



Cyprus Choice

Table of Benefits



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Pre-authorisation required

If you do not seek pre-authorisation for these services you may be liable to pay a contribution towards the cost of eligible services and 100% of the cost for services you were not eligible for.

01 / Core Plan

This Table of Benefit outlines all the options available to policyholders when choosing Cyprus Choice cover. You should read the Table of Benefits in conjunction with the Member Guide and Certificate of Insurance. You will only be covered for the options that appear on your Certificate of Insurance. All terms written in bold are defined in the Member Guide.

Geographical area options	Worldwide excl. USA		Worldwide incl. USA		Cyprus, Europe & Israel
Benefits	Basic	Select	Classic	Premier	Definitions
Reimbursement	100%	100%	100%	100%	Unless specifically noted to the contrary, treatment is reimbursed 100% up to reasonable and customary charges after the payment of any applicable deductibles . Where USA cover has been purchased, any treatment undertaken within the USA will be subject to 20% co-insurance , unless you receive a pre-authorization prior to your hospitalization .
Annual Maximum	€75,000	€125,000	€1,000,000	€2,000,000	This is the overall maximum benefit limit of your policy and applies per insured person , per period of cover . We will pay for the cost of benefits allowable under the policy subject to the overall annual maximum and any specified sub-limits.
Mandatory Deductible	€50	€50	€50	€50	The amount that each insured person must pay per period of cover before the policy will pay for eligible claims . Is applied per period of cover on in hospital and out of hospital claims . The deductible is not applicable to claims in relation to any of the optional modules of Vision, Dental and Maternity
Hospital charges					
Room and board	in full (semi private room)	in full (semi private room)	in full (standard private room)	in full (standard private room)	Charges for in-patient or day-patient room and board when a stay in hospital is medically necessary , the length of stay is judged medically necessary and treatment is managed by a specialist . If the treatment charges are determined by the choice of room, we will pay the treatment costs appropriate for that room type.
Hospital cash (Up to 30 nights)	€75	€150	€150	€200	The payment of a defined cash benefit for each night you receive in-patient care and the treatment received would ordinarily have been eligible treatment under this policy and was received free of charge (excluding maternity).
Parent accommodation	in full	in full	in full	in full	We will pay for the cost of one parent staying in a hospital overnight with an insured person under 18 years while such insured person is admitted and is receiving in-patient care .
Operating theatre, drugs and dressings & internal appliances	in full	in full	in full	in full	The costs of the operating theatre, the recovery room, internal appliances integral to the surgical procedure, drugs and dressings used in the operating or recovery room and drugs and dressings and durable medical equipment used during your hospital stay.
Intensive & high dependency care	in full	in full	in full	in full	Medically necessary costs for the use of an intensive care unit (ICU) or high dependency unit (HDU).
Surgery costs, surgeons' and anaesthetists' fees	in full	in full	in full	in full	The costs of medically necessary treatment required immediately before, during, and after the surgery. These include the surgeons' and anaesthetist's fees.
Physician and nurse fees	in full	in full	in full	in full	The cost of consultation fees associated with a medical practitioner/specialist or qualified nurse for the period of your in-patient or day-patient stay.
Diagnostic tests	in full	in full	in full	in full	The costs of medically necessary diagnostic tests including but not limited to pathology, radiology and electrocardiograms (ECG), when you are referred by your medical practitioner/specialist in order to diagnose or assess the symptoms of your medical condition during an in-patient or day-patient stay.

