ILA HealthCare Insurance Program
General Conditions – *Applicable as of 01 February 2026*

Contents

Welcome

Thank you for subscribing to **ILA,** the HealthCare Insurance Program for the Lebanese Expatriates in Africa.

ILA HealthCare Insurance Program was especially created to cater for the insurance needs of the Lebanese Expatriates in Africa. It offers them a full protection while in Africa and Lebanon, and it has enough flexibility (in Classes of Hospitalization, Network of Providers, Territoriality etc.) so all expatriates can find a suitable cover under this Program for their needs and budget.

This booklet includes the full details you need to know about this Insurance Program. You can download an electronic copy at **www.ila-insurance.com**

While this Program was initially created for the Lebanese Expatriates in Africa, it can also be subscribed by expatriates from other nationalities in Africa.

ILA HealthCare Insurance Program is Insured by LIAASSUREX SAL, registered in Lebanon in the Insurance Companies Register under No. 158 and governed by the provisions of Decree No. 9812 dated 04 May 1968, Beirut Commercial Register No. 34092. Its head office is located at LIAASSUREX Bldg. – Patriarch Hoayeck Street – Bab Idriss – Downtown Beirut – Lebanon.

GLOSSARY

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

Access Card
A personalized card issued in the name of each *Insured*, facilitating his/her access to the healthcare services covered under this Policy.

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

Ambulatory Plan
The Ambulatory Plan is an optional plan that can be subscribed to cover the diagnostic tests and treatments limitedly listed in the section "Ambulatory Plan" of this booklet and which do not require In-hospital confinement.

Applicable Plan
The set of healthcare benefits provided for in the Policy along with their Limitations and Exclusions, specifically as approved for coverage in the Policy Schedule for each *Insured*.

Approval of Coverage
A decision taken by the TPA in the name and on behalf of the Insurance Company, to cover a healthcare service sought by an *Insured*; this decision may also determine the conditions and extent of the approved coverage.

Chronic Condition
A Chronic Condition is a disease or illness, which has at least one of the following characteristics:
- It is permanent (i.e., a long-lasting condition);
- It needs long term monitoring, medical consultations, check-ups, examinations or tests;
- It comes back or is likely to come back;
- The *Insured* is required to be specially trained or rehabilitated;

Congenital Cases
These are defined as follows: diseases, anomalies, birth defects and deficiencies present at birth, either in an evident manner or in a potential manner triggered at a later stage.

Deductible
The percentage or amount of the incurred expenses to be borne by the *Insured*, if applicable. When applicable, it is mentioned in the Policy Schedule.

Doctor Visit Plan
The DV Plan is an optional plan that can be subscribed to cover the doctors' visits.

Emergency treatment
The treatment (medical or surgical) which may not be delayed, delivered in a hospital emergency room, of all accidents or incidents of sudden sickness, providing a legitimate professional concern that there may be a significant medical problem.

Employee
Any full time, permanent employee of the Policyholder, actively at work at the time when his/her cover under this Policy goes into effect. A trainee with the Policyholder is also considered as an Employee.

Enrollment date
The day, month and year appearing on the Policy Schedule, on which the *Insured* has been enrolled and covered under this Policy.

Insurance Company
The *Insurance Company* which guarantees the payment of the Healthcare Services and related benefits provided under this Policy.

Insured
- In case of a Group Policy, any employee and their Legal Dependents, if any, meeting the definitions hereinafter, listed in the application for Insurance or added thereafter and expressly accepted by the *Insurance Company* and listed in the Policy Schedule.
- In case of an Individual Policy, the Policyholder and/or his/her Legal Dependents if any, listed in the application for Insurance or added thereafter and expressly accepted by the *Insurance Company* and listed in the Policy Schedule.

Legal Dependents
The following dependents of the Policyholder or the employee: the wife(s), the unmarried children as of birth and till 17 years or 25 years if still a full-time university student.

Medical Report Form
A special form that must be completed by the attending physician of the *Insured* and submitted to the TPA prior to hospitalization. It is a mandatory prerequisite to benefit from In-Hospital Healthcare Benefits coverage under this Policy.

Orthosis
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.

Policyholder
The *Policyholder* is the subscriber of this Insurance Policy, which is issued in his name.
The *Policyholder* can be:
- any establishment, company, association, order or any other physical or juristic person acting in its capacity of employer or in any other capacity that applies for a Group Policy, which is accepted by the *Insurance Company*;
- any physical person, subscribing the Policy on Individual basis.

Pre-existing Conditions
A *Pre-existing 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* has consulted a medical practitioner prior to the commencement of insurance;
- or for which a reasonable person in the *Insured*'s position would have consulted a medical practitioner prior to the commencement of insurance;
- or which was not known to the *Insured* but is considered as a *Pre-existing Medical Condition* (i.e., when the illness, Injury, condition, or symptom exists in the human body before commencement of insurance).

Pre-operative tests
These are restrictively the basic medical tests conducted at the hospital prior to surgeries that are a pre-requisite for a proper application of anesthesia.

Prosthesis
The set of pieces and medical devices (such as screws and 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.

Reconstructive surgery
The use of surgery to restore the function or normal appearance of the body or by part of it, following an accident or a surgical procedure.

Third Party Administrator (TPA)
The party that acts in the name and on behalf of the *Insurance Company* in administering this Policy in part and in supporting and monitoring its proper implementation. It interfaces with the *Insured* through service centers and professional delegates. Particularly, the TPA continuously verifies the eligibility of the *Insured* to the healthcare services sought and takes the decision, in the name and on behalf of the *Insurance Company*, as to whether or not to grant the Approval of Coverage.
The selected TPA for the administration of this program is NextCare Lebanon SAL.

TPA Preferred Provider (TPA PP)
The providers of specific healthcare services (e.g. hospitals, medical centers, integrated clinics, pharmacies, laboratories, physiotherapy centers etc.) located throughout Lebanon, Africa and the MENA Region, adopted by the TPA as participating in its network of healthcare providers; A list of these Preferred Providers is available upon request; these centers or hospitals or part of their services or sections may be modified (added or deleted) during the Policy Period without prior notice or approval of the *Policyholder*.

Usual, Customary and Reasonable charges (UCR)
It is the amount that is treated as the standard or most common charge for a particular medical service when rendered in a particular geographic area. The *Insurance Company* refers to the UCR charges when proceeding with the reimbursement of healthcare fees paid directly by the *Insured*.

GENERAL TERMS AND CONDITIONS

Article 1: The Policy

a. The Application and Medical Questionnaire(s) of the *Policyholder* and the *Insured* members if any, the Special Condition Schedule (including but not limited to the Accepted Census List and the special limitations and/or exclusions if any), the Glossary, these General Terms and Conditions as well as any Attachment(s) and Endorsement(s) to any of the aforementioned, shall constitute the entire agreement of the parties hereto (Herein referred to as the Policy).

b. The Policy may be amended at any time with the agreement of the *Insurance Company* and the *Policyholder*, without the consent or intervention of the *Insured* members.

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

d. This Insurance comes with a Guaranteed Renewability feature. Therefore, the *Insurance Company* is obliged to renew the Insurance with the same conditions should the subscriber wish so, and hence, the *Insurance Company* has to keep the previous insurance conditions as they were for each adherent, without having the right to add any modifications, new exclusions or limit his/her insurance benefits.

e. The effective date of the Guaranteed Renewability for each *Insured* starts on the date zero of his adherence to the policy and this date shall be mentioned in the Policy's Special Conditions. In all cases, each adherent will be subject to an observation period of 180 days from the inception date, where the *Insurance Company* can apply any modification or exclusion to the insurance coverage of this *Insured* and this before fixing it. During this period of observation, the *Policyholder* and/or the *Insured* has to inform the *Insurance Company* with any sickness or development in his/her health status, under the penalty of enforcing the non-disclosure clause that may lead to the revocation of the coverage of this *Insured*.

f. If the *Insurance Company* applies special exclusions and/or limitations, the *Policyholder* is deemed to have approved them, in his name and in the name and on behalf of all the employees/members and their *Legal Dependents* listed in the Application for Insurance and/or the Accepted Census list, once he/she receives the Policy documents and/or the related access cards.

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 (UCR) 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.

