Individual & Family Health Care

Perpetual Policy

Introduction

Whereas the **Policyholder**, identified in the special conditions of this Policy, has filed an application which is considered as the founding basis of this Policy and its purpose and has accepted to pay the premium cited in the special conditions of this Policy,

Whereas the **Insurance Company** ---------- (hereinafter referred to as the **Insurance Company**), after having reviewed the application, has consented to provide the insurance coverage specified in the special conditions, the Policy coverage description and the **Policy Schedule** appended to this Policy,

Whereas the **Insurance Company** has contracted with GlobeMed Lebanon (hereinafter referred to as "the **Administrator**") to provide it with its services in performing some of the administrative and technical services related to the healthcare policies of the **Insured** and to coordinate their relation with the healthcare providers adherent to its network.

Therefore, the **Insurance Company** undertakes to settle the medical expenses based on the coverage stated in this Policy within the range and in conformity with the terms, conditions, limitations, and exclusions provided therein.

Accordingly, and in approval of its content, the **Insurance Company** has duly signed and stamped this Policy document to be effective as of the date stipulated in the **Policy Schedule** attached herewith.

Name and signature of the Insurance Company:

DEFINITIONS

Words, terms and expressions used in this Policy shall have the meanings set forth herein below:

1. ACCESS CARD

A personalized card issued in the name of each **Insured**, facilitating his/her access to the healthcare services covered under this Policy in Lebanon and abroad at the Network of **Participating Healthcare Providers**. The Access Card is the property of the **Insurance Company.**

2. ACCIDENT

Accident is a sudden, external and unexpected event that occur during the contractual period of this Policy that result in an injury, disability or death covered based on the Terms, Conditions, Limitations and Exclusions of this Policy.

3. ADMINISTRATOR

GlobeMed Lebanon S.A.L, the company with whom the **Insurance Company** is contracted to administrate this Policy and to support its implementation, through regional offices in Lebanon and professional delegates (e.g. physicians and other delegates).

The Administrator shall provide also the services specified in this Policy, for the Insured incurring claims outside the Domicile subject to the Terms, Conditions, Limitations and Exclusions of this Policy, through a network of third party administration companies (TPA) and/or International Assistance Companies contracted directly or indirectly with the Administrator.

Particularly, the **Administrator** continuously verifies the eligibility of the **Insured** to the **Healthcare Services** sought and takes the decision, whether to approve or reject the coverage. To that effect, the **Administrator** controls and reviews the medical, administrative, and accounting files of the **Insured** and coordinates with the attending physicians and the **Healthcare Providers** whenever needed.

4. AMBULATORY/PRESCRIPTION MEDICINE TRANSACTION

A virtual electronic form processed, through the personalized **Access Card** of the **Insured,** on the IT Systems adopted by the **Administrator**. It allows the **Insured** to benefit, whenever applicable, from the **Ambulatory Healthcare Benefit Plan** and/or the **Prescription Medicine Benefit Plan**. The transaction is unlimited by number per **Insured** per contractual period; it must be used based on a duly completed signed and sealed medical report issued by the **Insured's** attending physician. The medical report is valid for 15 days following completion by the attending physician, and should be duly written, dated, signed, and stamped by the attending physician registered in the NSSF.

The **Ambulatory/Prescription Medicine Transaction** and the proper implementation of the above conditions and procedures are a mandatory prerequisite to benefiting from the coverage of the **Ambulatory** and/or **Prescription Medicine Benefit Plan** coverage.

5. APPLICABLE PLAN

The set of **Healthcare Services** and its related benefits provided for in the Policy, along with their Limitations and Exclusions specifically identified, in the **Policy Schedule** of each **Insured**.

6. CHRONIC CONDITION

A **Chronic Condition** is a disease, illness, or injury which has at least one of the following characteristics:

(i) It has no known cure;
(ii) It is permanent (is a long-lasting condition);
(iii) It needs long term monitoring, medical consultations, check-ups, examinations or tests,
(iv) The Insured is required to be specially trained or rehabilitated;
(v) It comes back or is likely to come back.

7. CLASS OF RISK

The classification, by various types, of **Insured** and insurance benefits appearing in the publicized tariffs of the **Insurance Company**.

8. COINSURANCE

The percentage of the incurred claim expenses to be paid by the **Policyholder**.

9. DEDUCTIBLE

The fixed amount of the incurred claim expenses to be paid by the **Policyholder**.

10. DOCTOR CONSULTATION (DC) PLAN TRANSACTION

A transaction conducted through an electronic procedure, via the use of the **Insured**'s **Access Card** allowing the **Insured** to benefit, whenever applicable, from the **DC Plan**. It is limited by number per **Insured** per contractual period and must be used based on a duly completed signed and sealed medical report issued by the **Insured's** attending physician.

The **DC Plan Transaction** and the proper implementation of the above conditions and procedures are a mandatory prerequisite to benefit from the **DC Plan** coverage.

11. EMERGENCY TREATMENT

The **Emergency Treatment** is defined as a "severe" and "dangerous" health condition resulting from sudden sickness, Accident or bodily injury, that was not present

previously, and which raises a legitimate professional concern requiring immediate rushed diagnosis and treatment (medical or surgical) in a hospital emergency room-facility, whether followed by hospitalization or not.

12. ENROLLMENT DATE

00:00 hours of the day, month and year appearing on the Policy Schedule, on which the **Insured** has been enrolled, under this Policy, for the first time with the **Insurance Company.**

13. GUARANTEED RENEWABILITY EFFECTIVE DATE

00:00 hours of the day, month and year appearing in the **Policy Schedule**, at which the **Insurance Company** is deemed to have formally accepted to renew the Policy with a **Guaranteed Renewability**, as per the provisions of Article 8 herein. Such effective date applies per **Insured** and not necessarily for the whole Policy or for all **Insured**.

14. HEALTHCARE SERVICES

The medical, hospitalization and **Healthcare Services** that the **Policyholder,** the **Insured** and/or **Legal Dependents** benefit from under this Policy and that are delivered by the **Participating Healthcare Providers or Non-participating Healthcare Providers**.

15. HEALTHCARE PROVIDERS

The providers of specific **Healthcare Services** (e.g. hospitals, medical centers, integrated clinics, pharmacies, laboratories, physiotherapy centers, physicians), that spread throughout most of the Lebanese territory and abroad whether **Participating or Non-Participating** in the network of the **Administrator**

16. INSURANCE COMPANY

The **Insurance Company** duly registered and authorized to operate in Lebanon, which guarantees the payment of the Healthcare Services and related benefits provided under this Policy.

17. INSURED

The **Policyholder** and/or any other physical person listed in the application or included thereafter, formally accepted by the **Insurance Company** and listed in the **Policy Schedule.**

18. INJURY

A damage or harm to the body caused by a sudden and severe external cause or reason beyond the control of the Insured, within the Contractual Period of this Policy.

19. LEGAL DEPENDENTS

The following dependents of the **Insured**, whenever applicable: the spouse(s) and the unmarried children aged between zero day and 18 years or 25 years if still full time university students.

20. MEDICAL NECESSITY

Medical Necessity is used to refer to the accepted medical acts performed on the Insured, and which are justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care applicable in Lebanon and consistent with the exact disease, illness, injury or condition of the Insured.

21. MEDICAL REPORT FOR ADMISSION (M.R.A.)

The MRA is a special form, available at the **Administrator** that must be completed by the attending physician of the **Insured** and submitted to the Medical Officer of the **Administrator** prior to hospitalization. It is a mandatory prerequisite to benefiting from the In-Hospital coverage.

22. NEW HEALTHCARE TECHNOLOGY

Any new medical treatment or procedure invented which is not the standard of care in the Domicile.

23. NON-PARTICIPATING HEALTHCARE PROVIDERS

The **Healthcare Provider**s that are not contracted with the Administrator and accordingly are not part of its network of **Healthcare Providers**

24. ORTHESIS

The devices that are placed outside the body, yet attached to it, and used to fix the joint or to perform the function of the limbs such as splint, collar, corset, orthopedic shoes, brace, walker, etc…

25. PARTICIPATING HEALTHCARE PROVIDERS

The Healthcare Providers that are contracted with the Administrator and accordingly are part of its network of Healthcare Providers.

Physicians working and contracted with hospitals that are Participating Healthcare Providers are automatically considered as part of the Administrator network (for treatment inside the hospital) with the exception of those physicians excluded by the Insurance Company or the Administrator for whatever reason.

In addition to the above, healthcare centers located in the MENA region and in a number of other countries whenever such healthcare centers are contracted with the

Administrator, either directly or indirectly, through another TPA Company cooperating with the **Administrator**, are considered part of the Administrator network of Healthcare Providers, provided that such healthcare centers are included in this Policy.

In addition to all hospitals and clinics that are part of the health system of the French Social Security which are adopted by the **Administrator** to provide direct coverage of the healthcare expenses covered by the Policy, for hospitals that are members of the network in France.

A list of the Participating Healthcare Providers is available upon request with the **Insurance Company** or the **Administrator**. These Participating Healthcare Providers or parts of their services or sections may be modified during the Policy Period (added or removed) without the need of the prior notification or the approval of the **Insured**.

26. POLICYHOLDER

The applicant for the healthcare insurance Policy, acting in his/her own capacity and on behalf, and/or in the name and on behalf of the **Insured** and/or their **Legal Dependent**s, whose application is formally accepted by the **Insurance Company**.

27. POLICY SCHEDULE

A supplementary document to this Policy issued by the **Insurance Company** in which information on the contractual parties are specified, together with the specific conditions of this Policy, including but not limited to the Effective date, the Eligibility date, the Expiry date, the **Policyholder** name and address, contract number, Premium and Premium payment details, **Applicable Plan**s details, **Insured** members details (name, age, date of birth, gender, relation, plan per **Insured**, Hospitalization class, **Insured** members' first **Enrollment Date**, …etc.), the specific additional exclusions and or limitations and the Policy's special conditions, if any.

28. PREEXISTING CONDITION

A **Preexisting Condition** is an illness, Injury, condition, or symptom that existed prior to the commencement of insurance whether it was known to the **Insured** or not; or for which the **Insured** had consulted a registered medical practitioner prior to the commencement of insurance; or for which a reasonable person in the **Insured**'s position would have consulted a registered medical practitioner prior to the commencement of insurance; or which was not known to the **Insured** but is considered as a **Preexisting Medical Condition** (i.e. when the illness, Injury, condition, or symptom exists in the human body before commencement of insurance).

29. PROSTHESIS

The set of pieces and medical devices (such as screws, Pacemakers) that constitute, together, one device placed within the body to perform one function, whereby it replaces and/or supports an organ or the function of an organ.

30. WATING PERIOD

A waiting period is the initial period of time specified in the Policy during which coverage for certain Healthcare Services may be excluded.