01 / Core Plan /continued

Benefits	Basic	Select	Classic	Premier	Definitions
Hospital charges (continued)					
Post Hospital Expenses	€500	€1,000	€2,000	€3,000	Medically necessary post hospital discharge expenses for follow up outpatient consultations , wound changes, diagnostic tests , prescribed drugs and dressing , physiotherapies , Durable Medical Equipment associated specifically with your medical condition for which in-patient or day-patient stay occurred.
CT/MRI/PET Scans	in full	in full	in full	in full	The costs of radiology including CT, MRI or PET scan (or combination of these scans) when recommended by your specialist and undertaken in the form of day-patient treatment or out-patient department (OPD) treatment .
External prosthesis	€500	€1,000	€2,000	in full	We will pay for the initial prosthesis needed as part of your treatment and which is required at the time of your surgical procedure . We do not pay for any replacement prosthesis including any replacement devices required in relation to a pre-existing condition .
Home modifications	€1,500	€2,000	€2,500	€3,000	We will pay the costs of alterations performed in the home of the insured person who, as a result of an accident or illness which was covered under the policy , has suffered a bodily injury which has permanently immobilized the insured person in a wheelchair.
Operations, surgeries and treatments					
Reconstructive/remedial surgery	in full	in full	in full	in full	Surgery required as a result of an accident , illness or surgery which occurred during the period of cover and is undertaken within 12 months of the accident/illness/surgery occurring to restore natural function or appearance, subject to the cover being in force. Cover includes one reconstructive/remedial surgery per medical condition unless medically necessary to perform multiple surgeries.
Accidental dental treatment	€150	€250	€500	€1,000	Emergency dental treatment required for damage to sound, natural teeth following an accident . You must contact us within 48 hours of the accident and seek treatment within 7 days of the accident . If treatment continues for longer than one year from the date of the accident , your case may be reassessed by us .
Cancer treatment 	in full	in full	in full	in full	In-patient , day-patient or out-patient treatment given for a diagnosed cancer condition. This includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination as well as any prescribed drugs and dressings required to treat the medical condition .
Transplant services 	in full	in full	in full	in full	Treatment for and in relation to life-sustaining human organ, tissue and cell transplants including but not limited to kidney, pancreas, liver, heart, lung, bone marrow and cornea, in respect of the insured person as a recipient. The transplant shall be carried out in internationally accredited institutions by accredited surgeons and where the organ, tissue or cell procurement is in accordance with World Health Organisation (WHO) guidelines. We will only pay for medical costs associated with the donor as an in-patient or day-patient when services are rendered in the same network facility where the transplant occurs and where the donation does not lead to a loss of the donor's life. Costs associated with the donor search or procurement of the organ, tissue or cell are excluded. Cover includes the cost of anti-rejection medication (immunotherapy). The specific type and length of treatment will be determined by the type of transplant and underlying medical condition .
Renal dialysis 	no cover	no cover	€5,000	€10,000	Treatment of kidney failure requiring regular dialysis received in the form of in-patient care , day-patient treatment or out-patient treatment . This includes pre and post-operative renal dialysis and as part of intensive care and for on-going maintenance while waiting for a kidney transplant.
Psychiatric treatment and psychotherapy 	in full (15 days)	in full (15 days)	in full (30 days)	in full (30 days)	We will pay for in-patient care which is a medically necessary treatment of a recognised mental health disorder in a recognised psychiatric unit of a hospital . All treatment must be administered under the direct supervision of a consultant psychiatrist.

01 / Core Plan /continued

Benefits	Basic	Select	Classic	Premier	Definitions
Operations, surgeries and treatments (continued)					
Emergency cover outside geographical area of coverage	€10,000	€25,000	€40,000	€70,000	Emergency care for any accident or medical condition which has developed whilst travelling and are not pre-existing conditions outside of the geographical area of the policy until you are stable for transfer, or up to the benefit limit specified, whichever is the lesser amount.
Acute phases of chronic conditions	in full	in full	in full	in full	We will pay for acute flare up of a chronic condition which will entail providing active treatment towards in-patient care or day-patient treatment in order to stabilise the condition for the period of admission only.
Emergency out-patient care	no cover	€500	€1,000	€1,000	We will pay for emergency treatment at an accident and emergency unit or emergency room of a hospital .
Out-patient surgery	no cover	in full	in full	in full	Treatment costs for a surgical procedure performed as an out-patient .
Rehabilitation and palliative care following discharge from hospital					
Home nursing 	no cover	in full (30 days)	in full (30 days)	in full (30 days)	We will pay for home nursing following discharge from a hospital as consequence of eligible in-patient care. We pay if the home nursing: <ul style="list-style-type: none"> • is required only to provide medical care • is necessary, meaning that without it you would have to stay in hospital • starts immediately following discharge from hospital • is provided by a qualified nurse • is recommended or prescribed by your specialist.
Palliative care / hospice fees	no cover	no cover	€5,000	€10,000	Treatment following the diagnosis that your medical condition is terminal and you will no longer receive treatment that will result in a recovery. We pay for your palliative treatment , social, psychological and spiritual care and hospital or hospice accommodation, nursing care and prescribed drugs and dressings .
Rehabilitation services 	in full (30 days)	in full (30 days)	in full (60 days)	in full (90 days)	Rehabilitation undertaken in a hospital as an in-patient or in a recognised rehabilitation unit and under the direction of a specialist , including room and board , physical therapy, occupational therapy, dietitian and speech therapy. Treatment must begin within 30 days after the end of your treatment in hospital for a medical condition which is covered by your policy and arose as a result of the medical condition which required hospitalisation, or as a result of the treatment for that medical condition . We do not pay room and board for rehabilitation when the treatment given is solely physiotherapy .
Complications in pregnancy and other post-birth benefits (12 months waiting period)					
Pregnancy-related medical conditions	€4,000	€4,000	€4,000	€4,000	In-patient treatment of a medical condition which arises during the antenatal stages of pregnancy or during childbirth. We would consider treatment including, but not limited to: ectopic pregnancy, stillbirth, abnormal cell growth in the womb (hydatidform mole), retained placenta or placenta praevia, placenta abruption, pre-eclampsia or eclampsia and/or toxemia, pregnancy related diabetes, post-partum haemorrhage, miscarriage requiring immediate surgical treatment , failure to progress in labour, pregnancy related vitamin and mineral deficiency and cholestasis of pregnancy. We will cover the cost of emergency caesarean section, where it is medically necessary due to non-progression in labour. Where we are not satisfied that the caesarean section was medically necessary , we will only cover up to your maternity benefit limit , where purchased. We do not cover caesarean section costs due to a previously elective caesarean section.