Article 3: General Limitations

a. Annual Financial limitations:

No financial limitation is applicable to this insurance, unless it is otherwise identified in the Policy Schedule and/or under the Limitations to "In-Hospital Plan". However, and starting the date where the *Insured* is granted the Guaranteed Renewability, subject to the conditions stated in "paragraph d" above, the coverage will be subject to a lifetime limitation of 720 days of covered hospitalization, whether this limitation was used in the hospital or through a homecare covered

service, and this taking into consideration the financial limitation and exclusions mentioned in the Special or General Conditions applicable to this insurance.

b. Class of Hospitalization:

The applicable class of In-Hospital Healthcare benefits during the contractual period corresponds to the class of hospitalization to which the *Insured* is entitled as identified in the Accepted Census List attached to the Policy Schedule.

c. Duplicate and/or Supplementary Coverage:

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 these payers, 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 a subrogation and waiver document in favor of the *Insurance Company* to grant the *Administrator* the right to recourse to the other third-party payer to recover its rights and dues, whenever applicable. This limitation in the coverage is only applicable in Lebanon.

c. Age:

The age of the *Insured* persons under this Policy is computed on the basis of the inception year minus the year of birth.

d. Territoriality:

This Insurance covers the following territory (Unless provided otherwise in the TOB page 11):

- **In Lebanon for all covered cases, on direct billing basis.**
- **In the MENA Region, for all covered cases, on direct billing basis within the TPA PP *where* available, otherwise on reimbursement basis.**
- **In Africa, for all covered cases, on direct billing basis within the TPA PP *where* available, otherwise on reimbursement basis.**
- **Worldwide for hospitalization following a documented medical evacuation strictly in an air ambulance out of Africa, on direct billing basis where available, otherwise on reimbursement basis.**

Article 4: Waiver of Medical Confidentiality

- The *Insurance Company* and/or the TPA have the right and possibility to check on the *Insured*, and to inquire on his/her past/actual state of health and evolution, and to investigate all claims without exceptions (e.g. review the administrative and medical files), whenever and as often as reasonably required, and this prior to, during and after covering any healthcare service. For this, the *Policyholder* and the *Insured* hereby waive their right of medical confidentiality to the benefit of the *Insurance Company*, the TPA and the TPA delegates and hereby give the aforementioned full authority to access all medical information about the *Insured* from any healthcare provider (e.g., hospital, physician) and/or any other *Insurance Company*, guarantor or Third-Party Administrator, to receive copies of the aforementioned medical documents and use them as need be. In addition, the *Policyholder* and the *Insured*(s) authorizes their attending physician(s) to share with the TPA and their delegates the available information about their health status.

- The *Insured* may be requested by the TPA upon any admission to a healthcare provider, to sign a waiver of medical confidentiality text consistent with the aforementioned; such document must be signed by the *Insured* as a condition for benefiting from the insurance coverage.

Article 5: Premiums

a. Premiums are annual, they are payable by the *Policyholder* per the terms and conditions specified in the Policy Schedule, and it includes the cost, taxes and stamps.
b. Premiums are adjusted upwards or downwards according to additions, deletions or modification of coverage of *Insured* during the contract period.

The Special Conditions of the group insurance specify the mode and premium payment schedule.

c. If the *Policyholder* fails to effect the payment of the premium installment at any due date, as identified in the Policy Schedule, then the following procedure shall apply:
   - The *Policyholder* is granted the benefit of a first grace period of 7 (seven) days for the payment of the due amounts, during which the Policy will remain in full force and effect.
   - Failing a timely payment within that first grace period, the *Insurance Company* may elect to suspend the implementation of all its obligations deriving from this Policy for a period of 23 (twenty-three) days. If the payment is made within this second grace period, the suspension of the *Insurance Company*'s obligations is lifted; all claims incurred during that period may thereafter be filed by the *Insured* and eventually paid according to the Reimbursement Procedure.
   - Failing a timely payment by the *Policyholder* within that second grace period, the *Insurance Company* shall have the right to cancel the Policy as from the date at which the unpaid Premium installment was originally due. In all circumstances, the *Policyholder* shall remain liable for the payment of the due premium installment as liquidated damages, that will not be decreased or reduced. In all cases, and until the total payment of all due premiums, the *Insurance Company* has the right to suspend all the benefits of the *Insured*.
d. The payment of the premium in whole or in 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 made by the formal issuance of the signed and sealed Policy.

Lifetime Guaranteed Renewability

Article 6: Contractual Period and Renewability,
when these General Conditions are attached to a Group Contract

a. **The Contractual Period of this Policy is identified in the Policy Schedule, starting as from the effective date until the expiry date. At the end of the contractual period, the *Insurance Company* is obliged to renew the Insurance with the same conditions should the subscriber wishes so. Hence, it has to keep the previous insurance conditions as they were for each adherent, without having the right to add any modifications, new exclusions or limit his/her insurance benefits.**
b. The *Insurance Company* will not renew the contract if the subscriber/*Insured* decides so. However, it will give this subscriber/*Insured* the possibility to renew the contract within a period of one-month effective its expiry date.
c. The *Insurance Company* reserves the right to review the General and Specific conditions of this insurance at each renewal date, in case the subscriber requests a modification on the cover (i.e., Class upgrade, addition of benefits etc.) or in case the subscriber decides to renew the cover for some adherents selectively, without any justification and in a manner inconsistent with the customary practice in the health insurance industry. The *Insurance Company* reserves the right to reject the selective modification request without having to justify its decision.

d. The *Insurance Company* has the absolute right not to renew the Policy in case any part of the premium remains unsettled, and this without granting the subscriber any grace period and without having to inform him/her of this verbally or in writing.
e. Any false declaration or non-disclosure of information by the subscriber or by the *Insured* in the initial application, or in any proposal that comes in the observation period mentioned in this insurance, or in the application by the subscriber for any class upgrade or addition of benefits, will lead to a cancellation of the policy without the need of a written notice, and therefore will lead automatically to the nullification of the Guaranteed Renewability feature. Any coverage by the *Insurance Company* based on tolerance with its knowledge of the false declaration or the non-disclosure does not waive its rights to reject the renewal application later on or to modify the Terms and Conditions of the Policy.
f. The *Insurance Company* reserves the right when renewing the policy to modify the insurance premiums, and this based on the experience and its underwriting practice.
g. The *Insured* member has the right to guarantee the renewability of his/her contract individually, and this in case he/she leaves the group policy for any reason, provided he/she has completed one full year of coverage under this contract, where the renewal will be under any insurance product proposed by the Insurance Company, except for those products having higher benefits than this actual policy. In this case, the *Insurance Company* has to accept the application of the *Insured* in case he/she applied within a period of one month from leaving the group contract.

Lifetime Guaranteed Renewability

Article 7: Contractual Period and Renewability, *when these General Conditions are attached to an Individual Contract*

a. **The contractual period of this Insurance is identified in the Policy Schedule, starting as from the effective date until the expiry date. At the end of the contractual period, the *Insurance Company* is obliged to renew the Insurance with the same conditions should the subscriber wishes so. Hence, it has to keep the previous insurance conditions as they were for each adherent, without having the right to add any modifications, new exclusions or limit his/her insurance benefits.**
b. The subscriber has to apply annually to renew his contract before the expiry date; otherwise, the *Insurance Company* has the right to consider any delay in the submission of this application as a basis for reviewing the right of the subscriber from benefiting from the guaranteed renewability feature.
c. The *Insurance Company* reserves the right to review the General and Specific conditions of this insurance at each renewal date, in case the subscriber requests a modification on the cover (i.e., Class upgrade, addition of Covers etc.) or in case the subscriber decides to renew the cover for some adherents selectively, without any justification and in a manner inconsistent with the customary practice in the health insurance industry. The *Insurance Company* reserves the right to reject the selective modification request without having to justify its decision.
d. The *Insurance Company* has the absolute right not to renew the Policy in case any part of the premium remains unsettled, and this without granting the subscriber any grace period and without having to inform him/her of this verbally or in writing.
e. Any false declaration or non-disclosure of information by the subscriber or by the *Insured* in the initial application, or in any proposal that comes in the observation period mentioned in this insurance, or in the application by the subscriber for any class upgrade or addition of benefits, will lead to a cancellation of the policy without the need of a written notice, and therefore will lead automatically to the nullification of the Guaranteed Renewability feature.

Any coverage by the *Insurance Company* based on tolerance with its knowledge of the false declaration or the non-disclosure does not waive its rights to reject the renewal application later on or to modify the Terms and Conditions of the Policy.

f. The *Insurance Company* reserves the right when renewing the policy to modify the insurance premiums, and this based on the experience and its underwriting practice.

Article 8: 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 only entitled to a premium refund calculated on pro-rata basis less taxes and stamps. All *Insured* members having benefited from the coverage shall not be entitled for any refund.

Article 9: termination of Policy by the *Insurance Company*

This Policy is subject to termination by the *Insurance Company* in case of non-payment by the *Policyholder* of the premium due and in case of False Declaration, as stipulated in this Policy.