31. RENEWAL EFFECTIVE DATE

00:00 hours of the day, month, and year appearing in the Policy Schedule, at which the **Insurance Company** is deemed to have formally accepted to renew this Policy having been in force and effect without interruption, following the due signature by the **Policyholder** of the Policy documents and the payment of the due premium on time.

GENERAL TERMS AND CONDITIONS

Article 1: THE POLICY

a. The Application and medical questionnaire(s), if any, of the **Policyholder** and the **Insured**, the Preamble, the Policy coverage description, the **Policy Schedule**, (including but not limited to the Accepted Census List, and the special Limitations and/or Exclusions, if any), the Definitions, the General Terms and Conditions, the various Applicable Healthcare Plans including their relative Scope of Healthcare Benefits covered along with their Limitations and Exclusions, as well as any attachment(s) and/or endorsement(s) to any of the aforementioned, shall constitute the entire agreement of the parties hereto (herein referred to as the **Policy**).

b. Any amendment or addition to the Policy shall be void, unless it is in writing, signed and sealed by the **Insurance Company**. No insurance intermediary or any other party has the authority to amend this Policy or waive any of its provisions.

c. If special Exclusions and/or Limitations included in the Policy are applied by the **Insurance Company**, the **Policyholder** is deemed to have approved them, in his name as well as in the name and on behalf of the **Insured** and their **Legal Dependent(s)** listed in the Application, and/or accepted census list, by receiving the Policy documents and/or **Access Cards** relating thereto.

Article 2: GENERAL SCOPE OF BENEFITS

In return for the premium paid by the **Policyholder**, the **Insurance Company** shall cover **all usual, customary and reasonable Healthcare Services** and their related expenses incurred by the **Insured** under an **Applicable Healthcare Plan** while this Policy is in force, subject to its Terms, Conditions, Limitations and Exclusions. Any billing by any of the Participating **Healthcare Providers and/or the Non-participating Healthcare Providers** that is not usual, customary and reasonable, or which relates to a claim that is subject to malpractice, medical error, or dispute shall be excluded from the coverage of this Policy.

Article 3: GENERAL LIMITATIONS

a. Financial limitation

No financial limitation per contractual period is applicable per **Insured**, unless otherwise specified in the **Policy Schedule**. However, starting from the time when an **Insured** would eventually benefit from the **Guaranteed Renewability Feature**, as provided in article 8 (a), the Policy will be subject to a lifetime limitation per specific **Insured** identified in the **Policy Schedule** as the maximum number of covered hospitalization days. .

b. Hospitalization Class

The hospitalization class per contractual period corresponds to the class of In-Hospital Healthcare Benefits to which the **Insured** is entitled to as identified in the **Policy Schedule**.

The Coverage in France is limited to a shared room containing more than one bed, thereby known as "Chambre Collective".

c. Duplicate and/or Supplementary Coverage

(i) In the case of a supplementary coverage to the coverage provided by the National Social Security Fund (Co-NSSF Plan) identified per **Insured** in the **Policy Schedule**, the **Insurance Company** shall only cover the portion that is supplementary to the coverage provided by the NSSF scheme, even if the Participating **Healthcare Provider** is not contracted with the NSSF, and irrespective of whether the **Insured** had applied for and/or received such coverage benefits or not.

However, in case the hospitalization took place outside the Domicile, in one of the Middle East and North Africa Countries, (MENA Region), France or in any other country worldwide, the **Insured** is compelled to bear the expenses equivalent to the share covered by the NSSF for the claims related to such hospitalization, whereby, the **Insurance Company** only covers the additional expenses that were approved and determined upon the receipt of the hospitalization claim.

The healthcare coverage in France does not include any fees and/or medical and hospitalization expenses charged by the hospital and/or physicians in France including, for means of indication and not limitation, the additional medical fees requested by the treating physician (Dépassement d'Honoraire), whereby these additional fees, expenses and charges incurred remain on the full charge of the Insured.

(ii) In all other cases, the **Insured** will benefit from the balance between the amounts he/she is entitled to under concurrent or supplementary coverage (e.g. other insurance, self-funded scheme, workman compensation program, mutual societies, etc.), and all amounts he/she is entitled to under this Policy, irrespective of whether or not the **Insured** has been successful in receiving such other benefits. And the **Insured** commits to take all the necessary actions and measures to obtain the coverage from the other third party payers except in cases which are not covered by the third party payers whether fully or partially; In this case, the **Insurance Company** will cover the full cost of treatment or the remaining part of it in case the other third party payer has committed to cover part of the treatment. The **Insured** shall sign on a subrogation and waiver document in favor of the **Insurance Company** to grant it and the **Administrator** the right to recourse to the other third party payer to recover its rights and dues, whenever applicable.

d. Age

Insurance coverage is limited to the **Insured** aged between zero day and 65 years inclusive. The **Insurance Company** may, at its discretion, increase the age limit to 75 years inclusive (as the maximum insurable age) to one single **Insured** under a Policy that covers as **Insured** more than one family member. Age is computed based on the year per the effective Policy date minus the year of birth. The age limitation is automatically waived for **Insured** benefiting from the **Guaranteed Renewability Feature**, as provided in article 8 (a).

e. Domicile

The coverage under this Policy is limited to the **Insured** resident in Lebanon only. Accordingly, the **Insurance Company** shall have the right to terminate the Policy anytime if the **Insured** left the Lebanese territory for a period of 180 consecutive days during the contractual period. In this case, the **Insured** is entitled to a premium refund computed on the net risk premium on pro-rata basis applied by the **Insurance Company** based on the period of time the **Insured** has been covered since the effective date of the Policy. The premium refund will exclude all premiums related to the plan under which the **Insured** would have benefited from a covered claim.

f. Territoriality

This policy covers medical and hospitalization expenses incurred in the Domicile, the Middle East and North Africa countries (MENA Countries) and France, subject to the Terms, Conditions, Limitations and Exclusions provided herein. As for the rest of the countries worldwide, the coverage is subject to additional conditions or reimbursement procedures as decided by the Insurance Company.

MENA countries are defined as follows: Algeria, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Syria, Yemen, United Arab Emirates, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Tunisia.

Article 4: PAYMENT OF CLAIMS

a. Direct Payment

As a standard procedure, the **Insurance Company** shall settle, through the **Administrator**, the approved amounts of the claims, directly to the **Participating Healthcare Provider** and not to the **Insured**, based on a prior Approval of Coverage decision, as defined hereinafter, and up to the limits authorized therein, except in the cases where the reimbursement procedure is applicable. As for the Ambulatory Healthcare Benefits, direct payment is applicable only in Lebanon.

b. Approval of Coverage

The Approval of Coverage is a decision taken by the **Administrator** to cover the **Healthcare Services** requested by the **Insured** as per the Policy Conditions, provided that the requested **Healthcare Services** are within the scope of usual, customary and reasonable. This decision shall be binding and final for the **Insurance Company** and the **Policyholder** and/or the **Insured**. The **Administrator**'s decision may also determine the conditions and extent of the approved coverage.

The **Administrator** can refuse the coverage of the claim incurred at one of the physicians even if the latter is a member of the **Participating Healthcare Providers**. This case occurs in presence of fraud or attempted fraud or counterfeiting of the facts or the medical state of health or in case of a medical error or abuse that is contrary to the usual and reasonable medical principles and limitations.

c. Procedures for Approval

The **Administrator** may, upon the evaluation of each case, grant or deny the Approval of Coverage based on the Terms, Conditions, Limitations and Exclusions of the Policy, and within the scope of the usual, customary and reasonable services. This decision is relayed to the **Insured** and/or the **Healthcare Providers**. The procedures for Approval of Coverage provided for hereinafter are only applicable when the below procedures are complied with by the **Insured** depending on the following applicable cases:

(i) In the cases of non-emergency admission to a **Participating Healthcare Provider in MENA and France**, whether requiring an overnight stay at the hospital or not, as defined in the Policy, the Approval of Coverage must be secured by the **Insured** directly from the **Administrator**. The approval must be prior to his/her benefiting from a covered Healthcare Service by submitting the duly completed **Medical Report for Admission (M.R.A.)** to the **Administrator.**

(ii) In the cases of non-emergency admission to a **Non-Participating Healthcare Provider in MENA and France**, whether requiring an overnight stay at the hospital or not, as defined in the Policy, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

(iii) In the cases of non-emergency admission to a **Participating or Non-Participating Healthcare Provider** in countries outside MENA and France **(Worldwide)**, whether requiring an overnight stay at the hospital or not, as defined in the Policy, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

(iv) In the cases of emergency admission to a **Participating Healthcare Provider in MENA and France** whereby the health status of the **Insured** requires at least an overnight stay in the hospital, as defined in the Policy, Approval of Coverage must be requested by the **Insured** from the **Administrator**, immediately upon admission.

(v) In the cases of emergency admission to a **Non-Participating Healthcare Provider in MENA and France**, whereby the health status of the **Insured** requires at least an overnight stay in the hospital, as defined in the Policy, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

(vi) In the cases of emergency admission to a **Participating Healthcare Provider** in countries outside MENA and France **(Worldwide),** whereby the health status of the **Insured** requires at least an overnight stay in the hospital, as defined in the Policy, Approval of Coverage must be requested by the **Insured** from the **Administrator**, immediately upon admission.

(vii) In the cases of emergency admission to a **Non-Participating Healthcare Provider** in countries outside MENA and France **(Worldwide)**, whereby the health status of the **Insured** requires at least an overnight stay in the hospital, as defined in the Policy, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

(viii) In the cases of an emergency admission to a **Participating Healthcare Provider** in **MENA and France**, not requiring an overnight stay, the **Insured** must present his/her **Access Card** and ID or Passport to the hospital and wait for the **Administrator's** decision through the related electronic systems.

(ix) In the cases of an emergency admission to a **Non-Participating Healthcare Provider in MENA and France**, not requiring an overnight stay, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

(x) In the cases of an emergency admission to a **Participating Healthcare Provider** in countries outside MENA and France **(Worldwide)**, not requiring an overnight stay, the **Insured** must present his/her **Access Card** and ID or Passport to the hospital and wait for the **Administrator's** decision through the related electronic systems.

(xi) In the cases of an emergency admission to a **Non-Participating Healthcare Provider** in countries outside MENA and France **(Worldwide)**, not requiring an overnight stay, the **Insured** must settle the invoice and submit it for reimbursement as per article 4-d below.

d. Reimbursement

Reimbursement is an exceptional procedure strictly applied in the exclusive cases specified in this Policy. Based on that exceptional procedure, the **Insurance Company** reimburses totally or partially the amount of the invoice paid by the **Insured** as fees and expenses for covered **Healthcare Services** under this Policy, in compliance with the reimbursement conditions and procedures applicable exclusively in the following cases:

(i) In instances of non-emergency admission to a **Non-Participating Healthcare Provider in MENA and France**, whether requiring an overnight stay at the hospital or not, as defined in the Policy.