01 / Core Plan /continued

Benefits	Basic	Select	Classic	Premier	Definitions
Complications in pregnancy and other post-birth benefits (12 months waiting period) (continued)					
New born care 	no cover	no cover	€50,000	€100,000	<p>We will pay for treatment of any eligible medical conditions (including a congenital disorders) that manifest themselves within 30 days after birth.</p> <ol style="list-style-type: none"> This cover will be funded from the mother's new born care benefit, for the first 30 days from birth, or until their benefit limit is reached, whichever occurs first. This cover is on condition that the mother's policy includes new born care benefit and the newborn will be added within the first 30 days as a dependant. From 31 days after birth, or after the mothers new born care benefit limit has been reached, any eligible medical conditions that manifested themselves in the first 30 days from birth will be covered under the new born care benefit applicable under the dependant child's policy and up to the benefit limit specified. No further cover for any eligible medical condition manifesting itself within the first 30 days of birth will be provided other than under this benefit limit. <p>Please note:</p> <ol style="list-style-type: none"> 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. In the event of multiple births, the new born care benefit limit shown on the mother's policy is the maximum aggregate amount that can be claimed for, regardless of the number of babies born. Thereafter each eligible dependant baby will be covered by the applicable benefits available on their own policy.
Child accommodation	in full	in full	in full	in full	Room and board costs relating to a new born (up to 16 weeks old) to accompany its mother (being an insured person) while she is receiving treatment as an in-patient in a hospital .
Evacuation and repatriation services					
Medical evacuation 	no cover	in full (nearest country)	in full (nearest country)	in full (nearest country)	Costs of an insured person , in the event of emergency treatment not being readily available in the region or country of incident, to be transported by the most medically appropriate means to the nearest appropriate medical facility or, where Premier cover has been purchased, to the country of your choice within your geographical area (if, in the opinion of your medical practitioner/specialist and us that you are in the appropriate medical position to be able to undertake the journey), for the purpose of admission to hospital as an in-patient or day-patient .
Medical repatriation 	no cover	in full	in full	in full	<p>We will pay the reasonable expenses for:</p> <ul style="list-style-type: none"> the most medically appropriate transportation costs for the insured person. local travel costs to and from medical appointments when treatment is being received as a day-patient. standard hotel room in a 4* hotel or equivalent, to be determined by us, for the insured person immediately pre- and post-hospital admission periods provided that the insured person is under the care of a specialist for a period of up to seven days post discharge from hospital. an economy class airfare ticket to return the insured person to the site where the emergency initially arose or to the that person's country of residence. <p>Medical repatriation does not extend to include air/sea rescue or mountain rescue services. Only available within the geographical area of your policy.</p>