Article 10: False Declaration and Non-disclosure

a. Any false declaration or non-disclosure made by the *Policyholder* or the *Insured* will render this Policy null and void from inception, without the need for a written notice and without the right to the *Policyholder* for a premium refund.

b. Without prejudice to the rights of the *Insurance Company* to terminate the Policy or consider it null and void on any legal grounds whatsoever, the *Insurance Company* may deny the *Insured* any benefit under the Policy related to the facts and health situations that were the subject of a false declaration or non-disclosure, until the Policy is modified to exclude the medical cases or the body systems related to the false declaration or non-disclosure, that will thus constitute and be considered as a special exclusion to the Policy.

c. The silence or negligence of the *Insurance Company* in respect of any false declaration will not be considered as a waiver of its rights and measures, mainly regarding the rejection of any additional case, in respect of this false declaration, or the renewal of this Policy, or the modification of its conditions as long as the contractual or legal conditions for the exercise of those rights and measures remain.

Article 11: Addition of a New *Insured*

a. Newly hired Employees or newly qualifying *Legal Dependents* (e.g., the newly wed spouse and newborn children of the *Insured*) that meet the definition of these words as set in the Glossary section, are eligible for addition to the Policy during the time when it is in full force and effect.

b. The addition of new *Insured* is processed upon receipt by the *Insurance Company* of a written application filed to that effect by the *Policyholder* within 30 (thirty) days of qualification for eligibility, in addition to satisfactory evidence of insurability. The addition will take effect only upon formal written acceptance by the *Insurance Company* of the *Policyholder*'s application.

Article 12: Deletion of *Insured*

a. The deceased *Insured*, the newlywed Legal Dependent or any *Insured* member failing to meet the requirements of a Legal Dependent or Employee should be deleted from the Policy. The *Policyholder* should notify the *Insurance Company* promptly upon occurrence of the above and will endeavor to return the access card of the Deleted *Insured*.
b. If no claim was paid or payable by the *Insurance Company* under the Policy for a deleted *Insured* member, the *Policyholder* will be entitled to a premium refund based on pro-rata basis, and excluding any taxes and stamps.

Article 13: Reimbursement Obligation by the *Policyholder*

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

a. Any un-due payment (e.g., deductible).
b. If the *Insurance Company* pays in excess of the limits of benefits provided in the Policy.
c. Abusive usage of the benefits provided for under the Policy.
d. Abusive usage of the Access Cards and/or any other document delivered with the Policy.

Article 14: Loss of the Access Card

In case of loss of the access card, the *Insured* must immediately notify the *Insurance Company*; failing which 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 any of the Policy provisions, any coverage granted by the *Insurance Company* in some instances to the *Insured*, beyond or contrary to what it 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 be subrogated in all its rights which the *Insured* 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 to refuse the signature of any release without the prior written consent 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 that could have been recovered from third parties.

Article 17: Notices

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

Article 18: Legal Recourse

All disputes relating to the implementation, interpretation or cancellation of this Policy shall be resolved by the competent courts in Lebanon, according to the applicable Lebanese Law.

IN-HOSPITAL PLAN: BENEFITS, FEATURES, LIMITATIONS AND EXCLUSIONS

References in superscript are for paragraphs in these General Conditions with additional information

No Financial Limitations

Table of Benefits	Coverage
Financial Limitation [3-a]	**Unlimited, unless provided otherwise below or in the Special Conditions Schedule.**
Applicable Network in Lebanon [3-d]	For ILA ULTIMA: Full Network for Classes A & B and Excluding AUBMC & CMC for Class S. For ILA PREMIUM: Full Network excluding AUBMC & CMC for all classes. For ILA HDF-Santé: HDF and affiliated hospitals only.
Applicable Network outside Lebanon [3-d]	For ILA ULTIMA: Africa & the Middle East For ILA PREMIUM: Africa only For ILA HDF-Santé: Africa only
Hospitalization Class in Africa	**Whatever the Class of Hospitalization selected by the insured person, the hospitalization in Africa will be covered in a private hospital room.**
Medical / Surgical Treatment	Covered
One-day Treatments / Endoscopic Procedure	Covered
Intensive Care	Covered
Chemotherapy, Radiotherapy	Covered
Emergency Treatments	Covered
Pre-operative Tests	Covered
Physiotherapy / Rehabilitation following a covered hospitalization	Covered
Prosthetic Implants, following Sickness	For ILA ULTIMA: Covered without limitation For ILA PREMIUM: Covered up to USD 30,000- per year For ILA HDF Santé: Covered up to USD 30,000- per year
Prosthetic Implants, following Accidents	Covered without limitation
Reconstructive Surgery	Covered *But only following a covered accident or a covered surgical procedure occurred after the Insured person enrolment to this Policy.*
Sexually Transmitted Diseases *Includes also HIV and Aids, and treatment related thereto.*	For ILA ULTIMA: Covered with a limitation of USD 15,000- per *Insured* per year For ILA PREMIUM and ILA HDF Santé: Covered with a limitation of USD 10,000- per *Insured* per year
Congenital Cases	Covered *But limited only for cases that were neither diagnosed nor treated previously, and the complications that occur therefrom, which arise during the effective period of the policy.*

Private Room Cover in Africa

Automatic Lifetime Cover as from birth.

Maternity and related Benefits	Coverage
Maternity and Maternity Complications	Covered after a ten-month waiting period, unless continuity expressly granted.
Newborns under a covered maternity	**Covered as from birth whatever the state of health is, including Congenital Cases.**
Addition of *Insured* Free of Charge	Newborns from a covered maternity will be covered free of charge until the expiry of the mother's policy and under her same covers.
Incubators	Covered without limitation
Infertility E19	Only specific surgeries and hysteroscopy are covered.
Mental or Psychiatric Treatments, including nervous breakdowns L4	For ILA ULTIMA: Covered with a limitation of USD 15,000-per *Insured* per year and up to 30 days of hospitalization per year. For ILA PREMIUM and ILA HDF Santé: Excluded
Bariatric surgeries E6	Covered subject to medical necessity
Organ and Bone Marrow Transplantation *Includes all kinds of transplantation, surgical procedures for the Insured receiver only (Excluding the cost of organs).*	For ILA ULTIMA: Covered with a limitation of USD 100,000- per year For ILA PREMIUM and ILA HDF-Santé: Covered with a limitation of USD 50,000- per year.

Other Features and Benefits	Coverage
Homecare Services	Covered, excluding home nursing
Lifetime Guaranteed Renewability A6-A7	Included
Parental Accommodation	Covering an extra bed for a parent accompanying a confined child below 18.
Work Related Accidents	Covered, unless covered simultaneously elsewhere.
Ambulance (in Lebanon only)	For ILA ULTIMA: Covered on reimbursement basis, for a maximum of USD 250- For ILA Premium and ILA HDF Santé: Excluded
Passive War Risks / Terrorism E8	Covered in Lebanon only.
Worldwide Emergency Treatments Cover *As detailed here after P17, up to age 70 Included*	For ILA ULTIMA: Covered up to USD 200,000- per person per year. For ILA Premium and ILA HDF Santé: Excluded
Travel Assistance Plan *As detailed hereafter P17*	For ILA ULTIMA: Covered For ILA Premium and ILA HDF Santé: Excluded
Morgue and Burial expenses L6	For ILA ULTIMA: Covered up to USD 2,000- per person For ILA Premium and ILA HDF Santé: Covered up to USD 500- per person
Sleep disorders	Polysomnography and Sleep Apnea surgery are covered subject to special approval.
Epidemics and Pandemics E12	Covid-19 cases are covered up to USD 50,000- Other cases at the Insurance Company discretion. Malaria cases are covered without limitation.

Limitations to In-Hospital Plan

The following Limitations are applicable to the above scope of In-Hospital Plan coverage:

L1 **Hospitalization Class**: The *Insured* will be covered under the hospitalization class identified in the Policy Schedule, except in case of medical/surgical treatment that does not require an overnight stay at hospital, delivered in a "one day room unit". Refer also to " Hospitalization Class in Africa" in the TOB above.

L2 If the Policy is renewed for an *Insured* with an upgrade in benefits (e.g., hospitalization class from Class B to Class A), the upgraded benefits will be eligible after:
   a. 10 months following the renewal, in cases of maternity; and
   b. 4 months following the renewal, for Pre-existing conditions.
   This limitation will not be applied in case the upgrade is requested by the *Policyholder* as an employee special benefit, with the agreement of the *Insurance Company*.

L3 In instances where an *Insured* has been admitted to the hospital and covered under this Policy, and where this Policy has expired thereafter without renewal and he/she is still confined within the hospital, the in-hospital coverage will remain in force as per the previous policy for a maximum period of 30 uninterrupted hospitalization days following the expiry date of the policy.

