Allianz

Individual Benefit Guide

Plans for Lebanon

International Healthcare for you and your family

Valid from 1st July 2025

SNA

Welcome

You and your family can depend on us, as your international health insurer, to give you access to the best care possible.

To provide an efficient local service in Lebanon, we have selected Nextcare to administer your policy. Nextcare will deal directly with the network of medical providers, to ensure the direct settlement of your medical treatment within Lebanon.

This guide has two parts: 'How to use your cover' is a summary of all important information you are likely to use on a regular basis; 'Terms and conditions of your cover' explains your cover in more detail.

To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate and Table of Benefits.

The insurer of this policy is SNA s.a.l., registered in Lebanon in the Insurance Companies Register under No. 104, dated 23.3.1963 (as per decree No. 177/1 and subject to Legislative decree No. 9812 dated 4.5.1968 MOF 4698). Address: SNA Building Hazmieh, P.O. Box 16-6528, Beirut, Lebanon.

The policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. The Irish Branch is registered in the Irish Companies Registration Office with No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA acts as the reinsurer and provides administration services and technical support for the policy.

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How to use your cover

Support services

Talk to us, we love to help!

Our Helpline is available 24 hours a day, 7 days a week, to handle any questions about your policy or if you need assistance in an emergency.

For information and assistance with treatments inside Lebanon, call Nextcare:

Phone:	**+961 1 504000**
Email:	Nc_Claims.lb@nextcarehealth.com
Fax:	**+961 1 498323**
Address:	Nextcare Lebanon S.A.L. Essor Building, Father Naamtallah Kahale Street, PO Box 55-630, Sin el Fil, Lebanon. Nextcare Lebanon S.A.L is a limited company incorporated in Lebanon. Commercial Registration Number: 76719 Beirut.

For information and assistance with treatments outside Lebanon, evacuations and repatriations, call Allianz:

Phone:	**+353 1 630 1301**
Email:	client.services@e.allianz.com
Address:	Allianz, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

MyHealth Digital Services

Through MyHealth, available as a mobile app and online portal, you have easy and convenient access to your cover, no matter where you are or what device you are using. MyHealth digital services are provided through Allianz.

MyHealth app and online portal features

My policy
Access your policy documents and membership card on the go.

My claims
Submit your claims in three simple steps and view your claims history.

My contacts
Access our 24/7 multilingual Helpline. Live chat is also available (in English and on the online portal only).

Symptom checker
Get a quick and easy assessment of your symptoms.

Provider finder
Locate medical providers nearby.

Pharmacy aid
Look up the local equivalent names of branded drugs.

Medical term translator
Translate names of common ailments into 17 languages.

Emergency contact
Access local emergency numbers worldwide.

Additional useful features

- Update your details online: email, phone number, password, address (if it's the same country as the previous address), marketing preferences, etc.
- View the remaining balance of each benefit that is in your Table of Benefits.
- Pay your premium online and view payments received.
- Add or change your credit card details.

All personal data within MyHealth Digital Services is encrypted for data protection.

Getting started:

1. Login to MyHealth online portal to register. Go to my.allianzcare.com/myhealth, click on 'REGISTER HERE' near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number, which you can find in your Insurance Certificate.

2. As an alternative, you can register via our MyHealth App. To download it, search for 'Allianz MyHealth' on the Apple App Store or Android's Google Play service.

3. Once set up, you can use the email (username) and password you provided during registration to login to MyHealth online portal or app. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places. We also offer a biometric login option for the app, for example Touch ID or Face ID, where supported by your device.

For more information, please visit www.allianzcare.com/en/myhealth.html

Web-based services

On http://www.allianzcare.com/members you can:

- search for medical providers (you are not restricted to using the providers listed in our directory).
- download forms.
- access our Health and Wellness Library.
- access our 'My expat life' hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas.

Second Medical Opinion**

As your health partner, we aim to provide reassurance. Have you been diagnosed with a serious illness or had surgery recommended? Do you want expert help on the best treatment options available and where to get the most appropriate treatment? As part of your cover you have access to our Second Medical Opinion service.