01 / Core Plan /continued

Benefits	Basic	Select	Classic	Premier	Definitions
Evacuation and repatriation services (continued)					
Accompanying person expenses 	no cover	in full	in full	in full	Reasonable costs for an immediate family member to accompany you during a medical evacuation if there is a reasonable need, which would include physical assistance during transportation, you do not have a medical escort or the reason for evacuation relates to a serious, acute illness and only where the treatment received is on an in-patient or day-patient basis. Reasonable costs include: <ul style="list-style-type: none"> • 1 economy return flight (even if the insured person is travelling in another class for medical reasons). Or, where the accompanying person is providing medically necessary assistance to the insured person during transportation, we will cover the costs of the accompanying person's travel on the medically necessary transport • Reasonable living expenses • Reasonable costs for travel to and from hospital • Standard hotel room in a 4* hotel or equivalent, to be determined by us This benefit will only be paid once per medical condition and must be pre-authorised by us .
Incidental Expenses 	no cover	in full	in full	in full	The cost of incidental expenses related to the emergency including: <ul style="list-style-type: none"> • 1 economy return flight and accommodation for a child in the event of an evacuation, provided they are under the age of 18 and they would otherwise be left without a parent or guardian • Reasonable child care and pet care, where the child or pets remain in the country of residence.
Repatriation of mortal remains 	in full	in full	in full	in full	Reasonable costs for the transportation of your mortal remains following your death whilst outside of your home country. The costs of a local burial in the country where the death occurred, other than your home country, cremation costs in the country where the death occurred and transportation of the urn to your country of residence or home country. Where a local burial or cremation is chosen, costs will be covered to the same cost of repatriation to home country. We do not pay for the cost of burial caskets, or the transportation costs for someone to collect or accompany your mortal remains.
Compassionate travel 	no cover	in full	in full	in full	An economy return flight for you , together with any minors (under the age of 18), to travel from your country of residence to visit an immediate family member who is in a High-Dependency Unit, Intensive Care Unit or facing a life-threatening illness or injury in your home country. We will cover one visit per medical condition only. We will not cover any living expenses associated with the visit.
Local road ambulance	in full	in full	in full	in full	We will pay for in-country ambulatory transportation by road or, if medically necessary , air ambulance to the nearest suitable hospital or other place of treatment where services are available to provide treatment for your eligible accident or medical condition , as well as a clinical escort where deemed medically necessary to accompany you . We do not pay for mountain/air/sea rescue services.
Local air ambulance					
Non-emergency travel	no cover	no cover	no cover	1 economy class journey	We cover 1 economy return flight to the nearest centre of excellence to treat your medical condition when the treatment is not available in your country of residence , the treatment is elective, on an in-patient or day-patient basis, you are fit to travel as judged by a medical practitioner/specialist and the cost of the treatment is covered under your policy. We will not pay for living expenses before or after the treatment or for the cost of an accompanying person. We require a note from your medical practitioner to confirm the treatment is not available in your country of residence , or is not available to an acceptable medical standard.



02 / Out-patient Plan

Note: Out-patient cover is optional. You can only choose an Out-patient option at the same level or less than your Core cover.

Out-patient plans	Basic	Select	Classic	Premier	Definitions
Overall Out-patient benefit limit	€500	€1,500	€3,000	€5,000	We will pay for the cost of benefits allowable under the policy subject to the overall annual maximum and any specified sub-limits.
Consultations and scans					
Out-patient consultations	€25 in Cyprus/€50 Abroad within out-patient limit	€50 in Cyprus/€100 Abroad within out-patient limit	in full within out-patient limit	in full within out-patient limit	Out-patient medical practitioner/specialist or qualified nurse fees including consultations to: <ul style="list-style-type: none"> • assess the symptoms of your medical condition • arrange or receive treatment • follow-up on treatment already received • prescribe drugs and dressings
Routine chronic condition management	80% within out-patient limit	80% within out-patient limit	80% within out-patient limit	80% within out-patient limit	Management of chronic conditions requiring ongoing or long-term monitoring through consultations with a medical practitioner/specialist including examinations, check-ups and the prescribing of drugs and dressings . Prescriptions for drugs and dressings that exceed the period of cover will only be covered for the duration of the remaining period of cover .
Diagnostic tests	in full within out-patient limit	in full within out-patient limit	in full within out-patient limit	in full within out-patient limit	The costs of diagnostic tests used to diagnose or assess the symptoms of your medical condition when ordered by your medical practitioner/specialist .
Medicines and medical equipment					
Prescribed drugs and dressings	in full within out-patient limit	in full within out-patient limit	in full within out-patient limit	in full within out-patient limit	The cost of drugs and dressings prescribed by your medical practitioner/specialist and will only be used for the treatment of a medical condition or injury. Prescriptions for drugs and dressings that exceed the period of cover will only be covered for the duration of the remaining period of cover . Drugs and dressings does not include prescriptions which can be purchased over-the-counter.
Durable medical equipment	no cover	€150	€250	€500	The cost to rent, or at our discretion to purchase, any durable medical equipment that is ordered by a medical Practitioner/specialist to be used in the course of treatment for an accident or medical condition , or while undertaking nursing at home where medically necessary and where recommended by a medical practitioner/specialist .
Specialist and alternative treatments					
Physiotherapy	€150	€500	€1,000	in full within out-patient limit	We will pay for physiotherapy costs under the direction of a registered physiotherapist , where the treatment is of short duration to relieve pain or restore function. If you are not referred by a medical practitioner/specialist , you will need to gain pre-authorisation after ten physiotherapy sessions (unless we agree otherwise).
Complementary treatment	no cover	€500	€500	€1,000	Complementary treatment provided as an out-patient in respect of an eligible medical condition . The practitioner must be appropriately qualified and registered to practice in the country where the treatment is received.
Speech therapy	no cover	no cover	no cover	€1,000	Speech therapy as part of a treatment program for a medical condition and when referred by a medical practitioner/specialist .

