

**Direct Care Insurance Policy**



**Gan Direct**  
INSURANCE

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## DIRECT CARE CONSTRUCTION OF POLICY

### IMPORTANT NOTICE FOR INSURED PERSONS

#### 15 Day Money Back Guarantee

Please read through the Policy carefully and check the details on the Certificate of Insurance to confirm that the cover you have chosen meets Your requirements. If You are not satisfied, please provide written cancellation instructions and return the Policy with the Certificate of Insurance within 15 days after receipt. Your Premium will be promptly refunded in full, provided no claim has been paid, and Your Policy will be retroactively cancelled. Of course, if You cancel Your Policy You cannot make a claim under it and neither You nor We shall have any further rights, liabilities or obligations under the Policy. There will be no refund of a Premium if You cancel Your Policy after 15 days from the date You receive this Policy. If You have any doubts regarding the Terms of Your Policy, please contact the Plan Administrator directly for any clarifications, otherwise we shall assume that all Terms are understood and accepted by You.

#### Statements made in the Application

Please also read the copy of Your Application that accompanies this Policy. With regard to any omissions or false statements in Your Application write to us within 10 days if any information that appears in it is not correct or incomplete or if any past medical history has been left out of Your Application. Your Application forms part of the answers of the Policy. For all questions, the information provided in the Application must be true, accurate, complete and correctly recorded.

### HOW TO CONTACT US

We must be notified about any claim at the following telephone number 800 5 10 15.

### OUR AGREEMENT

We promise and agree to provide You with the cover and benefits defined in this Policy subject to all of the Terms contained herein. Your Application forms the basis of this Policy.

### COMMENCEMENT OF COVER

Your cover shall commence from the Effective Date.

### DEFINITIONS

Words and phrases expressed below have the meaning accredited to them hereunder.

**Out – Patient Treatment:** Necessary medical treatment for injuries or illnesses, including diagnostic procedures, at a recognised medical or other institution, that does not require an overnight stay in Hospital.

**Occupational hazard** - a work condition, a job that can result in or contribute in creating or influencing an illness or injury directly or indirectly.

**Occupational Disease** – a disease or disability accredited to someone's occupation.

**Occupation/Business/Work** – an activity in a certain place, area, or specialty, or an activity for which you are remunerated (monetary or other), an activity directed toward doing or constructing something.

**Payment** – includes paid employment in something, which yields profit (monetary or other).

**Alcohol and Substance Abuse:** Misuse, illegal use, over use or abuse of, or a dependency on, or an addiction to any alcohol, medicine, controlled substance, narcotic, toxin or chemical.

**Application:** The completely answered and signed form entitled "Application Form" and all amendments and supplements to that form submitted by You or on Your behalf for forming an insurance, or renewal of cover or reinstatement of the Policy.

**Certificate of Insurance:** A document issued to You in conjunction with the policy which proves your cover, the Period of Insurance, the level of cover and also specifies any endorsements that may apply.

**Chronic Condition:** A Medical Condition which has at least one of the following characteristics:

- Its duration is indefinite and has no known cure.
- It returns or is likely to return.
- It is permanent.
- You are required to reform yourself or be specially trained in order to cope with the chronic condition.
- It requires long term monitoring, medical consultations and tests.

**Co-Insurance:** Your obligation to pay that percentage of Eligible Charges specified in the Schedule excluding any possible exemption.

**Country of Residence:** The country in which You have Your usual residence (your residence for a period of at least 6 months for every Period of Insurance) on the Effective Date or on each Renewal Date.

**Short Rate Earned Premium:** Earned premium charged when the Policy is terminated prior to the expiration date at the policyholder's request. For the purposes of this Policy the Short Rate Earned Premium shall be the pro-rata earned premium with two months in addition to the period of coverage. For example, the Short Rate Earned Premium for a six month period shall be the eight month pro-rata premium.

**Covered Transplants:** The pre-approved transplant of the heart, lung, kidney, pancreas, liver, bone marrow in Your body from a human donor while Your Policy is in force.

**Day-Patient:** An Insured Person who is admitted to a Hospital solely to receive medically necessary treatment that is covered by this Policy and for a period of clinically-supervised recovery or treatment, but does not remain in Hospital overnight.

**Dentist:** A person who is licensed by the relevant authorities to practice dentistry in the state or country where the Dental Treatment is administered.

**Dental Treatment:** Treatment and supplies relating to the care, maintenance or repair of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

**Natural Child-birth/ Caesarean Section:** The birth, following the completion of 12 months from the commencement of the Policy, of a living or dead baby/babies after the 24th week of pregnancy, provided that the child's birth certificate and release order from the clinic are presented within 30 calendar days from the birth.

**Immediate/Direct Settlement:** Following your understanding with a doctor or/and the hospital and given that we have your authorisation, an immediate settlement of your hospital expenses is possible if it is covered by your contract.

Please Note that you remain responsible for any Co-Insurance and Exemption that is in effect regarding your Policy and which you must settle directly with the provider of medical services during the period of treatment. If you make arrangements with your doctor to this effect and if you authorise us, then it is possible for us to settle your hospital expenses directly if such expenses are indeed covered by your policy.

**Medicine:** Medically Necessary medicine prescribed by a Medical Practitioner and is not available without a prescription or is experimental.

**Planned Hospitalisation:** A planned non-emergency treatment that is Medically Necessary.

**Eligible Expenses/Charges:** The Reasonable and Customary Charges for those costs or expenses incurred by You during a Period of Insurance for Medically Necessary Treatment or medicine which are directly related to an insured Medical Condition, and for which You or another beneficiary will make a claim for and seek indemnity under the Policy.

**Insured Medical Condition:** Any Medical Condition which is covered under Your Policy.

**Emergency:** An Acute Medical Condition of sufficient severity which could reasonably place your life or any of your limbs in danger if Treatment is not provided within 24 hours.

**Endorsement:** Any amendment, or addition which is prepared by Us and issued, attached to or otherwise becomes part of your Policy.

**Deductible:** The first amount paid by You (or on Your behalf) for every Insured Medical Condition, for every Period of Insurance in respect to the Eligible Expenses/Charges and covers, before any benefits are paid under your Policy, and excluding the Co-Insurance. If Treatment has gone on for more than the Period of Insurance, we will treat it as a new claim for any further Treatment after that date and we will reapply any Exemption.

**Experimental:** Any Treatment or supply, including any medicine, that by its nature or composition deviates from, or is used or applied in such a way which deviates from generally accepted standards of current Medical Practice; or is under investigation to determine its safety and effectiveness; or is only available to individuals who are participating in a research study or clinical research; or is being researched or is without proof.

**Hospital:** Any nursing institution public or private, which operates legally and undertakes the care and treatment of patients and injured persons, provides organised facilities and the necessary technical equipment and the means for diagnosis and surgical procedures and provides 24-hour based services. Rehabilitation centres, holistic, homoeopathic, osteopathic, chiropractic treatment, sanatoriums and care homes are not considered hospitals.

**Area of Cover:** The Area specified on the Certificate of Insurance.

**Homeland:** The country which You are a citizen of or national or maintain your primary residence or usual place of residence or of which You possess a validly issued passport. Where you possess more than one passport and in the absence of other evidence, your Homeland will be deemed the country declared on the Application.

**Illness:** Any disturbance of the normal functioning of the Insured that appears for the first time thirty calendar days (30) after the commencement of the insurance and which is factually established, is not a result of an accident, is medically confirmed, requires treatment and stems from causes which did not exist during the making of the insurance.

The term illness does not include learning difficulties, or behavioural problems or mental or nervous disorders.

**Accident:** Bodily injury resulting from an incident that is external, violent, random and independent of the Insured's will, is visible on the exterior region of the Insured's body, is medically proven (e.g. x-ray) and requires hospitalisation.

**Effective Date:** The date specified on the Certificate of Insurance.

**In-Patient:** Any Insured Person who remains overnight or longer in Hospital, and is admitted solely to receive Medically Necessary Treatment for an Insured Medical Condition under the Policy.

