6006
E: info@cosmosinsurance.com.cy

Mobile application and your member portal

The mobile application and **your** member portal allows **you** to submit **your** claims online, to review the status of **your** claim, to request a guarantee of payment, see **your certificate of insurance** and **policy** details, and to look up provider details on our provider network.

You can access the portal from our website by visiting:
www.cosmosonline.cy/url/medical-client-portal
Your log in details (ID and password) is provided to you when you join the plan.

02

Your insurance policy

Your insurance policy

This member guide forms part of **your policy** which consists of the following documents/items:

1. Certificate of Insurance

Your certificate of insurance outlines the level of cover under the policy and provides information on:

- what area of the world **you** are covered for
- the effective start date of **your cover**
- the benefits, conditions and exclusions
- the **renewal date** of the **policy**
- the names and date of entry of any **dependant** covered by the **policy**
- any deductible, co-insurance and waiting periods that may apply; and
- the underwriting terms applicable to the **policy**.

You will receive a certificate of insurance when:

- **you** join CyprusCHOICE
- **you** change any personal details (e.g. add or remove any **dependants**)
- **your** cover is renewed at the beginning of each renewal

Please check **your certificate of insurance** to confirm all personal information is correct. Please contact **us** as soon as possible if any corrections are required. **You** should look after **your certificate of insurance** as **you** may need to produce this in certain jurisdictions to renew **your** visa and to demonstrate proof of cover.

2. Table of Benefits

The **table of benefits** outlines all the healthcare services and procedures that are covered by **your policy**. Please read this carefully so that **you** understand what is and what is not covered and the financial limits that apply.

Policy Schedule
Your policy schedule outlines the level of cover under the policy and provides information on:

- Details of the **policyholder, principal member** and all **insured persons** covered under the **policy**
- The effective date of **your cover**
- Policy number
- **Period of insurance**
- Details of the **your** insurance plan (area of cover, **benefits, deductible** and **co-insurance**) that may apply
- Modal premium, annual premium, frequency of payment and mode of premium payment

3. Membership Card

In respect of the environment and as part of **our** corporate social responsibility, **we** are trying our best to limit the number of documents printed as well as the use of plastic.

For this reason a digital membership card for **you** and each **insured person** in **your** family is available through you member portal or via the mobile app.

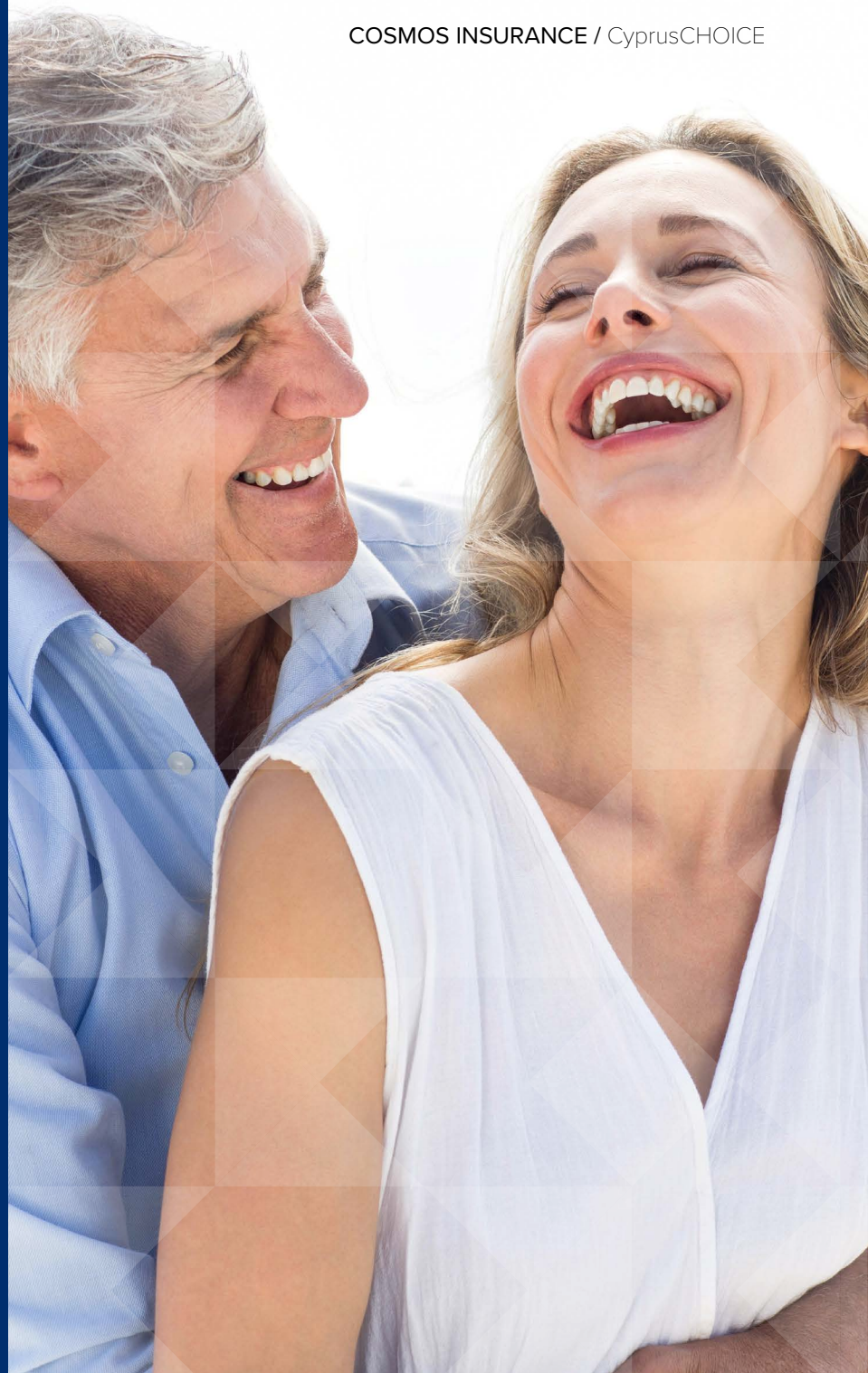
Should **you** wish to receive a physical membership card please let **us** know and **we** will issue one for **you**.

Please note that the possession of this card does not necessarily guarantee **cover**. If you are no longer covered by the **policy**, **your** card and membership number will be ineffective.

If **you** or any **insured person** loses a membership card, or if a correction is required, simply contact **us** and **we** will arrange for a new card to be sent to **you**. If you have urgent need of a new card, a temporary version is always available to be downloaded from **your** member portal.

03

Understanding the policy



Understanding the policy

The **policy** is designed to provide financial protection for the times **you** may require **treatment** and have incurred a financial cost.

We cover treatment which, in the opinion of a qualified **medical practitioner/specialist**, is appropriate and consistent with the diagnosis, is proven and demonstrated to be **medically necessary** and which is in accordance with generally accepted medical standards.

Your table of benefits and **certificate of insurance** will confirm which **benefits** are available to **you**.

In order to help **us** support **you** effectively **we** recommend that **you** contact **us** in order to pre-authorise certain **treatments** and services. This will enable **us** to review the required **treatment** and associated costs and confirm whether **you** will be covered under the terms of the **policy**. **We** recommend **you** notify **us** prior to any planned, non-**emergency** admission or **treatment**. **You** can refer to section one of this document for contact details of **our** international customer services team. Alternatively, a **pre-authorisation** form can also be obtained **from your member portal or mobile application**.