02 / Out-patient Plan /continued

Out-patient plans	Basic	Select	Classic	Premier	Definitions
Overall Out-patient benefit limit	€500	€1,500	€3,000	€5,000	We will pay for the cost of benefits allowable under the policy subject to the overall annual maximum and any specified sub-limits.
Prevention and wellbeing (6 months waiting period)					
Vaccinations	no cover	€100	€200	€300	Vaccinations must have completed clinical trials and be approved for use in the country where treatment is taking place. The cost for the visit and administration of the vaccination is included.
Annual health assessment	no cover	€250	€250	€500	We will pay for one health assessment per period of cover to assess your state of health where it is provided by a recognised medical practitioner/specialist or qualified nurse . The actual tests you have will depend on the health screening offered by your provider but may include routine tests such as blood sugar and cholesterol tests, a blood pressure test and a kidney function test. It may also include specific screening tests, such as mammogram, pap test, colon cancer screening, or prostate cancer screening.
Well-baby checks					Well-baby checks, undertaken 6 months after birth and up until the child's second birthday and as recommended by a medical practitioner/specialist , including physical examinations, measurements, screenings, evaluations and blood tests as is recommended in the country where the treatment is undertaken.
Sick Leave Benefit due to illness or accident					
Convalescence Cash Benefit	no cover	no cover	€100 each full week for to maximum of 2 weeks	€100 each full week up to maximum of 4 weeks	A cash benefit following discharge from hospital admission after a minimum in-patient stay of 5 nights, you are confined to home for a period of recuperation. Maximum benefit period four (4) weeks.

03 / Optional Benefits

These add-on packages give you the option to increase your level of cover in the areas that are important to you.

Optional Benefits				Definitions
Vision and Dental	Waiting Period	Option 1	Option 2	
Glasses and contact lenses	6 months	€250		The costs of spectacle lenses and contact lenses which are prescribed by an ophthalmologist or optician due to sight/vision change to correct the sight/vision problem, such as short or long sight to a maximum of one pair per insured person per period of cover . The cost of frames, only if you have been prescribed new spectacle lenses due to sight/vision change, and where confirmation of the prescription/purchase of lenses is provided, to a maximum of one pair per insured person for every two periods of cover . The cost of disposable contact lenses where submissions are for no more than 90 days' supply at any one time.
Laser eye surgery	18 months	€1,000		Treatment or surgery to correct eyesight, such as laser treatment , refractive keratotomy (RK) and photorefractive keratotomy (PRK). Limited to once per eye per lifetime up to the limit specified to the Table of Benefits. It must be undertaken by a recognised specialist , registered in the country where the treatment is undertaken.
Routine dental	6 months	€550	€1,000	Routine dental treatment which includes preventative care exams every six months (oral check, hygienist visit and oral x-ray) and basic restorative treatment including tooth fillings, basic non-surgical extractions (other than wisdom teeth) and root canal treatment . Costs of medically necessary drugs and dressings required as part of the eligible dental treatment . A co-insurance of 20% applies to this benefit .
Restorative dental	12 months	no cover		Major restorative treatment defined as the removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicectomy bridges and crowns (new or repair), provision of dentures, removal of wisdom teeth and dental implants where medically necessary rather than for cosmetic purposes compared with other treatment options available. Costs of medically necessary drugs and dressings required as part of the eligible dental treatment . A co-insurance of 20% applies to this benefit .