**Reasonable and Customary Charges:** The charges that are consistent with the general standard prices and do not exceed a corresponding charge of other hygiene suppliers in the same region and of the same price level where the treatment occurred or identical treatment or services for similar illnesses or accidents.

**Intensive Care Unit:** A Hospital unit where patients receive special support, observation and treatment procedures, that operates on a 24-hour basis with specially trained staff of doctors, nurses, technicians and is equipped with electronic machinery for the observation and constant detection of vital signs of the body, such as heart function, breathing, arterial blood pressure, temperature etc.

**Hospitalisation:** The Insured's stay in hospital as an in-patient or calendar days patient due to health problems that do not come under the exceptions, and cannot be treated except for hospital stay (e.g. at home) and whose medical necessity for admission has been sufficiently proven (medical file, opinions and medical reports). The treatment of such health problems must require immediate surgical intervention or immediate treatment that cannot take place in another setting apart from at the hospital and the regular observation of the patient shall be proven by the nursing file or the equivalent treatment forms (nursing charts, nursing file etc.) The term hospitalisation does not include the admission and stay at the hospital for a period of time beyond that which is medically necessary or for the carrying out of diagnostic tests only.

**Medical Practitioner:** Anyone who is legally practicing the medical discipline and is registered and established by the laws of the country in which he is practicing the profession. His/her speciality must be directly related to the Medical Condition of the patient. This person cannot be the insured or a member of his/her immediate family.

**Medical Necessity:** The offered health services that are certified by the company as medically necessary to (a) treat the essential medical needs of the insured, (b) be provided in the proper and medically appropriate way, taking into account the quality, as well as the cost of the offered services, (c) be prompt to diagnose an illness, (d) be essential for medical purposes and not for the convenience of other needs, (e) be proven by way of locally or internationally recognised protocol and scientific literature, that they are safe and effective for the treatment of the specific health problems.

Medical Necessity as defined in this Insurance Contract refers to the coverage of Eligible expenses and is not synonymous with the explanation given by an attending medical practitioner.

**Medical Suitability:** Is based on the prevailing standards of medical practice in relation to the particular pathological condition.

**Partner:** A person who resides with You in a conjugal relationship.

**Period of Insurance:** The first Period of Insurance is the period of 12 consecutive months that begins from the Effective Date.

**Policy:** The insurance contract between us that consists of Your Application, the Schedule of Insurance and any Endorsements.

**Plan Administrator:** The person appointed by Us for the correct appraisal and dispatch of claims or/and the independent administrator with whom the Company may be in collaboration with for the administration of this Policy.

**Notification:** A process where You are responsible for notifying Us prior to incurring costs or undertaking Treatment under the benefits in Your Policy. Once notification takes place a general determination of the Medical Needs is conducted based on and depending on the completeness and accuracy of the information provided to Us at that time. The

procedure of Notification does not guarantee that we shall reimburse you for charges imposed upon you.

**Pre-Existing Condition:** Any Medical Condition which is chronic, or subsequent to or a recurring complication or a consequence associated with or resulting from an illness or accident which based on medical reasoning, existed on or at any time prior to the Effective Date; whether or not symptoms had manifested, whether or not it was diagnosed, whether or not it was treated, or if you were aware it existed or not, even if it was disclosed in the Application or on any claim form or otherwise.

**Premium:** The consideration determined by us and at our discretion from time to time and which you are required to pay to us in order to activate and maintain Your Cover and the benefits under Your Policy.

**Relative:** Your spouse, partner, future spouse, son, daughter, son-in-law, daughter-in-law, parent, stepfather, stepmother, grandfather, grandmother, grandchild, brother, sister, brother-in-law, sister-in-law.

**Specialist:** A Registered Medical Practitioner, skilled in a generally accepted medical or surgical speciality or sub-speciality, and who holds a certificate for that speciality, which is recognised as such by the statutory bodies of the relevant country.

**Sub-Limit:** The maximum amount of reimbursements or benefits available to You under Your Policy for every Period of Insurance for Eligible Charges with respect to Insured Medical Conditions or sections of cover. The Sub-Limit is based on the maximum of the Sub-Plan and the related limitations indicated and defined in the schedule of benefits of the chosen Sub-Plan. The Sub-Limit is subject to the overall sum insured for every Period of Insurance for Your chosen Sub-Plan.

**Sub-Plan:** One of the pre-set levels of cover chosen by you under the Policy, as specified on the Certificate of Insurance.

**Surgery:** A generally accepted, diagnostic or surgical procedure or Treatment of a Medical Condition performed either by way of endoscopy or by surgical incision performed under general or local anaesthesia.

**Terms:** Terminology, provisions, conditions, definitions, limits, Sub-Limits, limitations, wordings, restrictions, agreements and/or exclusions.

**Terrorism:** Systematic or planned use of violence, intimidation or the threat of violence in order to intimidate or influence a group, community, population or government, especially as a means to coerce or dominate any demand and/or to place the public, or a section of the public, in a state fear.

**Bodily Injury:** means a recognised bodily injury which:

- a) results from an accident, and
- b) is exclusive and independent of any other cause, apart from an illness created as a direct result of the accident or medical or surgical treatment that is deemed necessary from an injury sustained from the accident, that causes the death or disablement of the Insured, within twelve months from the date of the accident.

**Permanent Total Disablement:** Disablement which entirely prevents the Insured from carrying out any business or activity in any profession and which lasts for twelve months and at the end of this period there is no hope for improvement.

## GENERAL TERMS

The following terms shall apply to all sections of this Policy and are prerequisite of Our liability under Your Policy:

### 1. The Entire Contract

The Application, the Certificate of Insurance, the Policy, and any Endorsements form the entire Contract between us and should be read together to avoid any misconceptions.

### 2. Third Parties

The only parties to this contract are You and Us. No other person has the right to impose or invoke the provisions of the Policy or part of it.

### 3. Compliance with Policy Terms

We shall not be liable under the Policy in the event of your failure to comply with the Terms of this Policy.

### 4. Your Duty of Care

You should at all times act in a prudent manner and should exercise reasonable care and take reasonable precautions to prevent Injury or Illness, to minimise any costs incurred and comply with recommended vaccination schedules and take the appropriate precautions against malaria and other medicinal precautions.

### 5. Premiums and Policy Duration

Your Policy is effective for 12 consecutive months. All Premiums are payable in advance irrespective of the type of cover provided under the Policy.

The Premium is payable in Euro or Cyprus Pounds and based on rates applicable to Your attained age on the Effective Date or renewal.

We cannot be held liable if Your Policy is terminated due to your credit card or debit card being declined or if it expires.

### 6. Laws and Taxes

We reserve the right to amend the Policy and the Premiums at any time in order to reflect any change in regulatory requirements, insurance law, insurance premium tax or other government levies as may be imposed upon Us.

### 7. Acceptance Clause

We are entitled to refuse or to accept an Application from any person without giving a reason. We reserve the right to apply new Terns, options, exclusions or Premium increases to reflect any circumstances you disclosed to us in Your Application or declared to Us as an important event.

### 8. Amendment of Terms

If the Company accepts to re-issue the Policy upon its expiry, the Company does not commit to do so with the same terms or

conditions but may alter the terms and conditions. The Insured may cancel his/her Policy within 30 calendar days following any Renewal Date and provided that no claim has been made, the Company will refund the premium paid to the Insured.

#### **9. Substitution**

The Insured must provide the Company without delay by written notice of any right of action against any third party arising out of any circumstances which give rise to a claim under this Policy. The Insured undertakes to cooperate with the Company to file a claim against anyone for a payment made that resulted in a loss of money for the Company and to account for any amounts recovered on the basis that the Company shall be entitled to recover first in full any amount paid by the Company prior to the Insured obtaining a right to any amount recovered. Should the Insured fail to file any valid claim against third parties and the Company thereupon becomes liable to make any payment under this Policy, the Company shall substitute the Insured in all his/her rights.

Any amount recovered by the Company shall be used to pay the expenses of collection and to reimburse the Company for any amount it may have paid or for which it is liable to pay under this Policy.