There are some services where we actively require you to pre-authorise and these are listed below:

- any **in-patient** or **day-patient treatment** in the United States of America
- **cancer** care
- **emergency** assistance and evacuation & repatriation services, including repatriation of mortal remains
- compassionate travel
- reconstructive/remedial surgery
- hospice care
- psychiatric **treatment** and psychotherapy (**in-patient care**)
- home nursing
- transplant services
- **rehabilitation** services
- renal dialysis; and
- **new born care**

These **benefits** are marked with a (📞) in **your table of benefits**.

You can access **our** services through **our** service and claim team. The contact details are available on the mobile application and **your** member portal as well as in section one of this booklet.

Important Information

Failure to pre-authorise services with mandatory pre-authorisation, may mean that some or all of the costs involved will be your responsibility to pay.

Deductibles and Co-insurances

You may have **deductibles** and/or **co-insurances** applied to **your policy**. If **you** do, you will be required to contribute to the cost of **your treatment**. Please refer to:

1. **your certificate of insurance** to identify the **deductibles** and **co-insurances** applied to the **policy**
2. **your table of benefits** for an explanation of how and where **deductibles** and **co-insurances** will apply to **your cover**
3. section 06 of this member guide for a definition of each term

Waiting Periods

Certain **benefits** may be subject to **waiting periods**. These **waiting periods** begin on the **policy start date** or on **your date of entry** (whichever is the later) and will be noted on **your certificate of insurance**.

Understanding the policy /continued

What to do in an Emergency

Where possible, in an emergency situation please contact **our** claims and service team whose details are specified on in section 01 of this document and on the mobile application or the member portal.

Our team of specially-trained advisors will help co-ordinate arrangements with local hospitals or even arrange for an evacuation or repatriation, depending on **your** circumstances. However, there may be occasions where **you** have not been able to contact **us** in advance of **treatment** and **you** are admitted to **hospital**.

Do not delay in receiving **treatment**. **You** or **your** representative should try to contact **us** at the earliest practical opportunity (usually within 48 hours of the emergency occurring). Alternatively make sure that the **hospital** is aware of **your** insurance cover with **us** so that they can contact **us** on **your** behalf. **We**, or **our** partners, will then communicate with the **hospital** to enable direct settlement, where eligible.

Receiving Treatment in the United States of America

If you require **treatment** in the USA, please check if **you** have coverage for **treatment** in this **geographical area**, as there may be restrictions in the **cover** that is provided under the **policy**. **You** must pre-authorise any **in-patient** and **day-patient treatment** in the USA otherwise eligible medical costs will be subject to a 20% **co-insurance** clause.

Receiving Treatment in Sanctioned Countries

If **you** require **treatment** in a country that has a UN sanction against them, **we** are not able to facilitate payment on **your** behalf. All **treatment** in sanctioned countries must be done on a reimbursement basis.

04

How to make a claim

How to make a claim

There are different ways in which **your** claim can be settled.

Pre-authorisation

It is important that **you** verify that the service or **treatment you** are receiving requires **pre-authorisation**. For services or **treatment** requiring **pre-authorisation**, **you** must contact **our** claims and service team 5 days before the planned service or **treatment**.

Direct Billing

Direct billing is widely available with providers within **our** network for both **in-patient** and **out-patient** services. There are certain **treatments** that are not available for direct billing and direct billing cannot be achieved with providers outside of **our** provider network. In these circumstances **you** will be required to pay for the cost of the service provided and to then submit a reimbursement claim to **us**, if applicable. Where direct billing is available, **you** will only be required to pay **your** member liability e.g., **co-insurance**, **deductible**/ excess, co-payment.

If any of the services or **treatments** are not eligible under **your policy**, **you** will be responsible for paying these costs. This includes costs that **we** have had to settle on **your** behalf in order for **you** to receive access to direct billing. **Our** claims and service team will work with you to settle the outstanding funds either by **you** making a lump sum payment for the amount owed or by **us** offsetting the amount owing against future claims. Settlement of the full amount owing must occur within 30 days of written notice from **us** (unless otherwise agreed upon) or **we** have the right to suspend **your benefits** (upon giving notice to **you**) until the **policyholder** or **you** have settled the full outstanding funds with **us**.

Important Information

- **Pre-authorisation** does not guarantee that all costs and expenses will be covered.
- **We** reserve the right to review each claim for medical expenses incurred and co-ordinate coverage according to the terms and conditions of this **policy**.
- All other costs and expenses that are not covered under this **policy** must be settled directly with the network provider and **we** shall have no liability in this regard (unless otherwise agreed with **our** claims and service team).
- For **in-patient** stays that extend beyond the pre-agreed duration approved by **our** claims and service team, **you** or **your medical practitioner** must send **us** a medical report before the pre-authorised duration ends, confirming any complications necessitating the extended **hospital** stay, **treatment** already given, proposed **treatment** and/or discharge date.
- **Our** reimbursement rates are based on **reasonable and customary** charges. Costs that are deemed not **reasonable and customary** will not be covered (unless **we** agree otherwise in writing with **you**) and **we** shall be entitled to charge **you** an additional fee for the costs incurred if not pre-authorised.

How to make a claim /continued

step 01

Pre-authorisation

1. Before **you** seek **treatment**, verify if the service requires **pre-authorisation**. If **pre-authorisation** is not required, **you** can begin making arrangements for **your** claim.
2. Contact **us** five days before the planned **treatment**.
3. **We** will send a **pre-authorisation** form to **you** or to the healthcare provider within one working day.
4. Have the healthcare provider complete the **pre-authorisation** form and submit to **us**.
5. **You** will be notified by **our** claims and service team once services have been authorised.

step 02

Make arrangements for your claim

Where possible, **we** can settle **your** claim directly with the in-network healthcare provider, or **you** can choose to pay upfront and submit **your** covered expenses for reimbursement. Please note that direct billing is only available with certain in-network healthcare providers.

Direct Billing

1. Locate an in-network healthcare provider on the provider finder which is located in **your** member Portal. Please ensure **you** review the Access Instructions (found next to each provider listing) as they contain important information.
2. Follow the access Instructions on the provider finder as **you** may be required to contact **our** claims and service team prior to presenting **your** membership card to a healthcare provider.
3. Where required, **we** will issue a Guarantee of Payment (GOP) letter to the healthcare provider confirming **your benefits**.
4. **You** will only be asked to pay **your** member liability (co-insurance/ deductible) at the time of service.
5. The healthcare provider will send the invoice directly to **us**.
6. Explanation of **benefit** statement which provides information about what was paid are available on the mobile application as well as on the member portal.

Reimbursement

1. Pay for the service upfront and submit your claim via the member portal or mobile application.
2. **We** will review the claim and notify **you** if additional information is required.
3. **We** will send any eligible reimbursement to **you** by cheque or bank transfer to the account of **your** choice.

How to make a claim /continued

Reimbursement Claims

If **you** have paid for **your treatment** upfront, **you** must submit the reimbursement to **us** within 6 months from the date of **treatment**. **You** can submit **your** reimbursement claim online via the member portal found at **www.cosmosonline.cy/url/medical-client-portal** or via the mobile application.