03 / Optional Benefits /continued

Optional Benefits				Definitions
Vision, Dental and Maternity	Waiting Period	Option 1	Option 2	
Glasses and contact lenses	6 months	€250		The costs of spectacle lenses and non-disposable contact lenses which are prescribed by an ophthalmologist or optician to correct a sight/vision problem, such as short or long sight to a maximum of one pair per insured person per period of cover . The cost of frames, only if you have been prescribed new spectacle lenses due to sight/vision change, and where confirmation of the prescription/purchase of lenses is provided. New spectacle lenses to a maximum of one pair per insured person for every two periods of cover . The cost of disposable contact lenses where submissions are for no more than 90 days' supply at any one time.
Laser eye surgery	18 months	€1,000		Treatment or surgery to correct eyesight, such as laser treatment , refractive keratotomy (RK) and photorefractive keratotomy (PRK). Limited to once per eye per lifetime up to the limit specified in the Table of Benefits. It must be undertaken by a recognised specialist , registered in the country where the treatment is undertaken.
Routine dental	6 months	€550	€1,000	Routine dental treatment which includes preventative care exams every six months (oral check, hygienist visit and oral x-ray) and basic restorative treatment including tooth fillings, basic non-surgical extractions (other than wisdom teeth) and root canal treatment . Costs of medically necessary drugs and dressings required as part of the eligible dental treatment . A co-insurance of 20% applies to this benefit .
Restorative dental	12 months	no cover		Major restorative treatment defined as the removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicectomy bridges and crowns (new or repair), provision of dentures, removal of wisdom teeth and dental implants where medically necessary rather than for cosmetic purposes compared with other treatment options available. Costs of medically necessary drugs and dressings required as part of the eligible dental treatment . A co-insurance of 20% applies to this benefit .
Natural childbirth	12 months	€4,000		Medically necessary costs incurred during normal pregnancy and childbirth including scans and delivery costs in a hospital or at home. Complications of pregnancy as a result of fertility treatment and artificial insemination (IVF) will be limited to this benefit if this option is purchased. Non- emergency caesarean section and medically necessary caesarean section costs due to previous elective caesarean section.
C-section				
Pre-and post-natal check ups				Pre and post-natal check-ups up to six weeks following birth for a mother, being an insured person , prior to and following childbirth.
Paediatrician costs				Well-baby examinations and paediatrician costs for the first examination/check-up of a new born baby , if the examination is made within 24 hours of delivery.

04 / Health Advice Services

The below service is included within **your** plans and there is no limit on its use.

Service	Service Description
Second medical Opinion* 	We provide you with complimentary access to an independent second medical opinion service. This service gives you access to medical specialists , identified and authorized by us , who can provide an independent and confidential review of your medical case when you are in doubt about your diagnosis, worried that your medication isn't working, or want to know if there are other treatment options.

* Pre- authorisation required for this service. If **you** do not seek pre-authorization we will not be liable to reimburse any costs **you** incur for seeking a second medical opinion.

05 / Deductibles and Co-insurances

This page outlines the contribution you may need to make towards the cost of your treatment. Please refer to your certificate of insurance to identify which contributions apply to your policy.

Contribution Type	Contribution amount	Definitions
Deductibles	Cyprus Choice comes with a mandatory deductible per insured member per period of cover of €50. However, there are several deductible options as presented below that reduce the annual premium. Deductible options: <ul style="list-style-type: none"> • €85/€150/€300/€500/€1,000/€2,000 Check your Certificate of Insurance to see which applies to your policy.	The annual amount that each insured person must pay each period of cover before the policy will pay certain benefits . Deductible amounts applicable will be indicated in your certificate of insurance .
Co-insurances	The following co-insurances apply to all Cyprus Choice policies : <ul style="list-style-type: none"> • 20% routine and restorative dental • 20% for any treatment undertaken in USA and you don't have pre-authorization from us prior to your treatment. The following co-insurances are optional: <ul style="list-style-type: none"> • 80% reimbursement on in-patient (Core benefits) • 20% co-insurance on out-patient (out-patient benefits). 	Co-insurance is the amount that you must contribute towards each treatment undertaken. Co-insurance may apply to specific benefits , or across multiple benefits . If the optional co-insurances has been selected, this will be indicated in your certificate of insurance .



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]”.

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Particulars of the Insurance Company

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