L4 The coverage of the **Mental or Psychiatric Treatments** including **Nervous Breakdowns**, is limited to the hospitalization in a recognized psychiatric unit of a hospital or medical center, excluding all kinds of rest cures, sanatoriums and special psychiatric hospitals. This coverage is excluded from the ILA PREMIUM and the ILA HDF-Santé Plans.

L5 The surgery for the **Parkinson Disease** is covered up to USD 15,000- per *Insured* per year only for ILA ULTIMA subscribers, but the treatment is however excluded. ILA PREMIUM and ILA HDF-Santé exclude the Parkinson Disease treatment and surgery from its cover.

L6 In case of the death of the *Insured* after his admission to the hospital for a covered hospitalization, the *Insurance Company* will pay to the beneficiary the amount mentioned in the table of benefit for **Morgue and Burial Expenses**. In this case, the payment will be made once the beneficiary has/have applied for the reimbursement along with all the necessary documents (bills etc.) and this during a maximum period of sixty days from the death of the *Insured*.

Exclusions to the In-Hospital Plan

The *Insurance Company* does not cover the following healthcare conditions, as well as the complications and/or consequences arising therefrom:

E1 All Ambulatory healthcare services not specifically covered under an *Applicable Plan*, defined as: Healthcare Services (e.g., diagnostic tests, check-up tests, treatments) that are medically justified but do not mandate hospital confinement, such as those delivered at a physician's office, clinic, medical center or out-patient hospital facility.

E2 All the cases and/or limitations and/or exclusions per *Insured* provided for in the policy schedule or the amendments.

E3 Any hospitalization not medically mandatory for the health of the *Insured* (e.g., sight correction surgery, organ donation, Cosmetic or Aesthetic Treatments and surgeries).

E4 **Peritoneal Dialysis and Hemodialysis**. 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, along with the relative AV Fistula surgery.

E5 **Pre-existing Conditions** are excluded the first six months for individual coverage, unless continuity is granted and stated in the Policy Schedule. This is also applicable for group coverage, unless stated otherwise in the Policy Schedule.

E6 **Bariatric Surgeries** (I.e., gastric bypass and other weight-loss surgeries) are excluded from the coverage. However, they may be covered for medically necessity and at the Insurance Company's discretion.

E7 Claims arising from the *Insured* taking an active part in any of the following events: war, warlike activities, civil strife and commotion, crimes and misdemeanors; also, any claim arising from an illegal act of the *Insured* during his stay in prison.

E8 The cover of the **Passive War Risks and Terrorism** is limited to Lebanon only.

E9 Treatment of injuries and sickness consequent to the participation of the *Insured*, as a professional, in **Hazardous Sports** (e.g., motor or motorcycling race, deep sea diving, scuba-diving, snorkeling, parachuting, hang gliding, delta-plane).

E10 Claims arising from ionization, polluting chemicals or nuclear contamination.

E11 Abortion that is not medically mandated.

E12 **Epidemics and Pandemics** are excluded from the coverage. On exceptional basis, Covid-19 hospitalizations will be covered up to USD 50,000- per person per year. At the discretion of the Insurance Company and on a case-by-case basis, other cases of Epidemics or Pandemics will be also covered under this same limitation of USD 50,000/ However, **Malaria** is covered under this insurance without any limitation.

E13 Harmful or hazardous use of alcohol, drugs and/or medicines and self-inflicted injuries.

E14 Dental and Gum medical or surgical treatment of any condition including the temporomandibular joints; unless following an accident fundamentally covered under this Policy.

E15 **External Prosthesis** and other any external artificial body part or Orthosis, such as a prosthetic limb or ear, knee or neck brace etc.

E16 Any treatment or procedure that is still **Experimental** or considered as a new healthcare technology.

E17 Any procedure or treatment related to the cardiovascular system. This exclusion will be waived three (3) months following the enrollment date of the *Insured*, unless it falls under a Pre-existing case.

E18 Rest cures, sanatorium, custodial care and periods of quarantine and costs related to convalescence even when initial hospitalization was covered under the Policy.

E19 All birth control procedures and their consequences, tubal legation, 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. Contrary to this general exclusion, laparoscopic surgeries, hysteroscopy and the specific surgeries for the treatment of impotence that leads to infertility (e.g., varicocele) are covered under this insurance.

E20 **Nose-related Surgery** unless due to a covered accident occurring during the policy's contractual period and on medical necessity bases. However, after the incessant renewal of the policy covering the same *Insured* under the same terms and conditions for two consecutive years, this exclusion shall be waived.

E21 All **Cosmetic** and/or **Plastic Surgeries** except in the following cases:

a. When they are necessary as a result of a covered accidental injury that was taken in charge during the policy period, and provided that the surgery should be performed within a maximum period of 9 months from accident.
b. **Breast Reconstruction** following breast excision covered under this policy, and when performed within a maximum period of 6 months from the surgery.

AMBULATORY PLAN

Benefits, Limitations and Exclusions

The *Insurance Company* covers as Ambulatory healthcare benefits, the diagnostic tests and treatments limitedly listed hereunder, which do not require In-Hospital confinement.

1. **Diagnostic tests**
   Radiology, C.T. Scans, MRI, Ultrasounds, Laboratory Tests, Nuclear Medicine Tests, Electroencephalogram, Electrocardiogram, Electromyogram, Audiogram, Stress Test, Evoked Response, Ocular Angiography, Thallium Myocardial Scintigraphy, Echocardiography, Holter Monitoring, VCT 64, PET Scan (Limited to cancer cases only), Ocular Coherence Tomography (OCT), Serum Free Light Chains (SFLC), Glaucoma Diagnosis Ophthalmology Test (GDX), Double, Triple and Quadruple Tests, Video Capsule Test, Osteodensitometry, Dental Panoramic X-ray, AmniSure Tests and Amniocentesis.
2. **Infertility Tests** (e.g., Spermogram, Hysterosalpingography, Spermoculture, Testicular Pelvic Echo-Doppler etc. are covered. However, In-Vitro, Ex-vitro and other artificial insemination will remain excluded.
3. **Treatments**
   Laser therapy, Physiotherapy, Kinesitherapy and Deflux Medicine.
4. **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.

Limitation to the Ambulatory Plan

All Ambulatory healthcare benefits are limited to the healthcare services delivered exclusively through the Healthcare Providers as per the following procedures:

1- The *Insurance Company* covers the ambulatory healthcare expenses, excluding doctor fees, less any applicable deductible, as stated in the Policy Schedule
2- **Genetic Tests** are covered for a maximum amount of USD 1,500- per person per year for ILA ULTIMA subscribers, and for USD 500- for ILA PREMIUM and ILA HDF-Santé Plans subscribers, and this subject to medical necessity.
3- The use of **Dental Panoramic X-ray** is limited to covered post-traumatic cases,
4- The *Insurance Company* covers limitedly one **Morphological Ultrasound** per pregnancy.
5- **Amniocentesis** is covered only for the pregnant woman when aged 35 years and above.
6- **Osteodensitometry** is limited to ages 55 and above, otherwise subject to medical necessity.
7- Ambulatory tests for **Pre-existing Conditions** are covered as from day one, for both individual and group coverages, without waiting period, except for all Circulatory System related tests, that will be covered after a three-month waiting period, unless continuity is granted and stated in the Policy Schedule.
8- **PCR test for Covid-19** is covered on reimbursement basis and only when result is positive. It is further limited to one reimbursement per related sickness. Other tests for the Covid-19 are not covered.
9- The **Calcium Score** (Coronary Artery Calcium or CAC test) is covered once per year and only under the ILA Ultima Plan.

Exclusions to the Ambulatory Plan

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

1- Doctors' fees.
2- Congenital diseases tests including **Thalassemia** tests.
3- Routine check-ups.
4- **Sexually Transmitted Diseases**, including **HIV**.

DOCTORS VISITS PLAN

Benefits, Limitations and Exclusions

Scope of Doctors Visits healthcare Plan

The *Insurance Company* covers strictly the following as D.V. Healthcare Benefits:
The full fees and expenses related to the medical services and procedures listed hereunder:

1. The normal, usual and customary consultation.
2. The following diagnostic services: Cardiac Echo Doppler, Arterial Doppler, Electrocardiogram, Cardiac Stress Test, Pulmonary Function tests (e.g., Spirometry), Ultrasonography, Electroencephalogram, Electromyogram, Audiogram for persons benefiting from the Ambulatory Plan.
3. Small surgery & endoscopic procedures not requiring an Operating or Emergency room or any other hospital services.

Limitation and Exclusions to the Doctor Visits Plan

1- All D.V benefits are limited to the healthcare services delivered exclusively at the doctor's clinic.
2- The *Insurance Company* covers the Consultations as specified above up to 10 visits per *Insured* per year with a maximum per visit as specified in the Schedule.
3- All exclusions applicable to the In Hospital plan are applicable to D.V. Plan.
4- Routine Eye & Ear examination are excluded.