You must attach **your** invoice with proof of payment (payment or credit card slip) for **your** claim to be processed. **Your** invoice must reference medical information including **your** diagnosis and/or procedure. Any additional information including medical documentation, discharge summary (in the case of **hospital** admission) should be attached to ensure **your** claim can be processed efficiently. Please retain the original invoices and supporting documentation for 6 months after the submission of **your** claim. **We** reserve the right to request original documents if required.

If **your** invoices do not contain sufficient medical information including **your** diagnosis and/or procedure, **you** will need to complete the manual version of the claim form which can also be found on the member portal. **You**r provider will need to complete the section requesting medical information.

We will settle or reject a claim, as the case may be, within 30 days of the receipt of the last necessary document.

Please note that any fee that **your medical practitioner/specialist** may charge for completing a **pre-authorisation** or claim form is **your** responsibility to pay.

05

What is covered / What is not covered

What is covered

All the **benefits** covered by this **policy** are shown in the **Table of Benefits** and the specific **cover** options **you** are covered under are outlined in **your certificate of insurance**. The **benefit limits** are per insured **person** and either per **medical condition** or **per period of cover**.

Please remember that this guide is not intended to **cover** all eventualities. **Our policy** has been designed to provide **cover** for **reasonable and customary charges** and for **medically necessary** and active **treatment** of disease, illness or injury.

What is not covered

There are certain **medical conditions** and **treatment** that **we** do not **cover**. If **you** are unsure about anything in this section, please contact **us** for confirmation that you are eligible before **you** go for your **treatment**.

Personal Exclusions

Please check **your certificate of insurance** to see if **you** have any personal exclusions or restrictions on the **policy**.

The exclusions in this section apply in addition to and alongside any such personal exclusions and restrictions and apply to any and all **related conditions**, their complications or increases in costs arising from them.

A

1. **Alcohol and substance abuse**
   Medical **treatment** and/or care for alcoholism, drug and substance abuse/dependency including any **medical condition** and/or bodily injury directly or indirectly arising from such abuse or dependency or for any **treatment** due to the **insured person** being under the influence and/or suffering from the effects of alcohol, intoxicants, drugs, narcotics or other such substances.
2. **Artificial life maintenance**
   Artificial life maintenance including life support machine use where such maintenance is judged by the treating **medical practitioner/specialist** that it will not result in recovery or restore **you** to **your** previous state of health.

B

3. **Birth control**
   Investigations, **treatment**, tests or prescribed **drugs and dressings** related to contraception, sterilisation, elective termination of pregnancy or family planning.

C

4. **Chemical contamination and exposure**
   Treatment of any **medical condition**, or for any claim arising directly or indirectly from chemical or biological contamination, exposure to asbestos or from contamination by radioactivity from any nuclear material whatsoever, however caused, including those caused by or contributed to by an act of war or **act of terrorism**.
5. **Conflict/acts of terrorism**
   Claims resulting from war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, riot, civil commotion, military or usurped power or any **act of terrorism**, except where such injury/illness is sustained as an innocent bystander and where there was no exposure to nuclear, chemical or biological weapons or contamination.
6. **Congenital conditions**
   Treatment costs for abnormalities, deformities, diseases, illnesses or injuries present at the time of birth, whether diagnosed at birth or after.
7. **Convalescence**
   Provision of care when it is used solely or primarily for convalescence, supervision, pain management or any other purpose other than for receiving eligible **treatment** as specified in the **table of benefits** or for the purpose of receiving services which would not normally require trained medical professionals to provide such assistance.
8. **Cosmetic treatment**
   Treatment costs relating to cosmetic or aesthetic **treatment** or any **treatment** which is carried out to restore your appearance as a result of any **medical condition** or psychological condition, **injury** or previous **surgery** except as is particularly specified in the **table of benefits**.
9. **Criminal acts**
   Intentional, fraudulent, illegal or criminal acts by the **insured person**, including resisting authority.

What is not covered /continued

D

10. Dental treatment
A **medical condition** or **related condition** arising from or as a consequence of gum disease, including but not limited to gingivitis (**treatment** extending beyond preventative scaling and polishing) or Periodontitis, jaw shrinkage or the **treatment** of bone disease when related to gum disease, disorders of the temporomandibular joint, Gnathological **treatment** and scans where the dental **treatment** is being covered by the **policy**. Any other dental **treatment** except as outlined in your **table of benefits** and as specified on **your certificate of insurance**.

11. Developmental disorders
Testing or medical **treatment** for learning difficulties, autism, hyperactivity, attention deficit disorder, speech disorders, dyslexia, social or behavioural problems, child development and physical developmental problems or **treatments** that encourage positive social-emotional relations.

12. Dietary supplements
Dietary supplements and substances including but not limited to vitamins, minerals, protein supplements, infant foods and organic substances regardless as to whether prescribed by a **medical practitioner/specialist** and/or are acknowledged as having therapeutic effects. However, products classified as vitamins and minerals are covered if needed during **pregnancy**, to treat diagnosed clinically significant vitamin deficiency syndromes or form part of an accepted clinical **treatment** plan.

13. Dietitian / Nutrition consultations
We do not **cover** the cost of a dietitian or nutritionist for the purpose of undertaking a dietary control regime related to the control of weight, or management of a **medical condition**.

E

14. Eating disorders
Investigations or **treatment** (including cosmetic **surgery**) for obesity, eating disorders, weight problems or weight loss whether or not resulting from any **medical condition** or psychological condition.

15. Emergency dental treatment
Emergency dental **treatment** that is not a result of an **accident**.

16. Emergency treatment outside geographical area
Treatment costs outside **your** geographical area unless if **your medical condition** requires urgent medical care. In such case **we** will pay for **emergency treatment** outside your geographical area up to the limit mentioned in **your table of benefits**.

17. Epidemics
Healthcare services relating to internationally and locally recognised epidemics, or pandemics.

18. Experimental treatment
Any costs in connection with **treatment**, services or drug therapy that is deemed by **us** to be experimental or unproven based on generally accepted medical practice or provided by an unlicensed physician or any **immediate family member**.

19. Eyesight
Surgery or procedure to correct short or long sightedness. The provision of any eyewear or contact lenses except where provided within **your table of benefits** as indicated on **your certificate of insurance**.

F

20. Fertility treatment
Treatment to assist reproduction, including but not limited to ART **treatment**, or surrogacy.

21. Footcare
Treatment for corns, calluses, or thickened or misshapen nails.

G/H/I/J/K/L

22. Genetic testing
Genetic tests, when such tests are solely performed to determine whether or not **you** may be genetically likely to develop a **medical condition**, unless pre-authorised and organised by **us**.

23. Harvesting
The **policy** will not **cover** the harvesting of stem cells, sperm, eggs, or umbilical cord blood for future use.

24. Hazardous activities
Claims arising as a result of participation in professional sporting activities or any hazardous sports or activity including, but not limited to kite-surfing, mountain biking, rock or cliff climbing, mountaineering, yachting outside territorial waters, motor sports, aerial activities and sports, bungee jumping, scuba diving (to a depth greater than 30 metres or where a current PADI certificate is not held), any sport involving animals, off-piste skiing (unless it takes place in a recognized and approved area) and speed races of any kind (except on foot).

25. HIV / AIDS
We do not **cover** costs which arise from, or are in any way related to Human Immune Deficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any variations thereof.

26. Home visits
Home visits from a **medical practitioner/specialist** are not covered unless **you** are medically incapable of going to the medical facility and the visit is pre-authorised by **us**.

27. Hormone Replacement Therapy
We do not **cover treatment** of the menopause, irrespective of whether it is due to a hysterectomy, early onset or as a normal consequence of aging.