When you access this service, we assign to you a dedicated case manager, i.e. a healthcare professional from our own Medical Team to guide and assist you. Your case manager will ask you to provide all the necessary information about your medical case: then he/she will help you find a hospital, doctor or specialist for the Second Medical Opinion and provide the opinion to you.

To access our service, simply contact us:
+353 1 630 1301
medical.smo@e.allianz.com

...and ask for the Second Medical Opinion service. You will need to state your policy number for identification.

Member services included in your cover

Your policy doesn't just cover your medical expenses. It also includes a range of free member services. Check your Table of Benefits to confirm which ones are included in your cover.

Olive – our health and wellness programme

Designed to motivate and guide you towards a healthier life. It includes access to:

- **Health and Wellness Hub**, offering online health assessments, webinars on wellbeing delivered by specialists, articles on topics such as sleep and nutrition, etc.
- **Our fitness app**, connecting with smart phones, wearable devices and other apps to monitor the number of steps taken, calories burned, sleep schedule and more. You can also join challenges with other users, and/or set up wellness goals and plans for yourself.
- **Mind coaching app**, your chat bot buddy to discuss your feelings with. You can also chat with a human coach, if you want a more personal touch.

TeleHealth Hub — video consultation services

If your plan includes cover for video consultation services, you have direct access to online doctor appointments. With TeleHealth Hub, you can save time by seeing a doctor via video from the comfort of your home or office. Offering a secure and confidential service, our telehealth network of doctors can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns. Prescriptions will be available if your plan covers them and if the local regulation allows.

EAP — Expat Assistance Programme

When challenging situations arise in life or at work, our EAP provides you and your dependants with immediate confidential support. The service includes:

- **Confidential professional counselling** via phone, video or in person on topics such as stress, work/life balance, parenting, anxiety, cultural shock, addiction concerns, etc.
- **Legal and financial referral services**, for example to help buying a home, handling a legal dispute or creating a financial plan.

Travel Security Services

24/7 access to personal security information and advice for your travels, helpful as the world continues to witness an increase in security treats. You can access:

- **Emergency hotline**, to talk to a specialist for any safety concerns associated with your travel destination.
- **Country intelligence**, which offers information and advice about many countries.
- **Daily security news updates**, to receive email alerts about high-risk events in or near your location, including terrorism or severe weather risks.

To know more or to access the above member services, visit:
www.allianzcare.com/en/support/member-resources.html#care

**Certain services that may be included in your plan are provided by third party providers outside the Allianz Group, such as the Expat Assistance Programme, Travel Security services, fitness app, Second Medical Opinion and tele-medicine services. If included in your plan, these services will show in your Table of Benefits. These services are made available to you subject to your acceptance of the terms and conditions of your policy and the terms and conditions of the third parties. These services may be subject to geographical restrictions. The fitness app does not provide medical or health advice and the wellness resources contained within Olive are for informational purposes only. The fitness app and the wellness resources contained within Olive shouldn't be regarded as a substitute for professional advice (medical, physical or psychological). They are also not a substitute for the diagnosis, treatment, assessment or care that you may need from your own doctor. You understand and agree that the insurer, its reinsurer and administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.

Understanding how your cover works

What am I covered for?

You and your dependants are covered for medically necessary treatment and related costs, services and supplies arising from the occurrence or worsening of a medical condition, in accordance with your Table of Benefits. Within the scope of your policy, you are covered for medical treatment, costs, services or supplies that:

- we determine to be medically necessary, appropriate for the patient's condition, illness or injury.
- have a palliative, curative and/or diagnostic purpose.
- are performed by a licensed doctor, dentist or therapist.

Your cover is also subjected to:

- **Policy definitions and exclusions** (also available in this guide).
- **Any special conditions** shown on your Insurance Certificate (and on the Special Condition Form issued before the policy comes into effect, where relevant).
- Any **policy endorsements**, these policy terms and conditions and any other legal requirements.
- **Costs being reasonable and customary** – these are costs that are usual within the country of treatment. We will only reimburse medical providers where their charges are in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline or reduce the amount we pay.

We generally cover pre-existing conditions (including pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please check your Table of Benefits to confirm if pre-existing conditions are covered.