Reimbursement procedure

1. When the reimbursement procedure is applicable, payment is effected on the condition that the *Insured* completes and submits a 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. A photocopy of the Access Card.
   c. The original receipts and bills issued by the attending physicians having performed the services.
   d. A photocopy of the results and diagnostic related to the services rendered, when applicable.

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

Worldwide Emergency Treatments Cover outside Lebanon and Africa
Covered only for ILA ULTIMA Plan subscribers

Schedule of Benefits

1.	Travel information service	Free Assistance
2.	Referral to Medical Correspondents Abroad	Free Assistance
3.	Long Distance Medical Advice	Free Assistance
4.	Dispatch of a Specialist Physician	Free Assistance
5.	Monitoring medical conditions	Free Assistance
6.	Medical translation service	Free Assistance
7.	Emergency Medical expenses Abroad	USD 200'000-
8.	Emergency medical evacuation or repatriation	USD 50'000-
9.	Repatriation of mortal remains	USD 50'000-
10.	Emergency dental care	USD 300-
11.	Transportation to join the Beneficiary	Round Trip Ticket
12.	Return of minor children	One Way Ticket
13.	Compensation in the event of loss or disappearance of baggage	USD 800-
14.	Delay in the arrival of checked-in baggage	USD 300-
15.	Loss of passport, driving license, national identity card abroad	USD 300-
16.	Advance of funds	USD 1'000-

Definitions

The stated below words and/or phrases wherever they appear have the following meaning:

Abroad: Outside Lebanon, Africa and the country of origin.

Benefit/Service/Cover: The Benefits/Services/Covers the Beneficiary or Covered person is entitled to receive as described in the General Conditions and usually summarized in the schedule of Benefits/Services/Covers.

General & Specific Policy Conditions: The terms and provisions of all aspects of the policy which state the rights and duties of the Beneficiary or Insurance Company. The policy conditions will usually be located in the policy schedule.

Beneficiary: means any of the covered persons whose name is stated on the certificate of coverage and having the right to receive the corresponding Benefits/Services/Covers or amount of compensation as outlined in the policy. In case of Accidental death, Beneficiary will be legal heirs of the Insured person.

Country of Permanent Residence means the country in which the Beneficiary normally resides, whether or not he/she holds its citizenship.

Covered Trip: An intended and planned trip undertaken by the Beneficiary outside his country of permanent Residence. The maximum duration of any one Covered Trip is 92 consecutive days.

Outpatient medical expenses mean the medical expenses needed to treat an injury or serious illness, where the Beneficiary can get treatment from a doctor, or a physician and he does not need In-hospital admission.

Deductible or Excess means the first amount of the claim which is payable by the Beneficiary where applicable.

Doctor or Physician: An officially registered medical practitioner according to the law of the place where the Claim happens.

The Assistance Company: International Assistance Network (IAN or any of its subsidiaries).

Fraudulent Claims: When the Beneficiary or someone acting on his behalf, uses any fraudulent means or devices in order to obtain any of the Benefits of this policy, consequently, any payment of any amount in respect of such Claim shall be cancelled.

Medical Supervision: The supervision, care, or management of a patient to combat, ameliorate, or prevent a disease, disorder, or injury wherein constant or regular observation is required.

Treatment: The action or manner of treating a patient medically or surgically particularly adapted to the special disease being treated by a professional that may deem the Beneficiary to be Not Fit for Travel.

Not Fit for Travel:

Beneficiaries who have conditions which may have serious consequences or require medical supervision prior to the trip, such as the following cases:

- Infants less than 48 hours old (longer after premature births)
- Women after the 36th week of pregnancy (32nd week of multiple pregnancy)
- Those suffering from:
    - An unstable medical condition.
    - Angina or chest pain at rest.
    - Any active infectious diseases.
    - Increased intracranial pressure.
    - Recent heart attack (past 1-8 weeks).
    - Recent stroke (past 1-8 weeks).
    - Recent surgery or injury where trapped air or gas may be present (e.g. abdominal trauma, gastrointestinal surgery, craniofacial and ocular injuries, brain surgery or eye operations).
    - Severe chronic respiratory diseases.
    - Breathlessness at rest.
    - Unresolved pneumothorax.
    - Sickle cell anemia.
    - Psychotic illness, except where fully controlled.

The Beneficiary may be considered fit for travel even if he/she suffers from any of the following medical conditions/illnesses provided his/her condition or injury is stable and he/she generally feels well:

- Paralysis and Motor neuron disease.
- Multiple Sclerosis and Parkinson.
- Allergies to certain food.
- High blood pressure, high cholesterol or diabetes.
- Blood disorder such as anemia (Provide no oxygen is required).
- Epilepsy (only if the Beneficiary has not had a seizure within 24 hours prior to the flight departure time).
- Arthritis.
- Insect bites.
- Minor injuries such as toe and finger injuries, twisted ankles, pulled muscles or small cuts.
- Sunburn.
- Hepatitis B or C.
- Dengue fever, Viral meningitis and Malaria.
- Cholera (as long as the symptoms have settled, the Beneficiary is well enough to travel and the public health authority in the destination country allows travel).
- Hepatitis A (as long as the Beneficiary feels well enough to travel).
- Shingles (as long as the rash is not weeping or is covered).
- Yellow fever (as long as the Beneficiary feels well enough to travel and the public authority in the destination country allows travel).
- Flu (as long as the symptoms have settled).
- A heart attack or angioplasty.
- Deep vein thrombosis (DVT) or pulmonary Embolism (PE).
- Stroke (CVA) or head injury.
- Surgery on the heart, chest or abdomen.
- Joint replacement or amputation.
- The Beneficiary does not require oxygen during the trip due to an existing condition.

Orthopedic material or orthosis: Anatomical parts or items of any kind used to prevent or correct temporary or permanent deformations of the body (walking sticks, cervical collar, wheelchair, etc.).

Prosthesis: These are deemed to be any item of any kind that temporarily or permanently replace the lack of an organ, tissue, organic fluid, member or part of any of them. By way of an example, mechanical or biological items such as cardiac valve parts, joint replacements, synthetic skin, intraocular lenses, biological materials (cornea), fluids, gels and synthetic or semi synthetic liquids that replace organic humors or liquids, medicine reservoirs, mobile oxygen therapy systems, etc.

Risk: Probability or threat of a damage, Injury, liability, loss, or other negative occurrence, caused by external or internal vulnerabilities, and which may be neutralized through pre-mediated action.

Injury: A medical problem caused by a sudden and severe external cause or reason beyond the control of the Beneficiary, within the validity period of this Policy.
Serious Illness: Any Illness that requires admission to hospital and which, in the opinion of The Assistance Company's medical team, prevents the Beneficiary from continuing travel on the date planned, or which involves the Risk of death.

Accident: The bodily Injury suffered during the validity of the policy, which derives from a violent, sudden, external cause and one that is not intended by the Beneficiary.
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 policy.
c. Injuries that are a consequence of surgical operations or medical treatments resulting from an Accident Covered by the policy.

Sudden Illness or Injury means a sudden, unexpected, unusual, specific, unforeseen, external event which occurs at a single identifiable time and place and independently of all other causes, resulting directly, immediately and solely in physical bodily injury or trauma and requiring immediate medical intervention treatment. An event which directly or indirectly exacerbates a previously existing pathology and/or a physical bodily injury shall not be considered an Accident.
Any sudden change in health diagnosed and confirmed by a legally recognized Doctor during the life of the policy and which is not comprised or derived from either of the following two groups:

- Congenital disease that exists at the moment of birth as a consequence of hereditary factors or complaints acquired during pregnancy.
- Pre-existing medical conditions that the Beneficiary suffered prior to the date of taking out this Policy, even if it wasn't diagnosed.

In the cases where a sudden illness is described as a Serious Sudden Illness it refers to any Illness that requires admission to hospital and which, in the opinion of the Assistance Company's medical team, prevents the Beneficiary from continuing travel on the date planned, or which involves the risk of death; or where treatment is medically necessary in order to maintain life and/or relieve immediate sudden pain or distress.

Pre-existing Medical Condition means a pre-existing physical defect, infirmity, injury, sickness, pathology, disease, affliction, anomaly that could be congenital or acquired, major risk factor, or any other medical condition, whether known or unknown to the Beneficiary, which he/she was suffering from prior to his/her date of travel from his/her country of permanent residence.

Medical Emergency means an unforeseen and non-recurrent sudden pathology which requires an emergency treatment to prevent or alleviate existing danger to life or health. An emergency no longer exists when medical evidence indicates that the Beneficiary is able to return to his/her Country of Permanent Residence to seek and/or continue treatment. A pathology related to a pre-existing medical condition does not fall under the definition of a sudden pathology. Each time the patient is able to visit the doctor's office in person; such cases shall not be considered an emergency.