28. Indirect loss
Losses that are not directly covered by the terms and conditions of this **policy**, including, without limitation, loss of opportunity and loss of profit.

What is not covered /continued

M/N/O

29. Maternity
You are not covered for costs relating to normal pregnancy or childbirth, voluntary caesarean section, or home birth unless maternity **benefits** are specifically shown on **your table of benefits** and **certificate of insurance**.

30. Medical equipment/medical error
Claims directly or indirectly arising from medical error or the failure of any medical/surgical equipment or device of any kind.

31. Non-clinical facilities
Treatment or services received in health hydros, nature cure clinics or any establishment that is not a **hospital**.

32. Not following advice
Treatment rising from or related to **your** failure to seek or follow medical advice or **treatment**, **your** unreasonable delay in seeking or following such medical advice or **treatment** or for complications arising from ignoring such advice. Any claim arising as a result of air travel when **you** are more than 28 weeks pregnant. Costs incurred where **you** have travelled to a country or specific area which **your** Government or Embassy (in **your country of residence**) have advised against travelling to under any circumstances.

33. Organ transplantation
Treatment costs for, or as a result of transplants involving mechanical or animal organs, the removal of a donor organ from a donor (unless the removal of the donor organ is undertaken at the time of the transplant and in the same medical facility as the transplant), the removal of an organ from **you** for purposes of transplantation into another person or the purchase of a donor organ. **We** also do not **cover** any costs associated with the purchase of a donor organ.

34. Orthodontic treatment
We do not **cover** the costs of orthodontic **treatment**, or the associated costs of a **dental practitioner** carrying out orthodontic **treatment**.

P/Q/R

35. Persistent vegetative state / neurological damage
Hospital treatment for more than 90 continuous days for permanent **neurological damage** or if you are in a **persistent vegetative state**. For the purpose of this **policy**, coma lasting more than 90 continuous days will be classed as permanent **neurological damage**.

36. Psychiatric and psychotherapy treatments
Any psychiatric and/or psychotherapy **treatment** that is not a **medically necessary treatment** of a recognised mental health disorder in a recognised psychiatric unit of a **hospital** and is not performed as part of an **in-patient care** administered under the direct supervision of a consultant psychiatrist.

37. Physical aids and devices
Any physical aid or device which are not appliances, prosthesis or **durable medical equipment**.

38. Pre-existing medical conditions
Pre-existing medical conditions, unless **your policy** is MHD underwritten, or **you** have declared **your pre-existing medical conditions** when **you** applied for cover and **we** accepted them.

39. Routine examinations/preventative care
Routine medical examinations undertaken six (6) months after **your** enrollment to the plan, health screening examinations or tests to rule out the existence of a **medical condition** for which **you** do not have any symptoms, unless these benefits are specified in **your table of benefits** and on **your certificate of insurance**.

S/T

40. Second opinions
The costs of any second or subsequent medical opinions from a **medical practitioner/specialist** for the same **medical condition** unless pre-authorised and organised by **us**.

41. Sexual/gender issues
Investigations and **treatment** of any sexual problems or dysfunction or any **treatment** including counselling and psychotherapy or any surgical procedure which is directly or indirectly associated with gender reassignment.

42. Sexually transmitted diseases
Investigations and/or **Treatment** for sexually transmitted diseases.

43. Sleep disorders
Investigations or **treatment** for sleep disorders (including sleep apnoea and insomnia), snoring or other sleep related breathing problems.

44. Speech therapy
We do not pay for speech therapy, save in relation to the restoration of normal speech post-trauma or an acute **medical condition** or is particularly specified in the **table of benefits**.

45. Suicide/self-inflicted injury/negligent or reckless behaviour
Cost of **treatment** from any suicide, attempted suicide, deliberate self-inflicted injury, negligent or reckless behaviour and/or needless self-exposure to peril, except in an attempt to save human life.

46. Travel and accommodation
Transportation or accommodation costs **you** incurred during trips made specifically to get medical **treatment** unless these costs are for an **emergency** medical evacuation and were pre-authorised by **us**.

47. Treatment / Care provided by relatives
Treatment or care cannot be provided by an **immediate family member** or **dependant** of the **insured person**.

U/V/W/X/Y/Z

48. Unlicensed/unrecognised treatment
Treatment provided or under the direction of a **medical practitioner/specialist** or medical facility that is not recognised by the relevant authorities in the country where the **treatment** takes place as having specialised knowledge, or expertise in, the **treatment** of the **medical condition** or injury being treated.

49. Utero foetal surgery
All costs associated with utero foetal surgery are excluded from **cover**.

06

Definitions

Definitions

Throughout this member guide certain words and phrases appear in **bold** type. This indicates that they have a defined meaning, as detailed below.

A

Accident
A sudden, unexpected, unforeseen or involuntary external event that results in physical injury to an **insured person** during the **period of cover**.

Act of terrorism
An act of terrorism means an act, including but not limited to, the threat or use of force or violence of any person or group of persons whether acting alone or on behalf of any organisations or governments, committed for political, religious, ideological or similar purposes or reasons including the intention to influence governments and/or to put the public or any section of the public, in fear.

Acute
The sudden onset of a **medical condition** which is likely to respond quickly to **treatment**.

Annual maximum
The maximum **we** will pay for all **benefits** in total, per **insured person**, per **period of cover**.

Appliances
Devices and equipment when used as an integral part of a surgical procedure administered by a **medical practitioner specialist** except those defined as **prosthesis** or **durable medical equipment**.

B

Benefit(s)
Insurance **cover** provided under the **policy** and any extensions, restrictions, special conditions or endorsements as noted in **your certificate of insurance**.

Benefit limit(s)
A limitation that applies to selected **benefits** or particular parts of a **benefit** as noted on **your table of benefits**. These can either be limited by cost or frequency. All **benefit** limits are applied per **insured person**, and either per **medical condition** or per **period of cover**.

C

Cancer
A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Certificate of insurance
The certificate outlining details of the **policyholder**, the **insured person(s)**, the **policy start date**, the **date of entry** of each **insured person** and the **renewal date**, a summary of the level of **cover** provided (which should be read in conjunction with the **table of benefits**), the **geographical area** of the **cover,** as well as any **deductibles**, individual exclusions **co-insurances** and **waiting periods** that may apply.

Chronic condition
A disease, illness or injury which has one or more of the following characteristics:
- it is recurrent in nature
- it has no known recognised cure
- it requires prolonged monitoring and/or supervision through consultations, **examinations**, check- ups, tests or medication
- it needs **palliative treatment**
- it requires **your rehabilitation** or for **you** to be specially trained to cope with it
- it may lead to disability.

Co-insurance
Applies to selected **benefits** and is the amount that is shared between **us** and **you** for each **treatment** undertaken. Where applied, they apply to each **insured person** for each **period of cover**.

Complementary treatment
Refers to therapeutic and diagnostic **treatment** that exists outside the institutions where conventional medicine is taught and specifically refers within the **cover** to acupuncture, homeopathy, osteopathy, chiropractic **treatment**, podiatry, traditional Chinese medicine and ayurvedic medicine, provided by a practitioner who is qualified and licensed to practice in the country where the **treatment** is given.

Convalescence cash benefit
A cash **benefit** following discharge from **hospital** admission after a minimun stay of five (5) nights, **you** are confided to home for a period of recuperation and with a maximum amount as it is stated to **your table of benefits**.

