ILA HealthCare Insurance Program
General Conditions

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.

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.

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 *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* 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 *Preexisting 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:

The Annual Financial Limitation is set at US Dollars One Million (USD 1,000,000-) per *Insured* during the Policy's contractual period 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.

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:

- 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 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. They are computed on pro-rata basis of the net annual premium per *Insured*, the expenses, taxes and stamps being added over (Except for deletion where taxes and stamps are not refundable).

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 per the terms and conditions 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 effected by the formal issuance of the signed and sealed Policy.

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.

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.
h. 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.

e. 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

Table of Benefits	Coverage
Financial Limitation	For ILA ULTIMA: unlimited per insured per year, *except provided otherwise*. For ILA PREMIUM: limited to USD 500,000- for Class A USD 300,000- for Class B USD 200,000- for Class S
Applicable Network in Lebanon	For ILA ULTIMA: Full Network for Classes A & B excluding AUBMC & CMC for Class S only For ILA PREMIUM: Full Network excluding AUBMC & CMC for all classes
Applicable Network outside Lebanon	For ILA ULTIMA: Africa & the Middle East For ILA PREMIUM: Africa only
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
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: Excluded
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.*
Mental or Psychiatric Treatments	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: Excluded
Organ and Bone Marrow Transplantation *Includes all kinds of transplantation, surgical procedures for the Insured receiver and donor (excluding the cost of organs).*	For ILA ULTIMA: Covered with a limitation of USD 100,000- per *Insured* per year For ILA PREMIUM: Covered with a limitation of USD 50,000- per *Insured* per year

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	The 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
Infertility	Only specific surgeries and hysteroscopy are covered.

Other Features and Benefits	Coverage
Homecare Services	Covered, excluding home nursing.
Lifetime Guaranteed Renewability	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: Excluded
Passive War Risks / Terrorism	Covered in Lebanon only.
Worldwide Emergency Treatments Cover *As detailed below*	For ILA ULTIMA: Covered up to USD 65,000- per person per year. For ILA Premium: Excluded
Travel Assistance Plan *As detailed below*	For ILA ULTIMA: Covered For ILA Premium: Excluded
Morgue and Burial expenses	For ILA ULTIMA: Covered up to USD 2,000- per person For ILA Premium: Covered up to USD 500- per person

Limitations to In-Hospital Plan

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

- Hospitalization class: The *Insured* will be covered under the hospitalization class identified in the Policy Schedule, except in case of medical or surgical treatment of covered healthcare conditions that does not require an overnight stay at hospital, delivered in a "one day room unit".
- 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:
  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*.
- 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 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.
- The coverage of the Mental or Psychiatric Treatments 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.
- 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 excludes the Parkinson Disease treatment and surgery from its cover.
- 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 burial and morgue 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:

1- 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.
2- All the cases and/or limitations and/or exclusions per *Insured* provided for in the policy schedule or the amendments.
3- Any hospitalization not medically mandatory for the health of the *Insured* (e.g., sight correction surgery, organ donation, Cosmetic or Aesthetic Treatments and surgeries).

4- Peritoneal dialysis, Hemodialysis and the arteriovenostomy related thereto. As a special exception to the above general exclusion, only the sessions of dialysis for acute renal failure delivered during the initial hospital admission, and till discharge will be covered.
5- Pre-existing conditions are excluded the first year for individual coverage, unless continuity is granted or stated otherwise in the Policy Schedule.
6- Weight control procedures and surgeries, unless medically necessary.
7- 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.
8- Passive War Risks and Terrorism are excluded in Africa.
9- 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).
10- Claims arising from ionization, polluting chemicals or nuclear contamination.
11- Abortion that is not medically mandated.
12- Epidemics and Pandemics.
13- Harmful or hazardous use of alcohol, drugs and/or medicines and self-inflicted injuries.
14- Dental and Gum medical or surgical treatment of any condition including the temporomandibular joints; unless following an accident fundamentally covered under this Policy.
15- External prosthesis and other any external artificial body part or orthosis, such as a prosthetic limb or ear, knee or neck brace etc.
16- Any treatment or procedure that is still experimental or considered as a new healthcare technology.
17- 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 preexisting case.
18- Rest cures, sanatorium, custodial care and periods of quarantine and costs related to convalescence even when initial hospitalization was covered under the Policy.
19- 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.
20- 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.
21- 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. Scan, 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) and Triple Test.
2. **Treatments**
   Laser therapy, Physiotherapy, Kinesitherapy and Deflux Medicine.
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.