(Short-Rate Cancellation)

The Insured or the Company may request the Cancellation of this Policy by giving not less than 15 calendar days advance written notice. In such an event coverage shall terminate from the Cancellation date determined by the Company or by the Insured as the case may be. The Insured will be charged the Short-Rate Earned Premium. If the Insured has paid more than the pro rata calculation, the Company shall refund the difference between the amount actually paid and the pro rata calculation. No refund shall be made if a claim has been made within the insurance period. If the Insured has paid less than the Short-Rate Earned

Premium, the Insured shall pay to the Company the difference between the Short-Rate Earned Premium and the amount actually paid.

#### **10. Choice of Law**

Your Policy shall be construed according to the laws of Cyprus and shall be subject to the exclusive jurisdiction of the courts of Cyprus.

#### **11. Misrepresentation/Fraud**

Any claim under Your Policy for which you do not act with good faith, or any claim that is in any respect fraudulent, unfounded or described inaccurately, or any claim for which you failed to implement the Terms of the Policy, shall render Your Policy void from the start and all claims and benefits under Your Policy shall be written off and (if appropriate) be recovered by Us and We shall not have liability for such benefits or claims. In addition, Your Policy shall be cancelled and rendered ineffective from the Effective Date without refund of Premiums.

#### **12. Other Insurance**

You must inform us if any of the benefits under Your Policy are covered or are reimbursed differently by any other insurance, membership benefit, reimbursement cover or right of contribution, right of substitution or recovery, Policy, or other obligation or provision of benefits by a third party. We shall not be liable to pay more than our rateable proportion towards the claim. We are not obliged to provide any benefit or to pay any claim in respect to treatment or supplies sponsored by any program or agency funded by any government.

Where expenses are made for treatment of a Medical Condition for which payment is made or is available through workers' compensation, employer's liability, or a similar law or government program, any payment made by Us will be secondary to any

payment or cover from elsewhere. If we discover that you were previously reimbursed for all or some of those expenses from any other source, we shall have the right to ask You to return the money. Where necessary, we retain the right to deduct such return from any impending or future claim settlements or to cancel Your Policy from the Effective Date.

### **13. Liability**

Our liability shall cease immediately upon cancellation or termination of Your Policy for whatever reason.

### **14. Arbitration**

No dispute or claim can be lodged for arbitration prior to Us dismissing Our liability wholly or partly, or Your right for cover under the Policy.

### **15. Termination of Cover**

We may at any time terminate Your Policy in the event of any non-payment of a Premium, fraud or misrepresentation, non-refund of an over-paid claim, or if you no longer meet the eligibility requirements of Your Policy. We may at our discretion reinstate the cover, though the Terms of cover may be subject to changes.

### **16. Right of Recovery**

In the event of overpayment by Us of any claim for benefits under Your Policy, for any reason,

we shall have the right to a prompt refund and recovery of the amount that was overpaid to You,

the Hospital, Medical Practitioner or other supplier of services or goods, as the case may be.

If You or the Hospital, the Medical Practitioner or other supplier of services and goods does not promptly return the money, we may, with regards to any other rights or remedies that are available to Us: reduce or deduct from the amount of any future claim that is

otherwise rightful cover or compensation under Your Policy, to the full extent of the refund due to Us and/or terminate Your Policy by giving you 30 calendar days written notice by mail to Your last known address and/or to charge such amount to any credit card if we have its details and if the overpayment was made to You.

### **17. Essential Facts & Change of Risk Disclosure**

You must disclose all essential facts to Us in Your Application. Failure to do so may affect Your rights under Your Policy. An essential fact is the information likely to influence us during the assessment of or the acceptance of Your Application for cover. If you have any doubts as to whether a fact is “essential,” then you should disclose it to us. Please note that Your disclosure of Pre-Existing Conditions will not result in abandoning the exclusion of our liability in relation to Pre-Existing Conditions.

You must also inform Us as soon as it is reasonably possible of any essential changes relating to You which may affect information given in connection with the Your Application. This includes any information as documented on the Application which may have altered prior to the Effective Date. We reserve the right to amend the Terms of Your Policy, to decline acceptance of Your Application or to cancel Your cover following any change of risk.

### **18. Medical Evaluation**

We reserve the right to request further tests and/or evaluation where we reasonably decide that the condition for which a claim is made may be directly or indirectly related to an excluded condition.

### **19. Deviation**

If We do not appeal any incident of any term of Your Policy, this shall not prevent Us from relying on that term on other occasions.

### **20. Local Insurance Law, Taxation & Regulations**

We do not accept liability in the unlikely event that You violate any

local insurance law, regulation or taxation issue by purchasing Your Policy. Your Policy is deemed to be constructed and issued in Cyprus.

You guarantee that you are not violating any local insurance law, regulation or taxation issue by purchasing Your Policy and that you understand and agree that Your Policy is not designed for you to comply with any particular local insurance law or regulation. You agree that you are solely responsible for your compliance with the laws that are in effect outside of Cyprus.

## 21. Eligibility and Age Restrictions

Your eligibility to be insured was based on your application. A child under the age of 1 month old is not eligible to be insured. For you to be a party to this Policy you must be an adult. If you are a child under the age of 18 years old, the Application must be signed on your behalf by your legal guardian. The maximum age for any one to be eligible for insurance is 60 years old and the insurance shall be automatically terminated on the Renewal Date following your 65th birthday. If your insurance was in force for ten continuous years prior to your 65th birthday it may be renewed until you reach 70 years old.

## YOUR COVER

We will provide cover for the benefits as shown in Your chosen Sub-Plan of the policy and subject to their terms. Any and all benefits which do not appear in the Schedule of Insurance although they are related to the chosen Sub-Plan shall not be covered. We will only be liable for those benefits listed and Medically Necessary Treatment and supplies which are directly related to insured Medical Conditions and for such charges which have been paid by you whilst Your Policy is in force.

## SCHEDULE OF COVER AND EXCESSES

Subject to the terms of Your Policy and provided that no other limitations apply, after the deduction of any Excesses and Co-Insurances, we will pay Eligible Expenses/Charges up to the overall aggregate maxi-

imum sum insured per Insured Person, per Period of Insurance. Please note: Eligible Expenses/Charges for certain benefits under Your Policy are payable only up to the Sub-Limit per Insured Person per Period of Insurance and/or only up to the Limit per Insured Person, as shown in the Schedule of Cover/ Certificate of Insurance.

## SECTION A: IN-PATIENT & DAY-PATIENT TREATMENT (INNER – HOSPITAL PROVISIONS)

Subject to the Terms of your Policy, we will pay In-Patient and Day-Patient charges you incur as follows:

### A1. Hospital Accommodation & Operating Theatre

We will pay Eligible Expenses/Charges for Hospital accommodation, food and nursing services, use of operating theatre, or recovery room, as well as the services and supplies which are provided by the Hospital during the In-Patient or Day-Patient Treatment. Personal expenses such as telephone calls, newspapers and guest meals are excluded from cover.

### A2. Accidents, Emergencies, Intensive Care

We will pay Eligible Expenses/Charges for: surgery, anaesthesia, processing and administration of blood or blood components (including haemodialysis), oxygen, other gases and anaesthetics; Medical Practitioner services, services and supplies usually provided in the Intensive Care Unit, Emergency Treatment for an insured Medical Condition e.g. fracture/plaster, suture of a wound.

### A3. Surgeons, Assistant Surgeons, Anaesthesiologists

We will pay Eligible Expenses/Charges for professional services rendered by surgeons, assistant surgeons and anaesthesiologists according to the remuneration schedule in this Policy. However, if surgeons are on standby, this is not considered a professional service and is not eligible for cover.

#### **A4. Medical Practitioners**

We will pay Eligible Charges for professional services rendered by Medical Practitioners.

#### **A5. Prescription Medicine, Dressings**

We will pay Eligible Expenses/Charges for Medicine and expendable supplies administered during treatment, received within treatment.

#### **A6. Restorative Surgery**

We will pay Eligible Expenses/Charges for Surgery required for the restoration of natural functions as a result of an Accident or Illness and is undertaken within 12 months after the date the Accident occurred or the date the Illness manifested, as long as the Accident or Illness and the restoration Surgery occur whilst Your Policy is in effect.