If you are uncertain whether your planned medical treatment is covered under your plan, please contact our Helpline.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate.

If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses.

If the eligible treatment is not available locally, and your cover includes 'Medical evacuation', we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Pre-authorisation Form before travelling.

You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

Your cover may be subject to a **maximum plan limit**. This is the maximum we will pay in total for all benefits included in the plan per member, per Insurance Year.

If your plan has a maximum plan limit, it will apply even where:

- the term 'Full refund' appears next to the benefit.
- a specific benefit limit applies – this is when the benefit is capped to a specific amount (e.g. US$ 4,050).

Benefit limits may be provided on a 'per Insurance Year' basis, on a 'per lifetime' basis or on a 'per event' basis (such as per trip, per visit or per pregnancy).

In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit (e.g. 80%).

Benefit limits related to maternity

The benefits **'Routine maternity'** and **'Complications of pregnancy and childbirth'** are paid on either a 'per pregnancy' or 'per Insurance Year' basis. Your Table of Benefits will confirm this.

Please note that under your plan, you are eligible for a lifetime minimum of 720 days of in-patient hospitalisation, up to the maximum plan limit.

If your maternity benefits are payable on a 'per pregnancy' basis

When a pregnancy spans two Insurance Years and the benefit limit changes at policy renewal, the following rules apply:

- In year one – the benefit limits apply to all eligible expenses.
- In year two – the updated benefit limits apply to all eligible expenses incurred in the second year, less the total benefit amount already reimbursed in year one.
- If the benefit limit decreases in year two and we have already paid up to or over this new amount for eligible costs incurred in year one, we will pay no additional benefit in year two.

Limit for multiple-birth babies, all babies born by surrogacy, adopted and fostered children

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy.
- is adopted.
- is fostered.
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is US$ 40,500 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

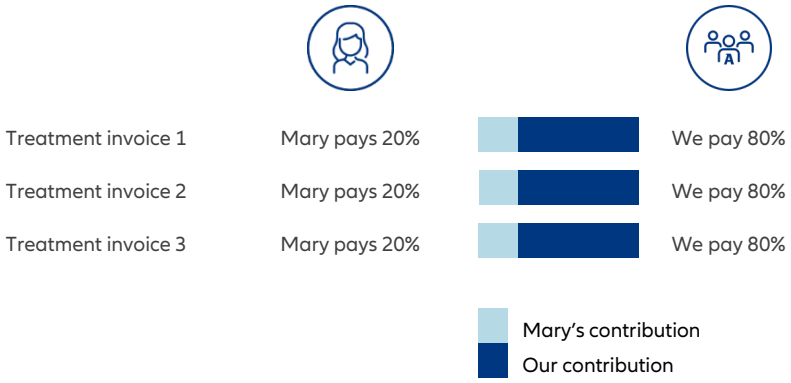
Your Membership Card

We issue a personal Membership Card to every insured member, which contains essential contact numbers. This means that you and your family are only a phone call away from help. For this reason, we suggest that you keep this card with your at all times.

The Membership Card aims to establish your identity and allows you to access the network of clinics, hospitals and pharmacies assigned to your healthcare plan. It is not transferrable and you must return it or destroy it when membership ends. The validity of the card is subject to continuity of membership.

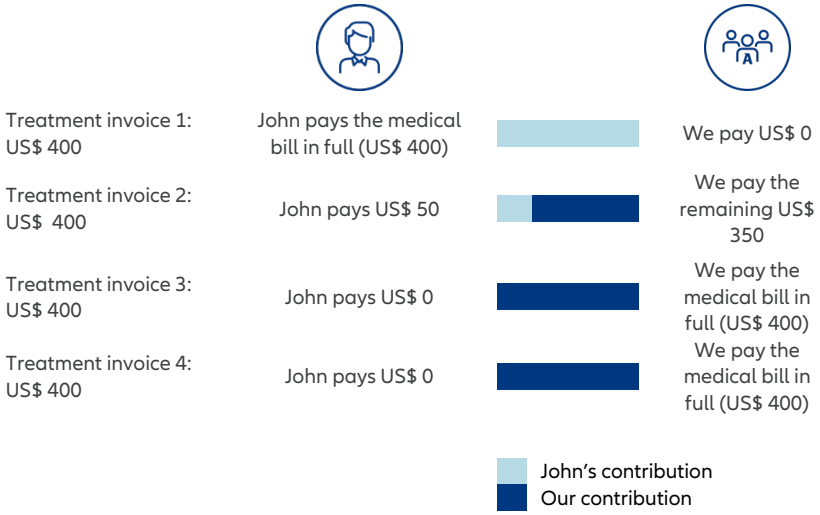
What are co-payments?