Unattended: When the Beneficiary is not in full view of and not in position to prevent unauthorized interference at the time of the damage, loss, or theft of their property or vehicle, or left in place where it can be taken without the Beneficiary's knowledge (including on the beach or beside the pool while the Beneficiary swims), or where the Beneficiary is unable to prevent it from being unlawfully taken.

Business Companion mentioned under the trip cancellation section refers to a fellow member of the same firm or business activity with whom the Beneficiary has planned to travel on the same flight and whose presence is mandatory in order for the trip to take place.

Immediate Family Member: Spouse (Person officially registered as wife or husband of the Beneficiary), children, parents, grandparents, grandchildren, siblings, mother and father-in-law and brothers and sisters in law.

Benefits Details

Whenever the Beneficiary is traveling out of his/her Country of Permanent Residence and up to a maximum of 92 consecutive days, the Assistance Company shall provide the following benefits:

1. Travel information service

The Beneficiary may, prior to his/her departure, call the appropriate Alarm Center on the Assistance Number mentioned on his card, in order to obtain important administrative or medical advice regarding passport and visa processes, vaccination requirements, taxes, customs duties, currencies, and other various requirements.

2. Referral to Medical Correspondents Abroad:

During his stay abroad, the Beneficiary can contact the Assistance Company to be directed to one of the doctors of his network. Most internationally accredited doctors speak English. The Assistance company shall not be held liable for any medical malpractice or inadequate or deficient treatment that might incur following that referral.

3. Long Distance Medical Advice

Should the Beneficiary, during his/her journey abroad, need medical advice, which is not available at their location, he/she may call the appropriate Alarm Center and get medical advice from a qualified physician. A telephone conversation does not permit the establishment of a diagnosis and must therefore be considered as mere advice.

4. Dispatch of a Specialist Physician

In such cases where medical repatriation proves to be impossible due to the patient's condition, the Assistance Company may, at its discretion, pay for the dispatch of a specialist physician to make an on-site evaluation with the attending physician and arrange for the eventual medical repatriation of the Beneficiary.

5. Monitoring medical conditions during and after hospitalization

The Assistance Company will monitor the Beneficiary's medical condition during and after hospitalization, subject to any and all obligations in respect of confidentiality and relevant authorization.

6. Medical translation service

The Assistance Company will arrange for the provision of medical translation to the Beneficiary over the telephone. If the external service provider is used for translation, the quality of the translation cannot be guaranteed. However, the Assistance Company will exercise reasonable care and diligence in selecting such providers.

7. Emergency Medical expenses Abroad

In the event of sudden illness or injury of the Beneficiary occurring outside his country of permanent residence, the Beneficiary must call the Assistance Company prior to his admission. The Assistance Company will guarantee the direct payment of the medical expenses incurred during hospitalization, up to the maximum limit stated in the schedule of benefits for the treatment of an injury or sudden illness sustained by the Beneficiary while his policy is in effect considering that cases are:

- Not due to any preexisting condition,
- Within the scope of policy particular and general condition,
- Not excluded as per policy particular and general exclusions, - As per the usual reasonable and customary charges, - Covered under Regular/Standard Admission Class.

a. Inpatient care: The Treatment of covered medical condition that cannot be treated on an ambulatory basis, as defined above, and requires an uninterrupted hospital confinement initiated during the policy period.

b. Emergency care: An Emergency is a treatment which may not be delayed due to sudden covered illness or accident, and which requires confinement to a hospital emergency room considering the admission is not due to any preexisting condition.

7.1 Emergency medical expenses due to Covid-19 (Ages above 75 years are not covered):

The Insurance Company shall cover only reasonable medical emergency expenses for accidents - Accidents and medical emergency as defined above under definitions section, as well as hospitalization costs resulting from it or consequent to the Beneficiary's becoming infected with an agent of an epidemic/pandemic disease (SARS-CoV-2 and any of its variants), up to a limit specified in the certificate of coverage according to the minimal and standard costs of hospitalization in the country where he/she is being treated.

The Covid-19 cover will be granted in view of the incident country local authorities' requirements at the date of the incident (i.e.: Proof of vaccination, vaccination certificate with QR code or mandatory negative PCR within 48 hours before arrival to destination country). Covid-19 PCR tests are excluded from this coverage.

Special Limitations/Exclusions applicable to Covid medical expenses cover

The Insurance Company does not cover the following conditions, the complications and the consequences arising therefrom:

- Out of hospital medical expenses including ambulatory services, screening tests, medication, vaccination and doctors' consultations
- Outpatient quarantine period and systematic isolation expenses upon arrival to country.
- Homecare and any expenses linked to paramedical expenses/medical equipment at home
- Any expenses incurred in the country of permanent residence.

8. Emergency medical evacuation or repatriation

8.1. If The Assistance Company's physicians decide that medical transportation of the Beneficiary is necessary, the Assistance Company shall arrange for and cover the expenses of the medical evacuation of the Beneficiary by helicopter, road or air ambulance, scheduled airline flight, or other means to a hospital where he/she can receive adequate treatment until his/her condition permits for his/her medical repatriation, if necessary, by the Assistance Company on a regularly scheduled airline flight to his/her country of residence. A direct medical repatriation may likewise be considered, depending on the medical case and the distance to be covered.

8.2. The Assistance Company reserves the right, at its sole discretion, to determine the location to which the Beneficiary will be evacuated and the means or method by which such evacuation or repatriation will be carried out. In making such arrangements, the Assistance Company may consider all relevant circumstances including, but not limited to the Beneficiary's medical condition, the degree of urgency, the Beneficiary's fitness to travel, airport availability, weather conditions and travel distance in determining whether transportation will be provided by private medically equipped aircraft, helicopter, regular scheduled flight, rail or land vehicle. Transportation shall be carried out under constant medical supervision, unless otherwise approved by the Assistance Company's Physician.

9. Repatriation of mortal remains

In the event of an accidental or a sudden death of the Beneficiary as a result of a sudden non-pre-existing illness, the Assistance Company shall assist with the necessary procedures and shall cover only the expenses of transportation for repatriation of the mortal remains to such a location as may be selected by the legal representative of the deceased. If requested by a family member or legal representative, the Assistance Company will pay for a local burial at the place of death, subject to any governmental regulations.

In the case of repatriation of the deceased, the administration and funeral expenses (including the purchase of the coffin) are not covered. The Assistance Company is exonerated from providing this service if it is not notified of the death of the Beneficiary (or any of its appointed parties) within 6 days following the death.

10. Emergency dental care

The Insurance Company shall cover the dental expenses incurred by the Beneficiary in emergency cases, arising as a result of a bodily injury or of an acute and sudden illness, with the exclusion of any kind of prosthesis and /or definitive filing. The coverage is restricted to the treatment of pain, infection and removal of tooth affected. Expenses are covered up to a limit mentioned in the certificate of coverage. The cover of emergency dental care is subject to USD 30 deductible per claim.

11. Transportation to join the Beneficiary following hospitalization of the Beneficiary

In the event where the Beneficiary, while travelling outside his country of permanent residence, is hospitalized for a period exceeding 7 consecutive days, the Insurance Company shall cover the costs for the round-trip ticket of one immediate family member, as designated by the Beneficiary, from the Beneficiary's country of permanent residence to the international or domestic airport terminal or train station closest to the hospital's location. The ticket will be an economy class ticket.

12. Return of minor children

If a Beneficiary has minor children (not yet 18 years old, unmarried and in school) who are left unattended as a result of a Beneficiary's injury, sudden illness or medical evacuation, the Assistance Company will arrange for transportation of such minor children to the Beneficiary's Country of Permanent residence.

13. Compensation in the event of total loss or disappearance of baggage

The Insurance Company will cover compensation in the event of the insured suffering a total loss of baggage checked by an International Airline for an International flight. This coverage includes compensation for clothing and personal effects which are stored in the lost personal

baggage. The minimum period of time that must elapse for the luggage to be considered lost once and for all will be that stipulated by the carrier company, with a minimum of 21 days.
In all cases, the original certificate of the carrier or complaint, reporting the occurrence of the loss, must be furnished.
The Company shall not be responsible for:

- Partial loss or damage to checked baggage.
- Wear, tear and depreciation of the article.
- Claims for valuable or fragile articles in checked baggage.
- Claims arising from detention, delay or confiscation by customers or other officials.
- Claims on items for which the insured has already been reimbursed by the Airline or another party.
- Claims on loss of business goods or samples or equipment of any kind.
- Money, jewelry, debit and credit cards, any type of missing documents/items is excluded from this guarantee.