(ii) In instances of non-emergency admission to a **Participating or Non-Participating Healthcare Provider** in countries outside MENA and France **(Worldwide)**, whether requiring an overnight stay at the hospital or not, as defined in the Policy.

(iii) In instances of emergency treatments (as defined in the Scope of In-Hospital Benefits) at a **Non-Participating Healthcare Provider in MENA and France** whether the health status of the **Insured** requires at least an overnight stay in the hospital or not.

(iv) In instances of emergency treatments (as defined in the Scope of In-Hospital Benefits) at a **Non-Participating Healthcare Provider (Worldwide)** whether the health status of the **Insured** requires at least an overnight stay in the hospital or not.

(v) When the **Insured** has secured the prior approval of Coverage from the **Administrator**, which is given upon the latter's discretion based on justified reasons, for In-Hospital **Healthcare Services** delivered at a **Non-Participating Healthcare Provider**.

(vi) When the **Insured**'s objection to a previously declined Approval of Coverage at a **Participating Healthcare Provider** has been validated by the **Administrator**.

(vii) In the instances where the **Insured** performed outpatients claims outside Lebanon (Ambulatory Benefits)

e. Procedures of Reimbursement

Within a period of 15 days from the date of the claim (being the date of the Insured discharge from the Hospital or the finalization of the Ambulatory Healthcare Services) incurred in Lebanon, or within 30 days from the date of claims incurred outside the Lebanese territories, the **Insured** must address a written request for reimbursement, directly to the **Insurance Company** together with all the requested original supporting documents, otherwise the claim will be rejected. The requested documents are mainly the original detailed bill, the original receipt confirming the settlement of the invoice, the medical discharge report and a copy of the Visa document with respect to claims incurred outside the Lebanese territories. In addition to that, the **Administrator and /or the Insurance Company** may ask the **Insured** to disclose copies of his/her medical file, especially the medical records related to his/her reimbursement claim (e.g. medical reports, medical documents, and the examination results).

f. Expenses viable for Reimbursement

(i) In the above instances provided for in sub-section d (i) and d (v), the reimbursement will be effected at a rate of 80% (eighty percent) only of the incurred fees and expenses that the **Insured** paid at a **Non-Participating Healthcare Provider** in each country.

(ii) In the above instances provided for in sub-section d (ii), the reimbursement will be effected at a rate of 80% (eighty percent) only of the incurred fees and expenses that the **Insured** paid at a **Non-Participating Healthcare Provider** on the basis of the preferential tariffs applicable to the **Insurance Company** at an equivalent **Participating Healthcare Provider** in Lebanon.

(iii) In the instances provided for in sub-section d (iii), the reimbursement will be effected at a rate of 100% (one hundred percent) of the incurred fees and expenses that the **Insured** paid at a **Non-Participating Healthcare Provider** in each country.

(iv) In the instances provided for in sub-section d (iv), the reimbursement will be effected at a rate of 100% (one hundred percent) (up to the **Limitations of the In-Hospital Healthcare Benefits)** of the incurred fees and expenses that the **Insured** paid at a **Non-Participating Healthcare Provider** in each country.

(v) In the instances provided for in sub-section d (vi), the reimbursement of the incurred fees and expenses will be effected based on the average cost of the normal hospitalization approved by the **Administrator**, which is calculated as follows:

The daily average of fees and expenses incurred for usual and/or intensive care hospitalization at an equivalent **Participating Healthcare Provider** in Lebanon, is retained for all kinds of surgical procedures (if the bill, subject of the claim is a surgical procedure) or for all kinds of medical procedures (if the bill, subject of the claim is a medical procedure). It is based on the Hospitalization Class, which the **Insured** benefits from, on the preferential tariffs and on the related statistics available in Lebanon for the year under consideration.

(vi) In the above instances provided for in sub-section d (vii), the reimbursement will be effected at a rate of 80% (eighty percent) only of the incurred fees of the outpatient claims (examinations) that the **Insured** paid outside Lebanon on the basis of the preferential tariffs applicable to the **Insurance Company** at an equivalent **Participating Healthcare Provider** in Lebanon.

In all the reimbursement cases, the total approved fees and expenses cannot exceed the financial limitation as identified in the Policy Schedule. The reimbursement of all claims will be effected in LBP or its equivalent in USD (converted at the exchange rate applicable at the date evidenced by the bill) whenever the **Insured** has paid, in a foreign currency, the expenses of the claim subject of the reimbursement.

Article 5: WAIVER OF MEDICAL CONFIDENTIALITY

a. The **Policyholder**, in his/her name and on behalf of the **Insured** and his/her **Legal Dependents**, hereby authorizes the **Insurance Company** and/or the **Administrator** to access all their medical information and files and inspect their accuracy and completeness through all feasible means, especially through **Participating** and **Non-Participating**

Healthcare Providers (hospitals, physicians, and laboratories), other insurance companies or any other risk carrier.

b. The **Policyholder,** in his/her above stated capacity, grants the **Insurance Company**, the **Administrator**, and any of their delegate absolute, conclusive, and irrevocable authority to access his/her medical files and the one related to the Insured and/or Legal Dependents and all the information included therein and receive copies thereof. To that effect, the **Policyholder** waives the medical confidentiality to the benefit of **the Administrator and/or the Insurance Company** regarding all the medical files whether related to current specific healthcare conditions or the past one, as well as all the claims incurred during the validity period of the Policy. The **Administrator** and/or **Insurance Company** have the right to refer the **Insured** and/or his/her Legal Dependents to any of the Healthcare Providers or pharmacies in this regard.

c. In this respect, the **Insurance Company** and/or the **Administrator** are entitled to request the examination of the **Insured** and/or his/her **Legal Dependents**, to enquire about their past and actual state of health and its evolution and to investigate the soundness of the claims, without exception (e.g. review the medical and administrative files) whenever and as often as it may reasonably require prior to, during, and after the delivery of any Healthcare Service. The **Insurance Company** or the **Administrator** shall have the right to send the Insured to a specialist or medical committee of its choice to examine him/her and check the medical case under question.

d. The **Policyholder** and the **Insured** hereby authorize the **Administrator** and its delegates to provide the attending physicians of the **Insured** and/or his/her **Legal Dependents**, with the information available at their end about their state of health, or about the approval or rejection decision of their medical coverage. Such information can be provided by any means chosen by the **Administrator**, either through email, or SMS or any other medium.

e. The **Policyholder** and the **Insured** acknowledge that their medical files and all the information included therein (e.g. information related to their state of healthy or about the approval or rejection decision of their medical coverage, etc….) will be exchanged and transferred, where appropriate outside the Domicile and will be placed by the **Administrator** and/or **Insurance Company**, on servers, clouds and disaster recovery site for backup outside the Domicile. In line of the internet nature and its related risks, the **Administrator** and/or the **Insurance Company** confirm that data and information related to the **Policyholder** and **Insured** is transferred in a secure environment; however, the **Administrator** and the **Insurance Company** will not guarantee or bear any responsibility for any outside hacking, attack or loss of data as a result of such exchange or transfer.

Article 6: PREMIUMS

a. Premiums are annual, payable by the **Policyholder** per the Terms and Conditions specified in the **Policy Schedule**. They include charges, taxes and stamp duties.

b. The payment of the premium in whole or part (Premium Deposit) at the time of first application or renewal application does not bind the **Insurance Company** and does not constitute acceptance of the submitted application; the **Insurance Company's** acceptance can only be affected by the formal issuance of the signed and stamped Policy or Renewal Certificate.

c. If the **Policyholder** fails to effect the payment of any due premium as indicated in the Policy Schedule, then the **Insurance Company** shall have the right to cancel the Policy from its inception or from its renewal date, as applicable, without any premium refund. In all cases, and until the payment is effected, the **Insurance Company** may freeze all benefits under the Policy and therefore may deny coverage of the **Insured** Healthcare Services.

Article 7: CONTRACTUAL PERIOD AND RENEWABILITY

a. The contractual period of this Policy is identified in the **Policy Schedule**, starting as from the effective date till the expiry date. No termination notice is required and no grace period allowed for. The Policy is viable for immediate renewal to the benefit of the **Insured** holding a Guaranteed Renewability policy in accordance with the conditions and preferences stated in article (8) here below.

b. In the instances where the **Insured** is not benefiting from the Guaranteed Renewability Feature, none of the two parties in this Policy is obliged to renew; however, both parties may agree to establish a new policy either with the same conditions or with different terms and conditions once the **Insurance Company** has studied the renewal application submitted by the **Policyholder**. In this case, the **Insurance Company** shall have the discretionary power to decide whether to renew or not.

c. In the instance where the renewal application is rejected by the **Insurance Company**, the full amount of premium deposit will be refunded to the applicant.

d. The renewed Policy will enter into force and effect for a new contractual period as of the date appearing in the new **Policy Schedule** attached to the renewal application and under the Terms, Conditions, Limitations and Exclusions set therein or in the new Policy documents that may be issued (e.g. Policy Schedule, Scope of Benefits).

Article 8: TERMS AND CONDITIONS OF THE GUARANTEED RENEWABILITY FEATURE

a. The **Insurance Company** has the absolute right to grant the **Policyholder** or any of the **Insured** listed in the Policy the right to benefit from the lifetime Guaranteed Renewability feature and that is:

   (i) Starting the effectual date of the Policy exclusively for the **Insured** aged between zero day and 46 years old inclusive. In case the delivery was covered within the GlobeMed Lebanon System, (GlobeMed Baby), the newborn baby will benefit

from the lifetime Guaranteed Renewability feature as from day zero, whatever his/her health is.

(ii) After the Policy has been effectual for a whole calendar year starting the Enrollment Date without any interruption as stipulated in article (7) section (b) hereinabove, and that is applicable exclusively for the **Insured** aged between 47 years and 65 years old.

b. In both cases mentioned above, it is necessary to attain the below conditions so that the **Insured** is entitled to benefit from the Guaranteed Renewability feature:

(i) Provided that the **Insured** is not and was not infected prior to his/her benefit of the Guaranteed Renewability feature with any of the major Illnesses (i.e. critical illness) or a **Chronic Condition**.