#### **A7. Diagnostic Tests and Procedures, X-rays, & MRI/CT Scans**

We will pay Eligible Expenses/Charges for diagnostic procedures and tests using radiology, ultrasonographic or laboratory services as long as they are directly related to the purpose of treatment (psychometric, behavioural and educational tests are not included). All diagnostic tests should be accompanied by their results confirming the medical condition and the necessity for treatment.

#### **A8. Treatment for Cancer**

We will pay Eligible Expenses/Charges for chemotherapy, radio therapy, directly relating to cancer Treatment and must be carried out / be administered within the hospital.

#### **A9. Physiotherapy**

We will pay Eligible Expenses/Charges for physiotherapy recommended by a Medical Practitioner and performed by a

professional physiotherapist during the course of treatment or stay at the hospital.

#### **A10. Parental Hospital Accommodation**

We will pay Eligible Expenses/Charges for standard Private Hospital Accommodation (room and board) regarding one of Your parents or one of Your legal guardians provided the person to stay with you is insured and remains with you in Hospital whilst you are under 16 years of age and have been admitted as an In-Patient.

#### **A11. Prosthetic Devices and Implants**

We will pay Eligible Expenses/Charges for Pre-certified artificial limbs, eyes, larynx or breast prostheses (carried out within 1 year after Surgery for breast cancer), but not for the replacement or repair thereof. We will pay Eligible Expenses/Charges for the following artificial body parts designed to form a permanent part of Your body and are implanted by Surgery for one or more of the following reasons: to replace a joint, to replace one or more heart valves, to facilitate cardiovascular flow with the use of splints, to replace the aorta or an aortic blood vessel, to replace a muscular clamp, to control urinary incontinence (bladder control), to act as a pacemaker or to remove excessive fluid from the brain.

#### **A12. New Baby Benefit**

We will pay the amount of benefit shown in the Schedule to assist with the initial expenses you incurred during the Period of Insurance whilst preparing the family home for Your Newborn provided that You have been continuously insured under Your Policy for at least 12 consecutive months immediately preceding the birth.

## **SECTION B: OUT-PATIENT TREATMENT AND FITNESS BENEFITS**

(Outer-hospital provisions)

Subject to the terms of this Policy, we will pay for the treatment and Surgery of an Out-Patient as well as fitness charges as follows:

### **A. LIMITATIONS WITH RESPECT TO SECTION B:**

1. Cover with respect to Section B is limited up to the Sub-Limit as defined in the Schedule of Cover/ Certificate of Insurance. Pre-surgery and post surgery tests as well as visits to the doctor are covered.
2. Where you later on choose to replace your Sub-Plan with an alternative Sub-Plan, upon receipt of your cover any Eligible Expenses/Charges related to the Out-Patient Treatment of an existing Insured Medical Condition which exceeds the benefits provided by the initial sub-plan shall be excluded.

### **B. WITH RESPECT TO SECTION B:**

Total Cover is limited to the total aggregate up to the Sub-Limit as defined in the Schedule of Cover and Exemptions, per Period of Insurance for outer hospital provisions. No other cover applies under Section B.

#### **B1.Family Doctor, Treatment & Referrals**

We will pay Eligible Expenses/Charges for professional services and for referrals rendered by family doctors and general practitioners provided however, if surgeons are on standby, this is not considered a professional service and is not eligible for cover

#### **B2.Diagnostic Tests**

We will pay Eligible Expenses/Charges for Diagnostic tests as long as they are accompanied by their results and prove a medical condition.

#### **B3.Prescription Medicine**

We will pay Eligible Expenses/Charges for medicine prescribed by any Medical Practitioner.

#### **B4.Physiotherapy**

We will pay Eligible Expenses/Charges for post surgery Physiotherapy, prescribed by a Medical Practitioner and performed by a professional Physiotherapist for the continuation of treatment; the amount is defined in the Schedule of Cover and Exemptions. You must submit a letter or reference report to the Plan Administrator once such treatment is required. In addition to the above, a medical report will be required following the visits.

## **SECTION C: TRAVEL, TRANSPORTATION AND OUT OF AREA BENEFITS**

In the section regarding travel, transportation and out of area benefits the following terms shall have the meaning attributed to them in this paragraph. The explanation attributed to them herein cannot be used for the same or similar terms used in the Policy or in other sections of the Policy.

<b>Relatives</b>	Mother, father, siblings, spouse and the children of the insured.
<b>Medical authority</b>	Any person holder of a valid license to practice medicine in the country where the insured is located.
<b>Medical team</b>	A treatment structure modulated to any special case and supervised by the regulating medical practitioner and the treating medical practitioner.
<b>Accident</b>	Any sudden, unforeseen and violent incident external to the victim, and independent of his/her

<b>Illness</b>	will, that results in causing a serious bodily injury that hinders the normal continuation of the trip. Any sudden and unforeseen change in health discovered by a competent medical authority and which hinders the normal continuation of the trip.
<b>Physical injury</b>	A wound or illness whose nature may attack the life of the patient or may in a short period of time result in the grave deterioration of the patient's health if the proper treatment is not administered to him.
<b>Damage</b>	Any incident capable of bringing about our intervention.

#### ARTICLE 1 MEDICAL TRANSPORTATION

In the event of a serious physical injury resulting from an accident or a sudden illness of the insured, the medical practitioners who have been notified:

- 1) Are informed of the condition of the patient or of the wounded.
- 2) Cooperate, if it is deemed necessary, with the treating medical practitioner and the medical practitioner who administered first aid.
- 3) Jointly make the best decisions according to the condition of the patient.

It is possible that these decisions entail the implementation of one or more of the covers defined below.

The non – justified rejection of these decisions may incur the loss of the right to the aid covers.

If it is deemed necessary we undertake, according to the condition of the insured, to organise transportation and the expenses of transportation of the insured to a treatment unit nearest to the place where the incident occurred, modulated to encounter the needs of the incident.

Transportation is done with an airline aircraft or another suitable public means of transport, In the event that transportation with an airline

aircraft is proven to be medically impossible, it shall take place with a private aircraft.

#### ARTICLE 2 RETURN/ REPATRIATION OF PATIENTS

In the event of an accident or illness of the insured, once the condition of the insured's health is stabilised at the treatment unit nearest to the place where the incident occurred, it undertakes to organise and the expenses of the return/repatriation of the insured, to a treatment unit nearest to his/her place of residence in Cyprus.

Transportation is done with an airline aircraft, helicopter or other available means.

#### GENERAL PROVISIONS

1. If it is deemed necessary a medical practitioner authorised by us may visit the patient and with the attending medical practitioner proceed with an examination to ascertain the costs required for the medical transport.
2. Except for the event of proven impossibility the patient or his/her entourage are obliged to come into contact with us the latest within three calendar days following the medical incident which potentially requires repatriation.

#### SPECIAL EXCEPTIONS TO THE COVER OF MEDICAL REPATRIATION

The following are not covered:

1. Medical transportation from convalescence homes, spas for conditions which brought about their stay in such institutes.
2. Medical conditions whose appearance is foreseeable from the previous personal medical history known to the insured.
3. Pre-existing, recurrent, chronic illness, whose condition is known to the insured and which is being treated.
4. Mental illnesses.
5. Non-justified abortions due to the condition of the insured's health.

6. The consequences of hereditary disorders or mental retardation.
7. Medical or surgical conditions that may be treated without risk on the spot in an instant whereas transportation could form a greater risk.
8. Conditions for which transportation could form a greater risk.

#### **ARTICLE 3 RETURN/ REPATRIATION OF ACCOMPANYING FAMILY MEMBERS**

In the event of repatriation of one of the insured in pursuance to article 2 or article 6 we shall organise and undertake the expenses for the return by air of the remaining accompanying family members, to their domicile (economy class).

#### **ARTICLE 4 VISIT BY A FAMILY MEMBER**

In the event that the treatment of the insured because of a sudden illness or accident lasts longer than 10 continuous calendar days we shall put at the disposal of a family member of the insured or of a family member designated by the insured, a return air ticket (economy class).