14. Delay in the arrival of checked-in baggage

In case the Beneficiary's registered baggage is temporarily lost during his trip outside the country of permanent residence and if not delivered to him within the 8 hours of his destination arrival and the Beneficiary had to buy essential items (clothes, toothbrush, etc.) the Insurance Company will reimburse the essential items limited to emergency clothing and toiletries not exceeding the limit mentioned on his certificate of coverage.
A written formal document should be obtained from the Airline company confirming the number of hours in respect of luggage delay and the retrieved date as well as the original invoices before any compensation.
Exclusions applicable only to this benefit (the general exclusions of the policy being equally applicable)

- Losses or deterioration due to delay
- If legal authorities detained the luggage.
- Trip scheduled to an unstable country if war is declared or not.
- Delay occurring while the Beneficiary is in the return trip to the country of permanent residence.

15. Loss of passport, driving license, national identity card abroad

In the case of loss of the Beneficiary 's passport, driving license, national identity card while abroad, the Insurance Company shall cover the expenses for obtaining a new passport, driving license, national identity card or equivalent consular document, up to the limit mentioned on the certificate of coverage.
The Beneficiary must report any loss or theft to the local Police within 24 hours of discovery and obtain a written report of the loss or theft of such documents.

Exclusions applicable to this benefit (the general exclusions of the policy being equally applicable)

- Loss or theft of the Beneficiary documents left unattended at any time (including in a vehicle or in custody of carriers) unless deposited in a hotel safe, safely deposit box or left in his/her locked accommodation.
- Loss due to delay, confiscation or detention by customs or other authorities.

16. Advance of funds

The Assistance Company will advance or guarantee payment up to the limit mentioned in the table of benefit, on behalf of the Beneficiary, in order to cover immediate expenses, in an unexpected emergency situation, further to loss and/or theft of personal documents and belongings, provided that this has been duly reported to the police or the appropriate local authorities.

The Beneficiary or any person acting on his behalf shall, in any case, have to sign an IOU (I owe you) favor the Assistance Company.

All sum advanced shall be repaid to The Assistance Company by The Beneficiary or its legal representative, as soon as he returns to his Country of Residence and within a maximum of one month from the date of advance or guarantee by the assistance company.

Obligations of the Beneficiary

In the event of a medical emergency or a sudden illness, the Beneficiary releases from professional secrecy all doctors and paramedical staff who might examine him/her both before and after the incident. The Beneficiary is required to communicate confidentially to the attention of the Assistance medical advisor, all facts and circumstances required under the guarantees of assistance abroad.

Any reluctance or omission in the communication of this data entitles the Assistance Company to suspend the assistance guarantees as soon as it becomes aware of the said facts or circumstances.

The Assistance platform cannot in any way replace the local emergency relief organizations. The Assistance platform is not responsible for the consequences of medical malpractice or inadequate treatment. In the case where any of the Beneficiaries has subscribed to another policy for the same risk (Insurance and / or Assistance), he is obliged to declare it to the Assistance Company.

Claims Conditions

IAN (International Assistance Network) part of the Eurocross Network, is the assigned assistance platform for this plan. It operates on a 24/7 basis, in agreement with the Beneficiary in order to respond to his/her needs. Any request for assistance must be made to the Assistance Company within 48 hours and prior to any expenditure commitment. The Assistance Company shall not be involved in the expenses that the Beneficiary would have incurred on his/her own initiative. However, in order not to penalize the Beneficiary who have shown reasonable initiative, the Assistance Company could consider coverage upon presentation of supporting documents.

In order to receive the benefits under this travel plan, the Beneficiary must contact the Alarm Center within 48 hours of the occurrence of the event by phone or email:

Tel: +961 4 548668 or +420 234 622 769 **Email:** lia.claims@ian-assist.com

If the Beneficiary is not in a position to contact the appropriate Alarm Center, notification given by a close person, the police, the hospital, the fire brigade, or any person having intervened upon the occurrence of the damage will be considered of the same worth as a call from the Beneficiary him/herself.

The Insurance Company reserves the right to verify the truthfulness of the damage declared. Failure to submit such required documents within a period of two months from the occurrence of the accident/sudden illness gives the Insurance Company the right to deny any benefits

and/or reimbursement in relation with the incurred costs. Furthermore, the Beneficiary must provide the requested original documents within twelve months:

a- The damage

- Official statement of accident issued by the police authorities.
- Copy of passport and visa (where applicable).
- Complete medical file established by the doctor or the hospital visited at the place of the accident, medical prescriptions.
- Medical and hospital bills.

b- The delay or loss of baggage

- Copy of check reimbursed from the Airlines.
- Letter from the Airlines.

Restrictive Conditions of Benefits Coverage

1- Liability

The Assistance Company can only intervene within the limit of the approvals given by the local authorities, medical and/or administrative, and can under no circumstances replace local emergency organizations nor bear the expenses incurred if they pertain to the public authority.

2- Exceptional Circumstances

The Assistance Company shall not be held liable in case of non-compliance with the obligations outlined herein, if such non-compliance leads to:

- A case of force majeure making it impossible to carry out the coverage.
- Events such as civil or foreign war.
- Revolution, civil commotion, riot, strike, sequestration or constraint by the public authorities, official prohibition issued by the authorities, piracy, detonation of explosives, nuclear or radioactive effects, climatic obstructions.

3- Limitation of Coverage

- Coverage shall cease automatically upon the expiration date of this contract.
- Coverage under this plan is secondary, which means that the Insurance Company will not pay any cost which is recoverable from any other insurance, fund or institution, except eligible amounts that exceed the limits covered by that other insurance, fund or institution, subject to the General Conditions of this contract, and up to the limits herein set.
- The Insurance Company shall not be held liable for the consequences of medical malpractice or inadequate or deficient treatment.
- The Insurance Company shall not be held liable for any medical post-treatment or follow-up incurred by the generating events.

4- Exemption from providing benefits

The Insurance Company is released from any obligation to provide benefits in the following cases:

- Failure by the Beneficiary to notify the Company within 48 hours of the event
- Failure by the Beneficiary to submit to the Company all documents required for setting the case of the accident. - All files or bills treated outside a guarantee of payment or a previously written authorization from The Company, if accepted, are subject to reimbursement according to the Company's standard prices in the incident country.

- Committing by the Beneficiary of a crime or an offense, which was the cause of the accident.
- Denial of the compulsory prior approval by the Company for the organization and financing of the assistance. Any decisions to undergo treatment, transfer to a different medical facility, or perform a necessary procedure, such as a surgery, or additional investigation, such as MRI or scanner, during an approved hospitalization must be subject to the Company's prior approval. Failure to notify the Company of such decision will result in the denial of coverage.
- Failure by the Beneficiary to notify the Company of the existence of another insurance covering the same risks.
- Failure by the Beneficiary to take measures which reasonably ought to have been taken to avoid the accident.
- Failure by the Beneficiary to provide the Company with the information it needs, and to give it honest and complete answers.
- Refusal by the Beneficiary or the person who decides for him/her to receive those benefits provided by the Company and mutually agreed upon by the Company doctors and those present at the place of the damage. Such refusal will result in the cancellation of the contract, unless the Beneficiary changes his/her mind before the expiration of the contract.
- Any workmen's compensation or any claim related to work or labor accidents, consequence of a risk inherent to the work or under the scope of employment performed by the Beneficiary.

General Exclusions

Expenses and damages resulting from the following events are not covered:

1- The practice of reckless undertakings or needless risk by the Beneficiary or not taking reasonable care, except in an attempt to save human life.

2- Brawl (punches during a violent dispute).

3- The practice of high-risk sports such as, but not limited to: parachuting, acrobatics, spelunking, races using mechanical appliances, high wire, ski jumping, sky flying & surfing, bungee jumping, Base jumping, hang gliding, open water swimming, scuba diving, jet skiing, kite & windsurfing, water surfing, wakeboarding, rafting & kayaking, shooting, indoor & outdoor climbing, alpinism, mountain biking, free falling, boxing, motor racing, rugby, aviation, ATV riding, mountain sickness related claims ,as well as all professional competition sports.
The Assistance Company shall study on case-by-case basis the circumstances related to the practiced sport.

4- War, declared or otherwise, revolution, sabotage actions, terrorism or vandalism strikes, street barricades erected at the time of public demonstrations, and generally troubles of all kinds and measures taken for restoring order.

5- Telluric movements, floods, volcanic eruptions, or other kinds of natural phenomenon considered as natural calamity.

6- Any expenses related to abuse of consumption of alcohol, narcotics, and/or other hallucinogenic substances.

7- All damage to health brought about by ionizing rays (nuclear radiation).