(ii) The Guaranteed Renewability feature is granted by the **Insurance Company** to each **Insured** being considered separately by means of an explicit written decision, whereby no assumptions may be implied by the renewal of the Policy or by any other fact. In all cases, the decision to grant the **Insured** the Guaranteed Renewability feature, should be contained explicitly in the **Policy Schedule** with the designation of the benefiting **Insured**'s name, and the plan under which the feature is covered; it will also identify the maximum number of covered hospitalization days per **Insured** per lifetime as stipulated in article 3 (a) above. In addition to that, the decision of the **Insurance Company** pertaining to the granting of the Guaranteed Renewability feature should be accompanied by the issuance of a personal **Access Card** bearing the Guaranteed Renewability flags. All other **Insured** listed in the **Policy Schedule** that do not benefit from the Guaranteed Renewability feature will remain subject to the yearly underwriting rules and provisions as applicable.

c. The **Policyholder** will still have to present annually an application for the renewal of the Policy prior to its expiry, failing to which the **Insurance Company** has the right to consider any late application as ground for withdrawing the benefits of the **Guaranteed Renewability** provisions identified in this Article. In spite of receiving the **Guaranteed Renewability Feature**, the application and the Policy remain subject to all applicable legal and contractual provisions provided herein, except that the **Insurance Company,** within the process of making the decision to amend, renew or terminate the coverage, shall not take into consideration the medical state of the **Insured** as long as the latter benefits from the Guaranteed Renewability feature under this Policy. However, if the In-Hospital lifetime limitation of the **Insured** is totally consumed, the Policy will then become null and void for the concerned **Insured** without any premium refund.

d. The **Insurance Company** reserves the right to reconsider the Terms and Conditions of the Policy at each renewal date, particularly in the event where the **Policyholder** requests a change in the Scope of Benefits (e.g. class upgrading, additional plans and/or benefits) or decides to renew for some **Insured** while, deleting others, without any obligation whatsoever to justify its decision. It has also, as its discretion, the right to reject the **Policyholder**'s request for the change without the need of any justification.

e. The **Insurance Company** reserves the right not to renew the Policy without any further written notice and/or grace period in case the premium due is not settled according to the Terms and Conditions of the Policy.

f. The **Insurance Company** reserves the right to introduce any amendment to the whole Policy or to any portion thereof at any renewal date (e.g. General Conditions, Premiums, Plans and Scope of Benefits), provided such amendments apply in equal terms to all the **Insured** falling under the same **Class of Risk.**

g. Any **Insured** who is subject to the Policy's "**Deletion of Insured**" clause (article 12), has the privilege to convert his/her coverage to a new Policy, i.e. the **Insured** may apply for a new Policy without any proof of insurability, while retaining the privilege to benefit from the **Guaranteed Renewability** conditions taking into account his/her **Enrollment Date** under the Policy from which he/she was deleted. This conversion privilege provided the following two conditions:

   (i) The conversion application is received by the **Insurance Company** within 30 (thirty) days from receipt of the deletion written notice;

   (ii) The application presented requests the same Scope of Coverage, Terms and Conditions as the ones stipulated in the Policy from which the **Insured** was deleted.

Article 9: TERMINATION OF POLICY BY THE POLICYHOLDER

a. This Policy is subject to termination by the **Policyholder** upon the receipt by the **Insurance Company** of a written notice accompanied with the **Access Card**(s).

b. The **Policyholder** is entitled to a premium refund computed on the net risk premium on pro-rata basis applied by the **Insurance Company** based on the period of time the **Policyholder** has been covered since the effective date of the Policy.

The premium refund will exclude all premiums related to the plan under which the **Insured** would have benefited from a covered claim.

Article 10: FALSE DECLARATION AND NON-DISCLOSURE

a. Any false declaration or non-disclosure made by the **Policyholder or the Insured and/or Legal Dependents,** whether during the signature of the initial application prior to the effective date of the Policy or the renewal applications thereafter**,** will render this Policy null and void from inception **a**nd the Guaranteed Renewability will be annulled without the need for recourse to the judicial authority and without the need for a written notice, and without any premium refund. The settled premiums remain the entitlements of the **Insurance Company**, and the **Insurance Company** has the right to collect all the due premiums in the form of damages.

b. Without prejudice to the rights of the **Insurance Company** to terminate the Policy or consider it null and void, or to terminate the coverage, the **Insurance Company** may deny any benefit under the Policy in case of any false declaration or non- disclosure of a health condition by any of the **Insured** until such time the **Policy** is modified in order to exclude the health conditions and/or medical systems object of the false declaration or non-disclosure, which will thus constitute and be considered as a special exclusion to the Policy.

c. Any silence, negligence or grace period benefits granted by the **Insurance Company** to the **Insured** while knowing the false declaration or non-disclosure, shall not be interpreted against the **Insurance Company** as a waiver of its rights and remedies especially with respect to rejecting the renewal application or to amend the Terms and Conditions of the Policy as long as the conventional or legal requirement for the exercise of such rights or remedies has not expired.

Article 11: ADDITION OF NEW INSURED

a. The **Policyholder** and/or the **Insured** has the right to request the addition of any of his/her Legal Dependents to the Policy during its contractual period, as per the procedure set by the **Insurance Company**, provided that the application for addition is made to the latter within thirty (30) days following the wedding or the birth accompanied with the appropriate premium deposit.

b. The mother's policy comprises the coverage of her newborn within GlobeMed Baby System from day zero, regardless of his/her health state, in conformity with the same conditions, preferences, medical plans, and throughout the contractual period left of the mother's policy.

c. Premiums are computed based on the short period scale applied by the **Insurance Company** on the net risk premium payable by the **Policyholder** per the Terms and Conditions specified in the **Policy Schedule**. They include charges, taxes and stamp duties

Article 12: DELETION OF INSURED

a. The deceased **Insured**, the newlywed **Legal Dependent** or any individual **Insured** no longer meeting the requirements of a **Legal Dependent**, should be deleted from the Policy as per the procedure set by the **Insurance Company**.

b. The **Policyholder** will be entitled to a premium refund for a deleted **Insured** (computed based on the net risk premium on pro-rata basis) provided that the latter didn't benefit from the coverage of any medical claim during the last contractual period including any claim that is currently under reimbursement.

However, if the deletion is related to a deceased **Insured**, whose payment of premium was based on installments as identified in the Policy Schedule, his/her legal heirs will still be entitled to a premium refund when applicable as identified above, even if a claim was paid during the contractual period, provided that the heirs submit an official death certificate within a maximum period of two months from the death of the **Insured**.

Article 13: REIMBURSEMENT OBLIGATION OF THE POLICYHOLDER

The **Policyholder** shall be liable to reimburse the **Insurance Company** all claim amounts paid by the latter in the following cases:

a. Any undue payment (e.g. **Deductible, Healthcare Services not covered**).
b. If the **Insurance Company** pays in excess of the limits of benefits provided in the Policy.
c. Abuse or misuse of the benefits provided for under the Policy.
d. Abuse or misuse of the **Access Card (s)**, or any other document delivered with the Policy document.
e. Breach of any of the Policy provisions.

Article 14: LOSS OF THE ACCESS CARD

In case of loss of the **Access Card**, the **Insured** must immediately notify the **Insurance Company** in writing. Any expenses incurred based on the usage of the non-reported lost **Access Card**, shall be borne by the **Policyholder**.

Article 15: NON-WAIVER OF RIGHTS

Without prejudice to the rights of the **Insurance Company** under common Law or under the Policy (particularly, provisions of Articles 1 (b) and 14), any coverage granted by the **Insurance Company,** in some instances, to the **Insured** beyond or contrary to what is strictly provided for herein in terms of Scope of Coverage, Exclusions, Limitations or procedures may neither be interpreted as an implied waiver of the latter, nor constitute an acquired right for the **Policyholder** or the **Insured**.

Article 16: SUBROGATION

The **Insurance Company** will subrogate the **Insured** in all his/her rights claims and lawsuits, which he/she may have against any third party liable for any obligation or expenses incurred based on whatsoever count or cause. In that case, both the **Policyholder** and the **Insured** undertake not to sign any release or discharge without the prior written approval of the **Insurance Company** and to provide the **Insurance Company** with all customary assistance and diligence as if they were themselves claimants; should they breach this undertaking, they shall be liable to reimburse the **Insurance Company** with all amounts of claims that could have been recovered from third parties.

Article 17: NOTICES

All notices and notifications must be sent by registered mail, telegram or Courier Service with acknowledgment of receipt. They are considered valid and lawful if sent to the addresses of the parties hereto appearing in the Policy's Preamble, **Policy Schedule** and in the **Policyholder's Application**. Any change of address is ineffective, unless notified in writing to the other party.

Article 18: HEADINGS

The headings contained in the Policy are for convenience of reference only and are not intended to define, limit or describe the scope and intent of any of its provisions.

Article 19: LEGAL RECOURSE

All disputes relating to the implementation, interpretation or cancellation of this Policy between the parties hereto (i.e. **Insurance Company** and **Policyholder**) shall be resolved by the council of arbitration for Insurance and/or by the competent courts in Beirut, according to the applicable Lebanese Law.

Article 20: THE CONTRACT LANGUAGE

This contract was drafted in Arabic; in case of discrepancy between the original language and the English translation, the original Arabic text shall prevail.

INDIVIDUAL/FAMILY IN-HOSPITAL PLAN

SCOPE OF
IN-HOSPITAL HEALTHCARE BENEFITS

The **Insurance Company** covers strictly the following as In-Hospital healthcare benefits:

1. The treatment (medical or surgical or endoscopic) of covered healthcare conditions, provided always that such treatment cannot be undergone on an **Ambulatory** basis, as defined hereinafter, and requires an uninterrupted hospital confinement initiated during the Policy contractual period.

2. All diagnostic endoscopic procedures; all surgical procedures (conventional or endoscopic) and all treatments of covered healthcare conditions, that do not require an overnight stay at the hospital are covered in the "one day room unit" under the class agreed to with the hospital, irrespective of the class of hospitalization of the **Insured**, such as - but not limited to - gastroscopy, chemotherapy, radiotherapy and excision of lymph node and Video Capsule Endoscopy. In absence of this section at the admitting hospital premises, appropriate room shall be approved according to the Insured class of hospitalization such as chemotherapy treatment.

3. Any medical treatment requiring a hospitalization service or its equivalent that starts at a hospitalization center, and can be continued for a specific period of time at the **Insured**'s home provided that this does not include rest cures, by an entity specialized in giving the hospitalization treatments and that is according to the decision and approval of the physician, and subject to **Medical Necessity** Conditions, without putting the **Insured**'s health at any risk.

4. Emergency treatments as defined in the Definitions section above.

5. Pre-operative tests, restrictively limited to the following: the basic medical tests, conducted at the hospital prior to surgery, which are a pre-requisite for a proper application of anesthesia.

6. Physiotherapy treatment related to a covered hospitalization, whether delivered at the hospital or outside, during the contractual period of the Policy.

7. The surgery and cost of all kinds of Organ transfer and/or transplantation, including bone marrow transplantation, done either from the Insured himself/herself or from another person, and Cornea Transplant surgery, up to USD 60,000 (sixty thousand US dollars) for class SP, USD 80,000 (eighty thousand US dollars) for class B and USD 100,000 (one hundred thousand US dollars) for class A per case per lifetime.