#### **ARTICLE 5 ACCOMMODATION EXPENSES OF A FAMILY MEMBER**

We also organise and undertake the accommodation expenses at a hotel up to 7 calendar days, and until the overall amount of 630 EURO, of a family member of the insured or of another family member who went to the place where the incident occurred according to article 4. (Only the overnight costs are undertaken)

#### **ARTICLE 6 REPATRIATION OF THE CORPSE**

- 6.1 The on the spot procedures and the immediate payment of the expenses for the transportation of the remains of the insured who died from an illness or accident, to his/her place of burial in Cyprus until the amount of 3.000 EURO.

6.2 The expenses for the necessary preparatory work and setting of the corpse into the coffin for transport. The burial expenses and funeral expenses are not included.

6.3 The repatriation of the insured's remains only once the necessary details, information and supporting documents are forwarded to the company.

#### **ARTICLE 7 ANNOUNCEMENT FOR THE PROVISION OF TRAVELLING AID**

In order for us to be able to intervene within the shortest deadlines, the insured or any person acting instead of and on his/her behalf, should mention by telephone, fax:

- a. Policy Number/ Insured's Name
- b. The name, address and telephone number of the hospital where the patient is at.
- c. The name, address and the telephone number of the attending medical practitioner.

Our authorised medical practitioners should, except when there is valid opposition, have free access to the insured in order to determine his/her condition.

#### **ARTICLE 8 RESTRICTION OF DETRIMENTAL EFFECTS**

The insured or the persons acting instead of him/her are obliged, to use every means which is at their disposal to restrict detrimental effects from the accident or sudden illness from the time of the incident.

#### **ARTICLE 9 PAYMENT - COMPENSATION**

- 9.1 In the event of the happening of an insured danger, the beneficiary or anyone acting on his/her behalf is obliged to make immediate contact with the help centre to notify the damage, as the obligation of the company is to provide the cover of this policy, in kind through its international network. Therefore expenses that are not connected to the covers offered by this policy or which are not approved by us are not undertaken nor are they paid.

Furthermore, it is stated that the Policy cannot under any circumstances confer the right to contract or use of services or means by any third person, neither any right of claim of the amount paid by the beneficiary without our approval.

Any payments (when and if related and approved by us) are made at our headquarters and based only on legal proof or translated and ratified supporting documentation for damages abroad.

9.2. Where maximum pecuniary cover is defined, V.A.T is included.

#### ARTICLE 10

It is hereby clarified that during the implementation of the provisions we are bound by the related legislative, administrative, medical rules that are in effect in any foreign country where the incident took place outside Cyprus.

#### EXCEPTIONS

- 1) Aid coverage is provided for journeys which last no longer than 60 consecutive calendar days.
  - 1.1) It is hereby clarified that the following persons are not covered:
    - a) Those who have a secondary residence abroad.
    - b) Students who go on recurrent trips with the same destination.
    - c) Also those persons who do not have a permanent home address within Cyprus.
- 2) The insured is not entitled to compensation for expenses which were paid directly by him/her without our previous approval.
- 3) Furthermore accidents caused by the following are not covered:
  - a) Wars, invasions, acts of a foreign or partially foreign enemy, hostilities (either in time of war or not) civil wars, uprisings, social unrest, terrorist or military dictatorship, political disturbances.
  - b) Self-inflicted wounds with intent, the participation of the insured in criminal acts.
  - c) The participation of the insured in bets, or demonstrations or competitions involving speed with mechanical means.
  - d) Participation in athletic races on a professional level or while preparing for the races.
  - e) Participation in assaults except for self-defence circumstances.
  - f) Use of alcohol, drugs and narcotic substances, apart from those taken following medical prescription.
  - g) Directly or indirectly inflicted or attributed or stemming from ionised radiation or from contamination of radioactivity from any nuclear fuel or from any nuclear refuse or other nuclear objects.
  - h) Implications from pregnancy within three months from the foreseeable date of delivery.
  - i) Psychological or psychiatric illnesses.
  - j) Bodily injuries or illnesses caused by attempted suicide.
  - k) Pre-existing, recurrent, chronic illness, whose condition is known to the insured and for which he/she is undergoing treatment.
  - l) Intellectual, mental, neurological disorders and epileptic seizures.
  - m) Accident or illness whose oncoming occurs during the performance of arrayed service in the armed forces of any country or organisation.
  - n) Air crash, unless if the crash occurs when the insured is travelling as a passenger on an airline aircraft that operates legally and carries out regular flights or charter flights.

#### ARTICLE 11 APPLICABLE LAW – JURISDICTION

Every dispute that arises relating to the implementation and interpretation of the present section as well the rights and obligations of either – side are explicitly agreed that they are subject to the jurisdiction of the competent Courts of Cyprus and are tried by them.

The applicable law is Cyprus Law.

## ARTICLE 12 INSURER'S LIABILITY

INTER PARTNER ASSISTANCE and ourselves cannot be held responsible for likely delays during the execution of the agreed services: in the event of a strike, explosion, insurrection, popular movement, restriction to the freedom of movement, sabotage, terrorism, civil or external war, emission of heat, radiation or in every case of force majeure.

## ARTICLE 13 SUBROGATION

INTER PARTNER ASSISTANCE and ourselves shall be subrogated up to the amount of the paid compensation to the rights and the actions of the insured against all persons responsible for damage.

## ARTICLE 14 STATUTE OF LIMITATIONS

All claims arising from the present section are statute barred within six years from the date the incident took place.

### SECTION D: Dread Disease, Disability & Death Benefits

We will pay the whole or part of the Sum Insured as set out in the Schedule to the person or persons mentioned therein who deserve payment provided that we receive satisfactory proof that (1) the events defined in the certificate of insurance occurred and (2) the right of the person or persons claiming benefit and (3) the age of the Insured.

We will pay the Sum Insured, in whole or in part, as set out in the Schedule of Cover, in the event of the Insured's death, or if the Insured suffers any of the medical events as defined. Such payments shall be subject to the provisions as defined under Claims Conditions.

#### D1. BENEFIT PERCENTAGES

We will pay the stated percentage of the Sum Insured in each of the following cases (a), (b) and (c) when one or more of the following particular events occur:

- a) Dread Disease Benefit: Provided that the Insured is exposed for the first time to any of the illnesses set out analytically in paragraph D2 below, the benefit of the Sum Insured as defined in the Schedule of Cover and is subject to reduction for any prior amount paid.
- b) Permanent Total Disability Benefit: Provided that the Insured shows permanent total disablement, as set out in paragraph D3 below, the benefit of the Sum Insured as determined by an independent medical board that we assemble and is subject to reduction for any prior amount paid under the Dread Disease Benefit.
- c) Death Benefit: Provided that the Insured dies from an occupational hazard, 100% of the Sum Insured as set out in the Schedule of Cover, subject to reduction for any prior amount paid under the Dread Disease Benefit and/or the Permanent Total Disability Benefit.

#### D2. DREAD DISEASE BENEFIT

The percentage of the Sum Insured as set out in paragraph D1 (a), will become payable if the Insured is diagnosed and is clinically proven as suffering from or undergoes any one of the medical events as defined herein. Any such diagnosis must be verified by a practising licensed medical practitioner in any member country of the European Union. Benefit is paid only once.

##### a) Medical Event Definitions

- I) Heart Attack: Necrosis of a section of the heart muscle as a result of insufficient blood supply to the area. The diagnosis will be based on all of the following criteria;
  - a) a history of regular chest pain,
  - b) recent electrocardiograph changes,
  - c) an elevation in cardiac enzyme levels
- II) Stroke: Any incident which results in subsequent neurological diseases lasting more than 24 hours and causes permanent paralysis, including:

- a) necrosis of brain tissue,
- b) haemorrhage of an endocranial vessel,
- or
- c) embolism from an external cranial source.

The diagnosis must be substantiated by proof of permanent neurological damage.