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- For ILA ULTIMA subscribers, Genetic Tests are covered once per contractual year for a maximum amount of USD 250- per person per year and this subject to medical necessity. They are excluded under the ILA PREMIUM Plan.
3- The use of Dental Panoramic X-ray is limited to covered post-traumatic cases,
4- The *Insurance Company* covers limitedly one Morphological Ultra Sound per covered pregnancy.
5- Amniocentesis is covered only for the pregnant woman when aged above 35 years.

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- All tests related to infertility (e.g., spermogram, hysterosalpingography, spermoculture, testicular pelvic echo-Doppler).
3- Congenital diseases tests including Thalassemia tests
4- Routine check-ups.

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.

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 effected 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 the country of residence in Africa – Covered only for ILA ULTIMA subscribers

The *Insurance Company* covers the *Insured* while travelling for a maximum of 92 consecutive days outside his/her country of origin and his/her country of residence, for emergency treatments of covered medical conditions under this Policy and for a maximum sum *Insured* as stated in the table above.
The emergency treatment is defined as follows:

> *"A health condition sustained as a result of sudden, non-excluded sickness or bodily injury, raising a legitimate professional concern that there may be a significant medical problem necessitating treatment, medical or surgical, which must not be delayed and which requires confinement to a hospital emergency room whether followed by hospitalization or not."*

- **Repatriation in case of Death (actual expenses)**

In the event of the death of the *Insured*, the Assistance 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 usual country of residence.
This cover is subject to a limit provided by the referred schedule.
Payment of expenses for interment, cremation or funeral ceremony is excluded from this guarantee.

- **Repatriation of family member travelling with the *Insured* (actual expenses)**

Should the *Insured* be hospitalized due to sudden illness or accident for more than ten days or deceased, the Assistance Company will meet the cost in respect of one immediate family member accompanying the *Insured* at the moment of the event, having the same country of residence as the *Insured*, provided this immediate family member is unable to travel by his/her own means of transport or the means of transport used for the initial trip.
This cover is subject to a limit provided by the referred schedule.

- ***Emergency* Dental Care up to USD 175.- with an excess of USD 30.-**

If and when found necessary, the Assistance Company will provide the *Insured* party with the dental assistance required abroad. However, this coverage is restricted to the treatment of pain, infection and removal of the tooth/teeth affected. This cover is subject to a limit provided by the referred schedule. USD 30 excess is applicable per claim.

- **Medical repatriation following illness or *accident* (actual expenses)**

In the event of an accident or sudden illness, the Company will take charge of transferring or repatriating the *Insured* to a properly equipped health center or to his/her usual country of residence.
The Assistance Company, through its medical team, will decide which health center the *Insured* is transferred to or whether repatriation is necessary, depending on the situation or gravity of the state the latter is in. Afterwards, the Assistance Company's medical team will maintain the telephone contacts necessary with the medical center and with the doctors attending to the *Insured*, and on the basis thereof will decide whether to transfer or repatriate the *Insured*, and on the most suitable means of transport to use.
For minor or less serious illnesses or accidents, which in the opinion of the medical team do not require repatriation, transfer will be performed in ambulance or another means of transport, to the place where adequate medical assistance can be provided.
This cover is subject to a limit provided by the referred schedule.

- **Prolongation of the *Insured* stay due to illness or *accident* up to USD 60.- per day up to 10 days.**

The Assistance Company will pay the *Insured* party's hotel expenses when, due to injury or illness and by medical prescription *Insured* must extend his stay abroad.
The staying expenses covered do not include those of maintenance, food, beverages.
Limit: USD 60-/ day with a maximum of 10 Days.

- **Unexpected return to Lebanon (actual expenses)**

The Assistance Company will pay the traveling expenses of the *Insured* party when he/ she has to interrupt the trip due to a legitimate claim at his***/*** her usual place of residence (legal residence) and whenever this displacement could not be carried out using the transport used or contracted on the trip and the presence of the *Insured* in requested by the authorities or to minimize the losses.

- **Escort of dependent child (actual expenses)**

If any of the *Insured* parties accompanying the transferred or repatriated *Insured* party were to be a child of under 15 years of age with no one to look after him/her, the Assistance company will provide a suitable person to take charge of and accompany him/her back to the domicile or to the usual place of residence.

- **Relay of urgent messages (actual expenses)**

The Assistance Company will take charge of relaying the urgent messages of the *Insured* to his/her family, relating to any event covered under this Policy.

- **General information services (actual expenses)**

Whilst traveling abroad, the *Insured* will be entitled to contact the Assistance Company in order to obtain miscellaneous information and services in the country where he/ she is located and in particular rental car referral and reservation and legal and administrative information and referral. Any miscellaneous service required by the *Insured* party that is not covered through this policy, shall remain at his/ her own charge.