   As for the cost associated with the cornea itself (e.g. cost of transportation) is covered up to USD 2,000 only per admission. The contract issued on Co-NSSF basis remains

subject to the conditions of point 12 under the limitations of **In Hospital Healthcare benefits.**

8. In the event of death of the **Insured** following admission and during hospitalization for a covered Healthcare Service under this Policy, the **Insurance Company** shall pay up to USD 2,000 (two thousand USD) as morgue and burial expenses. In this case, the **Insurance Company** reimburses the heirs upon their request of reimbursement accompanied by all the essential documents (e.g. the bills…) and that is in the course of 60 days from the **Insured**'s death.

9. All Vertebroplasty, Nucleoplasty, and Kyphoplasty surgeries and all consequences, treatments and medications related thereto subject to **Medical Necessity** Conditions.

LIMITATIONS
TO IN-HOSPITAL HEALTHCARE BENEFITS

1. **Hospitalization class**

The **Insured** will be covered:

a. In Lebanon, the Middle East and North Africa countries (MENA Region) and the rest of the countries worldwide under the Hospitalization Class identified in the **Policy Schedule** with the exception of the hospitalization processes that do not require an In-Hospital stay which are listed in sections (2) and (4) in the scope of In-Hospital healthcare benefits above.

b. In France under a shared room of hospitalization with more than one bed titled "Chamber Collective".

2. **Emergency Medical Treatment while Abroad:**

The **Insurance Company** covers the **Emergency Treatment** of eligible medical conditions outside of Lebanon, the Middle East and North Africa countries (MENA Region) and France, in a Healthcare Provider's room with two beds, provided always that such treatment is uninterrupted and initiated during the Policy contractual period.
The maximum amount of claims that may be borne by the **Insurance Company** per **Insured** under this Policy is $ 65,000 (sixty five thousand US Dollars) or its equivalent in foreign currency at the date of discharge, during the Policy Contractual Period and on the basis of the preferential tariffs applicable to the **Insurance Company** in the country where the treatment occurred. The difference between the incurred fees paid by the **Insured** and the maximum amount specified by $65.000 will be borne by the **Insurance Company**, whereas, the reimbursement will be effected at a rate of 80% (eighty percent) only of the incurred fees that the **Insured** paid on the basis of the preferential tariffs applicable to the **Insurance Company** at an equivalent **Participating Healthcare Provider** in Lebanon.

All exclusions (general or special) applicable under the In-Hospital Plan are applicable to the emergency medical treatment while abroad.

3. **Maternity**

a. When maternity is covered after a waiting period of 12 months under this Policy, the **Insurance Company** will bear the boarding costs of a nursery and/or the use of an incubator for the newborn baby, within the GlobeMed Baby System the coverage begins as of birth for as long as the required period of treatment is, and irrespective of the period of stay of the mother, the fees of one consultation of the attending pediatrician, in addition to Amniocentesis. The above will apply for a covered hospital confinement under both normal deliveries and cesarean sections.

b. In all cases, the **Insurance Company** will bear the fees and expenses for male circumcision, if performed during the same hospital confinement for the delivery of the newborn baby.

c. The Insurance Company shall also cover the IN-hospital medical treatment of transient neonatal jaundice, for GlobeMed Lebanon babies, as of birth and irrespective of the mother's period of stay. Such extension does not constitute any vested right for the newborn baby, in any other cover or benefit of whatsoever kind.

4. All the treatments of life threatening complications and/or consequences of Maternity that might take place will be covered by the **Insurance Company** starting the effective date of the Policy, whether during pregnancy or medically justified abortion, even when delivery (Normal and/or C/Section) is excluded from the coverage on the basis of waiting period. Maternity is always subject to Pre-existing Conditions.

5. All congenital cases and complications related therein for the newborn within GlobeMed Lebanon System (GlobeMed Baby) are covered as of birth.

6. In addition to the above, the **Insurance Company** covers the charges of an extra bed for one parent accompanying a confined child aged below 18 years by the time he/she enters the hospital.

7. All congenital cases that were neither diagnosed nor treated prior to the date on which the **Insured** has been enrolled for the first time with the **Insurance Company**, whether it was known to the Insured or not, and the complications that occur there from, which arise during the effective period of the **Policy** shall be covered.

8. Appendectomy will be covered including the use of Laparoscopic materials subject to **Medical Necessity** Conditions.

9. The **Prosthesis** related to a surgery as a result of a severe Accident or injury (Trauma) that occurred during the effective period of the Policy or its successive renewals (excluding **Orthesis**). The **Prosthesis** shall be covered only once, either promptly after the Accident, or within a period of 6 months following the date of the Accident, provided that the coverage of the **Insured** within the scope of GlobeMed Lebanon System is continuous without interruption ever since the Accident's date. The coverage of the **Prosthesis** is, at all times, subject to **Medical Necessity** Conditions. After the 6 months period following the date of Accident, the Prosthesis shall be covered as indicated in the Scope of In-Hospital Healthcare Benefits Point 10 below.

10. The coronary stent, the cardiac valve, the mesh for Inguinal Hernia or any **Prosthesis** not Accident-related are covered as per the normal, usual and customary need up to a maximum amount of $30,000 (thirty thousand US Dollars) on all Prosthesis per admission. In the case where the coverage is Co-NSSF, or any other supplementary coverage, the **Insurance Company** shall only cover the difference between the part covered by the supplementary coverage and the maximum coverage of $30,000 (thirty

thousand US Dollars) per admission. The limitation above does not include the NSSF coverage.

11. Sleep respiratory disorder cases, tests, procedures, and surgeries related thereto including Polysomnography shall be covered based on **Medical Necessity** Conditions.

12. The **Insurance Company** has the right to reject any upgrade in Policy Benefits after its issuance (i.e. upgrade in hospitalization class or change in the benefits from Co-NSSF to Co-NIL). If on exceptional basis, the **Insurance Company** accepts to amend the Policy Benefits after its issuance, or the upgrade took place at the date of renewal, the upgraded benefits will apply under the following conditions (except when premium is paid retroactively or within 4 months from NSSF cessation):

    a. After 12 (twelve) months following the renewal or policy amendment date for maternity;

    b. The upgrade in Policy Benefits will exclude any Preexisting Conditions present on or before the renewal or policy amendment date.

13. In all instances, an **Insured** who has been admitted to the hospital during the validity period of the Policy, which has expired thereafter without renewal and he/she is still confined within the hospital, benefits from a hospitalization coverage as per the previous policy conditions for a maximum period of 120 uninterrupted hospitalization days following the expiry date of the policy, regardless of whether his/her policy has been renewed or not during his/her hospitalization stay.

EXCLUSIONS
TO IN-HOSPITAL HEALTHCARE BENEFITS

The **Insurance Company** does not cover the following conditions, the complications, and the consequences arising there from:

1. All the cases and/or limitations and/or exclusions per **Insured** provided for in the **Policy Schedule** or the amendments.

2. All **Ambulatory Healthcare Services** (e.g. diagnostic tests, check-up tests, treatments, the services delivered by the physician at his/her clinic, medical center or out-patient hospital facility) that are medically justified but do not mandate hospital confinement even if these services are covered under the **Ambulatory** healthcare plan.

3. All treatments, conditions and the complications and consequences arising there from, even if medically necessary, resulting from the Insured's decision to be discharged from the hospital at his/her own risk against the treating physician's advice.

4. Any hospitalization not medically mandatory for the **Insured**'s health (e.g. Sight correction surgery, Multifocal Lens and Organ donation).

5. Any treatment or procedure, which is still experimental (e.g. Suture mediated closure system) or considered as a New Healthcare Technology.

6. Claims relating to **Preexisting Conditions**:

    a. This exclusion will be waived twelve months following the **Enrollment Date** of the **Insured**, except as stipulated otherwise in the Policy Schedule.

    b. The automatic waiver of **Preexisting Conditions**, as mentioned in point a above, does not have any effect on the other exclusions listed in the Policy, that remain in full force and effect.

    c. In all instances, the **Policyholder** and the **Insured** remain subject to the duty of full disclosure and full declaration of their health condition and that of their **Legal Dependent**s, as well as any fact relating thereto. Thus, any false declaration or non-disclosure made by the **Policyholder** and/or by the **Insured**, discovered at any time, will render this Policy null and void from inception without the need for a written notice, pursuant to Article 10 of the Policy, even if the **Policyholder** and/or the **Insured** has benefited from the waiver of the **Preexisting Condition** exclusion or the Guaranteed Renewability feature.

    d. Granting the **Insured** the right to benefit from the Guaranteed Renewability feature does not repeal the exclusion related to preexisting conditions.

e. This exclusion is not applicable for the congenital cases that were neither diagnosed nor treated prior to the date on which the **Insured** has been enrolled for the first time with the **Insurance Company**, whether it was known to the Insured or not, and the complications that occur there from, which arise during the effective period of the Policy.

7. Any procedure or treatment related to the cardiovascular system.
   This exclusion will be waived 3 months following the **Enrollment Date** of the **Insured**, unless it falls under a Preexisting Condition.

8. Cases of Inguinal hernia, Thyroglossal cyst, Ectopic testis and Intervertebral Herniated disc during the first 12 (twelve) calendar months of the adhesion of each **Insured**. This exclusion will be waived if the Policy is renewed covering the same **Insured** under the same Terms and Conditions.

9. SMR (Sub-Mucosal Resection) and Turbinectomy nose related surgeries, unless due to a covered Accident occurring during the Policy's contractual period, subject to **Medical Necessity**. However, after the incessant renewal of the Policy covering the same **Insured** under the same terms and conditions for two consecutive years, this exclusion will be waived strictly, for the nose surgeries, and subject to **Medical Necessity** conditions.

10. The delivery process and the Epidural. This exclusion will be waived for the **Insured** and/or the spouse if the Policy is renewed covering the same **Insured** under the same terms and conditions 12 months at least following their respective **Enrollment Date.**

11. Abortion that is not medically mandated is permanently excluded from coverage.

12. Peritoneal dialysis, Hemodialysis and the Arteriovenostomy related thereto.
    As a special exception to this exclusion, only the sessions of dialysis for acute renal failure delivered during the initial hospital admission, and till discharge will be covered.

13. The cost of Orthesis and medical appliances including but not limited to knee brace, collar brace, lumbar support, heel pads, arch support and hearing aids.

14. Dental and gum medical or surgical treatment of any condition including abscess, denture and disorders of the Temporomandibular joints; as a special exception to this exclusion, dental and gum treatment are covered if it meets all the following conditions:

    a. whenever the dental and gum treatment are necessitated as a result of an Accidental injury, while the Policy is in force, and as a result of the said Accident , subject to **Medical Necessity** Conditions.

    b. The Accident is fundamentally covered by the Policy, provided the case was examined by a second medical opinion at a specialist determined by the **Administrator** prior to initiating the treatment.

c. The dental and gum treatment should be provided immediately after the Accident or within a maximum of 6 (six) months as of the Accident date, thus the **Insurance Company** does not cover any treatment that might be provided to the **Insured** after the period of six months from the Accident.

d. The treatment should be requested within 6 months as of the Accident and subject to **Medical Necessity** Conditions.