The following are excluded, from (I) and (II)

- a) TIA – Transient Ischemic Attack
- b) Coronary Artery Surgery: Undergoing an open-heart surgery to correct aortostenosis or two or more blocked coronary arteries with venous or arterial grafts in persons with restricted vascular symptoms, but excluding non-surgical procedures such as angioplasty (balloon) or the restoration of aortostenosis or blockage by laser.
- III) Cancer: Every malignant mass which embodies uncontrolled growth and spread of malignant cells and infiltration and destruction of healthy tissue. The term 'cancer' also includes leukaemia and Hodgkin's disease.  
Excluded:
  - a) Stage 1 of Hodgkin's disease
  - b) All types of skin cancer including melanoma of stage IA (T1a NOMO)
  - c) All masses histologically described as pre-malignant CIN stage, or display an early transition to malignancy and prostate cancer stage 1 (T1a, 1b, 1c).
  - d) Non-invasive carcinomas in situ.
  - e) Cancer which formed due to presence of the HIV virus.
- IV) Kidney Failure: Final stage kidney disease due to chronic irreversible failure of both kidneys to function. This must be evidenced by the Insured undergoing regular dialysis.

V) Major organ transplant: Surgical intervention for heart transplant, lungs, kidneys, liver and bone marrow as the recipient of the graft and not as the donor.

#### b) Exclusions

We shall not be liable for payment according to the Dread Disease Benefit for any medical event which occurs within 3 calendar months from the commencement date of or renewal of cover under this Policy, whichever of the two occurs later on.

### D3. PERMANENT TOTAL DISABILITY BENEFIT

The percentage of the Sum Insured, as stated in Clause D1 (b), will become payable if the Insured suffers Permanent Total Disablement, as defined herein, resulting solely and independently of any other cause from bodily injury or illness as defined herein, subject to the terms, conditions and exclusions contained herein.

Provided Always That:

1. Compensation shall not be paid for more than one of the events in the Schedule of Compensation in respect to the consequences of an Accident or illness, except for any compensation payable hereunder.
2. The total sum payable under this Insurance in respect of any one or more Accidents shall not exceed on the whole the largest sum insured under any of the events contained in the Schedule of Compensation or has been added to this Policy by endorsement, apart from the fact that the Company will in addition pay for Medical Expenses.
3. If an Accident or illness causes the death of the Insured within twelve months following the date of the Accident or illness and prior to the final settlement of the compensation for disablement provided for under the Events in the Schedule of Compensation, the only compensation which is payable shall be that provided for in cases which have resulted in death.

Compensation shall only be payable under the events in the Schedule of Compensation if:

a) Under the events, the loss occurs within twelve months from the date of the Accident,

b) Under the event, the Insured becomes totally disabled within twelve months from the date of the Accident, and such disability lasts for twelve months.

	Rate per cent of the sum insured
Loss of two limbs	100%
Loss of two eyes	100%
Loss of one limb and an eye	100%
Total loss of hearing resulting from bodily injury	100%
Loss of speech resulting from bodily injury	50%
Loss of a limb	50%
Loss of an eye	50%
Loss of a shoulder	75%
Loss of a hip	75%
Permanent Total Disability	100%
Loss of the lower jaw	100%
Loss of hearing in one ear	15%
Loss of a thumb (two phalanx)	25%
Loss of a thumb (one phalanx)	10%
Loss of any finger (three phalanx)	10%
Loss of any finger (two phalanx)	8%
Loss of any finger (one phalanx)	2%
Loss of four fingers including thumb	40%
Loss of a big toe	10%
Loss of any toe except for the big toe	3%
Loss of the big toe along with loss of four toes	20%
Anchylosis of a hip	40%
Anchylosis of a knee	20%
Reduction in size of a leg by 5 centimeters at least	30%

#### D4. DEATH BENEFIT

The Sum Insured, as stated in the Schedule of Cover at the time of death of the Insured.

#### SECTION E: EXCLUSIONS

E1. We will not pay any charges/expenses or damages you have incurred and which directly or indirectly relate to or arise from or are in connection with:

1. Any illness or bodily injury as well as their recurrences and complications which required medication to be administered, medical advice or treatment to be given or there were symptoms or it was known or should have reasonably been known to the Insured whether it was diagnosed or not prior to the commencement of the insurance. Any pre-existing condition which was disclosed by the insured is an exception unless it is accepted by us in writing. Any undisclosed pre-existing condition shall form the reason for non coverage of the eligible expenses or termination of the insurance policy.
2. A voluntary abortion not including a medically imperative miscarriage where the life of the mother is being threatened, ectopic pregnancy and still birth.  
Birth defects or congenital illness: Treatment for any abnormality, deformity, disease, illness or injury present at birth whether diagnosed or not.  
Pregnancy and childbirth: (pre-natal care, delivery, post-natal care, and care of newborns, including complications of pregnancy, miscarriage or termination of the pregnancy including abortion).
3. Any Medical Condition sustained while participating in any activity where such activity is undertaken against medical advice.
4. Hair loss, including without limitations wigs. Treatments for the hair, hair transplants or any medicine that promises to promote hair growth, whether or not recommended by a Medical Practitioner.
5. Any exercise program, whether or not recommended by a Medical Practitioner.
6. Any treatment that either promotes or attempts to promote, improve, prevent or correct impotency, sexual activity or sexual dysfunction or any consequence thereof.
7. Dental/ Orthodontic Treatment: Treatment relating to teeth, roots, gums (e.g. extraction of teeth, cysts, abscesses etc.) Furthermore, no compensation shall be paid for any kind of additional work (e.g. bridges, crowns, implants) or for orthodontic treatment.
8. Charges for treatment which is not administered or ordered by a Medical Practitioner, or services or supplies which are not medically necessary, or charges which exceed Reasonable and Customary, or for surgery or treatment which is Investigational, Experimental or Unproven, or is pending during commencement of the cover. Charges for speech therapy, occupational therapy and verbal therapy and examination of natural functions using electronic means, acupuncture, recreational therapy, sleep therapy or music therapy, exercise programmes whether or not recommended by a Medical Practitioner.
9. Manual Labour: Bodily Injury sustained by any Insured Person while engaging in manual labour outside Cyprus for remuneration in connection with any business or activity.
10. Mental or Nervous Illnesses and other Disorders: Treatment for or related to any psychiatric, psycho-geriatric, nervous or mental illnesses or disorders of any kind, sleep disorders including sleep apnoea, snoring or any sleep-related respiratory disorders, any learning, behaviour or development disorder, such as dyslexia, attention deficit hyperactivity disorder (ADHD), or height deficiency, or physical growth problems, bulimia or anorexia or weight problems.
11. No underlying illness or injury: Treatment for symptoms that do not arise from or is required due to complications or consequences of a treatment or condition not covered hereunder. This includes but is not limited to:

- a) Treatment in order to relieve symptoms commonly associated with any bodily change arising from any normal or natural cause such as ageing (e.g. osteoporosis), menopause or puberty (e.g. acne).
  - b) Treatment in order to relieve symptoms associated with the menstruation cycle (e.g. dysmenorrhoea) or any other hormonal disorder (e.g. polycystic ovarian syndrome).
  - c) Treatment in order to relieve symptoms associated with any allergic conditions or disorders.
  - d) Charges for Hormone replacement therapy (HRT) or bone densitometry.
12. Other insurance: Sums which the covered person is entitled to receive on the basis of other group or personal insurance cover or medical fund. The payable benefits, under the Policy, are limited to the sum of the expenses that the insured has paid towards medical expenses.
13. Chronic supportive Treatment of renal failure, including dialysis. We will, however, pay Eligible Charges for renal dialysis carried out immediately prior to and post operation, or in connection with acute secondary failure when dialysis is part of the intensive treatment.
14. Any Medical Condition caused by or is a result of any of the following acts or events:
- i) War or any act of war (whether declared or not), invasion, acts of a foreign enemy, warlike operations, civil war;
  - ii) Mutiny, riot, strike, coup d'etat, military or popular uprising, insurrection, rebellion, revolution, military or usurped power;
  - iii) Act of Terrorism, unless you suffer injuries although you are innocent and find yourself there by chance. There is no cover for treatment of a Medical Condition which is in some way caused or contributed to by an act of Terrorism involving the use or release or the threat of any nuclear weapons or devices, or chemical or biological factors.
15. Treatment of any condition of the breast or of the prostate, tonsillectomy, adenoidectomy and ear conditions, haemorrhoidectomy, fistula, cysts, chaps, any disorder of the reproductive system, gynaecological problems, hernia, including hernia of the intervertebral disc (discopathy, all forms of), thyroid gland and conditions myoskeleton system including meniscus, ligaments and tendons that exists, manifests or involves procedures which occur or are recommended during the first twelve months of cover under Your Policy, beginning from the Date of Your Initial Registration on the Policy. Note: Cover of any Treatment related to any of these conditions may be separately or further restricted or be excluded under the exclusion of and definition for Pre-existing or Chronic Conditions.
16. Any congenital condition, hereditary anomalies and illnesses, diseases or conditions irrespective of the time the related symptoms or signs developed.
17. Birth control, sterilisation (or its reversal) vasectomy (or its reversal), contraception, sterility, fertility, impotence, any treatment or supply that either encourages or prevents contraception, or any form of assisted conception or assisted reproduction, or any subsequent complication including but not limited to premature or multiple births following assisted conception.
18. Relaxation cure, admission to an institute, isolation, sanatorium care.
19. Any Treatment or supply that is:
- i) Not presented to Us for payment in the form of a completed notice of claim within 30 calendar days from the date charges were incurred for such a treatment or supply.
  - ii) Not regulated nor prescribed by a Medical Practitioner.
  - iii) Not Medically Necessary.
  - iv) Administered without charge to You.

- v) In an amount greater than the reasonable and customary charge.
  - vi) Administered or provided by a Relative or by a person that resides or has resided at Your home
  - vii) Required or recommended as a result of complications or repercussions that arise from or are related to any treatment which is not covered by Your Policy, or
  - viii) Any In-Patient treatment which could be provided as a Day-Patient or Out-Patient treatment.
20. Telephone consultations, medical reports, completion of claim forms, or if you failed to keep a scheduled appointment.
  21. Any treatment or supply that is experimental, or related to genetic medicine or genetic testing, including amniocentesis, genetic screening, risk assessment, prevention or ascertainment of a genetic disposition, genetic counselling and treatment of genes.
  22. Treatment or supply received at any hydro-sanatorium, natural treatment clinic, spa, health farm or similar establishment. Any treatment against obesity.
  23. Any medical prescription that is associated with a special diet, weight control, children's food, baby supplies or vitamin/mineral supplements, or any alternative medicine (such as chiropodists, optometrists, and podiatrists, non-prescription medicine, food vitamin extracts, or nutritional supplements), vitamin or herbal treatment, non-approved medicine or are used "without a label", or medicine not prescribed by a Medical Practitioner.
  24. Cosmetic or aesthetic surgery except if it is necessary following an accident which was covered by the programme and takes place within twelve months from the accident.
  25. Any Medical Condition sustained while taking part in mountaineering activities which require special equipment and for which ropes or guides are normally used; Athletic activities (except for activities that do not require contact, non-professional activities,

and which You engage in solely for recreational, entertainment or fitness purposes); aviation (except when travelling as a fare paying passenger on a certified passenger aircraft); hang gliding, parachuting, or hot air ballooning. Snow skiing (except in the case of skiing within properly prepared and marked areas and in strict compliance with all applicable laws or regulations, in accordance with the advice of the local ski school or the local institutional authority); racing of any kind including horse racing, automobile (of any type) or motorcycle; underwater activities that involves underwater respiratory equipment.

26. Events owing to alcoholism, use of drugs or hallucinatory substances. Addiction or abuse of narcotic or/and other substances, treatment arising from or is related to addiction to or abuse of alcohol, narcotics or other addictive or/and prohibited substances.
27. Suicide or attempted suicide, or any other intentional self-inflicted injury or illness, or intentional exposure to danger.
28. Any sexual disorder, venereal disease or other sexually transmitted disease.
29. Any Medical Condition sustained from Your involvement in violating the law, including without limitations, Your engagement in an illegal or malicious activity or act, but not including minor traffic violations.
30. Professional services provided by a psychotherapist, psychologist, family therapist.
31. Any sleep disorder, including sleep apnoea, scoliosis of the nasal diaphragm, snoring, fatigue, jet lag or stress.
32. Orthoptics, optic therapy or visual eye training.
33. The feet, including without exceptions: orthopaedic shoes, prescribed orthopaedic devices to be attached to or placed in shoes, treatment of weak, dislocated, flat, unstable or asymmetrical feet, metatarsal pain, prominent bones, deformed or big toes with calluses, and any treatment or supply for calluses.

34. Radioactivity and Contamination: radioactive ions, radioactive pollution due to any nuclear matter, refuse, burning of nuclear matter or nuclear accident. Any hazardous properties of explosive matter, nuclear and chemical contamination.
35. Asbestos or any other similar condition.
36. Military service, naval or air force at time of war, or while under orders for war-like operations and exercises.
37. Any cost for purchase, maintenance or transfer of transplant organs.
38. Normal eye tests, treatment, supplies, examinations or fittings or surgery related to vision. However, we will pay Customary Charges for surgery to correct one's sight following an injury. (PDT Photodynamic treatment).
39. Normal hearing tests, treatment, supplies, examinations or fittings related to hearing aids, provision, maintenance or fitting any hearing implants or hearing transplants, or any corrective surgery for non-medical impediments or for hearing impediments due to natural degeneration.
40. Treatment of the temporal-jaw joint, varicose vein.
41. Mental, nervous or psychic disorders, bulimia, anorexia, neurosis and epilepsy. Psychiatry, geriatric.
42. Treatment or supply obtained or received after the expiry date of Your Policy for whatever reason including non-renewal and non payment of the Premium.  
Any second or subsequent medical opinion from any Medical Practitioner or Specialist which is not required by Us.
43. Congenital condition, hereditary anomalies and illnesses, conditions or diseases irrespective of the time the symptoms appeared.
44. Routine examinations, preventive medicine, inoculations, medical aids, artificial limbs and devices during hospitalisation.
45. Removal of spots unless it is proven to be malignant following a histological examination provided that the terms and conditions are complied with.

46. General investigatory gynaecological surgeries, laparoscopic or not shall only be covered if the illness is established following a histological examination as well as appearing on the laparoscopy film.

E2.The Dread Disease Benefit and Permanent Total Disability Benefit shall not apply if:

- a) The Insured failed to seek care and medical advice as soon as possible.
- b) The Insured was a resident outside of Cyprus as defined in the Policy for more than 13 weeks in any 12 consecutive calendar months, without giving prior written notice to us, and receiving our written agreement regarding this.
- c) The Insured has been diagnosed as suffering from AIDS or is HIV positive or antibodies for such a virus have been diagnosed.

## CLAIMS

The Benefits, as defined under Section D, will become payable following the occurrence of an event to the satisfaction of the Insured, subject to the following conditions:

### Clause 1. Notification of Claim

- a) Dread Disease Benefit: The Beneficiary shall notify the Company that the Insured has suffered any one of the Medical events covered within six calendar months of diagnosis or surgery, and shall permit any doctor appointed by the Company to examine the Insured at their discretion.
- b) Permanent Total Disability Benefit: The Beneficiary shall notify the Company of the Total Disablement of the Insured no earlier than four calendar months, nor later than one year after the disability began, and shall permit any doctors appointed by the Company to examine the Insured at their discretion.

- c) Death benefit: The Beneficiary shall notify the Company of the Death of the Insured within six calendar months of the issue of the Death Certificate.

### Clause 2. Documentation

Following a notice of claim for Dread Disease or Permanent Total Disability Benefits the Beneficiary shall be responsible for obtaining and presenting, at his/her own expense, a report from the Insured's Attending Medical Practitioner, as well as any further medical reports deemed necessary by the Company to substantiate the claim.