Congenital disorder
Abnormalities, deformities, diseases, illnesses or injuries present at the time of birth, whether diagnosed at the time or not.

Country of residence
Cyprus, in which **you** reside for a period of no less than three months per **period of cover**.

Cover
The level of insurance coverage which applies to **you** and any **dependants** and is subject to financial limits which are set out in **your certificate of insurance** and **your table of benefits**.

Cyprus
The geographical area of Cyprus with the exception of the areas of the Republic of Cyprus where the Government of the Republic of Cyprus does not exercise effective control.

D

Date of entry
The date shown on the **certificate of insurance** on which **you** were first included under the **policy** and from which **you** have been on continuous **cover** with **us**.

Day-patient
A person who is admitted to a **hospital** or day care unit where they need a period of medically supervised recovery but do not stay overnight.

Definitions /continued

Deductible
The annual amount that each **insured person** must pay each **period of cover** before the **policy** will pay certain **benefits**. Where applied, **deductibles** are payable per **insured person** per **period of cover**, unless indicated otherwise in the **table of benefits**. Deductible amounts applicable will be indicated in **your certificate of insurance**.

Dental practitioner
A person who is legally licensed to carry out this profession by the relevant licensing authority to practise dentistry in the country where the dental **treatment** is given and recognised by **us**.

Dependant(s)
One spouse or adult partner or any unmarried children, step-children or legally adopted children provided that they are living with the **principal member** and are under the age of 19 (or under age 26 and in full-time education or servicing their military duty) on the **start date** of the **policy** or at any subsequent **renewal date**. All **dependants** must be named as **insured persons** in the **certificate of insurance**.

Diagnostic tests
Investigations such as x-rays, blood tests and pathology to assist in finding the cause of symptoms of a **medical condition**.

Drugs and dressings
Essential prescription drugs, dressings and medicines needed to treat an eligible **medical condition**, which are authorised and recognised in the country where they are prescribed and are administered by a **medical practitioner/ specialist**. **We** do not cover prescriptions for **drugs and dressings** that can be purchased over the counter.

Durable medical equipment
Any medical items, supplies, equipment or devices used in the course of medical **treatment** or home care. These may include but are not limited to orthopaedic supports and braces (including arch-supports), crutches, wheelchairs, speaking aids and any medical or surgical supplies.

E

Emergency
A sudden, serious, and unforeseen **acute medical condition** or injury requiring immediate medical **treatment** to avert death or significant bodily impairment. Such **treatment** being undertaken within 24 hours of the **medical condition** or injury occurring.

Emergency dental treatment
Dental **treatment** necessary as a result of an **accident** caused by an extra-oral impact (i.e. any form of impact/ **accident** or injury occurring from outside the oral cavity) received within 48 hours from the date and time of the **accident** for the immediate relief of pain caused by natural teeth being lost or damaged.

Europe
Aland Island, Albania, Andorra, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Georgia, Germany, Gibraltar, Greece, Hungary, Iceland, Isle of Man, Italy, Kazakhstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Republic of Ireland, Romania, Russia (excluding Crimea), Svalbard and Jan Mayen, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, United Kingdom, Vatican City.

Examinations
Routine examinations including a review and record of the patient's complete medical history, a check of all body systems and a review and discussion of the exam results with the patient. Well-child examinations include a review and record of the child's complete medical history and a check of all body systems in accordance to normal growth and development.

F/G

Geographical area
The geographical scope of the **cover** provided and where **treatment** can be undertaken. This will be highlighted in **your certificate of insurance**.

Group agreement
The agreement **we** have with the **policyholder** which sets out which persons are eligible to be covered under the **policy**, when **cover** begins, how it is renewed and how premiums are paid.

H

Home birth
Delivery of a child in a non-clinical setting using natural childbirth methods attended by a midwife with expertise in managing home births.

Hospital
Any establishment, which is licensed as a medical or surgical **hospital** under the laws of the country where it operates or other suitably licensed medical facilities used for the same purpose and which are licensed and supervised by the appropriate medical authorities in the country in which they are based.

I/J/K/L

Immediate family member
A relative limited to mother, father, brother, sister, son or daughter, any step-children or legally adopted children and spouse.

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

Insured person(s)/you/your
The **principal member** and the **dependants** (if any) named on the **certificate of insurance**.

M

Medical condition
Any disease, injury, or illness, including **mental health disorders**.

Medical history disregarded (MHD)
Insurance policies with **Medical History Disregarded** do not require the customer to provide details of their medical history before their **policy** is accepted. **Cover** is provided for **treatment** of **pre-existing medical conditions**.

Definitions /continued

Medically necessary
Treatment, which in the opinion of a qualified **medical practitioner/specialist** is appropriate and consistent with the diagnosis, is proven and demonstrated to have medical value and which is in accordance with generally accepted medical standards and could not have been omitted without adversely affecting the **insured person's** condition, or the quality of medical care rendered. Such **treatment** must be required for reasons other than the comfort or convenience of the patient or **medical practitioner/specialist** and provided only for an appropriate duration of time.

Medical practitioner
A physician who has attained primary degrees in medicine or surgery at a recognised medical school and who is licensed to practice medicine under the law in the country in which **treatment** is given within the limits of their license.

Mental health disorders
Any disorder associated with substantial distress or impairment which impacts the patient's ability to function in a major life activity, such as employment. These disorders must meet international criteria classification against, for example, the Diagnostic and Statistical manual (DSM-IV-TR).

N/O

New born
A baby who is within the first 16 weeks of its life following birth.

New born care
Refers to any **medical condition** arising which requires **treatment** within the first 30 days of birth.

Out-patient
A patient who attends a **hospital**, consulting room or clinic and is not admitted as a **day-patient** or **in-patient**.

P/Q

Palliative treatment
Treatment aimed at alleviating the physical/ psychological suffering of progressive, incurable illness.

Period of cover
The **period of cover** set out in the **certificate of insurance**. This will usually be a 12-month period starting from the **start date** or any subsequent **renewal date** as applicable.

Persistent vegetative state / neurological damage
Chronic state of unconsciousness resulting from overwhelming damage to the cerebral hemispheres whereby **you** are unable to express any behavioural or cerebral metabolic evidence of possessing cognitive function or being able to respond in a learned manner to external events or stimuli.

Physiotherapist
A practising physiotherapist who is registered and licensed to practise in the country where **treatment** is provided.

Physiotherapy
Treatment recommended by a **medical practitioner/ specialist** as being **medically necessary** to treat an illness, bodily injury or **medical condition** where provided by a licensed and qualified **physiotherapist**. **Physiotherapy** does not include ante-natal and maternity exercises, manual therapy or sports massage.

Policy
Our contract of insurance with the **policyholder** and the **cover** which it provides **you**.

Policyholder (group policies)
A company, association or school which has taken out the **group agreement** with **us**.

Policyholder (individual policies)
The person identified as the policyholder on the application form and whose name the **policy** is held.

Post Hospital Expenses
Medically necessary expenses occurring immediately after and within the first ninety (90) days following **your treatment** as an **in-patient** or **day-patient**, such as **outpatient consultations**, wound changes, **diagnostic tests, prescribed drugs and dressings, physiotherapies, Durable Medical Equipment.**

Pre-authorisation
The confirmation needed from **us** before receiving **treatment** of an injury or **medical condition** for selected **benefits** as defined in the **table of benefits**.