15. All cosmetic and/or plastic surgeries except in the following cases, where they are included in the coverage:

    a. Cosmetic and/or plastic surgery that is necessary as a result of an accidental injury, occurring during the Policy's contractual period, provided that these conditions are met jointly:

        (i) The Accident is initially covered by the policy, provided the case was examined by a second medical opinion at a specialist determined by the **Administrator** prior to initiating the treatment.
        (ii) The surgery should be performed directly after the Accident or within a maximum period of 9 (nine) months from Accident date; consequently, the **Insurance Company** does not cover any treatment that might be provided to the **Insured** after the period of nine months from the Accident.
        (iii) The treatment should be requested within 9 months as of the Accident and subject to **Medical Necessity** Conditions.

    b. Breast reconstruction, complications and follow-up following partial or complete breast excision due to a breast cancer, on a condition that the following provisions are met jointly:

        (i) The excision surgery is initially covered by the Policy.
        (ii) On the condition to perform the reconstruction surgery within a maximum period of 6 (six) months as from the excision surgery consequently, the **Insurance Company** does not cover any surgery that might be provided to the **Insured** after the period of six months from the excision.
        (iii) The Policy should be either in-force or renewed without any laps time.
        (iv) The treatment should be requested within 6 months from the surgery and subject to **Medical Necessity** Conditions.

16. Special diets and weight control procedures.
    As a special exception to this Exclusion and after a waiting period of 12 months, only the surgery related to **Morbid Obesity** shall be covered subject to **Medical Necessity** conditions.

17. All procedures relating to the treatment (medical and/or surgical) of the falling of hair and treatment of Hirsutism and all consequences related thereto.

18. Rest cures, sanatorium, custodial care and periods of quarantine, costs related to convalescence even when initial hospitalization was covered under the Policy.

19. Sexually Transmitted Diseases (S.T.D.) including AIDS and all screening tests, medications and treatments related thereto.

20. Tubal ligation, as well as all birth control procedures and their consequences, treatment of impotence, infertility, sterility, and all screening tests, medication and treatments related thereto and their consequences, including In-vitro and Ex-vitro or any other artificial insemination procedures; All procedures related to the change of sex; All sexually fortifying products medicines (e.g. Viagra) and procedures, and the treatment of all consequences related thereto.

    As an exception to this general exclusion, coelioscopy, hysteroscopy, surgery related to impotence strictly when it is a cause of infertility and all procedures relating to Varicocele shall be covered, based on **Medical Necessity** Conditions.

21. Mental or psychiatric disorders, nervous breakdowns, and psychological tests or evaluation.

    As a special exception to this exclusion, only the In-Hospital treatment of psychotic disorders (e.g. schizophrenia, bipolar affective disorders) strictly at a **Participating Healthcare Provider** will be covered subject to **Medical Necessity** up to 30 days per **Insured** per year.

22. Any claim relating to suicide, self-inflicted injury or any such attempt whether the **Insured** is sane or suffers from a disorder as a result of an illness or a psychological or mental malfunctioning.

23. Any claim relating to alcoholism, drugs and like substances; addiction to and abuse of medicines under no medical supervision, and all consequences arising there from.

24. Treatment of injuries and sickness consequent to the participation of the **Insured**, either as an amateur or professional, in hazardous sports (e.g. motor, ATV or motorcycling race, deep sea diving, scuba-diving, snorkeling, parachuting, hang gliding, delta-plane).

25. Claims arising from the **Insured** taking active participation or involvement in any of the following events: war, acts of terror, warlike activities, civil strife and commotion, crimes and misdemeanors; any claim arising from the commission of a violation, misdemeanors or a crime by the **Insured** and any claim arising from an illegal act of the **Insured** during his stay in prison.

26. Claims arising from ionization, polluting chemicals or nuclear contamination.

27. All treatments related to speech therapy.

28. All kinds of surgical procedures related to the Parkinson disease.

29. Surgical resection of Prostate by any new technique that is still experimental and not FDA approved. As a special exception to this exclusion, surgical resection by HIFUS

procedure (Ablatherm or "Green Laser") shall be covered subject to **Medical Necessity** Conditions.

30. All kinds of genetic tests and procedures (whether medical or surgical) including genetic engineering and cloning.

31. Road, Marine and Air ambulance expenses.

32. The long term care needed after an Accident or Illness, whether in a Healthcare Provider or in the Insured's home, is not covered under this Policy even if it was requested or recommended by the treating physician.

SECOND MEDICAL OPINION/CASE MANAGEMENT PLAN

SCOPE OF BENEFITS

The **Insured** may be entitled to receive a **Second Medical Opinion** and/or **Case Management Consultation** for specific covered medical conditions under the **In-Hospital Plan** or under the **Ambulatory Plan**. This service will be provided by medical specialists of major hospitals of the highest medical expertise. The **Second Medical Opinion** and/or **Case Management** are meant to assist the **Insured** and the attending physician to decide on the diagnosis and/or treatment protocols of the following medical conditions:

a- Cardio vascular and neuro-vascular conditions,
b- Cancer,
c- Systemic autoimmune diseases,
d- Any condition of life threatening nature.

LIMITATIONS

1. The **Second Medical Opinion** and/or **Case Management Consultation** benefit will be limited to a maximum number per **Insured**, determined as follows:

   - One (1) per covered pathology,
   - Two (2) per contractual period,
   - Six (6) per lifetime when the **Guaranteed Renewability** clause is applicable.

   As an exception to the above limitations, the **Insured** under the **Ambulatory Plan** will also benefit from an additional one (1) **Second Medical Opinion** per covered **Ambulatory Healthcare Benefit**, per contractual period.

2. The **Second Medical Opinion** and/or **Case Management** benefit may be obtained provided that a specific request from the **Insured** is received along with a detailed medical history report, and approved by the **Administrator**, in accordance with the conditions of the Policy.

3. The stipulated services under the scope of benefits are presently rendered within 5 working days once the file is completed.

EXCLUSIONS

All exclusions (general or special) applicable under the **In-Hospital Plan** and the **Ambulatory Plan** (when in force) are applicable to the **Second Medical Opinion**/**Case management Plan**.

INDIVIDUAL/FAMILY AMBULATORY PLAN

SCOPE OF
AMBULATORY HEALTHCARE BENEFITS

The **Insurance Company** covers, as **Ambulatory healthcare benefits** on a Co-Nil basis, the diagnostic tests and treatments strictly listed hereunder, which do not require In-Hospital confinement:

1. DIAGNOSTIC TESTS

Radiology, C.T. scan, PET Scan, Coroscan, MRI, Ultrasonography, Laboratory tests, Nuclear medicine tests, Electroencephalogram, Electrocardiogram, Electromyogram, Audiogram, Stress test, Evoked Response, Ocular Angiography, Ocular Coherence Tomography (OCT), Congenital tests (including Thalassemia related tests), Glaucoma diagnosis test (GDX), Uroscan, Leukoscan, Thallium Myocardic Scintigraphy, Echocardiography, Holter Monitoring, H.I.V. Screening tests.

2. TREATMENT

Laser therapy, Physiotherapy, and Kinesitherapy are subject to **Medical Necessity** Conditions.

3. Physicians fees relating to the necessary interpretation of technically specialized tests are covered, provided they are conducted at the same facilities where tests were performed.

LIMITATIONS
TO AMBULATORY HEALTHCARE BENEFITS

Ambulatory benefits are limited to Healthcare Services provided exclusively by centers within the **Participating HealthCare Providers**, determined as follows:

1. The **Insurance Company** covers 85% (eighty five percent) of **Ambulatory** healthcare expenses, net of any **Coinsurance** and/or **Deductible** and excluding doctor fees, up to a maximum number of **Ambulatory** transactions per **Insured** per year, as identified in the **Policy Schedule**.

2. The coverage decisions are subject to the monitoring of the **Ambulatory** Expert System, an IT System specialized in auditing the coverage and treatment requests as per the Insured's medical conditions and based on **Medical Necessity**.

3. The use of MRI is subject to **Medical Necessity** Conditions.

4. The use of dental panoramic X-ray is limited to post-traumatic cases covered by the policy and subject to subject to **Medical Necessity** Conditions.

5. Osteodensitometry is subject to subject to **Medical Necessity** Conditions.

6. Thallium Myocardic Scintigraphy and Abdomino-Pelvic Ultrasound are subject to **Medical Necessity** Conditions.

7. The **Insurance Company** covers strictly one Morphological Ultra Sound per pregnancy period, only if performed for a covered pregnancy.

8. Fetal Ultrasound is subject to **Medical Necessity** Conditions.

9. PET scan is subject to subject to **Medical Necessity** Conditions.

10. The use of Coroscan is subject to **Medical Necessity** Conditions.

11. Testicular Pelvic Echo Doppler (if not related to Infertility) is subject to **Medical Necessity** Conditions.

12. The coverage of **Ambulatory** healthcare expenses related to the surgery of all kinds of organ transfer and/or transplantation, including bone marrow transplantation is subject to **Medical Necessity** Conditions. Pre-operative tests are covered on reimbursement basis strictly in case the surgery took place within the same contractual period. Coverage of all **Ambulatory** healthcare expenses related to the surgery of all kinds of organ transfer and/or transplantation, including bone marrow transplantation remains at all times subject to the financial limitation as indicated in point 7 under the scope of **In-Hospital** healthcare benefits.

EXCLUSIONS
TO AMBULATORY HEALTHCARE BENEFITS

All exclusions applicable to the In-Hospital plan are applicable to the **Ambulatory** Plan, including routine checkups, in addition to the following cases:

1. Doctors ‘fees.

2. All tests related to infertility (e.g. Spermogram, Hysterosalpingography, culture of sperm, testicular pelvic echo-Doppler unless if it is not related to Infertility).

3. Hepatitis Type B & C Tests except when required for pre-marital tests on reimbursement procedures basis.

4. Syphilis tests, except when required for pre-marital tests on reimbursement procedures basis.

INDIVIDUAL/FAMILY PRESCRIPTION MEDECINES PLAN

SCOPE OF THE PRESCRIPTION MEDICINE BENEFIT PLAN

The **Insurance Company** covers under the Prescription Medicine Benefit Plan the medicines duly registered and approved by the Lebanese Ministry of Health, and as per the tariffs set by the latter, prescribed by the **Insured**'s attending physician.

LIMITATIONS TO THE PRESCRIPTION MEDICINE BENEFIT PLAN

1. All the benefits of the **Prescription Medicine Benefit Plan** are limited to products dispensed exclusively through a Participating Healthcare Provider in Lebanon.