8- Any loss arising from biological and/or chemical material(s), substance(s), compound(s) or the like used directly or indirectly for the purpose to harm.

9- Expenses related to mental health disorders and any Psychiatric disorder or any of its manifestations or complications.

10- Suicide or attempted suicide.
11- Ablation and transplantation of organs, tissues, or cells.
12- All events and accidents associated with or resulting from pregnancy and/or breast feeding, including diagnosis, follow-up treatments, abortion, or delivery. All Healthcare Services & Treatments for In-Vitro Fertilization (IVF), embryo transport, ovum and male sperms transport.
13- a) Any internal or external device/ material used on temporary or permanent basis such as but not limited to orthopedic, cardiac, vascular, urological, digestive devices/materials, etc., as well as anatomical prosthesis, any walking aids and splints.
b) All operations related to previous prosthesis or device as described in 13-a
14- Physiotherapy including all forms of physical re-education.
15- Elective stay at a convalescent home or a revalidation center.
16- All treatments related to congenital or acquired malformations.
17- Endemic, epidemic and pandemic diseases.
18- Venereal and Sexually Transmitted Infections.
19- Any Health Services that are received as Out-of-Hospital Benefits as well as outpatient doctor visits.
20- Spontaneous consultations of doctors and specialists, and all kinds of check-ups or medical investigations.
21- Treatment, hospitalization or any medical costs related to a pre-existing medical condition as described under Definitions section. This exclusion extends to any medical situation whether known or unknown, diagnosed or not, treated or not before the Beneficiary current travel dates and possible complications thereto. Pre-existing medical conditions, and any related treatment to it; repatriation, evacuation or Emergency Room expenses, are not covered under this plan.
22- Any subsequent admission to the hospital, related to the first one, unless considered as an emergency treatment by the Assistance Company physicians.
23- Gallstones and Cholelithiasis and any complication resulting from that.
24- Nephrolithiasis as well as ureterolithiasis and their complications.
25- Any vascular, cardiovascular, cerebrovascular illness and their related complications are excluded from the coverage of this policy
26- Any medical condition for which the Beneficiary didn't take the recommended treatment or prescribed medications as directed by his medical practitioner in his Country of Permanent Residence.
27- Medicines purchased outside hospitals or Emergency rooms are excluded, except for medicines prescribed in the emergency room and not available on-site."
28- Unconventional trips.
29- In case of approval of a non-urgent hospital admission: prior any admission, authorization by the Assistance Company doctors concerning the choice of the hospital is mandatory; otherwise, the hospitalization fees are not covered by this certificate of coverage.
30- Allergic and auto-immune disorder and their complications.
31- In case of a non-typical or uncommon pathological disorder, failure to present to the Assistance Company doctors a clear and definite medical and etiological diagnosis within 3 (three) days of the hospital admission.
32- Every hospitalization undertaken initially in a diagnostic search purpose.
33- Investigations, treatment, or surgery which in the opinion of the medical practitioner in attendance and/or the Company doctor can wait until return of the Beneficiary to country of permanent residence

34- Diagnostic investigations and procedures undertaken in search for pre-existing diseases and medical conditions excluded in the scope of the present coverage as described in Exclusion (23) and the definition section.
35- No coverage shall be rendered in case the Beneficiary has another valid medical or insurance coverage outside his/her Country of Permanent Residence.
36- In addition, the Beneficiary is not covered when a trip is undertaken:
    - Against medical advice.
    - Following acknowledgement of a diagnosis establishing an illness in terminal phase.
    - With the intention to receive medical treatment, medical investigation or follow-up treatment for a pre-existing medical condition.
    - During a period of illness, major treatment, or incapacity to work.
    - When a doctor has ordered an operation, which has not yet been performed.
37- Industries, Seepage, Contamination and any kind of pollution or environmental liability.
38- Absolute Fungi Liability in accordance with the Absolute Fungi Liability Exclusion.
39- Asbestos risks.
40- Treatments and Services related to viral hepatitis and associated complications, except for treatment and Services related to Hepatitis A.
41- Terrorism unless an extra Premium is paid by the Beneficiary.

Payment of Claims

Direct Payment within the Administrator Network of Providers

1. As a standard procedure, the *Insurance Company* through the TPA, shall effect the payments of claims directly to the TPA PP and not to the *Insured*, based on a prior Approval of Coverage as defined hereinafter and up to the limits authorized therein, except in cases where the reimbursement procedure is applicable.
2. The Approval of Coverage for direct payments provided for hereinafter is only applicable when the healthcare services are sought at a TPA PP and when the following procedures are complied with by the *Insured* depending on the applicable cases:
   - In the cases of non-emergency admission to a TPA PP whether requiring an overnight stay at hospital or not, the Approval of Coverage must be secured by the *Insured* from the TPA prior to his/her admission by submitting the duly completed Medical Report Form.
   - In the cases of emergency admission for at least an overnight stay as defined in the Policy, Approval of Coverage must be requested by the *Insured* from the TPA immediately upon admission, but not later than the next working day if admission falls within a holiday.
   - In the cases of admission to an emergency room within a TPA PP not requiring an overnight stay, the *Insured* must deposit his/her Access Card with the said provider awaiting the TPA's decision.
3. The TPA may, upon evaluation of each case, grant or deny the Approval of Coverage, based on the terms, conditions, limitations and exclusions of the Policy. This decision is relayed to the *Insured* through the Services Center or the TPA delegate.

Reimbursement

The *Insured* may be, subject to acceptance by the *Insurance Company*, reimbursed the incurred total or partial fees and expenses of covered healthcare services under this Policy in the following cases and as follows:

a- As an appeal by an *Insured* to a previously declined Approval of Coverage at a TPA PP; the reimbursement will be effected based on the actual costs/expenses incurred by the *Insured* without any penalty but with the application of the UCR rule.

b- In instances of an emergency hospitalization at a non-TPA PP in Lebanon; the reimbursement will be effected based on the preferential tariffs applicable to the TPA at an equivalent PP in Lebanon with the application of the UCR rule.

c- In instances of non-emergency hospitalization at a non-TPA PP in Lebanon; the reimbursement will be effected based on the preferential tariffs applicable to the TPA at an equivalent PP in Lebanon with a 20% deduction on these tariffs.

d- In instances where a PP was excluded from the network during the contract year and where an *Insured* has to follow-up for a treatment he/she already started at this provider, the reimbursement will be effected based on the actual costs/expenses with the application of the UCR rule.

e- In instances of emergency or non-emergency treatment or hospitalization in Africa, where the reimbursement will be effected based on the actual costs/expenses incurred, with the application of the UCR rule. Furthermore, the reimbursement will be solely based on the documents provided by the *Policyholder* without the request of any additional document.

f- In all other instances, the reimbursement will be effected based on the preferential tariffs applicable to the TPA at an equivalent PP in Lebanon without any deduction.

g- For the Ambulatory benefit claims incurred in Lebanon, reimbursement will be effected based on the preferential tariffs applicable to the TPA at an equivalent PP in Lebanon with a 25% deduction on these tariffs.

h- For the Ambulatory benefit claims incurred in Africa, reimbursement will be effected based on actual costs/expenses incurred by the *Insured* without any penalty but with the application of the UCR rule.

i- For the physiotherapy sessions under the Ambulatory benefit, the reimbursement will be made based on the following maximums:
   - USD 25.00 per session without any deductible, other than the excess, when applicable, for sessions done in Lebanon, and
   - USD 40.00 per session without any deductible, other than the excess, when applicable, for sessions done outside Lebanon.

The above reimbursement is subject to complying with a special procedure provided for hereinafter:

1. A written request for reimbursement must be addressed directly to the *Insurance Company*, together with all the requested supporting documents (e.g., waiver of confidentiality document, detailed original bill, discharge report, medical and examination reports etc.).
2. In all the instances provided for above, reimbursement is effected on the condition that the *Insured* has filed a claim with the *Insurance Company* within 31 (thirty-one) days from hospital discharge.
3. In all emergency cases in Lebanon, reimbursement may be effected on the additional condition that the *Insurance Company* or the TPA is informed of the hospitalization within 48 (forty-eight) hours from admission.
4. In all non-emergency cases, when a healthcare service is sought at a non-TPA PP in Lebanon or abroad, reimbursement may be effected on the condition that the *Insured* has sought a special Approval of Coverage from the *Insurance Company* or the TPA prior to admission.
5. The reimbursement of all claims incurred in a foreign currency (i.e., not Lebanese Pounds) will be effected in US Dollars, converted at the exchange rate applicable at the date of discharge from the healthcare provider as such date is evidenced by the bill.
6. The reimbursement by the *Insurance Company* to the *Policyholder* or directly to the *Insured* will be made within a period of maximum 14 working days from receiving all the requested claims documents.