- **Delivery of Medicines (actual expenses excluding the cost of medicines)**

The Company will take charge of delivering the medicines prescribed urgently by a doctor for the *Insured* party during the trip and which cannot be found in the place where he/she had traveled to.
Under no circumstances, will the Company meet the cost of the medicines.

- **Advance of Bail Bond up to USD 12,500.-**

The Assistance Company will advance funds for any legal bond required on behalf of an *Insured* up to the amount provided by the referred schedule.
However, the *Insured* will be required to repay such sum as may have been advanced within 45 days. The Assistance Company will require valid credit authorization prior to any such fund advance.
This cover is subject to a limit provided by the referred schedule.

- **Advance of funds up to USD 1,500.-**

If during a trip abroad, the *Insured* were deprived of cash due to loss of credit card, the Company will advance funds on behalf of an *Insured* up to a maximum of USD 1,500.
The assistance company will require valid credit authorization prior to any fund advance related to such fund advance.

- **Medical consultation, evaluation and referral.**

Through the assistance company call center, the *Insured* will be refereed to any agreed medical center or medical practitioner of the Reinsurance international network.

This assistance service is provided by AXA Assistance.

Liability Condition

In the event of any claim the liability of the Company shall be conditional on the *Insured* claiming indemnity or benefit having complied with and continuing to comply with the terms of this Policy.

In the event of a claim under this Policy the *Insured* shall:

- Take all reasonable precautions to minimize the loss.
- As soon as possible telephone the Company to notify the claim stating the Benefits required.
- Freely provide the Company with all relevant information.
- Make no admission of liability or offer promise or payment of any kind.

IPA will not reimburse or consider reimbursing any expenses which were not previously approved. Previously approved expenses will have to include the claim number obtained from IPA prior to sending the official receipts and/or letter explaining the reason and circumstances of why the Travel Assistance Services for which expenses are claimed were not obtained from IPA directly.

The Company is not liable in respect of any Benefit, which would otherwise be payable under this Policy, should there be another insurance in force covering the same benefits which predate this policy.

General Exclusions

1. Loss, damage, illness and/or injury directly or indirectly caused by, arising out of and/or in consequence of the following are excluded from the guarantee/cover granted under this Policy:
   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 costs for which are themselves excluded;
   b- Extraordinary natural phenomena such as floods, earthquakes, landslides, volcanic eruptions, atypical cyclonic storms, falling objects from space and aerolites, and in general any extraordinary atmospheric, meteorological, seismic or geological phenomenon;
   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; except passive war;
   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 in the following sports: motor racing or motorcycle racing in any of its modes, big game hunting outside European territory, 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 of resident country;

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; and,

o- The accidents deemed legally to be work or labor accidents, consequence of a risk inherent to the work performed by the *Insured*.

2. In addition to the foregoing General Exclusions, the following benefits are not covered by this insurance:

a- the services arranged by the *Insured* on his/her own behalf, without prior consent of IPA, except in the case of an emergency/urgent necessity. In that event, the *Insured* shall furnish the Company with the vouchers & original copies of the invoices;

b- Illnesses or injuries arising from chronic ailments or from those that existed prior to the inception date of the policy;

c- Death as a result of suicide and the injuries or after-effects brought about by suicide and/or attempted suicide;

d- 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;

e- Illness/injuries resulting from refusal and/or delay, on the part of the *Insured* or persons responsible for him/her, in the transfer proposed by the Company & agreed by its medical service;

f- Rehabilitation treatments;

g- Prostheses, orthopedic material or orthesis & osteosynthesis material, and spectacles;

h- Illness or injuries caused by pregnancy and childbirth or any complication therefore or voluntary termination of pregnancy;

i- Costs and/or damages caused by baggage that is not sufficiently well packaged or identified, as well as fragile baggage or perishable products;

j- Assistance or compensation for events that occurred during a trip that had commenced, in any of the following circumstances:

- Before this insurance comes into force;
- With the intention of receiving medical treatment;
- After the diagnosis of a terminal illness;
- Without prior medical authorization, after the *Insured* had been under treatment or medical supervision during the twelve months prior to the start of the trip;

k- Expenses that arise once the *Insured* is at his/her usual country of residence, 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 Agreement have elapsed or after 90 days has elapsed since the start thereof, notwithstanding what is provided for in the Additional Clauses or in the Private or Special Conditions.

The Company is exempt from liability when, as a result of force majeure, it is unable to put into effect any of the benefits specifically envisaged in this policy.

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 effected based on USD 20.00 per session without any deductible, other than the excess, when applicable.

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.