2. The **Insurance Company** covers 85% (eighty five percent) of prescribed medicines bill, excluding doctor fees and net of any **Coinsurance** and/or **Deductible** as identified in the **Policy Schedule.**

3. The coverage decisions of the medications is subject to the monitoring of the Prescription Medicine Expert System, an IT System specialized in auditing the coverage and treatment requests as per the Insured's medical conditions and based on **Medical Necessity**.

4. Covered products and medicines are included in a formulary list kept with the **Administrator**; it can be made available to the **Insured** upon request. The formulary may change from time to time by decision of the **Insurance Company** or the **Administrator**.

5. The quantity of covered prescribed medicines per transaction is limited to the normal, usual and customary need for a maximum of one month of treatment per transaction.

6. The covered vaccines are those obligatory to prevent the following diseases:

    a. Polio, Diphtheria, Pertussis, Tetanus, Hepatitis Type B, Haemophilus Influenza, Measles, Mumps, Rubella, as per the age of the **Insured** and the quantity and immunity schedule suggested by the "United States Advisory Committee On Immunization Practices (ACIP)", which is a related department to the "Centers for Diseases Control and Prevention (CDC)" in Atlanta, Georgia;

    b. Influenza Virus, vaccine is covered once a year for the **Insured** over the age of 50, and all Insured at high risk of contracting the virus, classified as such by the CDC; and per the quantity and schedule specified there.

c. Streptococcus Pneumonia vaccine for all children and adults, per the quantity and schedule recommended by the CDC.

d. Meningococcal vaccine, per the quantity and schedule recommended by the CDC, for all adolescents 11-12 years and above, and high risk populations.

7. The coverage of prescribed medicines related to the surgery of all kinds of organ transfer and/or transplantation, including bone marrow transplantation is subject to **Medical Necessity** Conditions and subject to the financial limitation as indicated in point 7 under the scope of In-Hospital healthcare benefits.

EXCLUSIONS
TO THE PRESCRIPTION MEDICINE BENEFIT PLAN

1. All exclusions applicable to the In-Hospital plan are applicable to the Prescription Medicine Benefit Plan.

2. This plan excludes the treating physician fees.

3. All over-the-counter products that can be dispensed without a medical prescription (e.g. beauty and cosmetic items, vitamins and mineral products, personal and household hygiene products). All homeopathy and phytotherapy products.

4. Antiseptic products (e.g. Dettol, Mercryl, soaps).

5. All hair treatment products.

6. All products for gum or dental care (e.g. hygienic or treatment products).

7. All sexually fortifying products. All products and medicines for contraception and for the treatment of sterility, impotence and infertility.

8. All products related to the treatment of mental and psychiatric disorders, (such as psychosis, anxiety, depression, mania, etc.). In addition to amphetamine, hypnotic and sedative products.

9. Dietetic products for all ages.

10. Dermatological products except those used for the treatment of allergic reactions, infectious diseases (e.g. chicken pox), or consequences of Accidents (e.g. burns).

11. All medicines used for the treatment of chronic diseases (e.g. Diabetes, Hypertension, Dyslipidemia (high cholesterol &/or high triglyceride), Epilepsy, Parkinson, Cardiovascular, Cancer). This exclusion will be waived under this plan, for the **Insured**

who is benefiting from the **Guaranteed Renewability Feature**, under the Prescription Medicines Plan, as per the Coinsurance identified in the Policy Schedule.

12. All hearing and optical apparatuses (e.g. lenses, glasses) and the products used for their cleaning and upkeep.

13. All products for the treatment of Sexually Transmitted Diseases and AIDS.

INDIVIDUAL/FAMILY DOCTOR VISIT PLAN
HEALTHCARE PLAN

SCOPE OF M.D. HEALTHCARE BENEFITS

The **Insurance Company** covers exclusively the following as M.D. Healthcare Benefits:

The full fees and expenses related to the medical services and procedures listed hereunder, rendered by a physician member of the **Participating Healthcare Provider** at the latter's clinic:

1. The normal, usual and customary consultation.

2. The following diagnostic services: Cardiac Echo Doppler, Arterial Echo Doppler, Electrocardiogram, Cardiac Stress Test, Pulmonary Function Tests (e.g. Spirometry), Ultrasonography, Electroencephalogram, Electromyogram, Audiogram.

3. Small surgery and endoscopic procedures not requiring an operating room or emergency room or hospital services.

4. The administration of the following vaccines: Oral Polio Vaccine (OPV), Diphtheria Pertussis, Tetanus (DPT), Tuberculin test (PPD), Hepatitis B, Haemophilus Influenza (HIB), Measles, Mumps, Rubella (MMR) for those benefiting from the prescription medicine benefit plan.

LIMITATIONS TO M.D. HEALTHCARE BENEFITS

1. All M.D. Benefits are limited to the **Healthcare Services** delivered exclusively through a physician member of the Participating **Healthcare Provider** at the latter's clinic. However, as an exception to the above, if services are delivered by a physician not member of the Participating **Healthcare Provider**, the reimbursement procedures may apply only in and under the following instances and under the following terms and conditions:

   a. **<u>In the cases of consultation:</u>**
   The eligible fees will be reimbursed at 80% of NSSF tariffs applicable to the specialist and the general practitioner, with a deduction of $2 (two US Dollar) per claim as administration fees.

   b. **<u>In the cases of obstetrical echography for pregnant woman:</u>**
   The eligible fees and expenses will be reimbursed based at the preferential tariffs applicable to the **Insurance Company** at an equivalent Participating **Healthcare Provider.**

c. <u>In the cases of small surgery and /or endoscopic procedures:</u>
The eligible fees and expenses will be reimbursed subject to a prior approval to be delivered by the **Administrator,** at 80% of NSSF tariffs.

d. <u>In the cases of vaccines:</u>
The eligible expenses will be reimbursed based on the preferential tariffs applicable to the **Insurance Company** at an equivalent Participating **Healthcare Provider**, if delivered for infants under the full age of 15 years.

2. The **Insurance Company** covers the doctor visits consultation, provided for under section 1 of the **Scope of Benefits**, up to a maximum number of consultation coupons per **Insured** per year as identified in the **Policy Schedule**.

3. To benefit from the diagnostic services provided for under section 2 of the **Scope of Benefits** above, the **Insured** must provide the Physician with his personal **Access Card** in addition to an M.D. **Plan Transaction** to be properly completed by the latter.

4. To benefit from the small surgery and /or endoscopic procedures provided for under section 3 of the **Scope of Benefits** above, the **Insured** must provide the Physician with the **Medical Report** form approved by the **Insurance Company** to be properly completed by the latter, and then submitted to the **Administrator** for prior approval.

5. To benefit from the administration of vaccines provided for under section 4 of the **Scope of Benefits** above, the **Insured** must provide the Physician with his/her personal **Access Card** in addition to an M.D. **Plan Transaction**.

EXCLUSIONS
TO M.D. HEALTHCARE BENEFITS

All exclusions applicable to the In Hospital plan are applicable to M.D. Plan.

REIMBURSEMENT PROCEDURE

1. When the reimbursement procedure is applicable, payment is effected on the condition that the **Insured** completes and submits a duly written request for reimbursement, together with the following documents:

   a. A detailed report from the attending physician identifying the nature and reason of the services rendered.

   b. The M.D. **Plan Transaction**.

   c. A photocopy of the **Access Card**.

d. The original receipts and bills issued by the attending physicians having performed the services.

e. A photocopy of the results and diagnostic related to the services rendered, when applicable.

2. Reimbursement will be only effected provided that the documents mentioned above are filed with the **Insurance Company** within 15 days from the date of the services rendered.

TRAVELER ASSISTANCE SERVICES PLAN

In addition to the Definitions sections, words, terms and expressions used in the Policy, the following terms and expressions shall have the meanings set forth below that will be used specifically within the scope of the Traveler Assistance Services Plan ("the Plan"):

1. Accident

In addition to the definition of the Accident used in the Policy, the following shall also be construed to be Accidents:

a. Asphyxia or Injuries as a consequence of gases or vapors, immersion or submersion, or from the consumption of liquid or solid matter other than foodstuffs.
b. Infections resulting from an Accident covered by the Plan.
c. Injuries that are a consequence of surgical operations or medical treatments resulting from an Accident covered by the Plan.

2. Assistance Company

Companies contracted directly or indirectly with the Administrator and specialized in offering medical and assistance services.

3. Children

Persons from 30 days old to 18 years old unless otherwise agreed and expressed in the Plan

4. Claims

A document or request filed by a Policyholder and/or Insured stating that an Accident or Injury occurred and that the Insurance Company should provide coverage as per the Plan.

5. Immediate Family Member of the Insured

Spouse, children, parents, grandparents and siblings

6. Illness

Sudden and unforeseen sickness or disease contracted, commencing or originating after the beginning of the travel abroad undertaken by the **Insured** during which such sickness or disease gives rise to a request for assistance by the **Insured** or his representatives.

7. Insured

Insured means the person aged between 30 days and 75 years, whose name and address are specified in the Plan, with respect to whom the service fee has been paid before his/her travel and who is a permanent resident of the Domicile.

Not eligible Insured:

a) Insured intending to travel more than 90 consecutive days.
b) Persons of less than 30 days old.
c) Persons aged from 75 years old and above, except in case a specific Plan including such Cover for persons aged from 75 years and above are contracted.
d) Non-residents in the country where the Plan is issued.
e) Those who have initiated the trip prior to the insurance underwriting.
f) Insured travelling for work reasons (paid or otherwise), undertaking physical or manual hazardous activities such as: use of machinery, loading and unloading, working at heights or in confined spaces, assembly of machinery, working on floating or underwater platforms, mines or quarries, use of chemical substances, laboratory work of any kind and any other hazardous activities.
g) Insured travelling to seek medical treatment, waiting to be seeing by a doctor or waiting for an operation or deemed not fit to travel.
h) Insured seeking to immigrate or obtain political asylum.

8. Spouse

Person officially registered as wife or husband of the Insured.

9. Usual Place of Residence

The home or residence of the Insured in the Domicile

10. Alarm Center

The **Alarm Centre** provided by the **Administrator** to answer the calls of the **Insured** during his/her travel informing about an Accident or Injury which will inform in its turn the **Assistance Companies** in order to proceed with the necessary actions to assist the **Insured**.

ARTICLE 1: SCOPE OF TRAVELER ASSISTANCE SERVICES

The **Insurance Company** offers exclusively and through the Assistance Company, the following Traveler Assistance Services, to the **Insured** travelling outside the Domicile for a period not exceeding 90 consecutive days. The **Insurance Company** will cover all the services of the present Plan specified in article 2 below and any expenses incurred by the **Insured** in relation to such services during the period of this Plan and based on its provisions, conditions, limits and exceptions.