Pre-existing condition
Any **medical condition**, **mental health disorder** or any **related condition** for which **you** have received **treatment**, suffered any symptoms (whether investigated or not) or sought advice for prior to **your date of entry**.

Pregnancy
Refers to the period of time from conception until delivery.

Premature birth
A baby born prior to the start of the 37th week of **pregnancy**.

Principal member (group policies)
An employee/member/student of the employer/Association/ school whom **we** have agreed to **cover** under the **policy**.

Principal member (individual policies)
The person identified as the **policyholder** on the application form and in whose name the **policy** is held.

Prosthesis
An artificial substitute or replacement for part of the body limited to eyes, joints and limbs. For internal prosthesis, refer to **'appliances'**.

Qualified nurse
A nurse whose name is currently on any register or roll of nurses, maintained by any statutory nursing registration body within the country where **treatment** is provided and recognised by **us**.

R

Reasonable and customary charges
The standard fee that would typically be made in respect of **your treatment** costs, in the country where the **treatment** took place. **We** may require such fees to be substantiated by an independent third party.

Rehabilitation
Medically necessary treatment in the form of a combination of therapies such as physical, occupational or speech

Definitions /continued

therapy aimed at restoring independent activities of daily living and the normal form and/or function of an **insured person** following a **medical condition**.

Related condition(s)
Any **medical condition** that **we** deem to be either an underlying cause of or directly attributable to the **medical condition** to which **you** are claiming.

Renewal date
The anniversary of the **start date** of the **policy** as shown on **your certificate of insurance**.

Room and board
Refers to a standard private single room or semi- private room with a private bathroom.

S

Specialist
A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery who is licensed to practise medicine by the relevant authority in the country where the **treatment** is given, and is recognised as having a specialised qualification in the field of, or expertise in, the **treatment** of the disease, illness or injury being treated.

Start date
The date from which **your cover** begins under the **policy** as shown on **your certificate of insurance**.

T

Table of benefits
The list of benefits outlining the scope of **cover** provided including any monetary or frequency limits that may be applicable.

Terminal
Where **treatment** can no longer be expected to cure the **medical condition** and with death anticipated within 12 months of diagnosis.

Treatment(s)
Any medical, dental or surgical services (including **diagnostic tests**) that are needed to diagnose, relieve, manage or cure any **medical condition**, illness or injury under the direction of a recognised **medical practitioner/specialist**.

U /V

Urgent medical care
Care needed for a **medical condition** that does not require **emergency** care but for which, based on medical appropriateness, **treatment** must be provided sooner than a normally scheduled appointment.

Vaccinations
All basic immunisations and booster injections under the regulation of the country where the **treatment** is given, any **medically necessary** travel vaccinations and malaria prophylaxis, vaccinations to aid the prevention of **cancer**, such as the Human Papilloma Virus (HPV), and vaccinations recommended as part of a national immunisation programme in **your country of residence** or home country. Routine vaccinations and immunisations include influenza (seasonal flu) vaccination, Diphtheria, Hepatitis A & B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Haemophilus Influenza B, Rotavirus, Meningococcal and Pneumococcal Conjugate.

W/X/Y/Z

Waiting period
Is a period of time starting on the **date of entry** of the **insured person**, during which the **insured person** is not entitled to cover for particular **benefits**. **Your table of benefits** will indicate which **benefits** are subject to **waiting periods**.

We/us/our
Cosmos Insurance Company Public Ltd. and any company(ies) that provide administrative, management and related services involved in the operation of this **policy**.

07

General Conditions

General Conditions (Group & Individual Policies)

Other insurance

If there is any other insurance covering any of the **benefits** that are provided under the **policy** for which a claim is made, then **you** must disclose this to **us** at the time of submitting the claim. In these circumstances, **we** will not be liable to pay or contribute more than **our** proper rateable proportion.

If it transpires that **you** have been paid for all or some of the claim costs by another source of insurance **we** have the right to a refund from **you**. **We** reserve the right to deduct such refund from **you** from any impending or future claim settlements or to cancel the **policy** from the **start date** of the **policy**, or **your date of entry** (whichever is the later) without a refund of premium.

Subrogation

If **we** feel it is appropriate **we** may exercise rights of subrogation. This means that if **you** have suffered an injury of loss that has resulted in a claim under the **policy** **we** may take over **your** right to seek compensation from the party that caused the injury or loss.

Help and Intervention

Our provision of help and intervention under the **policy** is subject to national and international laws and the availability of qualified medical facilities. Whilst **we** will do **our** best to overcome any local restrictions there may be times when these either prevent **us** from providing help and intervention or limit **our** ability to do so.

Currency Conversions

If the currency of the invoice is different to the **policy** currency, the exchange rate is based on the date of service or **treatment** to convert the incurred amount to the **policy** currency. This same rate is then used to convert the payable amount from the **policy** currency back to the incurred currency thereby not creating a shortfall for the payment recipient.

Third Party Rights

The **policy** is a contract between **us** and the **policyholder**. The **policyholder** is the only entity with the right to enforce the terms of the **policy** or, with **our** consent, to vary its terms. **We** have agreed with the **policyholder** that third parties will not have any right to enforce the **policy**. This does not affect **your** right to bring a complaint against **us**.

When we need your Consent

In order to provide insurance **cover** and deal with insurance claims, **we** may need to process categories of personal data which have additional protection under data protection law, such as **your** health data. **You** and **your dependant's** consent to this processing may be necessary for **us** to achieve this. **You** and **your dependant's** consent may be withdrawn at any time. However, if consent is withdrawn this will impact **our** ability to provide insurance or pay claims.

Data Protection

In order for **us** to provide insurance quotes, insurance policies or deal with any claims, **we** need to collect and process personal data about **you** and **your dependants**, including:

- individual details, such as name, address, date of birth and **your** employer;
- risk details, which is information **we** need to collect in order to assess the risk to be insured and provide a quote. This may include data relating to **your** and **your dependant's** health;
- current and past claims details, which may also include data relating to **your** and y**our dependant's** health.

We might collect **your** and **your dependant's** personal data from various sources, including **your** employer, **your** employer's insurance broker and medical experts appointed to treat **you** in the event of a claim. **We** will keep **your** personal data only for so long as is necessary and for the purpose for which it was originally collected. The provision of insurance involves the sharing of personal data between different insurance market participants and third parties who provide services in connection with the insurance, such as medical experts, each of whom may be located outside of the European Economic Area.

If **you** have any questions in relation to our use of **your** or **your dependant's** personal data, please visit **www.cosmosinsurance.com.cy/en/terms**

Law Applicable to this Policy

The policy has been issued in accordance with and is governed by the laws of Cyprus unless otherwise specified on the **certificate of insurance**.

General Conditions (Group Policies)

Eligibility

The policy is available to employees/members/students and their eligible **dependants** (spouse/partner and/or children).

Employees must:

- be employed full time by their employer by which **we** mean 21 hours per week or more.
- be aged under 65. If the employee is aged 65 or over, this must be declared to **us** in writing and will be subject to agreement by **us**. The maximum age of **coverage** in any event is 80.
- live or work in **Cyprus**.

We require members to complete a health declaration during the health insurance application process for them and their **dependants**. This will be required for all future additions to the **policy**.

Your cover will continue under the **policy** until **you** cease employment, **cover** is removed by the **policyholder, you** cancel **your cover** of **your** own accord, or retire from employment.

Dependants applying to the plan must be living with the principal member (employee/member/student).