### Clause 3. Discharge

- a) Dread Disease Benefit: Payment of the Benefit for any of the conditions covered shall constitute a full discharge of the Company's liability under the Benefit. In such a case the cover under the Permanent Total Disability Benefit and Death Benefit shall continue, reduced by the amount of benefit paid.
- b) Permanent Total Disability benefit: Payment of the Benefit shall constitute a full discharge of the Company's liability under this Benefit and the Dread Disease Benefit. In such a case the cover under the Death shall continue, reduced by the amount of benefit paid.
- c) Death Benefit: Payment of the benefit shall constitute a full discharge of the Company's liabilities under this Policy

### HOW TO MAKE A CLAIM

Please follow the guidelines below to help Us process Your claims immediately and satisfyingly.

- All claims should be submitted with a fully completed claim form, original invoices, receipts and any other supporting documentation within 30 calendar days of the Initial Treatment. We may deny cover for any claim submitted after the said deadline.
- If any other forms or details are required for all claims they should be presented.

- Before You proceed with a claim, it is important that You review again the relevant Terms of this Policy with respect to the covers for the Treatment You are seeking and the Pre-Certification requirements.

We will supply You with a personalised membership card which contains essential contact numbers and addresses. We therefore suggest You have this card with You at all times.

### A. Emergency Admissions

In the event of Emergency Admissions, You should contact the helpline as soon as possible before you exit the Hospital, giving full details of the Medical Condition and Treatment together with the name of the Specialist and Hospital details. Please do not delay in seeking Emergency Treatment.

### B. Planned In-Patient & Day-Patient Treatment

In the event of a planned admission as an In-Patient or Day Patient to a Hospital, You should contact the Pre-Certification helpline as soon as possible prior to Your admission, giving Your full details, details of the Medical Condition, details of the proposed Treatment (including dates and name of procedure if known) together with the name of the Specialist and Hospital details. Where possible We will make arrangements with the Hospital or Treatment provider so that all Eligible Charges are settled directly (direct billing). Where this has been arranged, you should send us the original claim form and the unpaid invoices (if given to you by the Hospital). You are responsible for paying any Excess and Co-Insurance to the Treatment provider. If direct billing has not been arranged, You should pay all of the charges and submit the originals to Us, together with the claim form.

### C. Out-Patient Treatment

You will have to pay for any Treatment you receive as an Out-Patient and then submit Your charges, according to the cover and terms of the Policy.

- Whenever You visit a Medical Practitioner or Specialist as an Out-Patient, please make sure you take with You our claim form to complete.
- Fill in the section that is assigned to You, the date and sign the claim form. Make sure that the Medical Practitioner or Specialist provides all relevant medical information in the specified section and then dates, signs and seals the claim form.

Attach all original invoices, receipts and copies of diagnostic tests to the claim form and post them to Us at the following address.

**ALL CLAIM FORMS SHOULD BE SENT TO:**

P. O. Box: 51998, 3509 Limassol Cyprus, or at Our Area Offices.

**CLAIMS HANDLING SERVICE STANDARDS**

Upon receipt of all completed final claims and supporting documentation required by Us, it is Our aim to complete Your claim and make payment to You or to the Hospital or to the provider as follows:

Payments within 20 working days.

**GENERAL CLAIMS CONDITIONS AND INFORMATION**

1. Claims may only be made for Treatment actually administered during a Period of Insurance and benefits will be considered only for Eligible Charges which You incur prior to expiry or termination of Your Policy.
2. All documents, medical reports and other material that we require and request to examine a claim shall be provided to us without expense to us. In cases where we require medical information in order to assess a claim but this is not obtained, it is Your responsibility to obtain such information from Your current or previous Medical Practitioner, as appropriate.
3. Where we deem a consequence is not covered under Your Policy based on exclusion, the burden of proof to the contrary shall rest upon You.
4. In the Application, provision is made for details of Your Medical Practitioners over the last 12 years. If such details are not provided in the Application and you submit a claim after the Effective Date which We deem as being for a Pre-Existing Condition, such a claim will be rejected.
5. When an Excess applies to the Policy, the payment of any benefit will occur only if the total amount of Eligible Charges for Treatment and supplies covered under the Policy exceeds the Excess in each Period of Insurance. The Excess will be deducted from all Eligible Charges in respect to each new Insured Medical Condition for every Period of Insurance. You are liable for the amount of the Excess and any Co-Insurance, and You should settle these amounts directly with the relevant medical provider.
6. You may choose to have Your claim reimbursement paid in any currency convenient to Your location. However, the payment will be converted to the equivalent amount in the base currency of Your Policy. If we have to make a conversion from one currency to another, We will choose a fair exchange rate on the date on which You paid for Your Treatment, or if Your Treatment spanned over a period of time and We pay the provider, We will choose a fair exchange rate on the date of processing the payment. We are not responsible for any loss you may incur due to fluctuations in exchange rates or for any bank charges You may incur when You change a foreign currency cheque, or when you receive a bank transfer from Us.
7. Without delay, You must give Us written notification of any claim or right of action against any third party arising out of any circumstances for which a claim was made under Your Policy. You must continue to keep Us fully informed in writing and take all steps reasonably required when you proceed with a claim against that other party. To the extent permissible under the laws of Your Country of Residence, We shall be entitled to take legal action in Your name for Our benefit and claim for indemnity or damages or other measures which relate to any benefit and expense paid or should be paid under Your Policy. We shall have full discretion in the conduct of any such proceedings and in the settlement of any claim.

8. In the event we deny all or part of a claim, you shall have 90 calendar days from the date that the notice of denial was mailed to You to file a written appeal with Us. Upon receipt of a written appeal, we will respond in writing as soon as it is reasonably practicable and in any event within 90 calendar days from receipt thereof.
9. You cannot bring a legal action for recovery under Your Policy within the first 90 calendar days after we have been furnished with all supporting documentation of your claim or after the lapse of 12 months from the date supporting documentation of the loss should have been given to Us.
10. For your claim to be considered, you as well as Your Medical Practitioners, the Hospitals and other healthcare providers and medical service providers shall undertake to cooperate fully with Us and this includes granting full right of access to all relevant or related medical documentation, medical histories, reports, lab or test results, x-rays, treatment report, to examine You whenever and as often as may be reasonably required within the duration of the claim, and other available evidence, relating to or affecting the investigation, judgment or administration of the claim. We may deny cover of a claim when there has been a refusal or material failure to cooperate.
11. Eligible Charges will be paid by cheque or transfer to You or to Your last known residence or mailing address or at Our Area Offices.
12. Under Your Policy, you can claim benefit from the beginning of the Treatment until the time when it is medically confirmed that the Treatment is no longer necessary, or until Your Policy is no longer in force, whichever is the earlier. If you subsequently claim for a new course of Treatment, which is not in any way connected with the former Treatment, the subsequent claim will be regarded as a new claim.
13. If Treatment has gone on for more than one Period of Insurance, We will treat it as a new claim for any further Treatment after that date and will reapply any Excess.

14. If You are under 18 years of age, claim payments will be made payable to Your legal guardian.

## MEDICAL MANAGEMENT SERVICES

### Pre-Certification

For many of the benefits under Your Policy You are required to notify Us PRIOR to incurring any expense or undertake any Treatment and before being admitted to Hospital.

### Network

You are free to choose the provider and location for Your Treatment within the Geographic Area of Your Cover.

## MAKING A COMPLAINT

Our aim is to provide You with a first class standard of service at all times. Nevertheless, there may be an occasion when You may feel this objective has not been achieved by Us. In the unlikely event of this happening, should You have any complaint or query regarding the service provided by Us under Your Policy, then please contact immediately one of Our Customer Service Advisors.

If You remain unsatisfied with Our response, we advise You to write explaining the nature of Your query or complaint to:

The General Manager

Please quote Your Certificate of Insurance number and give full information regarding the query or complaint. Also include your contact details. We aim to send a written acknowledgment within 5 working calendar days of receipt and give You details of who is handling Your complaint and how to contact him or her. We aim to resolve or respond to Your complaint within 4 weeks of receiving the complaint.



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