ARTICLE 2: SERVICES OF THE TRAVELER ASSISTANCE PLAN

A) MEDICAL EMERGENCY REFERRAL

In an emergency situation, the Administrator, through the Alarm Center will provide the **Insured** with basic information such as: name of doctors, specialists, dentists or paramedical staff nearby, location of hospitals, medical centers, drugstores, ambulances…

Upon specific request of the **Insured**, the Administrator, through the Alarm Center will summon a doctor to call at the **Insured**'s bedside and will organize an appointment with an appropriate medical facility. In this case, the doctor's fees shall be paid directly by the **Insured**.

B) COMPASSIONATE ASSISTANCE

1. Travel of one Immediate Family Member to stay with the Insured in case of Accident.

In the event that the Insured is travelling alone and admitted to hospital for more than seven days as a result of an Accident covered in the Plan, the Insurance Company will take charge of the outbound and return journey of one designated Immediate Family Member at the Insured's choice, from the Domicile of the Insured to the place of hospitalization of the Insured.

2. Escort of Children in case of Accident of the Insured.

If a Children was accompanying the Insured during the Accident and who did not have anyone to accompany him/her, the Insurance Company will provide a suitable person to look after the Children during the trip to the hospital where the Insured is hospitalized, or to the Domicile, whenever there were no other person who could take charge of him/her.

C) PERSONAL ASSISTANCE

I- <u>Coverage:</u>

1. Transport to a properly equipped medical facility in case of Accident.

In the event of Injury, the Insurance Company will take charge of transferring the Insured to a proper equipped medical facility.

The Administrator, through its medical team, will decide if transferring is necessary, depending on the situation or gravity of the condition of the latter.

Afterwards, the Administrator's medical team will maintain the telephone contacts necessary with the medical centre and with the doctors attending to the Insured, and on the basis thereof will decide whether to transfer the Insured, and on the most suitable means of transport to use.

Transfer will be performed in ambulance or another means of transport, to the place where adequate medical assistance can be provided.

2. Repatriation to the Domicile in case of Accident.

In the event of an Injury, the Insurance Company will take charge of repatriating the Insured to his/her Domicile.

The Administrator, through its medical team, will decide if repatriation is necessary, depending on the situation or gravity of the condition of the latter.

Afterwards, the Administrator's medical team will maintain the telephone contacts necessary with the medical centre and with the doctors attending to the Insured, and on the basis thereof will decide whether to repatriate the Insured, and on the most suitable means of transport to use.

3. Repatriation of mortal Remains to the Country Of Residence.

In the event of the death of the Insured, the Insurance Company will make the arrangements necessary for his/her transport or repatriation and will meet the cost of the transfer expenses to the place of interment, cremation or funeral ceremony at his/her Domicile.

Payment of expenses for interment, cremation or funeral ceremony is excluded from the coverage under this Plan.

II- <u>Exclusions:</u>

The Insurance Company shall not be liable for Claims resulting from:

1. Any losses the insured is not a fare paying passenger inside such common carrier.
2. Travel by aircrafts or any other common carders whether licensed to carry passengers against fare or not.
3. Armed conflicts (having existed or not official declaration of war).
4. The use of helicopters and means of aerial navigation not authorized for the public transporting of passengers.
5. Active participation in criminal acts or in bets, challenges or arguments except in the case of legitimate self defense or state of need.
6. Participations in any organized dangerous competition, races, sports and training thereon.
7. Suicide or attempting suicide or any willful Injury.
8. Addiction to alcohol or narcotics or misuse of drugs.
9. Blood transfusion and Acquired Immune Deficiency Syndrome (AIDS).
10. Any bodily Injury or sickness the Insured was suffering from prior or at the commencement of this Plan.

11. Pregnancy, childbirth, miscarriage (whether legitimate or not) and any complications resulting there from.
12. Death or total permanent disability as a direct result from an Accident, which occurred in the Domicile of the Insured.

ARTICLE 3: FINANCIAL LIMITATION OF THE TRAVELER ASSISTANCE SERVICES

A financial limitation is applicable per Insured per contractual period up to USD 100,000 for all the Traveler Assistance Services as defined in Article 2 of this Plan.

ARTICLE 4: INSURED'S OBLIGATIONS IN CASE AN ACCIDENT OCCURS

In case an Accident occurred, the **Insured** has to inform the Administrator, through the Alarm Center and in writing, as per the conditions set for each covered case. In case the **Insured** does not abide by this obligation, he/she will lose the right of coverage either partially or totally.

ARTICLE 5: GEOGRAPHICAL AREA

The Plan covers the Insured through their travel to any country worldwide except in the Domicile.
The Plan does not cover the **Insured** in case the travel occurred in war circumstances.

ARTICLE 6: RESPONSIBILITY

The **Administrator** and/or **Insurance Company** will not be responsible on any delay or hindrances that will arise during the provisions of the Traveler Assistance Services.

ARTICLE 7: GENERAL EXCLUSIONS

1) Loss, damage, Illness and/or Injury directly or indirectly caused by, arising out of, and/or during, t h e following are excluded from the Cover granted under this Plan:

    a) The bad faith of the Insured, by his/her participation in criminal acts, or as a result of his/her fraudulent, seriously negligent or reckless actions including those actions of the Insured in a state of derangement or under psychiatric treatment for which are themselves excluded;
    b) Extraordina1y natural phenomena such as floods, ea1thquakes, landslides, volcanic eruptions, atypical cyclonic storms, falling objects from space

and aerolites, and in general any extraordinary atmospheric meteorological, seismic or geological phenomenon any other type of natural disaster;

c) Events arising from terrorism, mutiny or crowd disturbances;
d) Events or actions of the Armed Forces or Security Forces in peacetime;
e) Wars, with or without prior declaration, and any conflicts or international interventions using force or duress or military operations of whatever type.
f) Those caused by or resulting from radioactive materials and nuclear energy;
g) Those caused when the Insured takes part in bets, challenges or brawls, save in the case of legitimate defense or necessity;
h) Illness or Injuries existing prior to the claim, unless expressly included in the Private or Special Conditions and subject to payment of the relevant surcharge Premium;
i) Those that occur as a result of the participation by the Insured in competitions, sports and preparatory or training tests;
j) Engaging of the Insured in the following sports: motor racing or motorcycle racing in any of its modes, big game hunting outside the Domicile, underwater diving using artificial lung, navigation in international waters in craft not intended for the public transport of passengers, horse riding, climbing, pot holing, boxing, wrestling in any of its modes, martial arts, parachuting, hot air ballooning, free falling, gliding and, in general, any sport or recreational activity that is known to be dangerous;
k) Participation in competitions or tournaments organized by sporting federations or similar organizations.
l) Hazardous winter and/or summer sports such as skiing and/or similar sports.
m) Permanent resident and students outside the Domicile.
n) The use, as a passenger or crew, of means of air navigation not authorized for the public transport of travelers, as well as helicopters;
o) The Accidents deemed legally to be work or labor Accidents, consequence of a risk inherent to the work performed by the Insured.
p) Internationally and locally recognized epidemics.
q) Illnesses or Injuries arising from chronic ailments or from those that existed prior to the inception date of the Plan;
r) Death as a result of suicide and the Injuries or after-effects brought about by suicide and/or attempted suicide or any self-inflicted Injuries.
s) Illness, Injuries or pathological states caused by the voluntary consumption of alcohol, drugs, toxic substances, narcotics or medicines acquired without medical prescription, as well as any kind of mental Illness or mental imbalance;
t) Illness or Injuries resulting from refusal and/or delay, on the pmt of the Insured or persons responsible for him/her, in the transfer proposed by the Administrator and agreed by the attending physician;

u) Illness or Injuries caused by pregnancy and childbirth or any complication therefore or voluntary termination of pregnancy;
v) Mental Health diseases,
w) Venereal sexually transmitted diseases.
x) All pre-existing, congenital and/or Chronic Medical Conditions.
y) Any cardiac or cardio vascular or vascular or cerebral vascular Illness or conditions or after-effects thereof or complications that, in the opinion of a medical practitioner appointed by the Administrator, can reasonably be related thereto, if the Insured has received medical advice or treatment (including medication) for hypertension 2 years prior to the commencement of the travel.

2) In addition to the foregoing General Exclusions, the following Healthcare Services and related benefits are not Covered by this Plan:

a) The services managed by the Insured on his own behalf, without prior communication or without the consent of the Insurance Company through the Administrator, except in the case of an extreme emergency/urgent necessity. In that event, the Insured shall furnish the Administrator with all needed documents and files and original copies of the invoices;
b) Assistance or Healthcare Services, which are not medically necessary and all Elective and/or non-Emergency medical condition and its complications.
c) Rehabilitation treatments;
d) Prostheses, Orthopedic material or thesis and osteosynthesis material, as well as spectacles.
e) Assistance or compensation for events that occurred during a travel that had commenced, in any of the following circumstances:
    i. Before the Plan comes into force;
    ii. With the intention of receiving medical treatment;
    iii. After the diagnosis of a terminal Illness;
    iv. Without prior medical authorization, after the Insured had been under treatment or medical supervision during the twelve months prior to the commencement of the travel;
f) Expenses that arise once the Insured is at his/her Domicile, those incurred beyond the scope of application of the guarantees of the insurance, and, in any case, after the dates of the travel object of the Plan have elapsed or after 90 days has elapsed since the commencement of the travel thereof, notwithstanding what is provided for in this Plan.
g) Any Healthcare Services that are received as Ambulatory Services.
h) All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
i) Services that do not require continuous administration by specialized medical personnel.

j) Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies)
k) Healthcare Services that are not performed by authorized Healthcare Providers, apart from Healthcare Services rendered in a Medical Emergency.
l) Prosthetic devices and consumed medical equipments.
m) Treatments and Services arising as a result of hazardous activities, including but not Limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities.
n) Costs associated with healing tests, vision corrections, prosthetic devices or hearing and vision aids.
o) Insured treatment supplies (including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products, non-prescription drugs and treatments, excluding such supplies required as a result of Healthcare Services rendered during a medical emergency).
p) Services rendered by any Healthcare Provider relative of an Insured and the Insured member's family, including Spouse, brother, sister, parent or child.
q) All Healthcare Services & Treatments for In-Vitro Fertilization (IVF), embryo transport, ovum and male sperms transport.
r) Treatments and Healthcare Services related to viral hepatitis and associated complications, except for treatment and Healthcare Services related to Hepatitis A.
s) Air or Terrestrial medical evacuation except for Emergency cases or unauthorized transportation services.
t) Healthcare Services and associated expenses for organ and tissue transplants, irrespective of whether the Insured is a donor or recipient.
u) Any test or treatment not prescribed by a Doctor.
v) Diagnosis and treatment Services for complications of excluded Illnesses.

Irrelevant of the Exclusions mentioned with the general conditions, the **Insurance Company** will not reimburse the **Insured** with amounts paid by the latter without the explicit approval of the Administrator, through the Alarm Center.