Dependant spouse/partner must be under the age of 65.

Dependant children must be under age 19 (or under 26 if a full-time student or serving their military duty) and may remain covered under the **policy** until the first **renewal date** following their 19th birthday (or 26th birthday where in full-time education, or following completion of full time studies or following the completion of their military service) at which time their cover under the policy will end.

New borns are covered for the first 30 days after birth under their mother's **policy**, if the **policy** contains **newborn care** benefits and the mother has been covered by the policy for twelve (12) months, with the recondition that **new born** will be enrolled on the **policy** as a **dependant** within the first 30 days. If the **new born** is enrolled after 30 days from his/her date of birth, they may be subject to eligibility restrictions, including exclusion of any **pre-existing condition**.

Dependants will remain covered by the **policy** whilst the **principal member** remains employed by the **policyholder**.

Additions, Modifications and Cancellations

To add or cancel any **dependants** under this **policy** or to modify any details, please consult with the **policyholder** (employer/association/school).

For any addition or cancellation of members to the **group agreement**, **we** require notification from the **policyholder** (employer/association/school) within 30 days following the date on which the addition or cancellation is to be effective. Beyond that time, **we** reserve the right to make the required change on the date of notification or invalidate the **cover**.

For enrolment to the **group agreement, date of entry** cannot be backdated to account for claims that have already occurred. Additionally, for any cancellation to the **policy, we** will not be able to backdate the cancellation if claims have been processed or if **pre-authorisation** has been granted.

We are entitled to refuse, accept or impose terms for an application submitted by **you** or by any **dependants** and also reserve the right to ask for evidence of age, state of health (including medical records), employment status and proof of full-time education, adoption or any other change of circumstances at any time during the **period of cover**.

The **Policyholder** has the right at any time to cancel the **Policy** by sending a written notice to the **Company**. In that case **our** obligation is limited to the return of the **premium** that corresponds to that part that is terminated that may have been collected for a period subsequent to the termination period.

General Conditions (Group Policies) /continued

Death of the Principal Member

Should the **principal member** die, their partner or spouse (provided they are already covered by the **policy** as a **dependant**) will automatically become the **principal member** for the remainder of the **period of cover** or, if earlier, the date on which their **cover** under the **policy** comes to an end.

Premiums

The **policyholder** has taken out the **policy** with **us** and is responsible for paying the premiums due under the policy. If the **policyholder** (**your** employer/association/ school) fails to pay those premiums within thirty (30) days or comply with the terms and conditions of the **policy we** may terminate the **policy** and refuse to pay claims.

Alterations to the Policy

We may change the premium rates, **benefits** and terms and conditions of the **policy** from time to time,or withdraw the plan, but any such changes will not apply until the next **renewal date** following the introduction of such changes, unless **we** are legally obligated to do so beforehand.

Start Date and Renewal Date of Cover

Your cover under the **policy** is effective from either **your date of entry**, or the **start date** of the **policy** (whichever is the later) as shown on **your certificate of insurance** and is renewed annually the day following the expiry date thereafter. This is normally in twelve (12) month periods unless otherwise agreed between **us** and the **policyholder**. **You** will receive a **certificate of insurance** at the beginning of each new **period of cover**. **Your cover** is renewed (by way of premium payments) by the **policyholder** under the **group agreement**. Both **your cover renewal date** and the group **renewal date** are shown on **your certificate of insurance**.

Full Medical Underwriting Terms & Conditions

If any applicant is subject to Full Medical Underwriting, he/she must declare to **us** any and all known **pre-existing conditions**. These **pre-existing conditions** may be excluded on the **policy** and will be specified on **your certificate of insurance**.

Any undeclared **pre-existing conditions** are subject to review by **us** and can result in a restriction in **cover** or cancellation of the **policy**.

Termination

Your cover under this **policy** will end in each of the following situations:

- upon the death of the **Insured**
- the **policyholder** has failed to pay the premium on the date due. At **our** discretion, **we** may reinstate **cover** if the outstanding premium is paid to **us** although **we** reserve the right to make any variation in the **cover** provided
- where **you** have deliberately or recklessly misled **us** either by misstatement or concealment of a material fact or otherwise failed to act in good faith
- where **you** have failed to observe or breached the terms and conditions of the **policy**
- where **you** have either acted in a fraudulent manner or submitted an exaggerated claim
- on the date the **policyholder** advises **us** that **you** are no longer to be covered by the **policy**.

We will have no liability to pay for **treatment** received after the date the **policy** is terminated even if **treatment** has already been **pre-authorised** but not received as at the date of termination.

General Conditions (Individual Policies)

Eligibility

You, the **policyholder/principal member**, must ensure that information provided to **us** is accurate, true and complete to give **us** a fair representation of the risk **we** are being asked to take on. If **we** discover that **your** representations to **us** were false, misleading or untrue then **we** reserve the right to either void the **policy** including not returning the premium paid, or apply different terms and/or conditions to the plan. These changes may increase the premium **you** have to pay or reduce the **benefits** available under the plan.

The **principal member** must live in Cyprus. You must tell **us** if you change your address.

Insured members must be under the age of 64 years to join the **policy**.

Dependants (spouse/partner and/or children) applying to the plan must be living with the **principal member** and will be covered under the same level of benefit.

Your cover will continue under the **policy** until **you** cancel **your cover** of **your** own accord, in accordance with the terms of the **policy**.

Dependant children must be under age 19 (or under 26 in full-time education or serving their military duty/ service) and may remain covered under the **policy** until the first **renewal date** following their 19th birthday (or 26th birthday where in full- time education or serving their military duty) at which time their cover under the **policy** will end.

New borns are covered for the first 30 days after birth under their mother's **policy**, if the **policy** contains **newborn care benefits** and the mother has been covered by the **policy** for twelve (12) months with the precondition that the **new born** must be enrolled on the **policy** as a **dependant** within the first 30 days. If the **new born** is enrolled after 30 days from his/her date of birth, they may be subject to eligibility restrictions, including exclusion of any **pre-existing condition**.

Additions, Modifications and Cancellations

Any change to the benefits is allowed only at Renewal and after the submission of the relevant Alteration Form and following acceptance by **us**.

To add **dependants** under this **policy** or to modify any details, **you** must submit the relevant alteration form and submit it to **us**.

You have 14 days upon receipt of **your policy** to review **your cover** and ensure it meets **your** requirements. During this period **you** may cancel **your policy** with guarantee of a full refund as long as **you** have not been reimbursed for any claims during this time. After this period, **you** may cancel **your policy** or remove at any time but **you** will not be eligible for a refund.

We are entitled to refuse or accept an application submitted by **you** or by any **dependants** and also reserve the right to ask for evidence of age, state of health (including medical records), employment status and proof of full-time education at any time.

Death of the Principal Member

Should the **policyholder** die, their partner or spouse (provided they are already covered by the **policy** as a **dependant**) will automatically become the **policyholder** or/and the **principal member**.

General Conditions (Individual Policies) /continued

Premium

You have taken out the **policy** with **us** and **you** are responsible for paying the premium due under the **policy**. If **you** fail to pay the premium within thirty (30) days or comply with the terms and conditions of the **policy we** may terminate the **policy** and refuse to settle claims.

Alterations to the Policy

We may change the premium rates, **benefits** and terms and conditions of the **policy** from time to time,or withdraw the plan, but any such changes will not apply until the next **renewal date** following the introduction of such changes, unless **we** are legally obligated to do so beforehand.

Start Date and Renewal Date of Cover

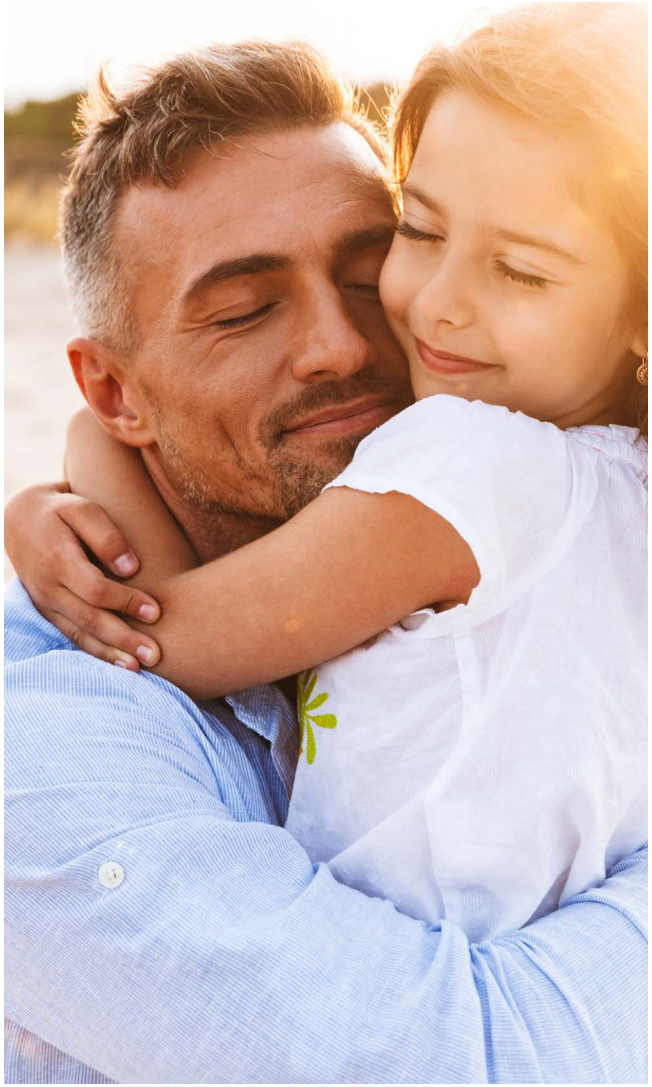
Your cover under the **policy** is effective from the **start date** of the **policy** as shown on **your certificate of insurance** and is renewed annually the day following the expiry date thereafter. This is normally every 12 month period unless otherwise agreed between **us** and **you**. **You** will receive a **certificate of insurance** at the beginning of each new **period of cover** and **we** will also advise under what terms the **policy** will continue. If **we** do not hear from **you** in response **we** will renew **your** plan on the new terms. If **you** have opted to pay premiums by credit card or other automatic payment method, **we** may continue to collect premiums by such method for the subsequent **period of cover. Your cover renewal date** is shown on **your certificate of insurance**.

Termination

Your cover under this **policy** will end in each of the following situations:

- upon the death of the **Policyholder** and/or the **Principal Member**
- at the **renewal date** you advise **us** that **you** no longer wish to be covered by the **policy**
- **you** have failed to pay any premium on the date due. At **our** discretion, **we** may reinstate **cover** if the outstanding premium is paid to **us** although **we** reserve the right to make any variation in the **cover** provided
- where **you** have misled **us** either by misstatement or concealment of a material fact or otherwise failed to act in good faith
- where **you** have failed to observe or breached the terms and conditions of the **policy**
- where **you** have either acted in a fraudulent manner or submitted an exaggerated claim.

We will have no liability to pay for **treatment** received after the date the **policy** is terminated even if **treatment** has already been **pre-authorised** but not received as at the date of termination.



08

How to make a complaint

How to make a complaint

Our aim has always been to meet and exceed customer and partner expectations, by providing immediate solutions and excellent customer service. In instances where **you** feel that we have not met **your** expectations, **we** would like to ask **you** to let **us** know, in order to help **us** identify and correct or improve **our** weaknesses in policies and procedures.

Should **you** have any query or complaint, please contact immediately **your** insurance intermediary or the branch through which **you** have arranged this insurance **policy**. If, following this communication, **you** are still dissatisfied or feel that **your** complaint has not been properly handled, then please contact **us** immediately through any of the following means:

1. In writing, by completing and submitting a "Complaint Form", which **you** may download from **our** website, under the "Complaint Procedure" label, and by sending it "for the attention of the Complaints Officer":
   – via post to the following address: P.O. BOX 21770, 1513 Nicosia
   – via email, to info@cosmosinsurance.com.cy
   – via fax, to +357 22 022000
2. Via phone, by calling +357 22 796000 and asking to talk to the Complaints Officer.

Following the receipt of **your** complaint and within a period of two (2) working days, **we** will send **you** a written confirmation of its receipt.

Our aim is to investigate all complaints and respond to them within fifteen (15) working days following receipt. In cases where this is not possible, **we** will inform **you** accordingly, in due time, for both the delay and its reasoning. In any case, **we** will respond to **your** complaint within thirty (30) working days following its receipt.

In the event that **we** (**us** and **you**) cannot reach a mutual agreement, falling within the terms and conditions of this **policy** and based on **our** standard company's procedures, **you** retain **your** right to pursue **your** complaint via an appeal to the Financial Ombudsman of the Republic of Cyprus or by taking legal measures.

To help **us** resolve **your** complaint, please supply the following information:

- **your** name and membership details
- a contact telephone number
- a description of **your** complaint
- any relevant information relating to **your** complaint that **we** may not have already seen.

The Financial Ombudsman Service

We will generally issue **our** final response within eight weeks from when **you** originally contacted **us**. However, **we** will respond sooner than this, if **we** are able.

If it looks as though **our** review of **your** complaint will take longer than this, **we** will let **you** know the reasons for the delay and will keep **you** informed and updated. If **we** cannot respond fully to **your** complaint within eight weeks, or **you** are unhappy with **our** final response, **you** can refer **your** complaint to the Financial Ombudsman Service for an independent review. The Financial Ombudsman Service will only consider **your** complaint once **we** have issued a final response, or if eight weeks have passed since **you** first notified us of **your** complaint.

How to contact the Financial Ombudsman Service

- By facsimile (fax) to +357 22 660584 or to +357 22 660118
- By electronic mail to the address: complaints@financialombudsman.gov.cy

You can find more information on how to submit a complaint to THE FINANCIAL OMBUDSMAN OF THE REPUBLIC OF CYPRUS by visiting **www.financialombudsman.gov.cy**

Notes

Information provided in accordance with Regulation no. 20 of the "INSURANCE AND REINSURANCE SERVICES AND OTHER RELATED ISSUES REGULATIONS OF 2016" issued under the "INSURANCE AND REINSURANCE SERVICES AND OTHER RELATED ISSUES LAW OF 2016 [38 (I)2016]".

Underwritten by Cosmos Insurance Company Public Ltd. is a Cyprus based Published Limited Company, registered Head Office in Nicosia, Republic of Cyprus, with registration number HE 16361, regulated by the Superintendent of Insurance (the head of the Insurance Companies Control Service in Cyprus), authorised to transact insurance business by the Superintendent of Insurance with license No71.

Particulars of the Insurance Company

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