A co-payment is when you pay a percentage of the medical costs. Your Table of Benefits will show whether this applies to your plan. In the following example, Mary requires several dental treatments throughout the year. Her dental treatment benefit has a 20% co-payment, which means that we will pay 80% of the cost of each eligible treatment. The total amount payable by us may be subject to a maximum plan limit.



What are deductibles?

A deductible (also known in health insurance as an 'excess') is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. Your Table of Benefits will show whether this applies to your plan. In the following example, John needs to receive medical treatment throughout the year. His plan includes a US$ 450deductible.



Seeking treatment?

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – while you focus on getting better.

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm what is covered. However, you can always call our Helpline if you have any queries.

Some treatments require our pre-authorisation

Your Table of Benefits will show which treatments require our pre-authorisation (via a Pre-authorisation Form). These are mostly in-patient and high cost treatments. The pre-authorisation process helps us assess each case, organise everything with the hospital before your arrival and make direct payment of your hospital bill easier, where possible.

If you choose to be treated **within our provider network in Lebanon**, your medical provider will automatically deal directly with us for the pre-authorisation, where necessary. However, if you choose to be treated outside of the network or outside of Lebanon, you will need to ensure that you contact us for the necessary pre-authorisation.

Unless we agree otherwise, if you make a claim without obtaining our pre-authorisation, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.

- If the treatment is subsequently proven to be medically necessary, we will pay **80%** of in-patient benefits and **50%** of other benefits.

Treatment within your Lebanon provider network

You have access to a complete network of medical providers – this network is administered by Nextcare, our expert third-party administrator in the region. The type of network selected for you is indicated on your Membership Card and you can find the detailed list of medical providers included in your network by clicking on the link below:

www.nextcarehealth.com/healthcare-network/

When visiting a network medical provider, simply:

1. Present your Membership Card.

2. The provider will contact Nextcare directly to process the necessary paperwork.

3. Nextcare will settle the bill directly with your medical provider on behalf of the insurer (subject to the limit of your plan and to any deductible/co-payment that applies). If you are responsible for the payment of any or all of the costs yourself (for example in the case of a deductible, co-payment or breach of benefit limit), please settle this amount directly with the provider at the time of treatment.

Please note that some benefits may be available on a reimbursement basis only i.e. you will have to pay for eligible treatment and then complete and submit a Claim Form. This currently applies to the following benefits:

- Medical practitioner fees
- Specialist fees
- Complementary treatment, i.e. chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine, acupuncture and podiatry
- Speech therapy and occupational therapy
- Health and wellbeing checks
- Dietician fees
- All optical and dental benefits
- Medical aids

- Vaccinations
- Psychiatry and psychotherapy (only when provided on an out-patient basis)

For more details, see the 'Claiming for your out-patient and other expenses' section.

Treatment outside your Lebanon provider network

Getting in-patient treatment (pre-authorisation applies)

In Lebanon

1. Download a Pre-authorisation Form from our website: www.nextcarehealth.com

2. Send the completed form to us at least **five working days before treatment**, by:
    - Email to: Nc_Claims.lb@nextcarehealth.com.
    - Fax to: + 961 1 498323
    - Post to the address shown on the form.

We'll contact your medical provider directly to arrange settlement of your bills (where possible).

Outside Lebanon

1. Download a Pre-authorisation Form from our website: www.allianzcare.com/members
2. Send the completed form to us at least **five working days before treatment**, by:
    - Email to: medical.services@e.allianz.com
    - Post to the address shown on the form.

We'll contact your medical provider directly to arrange settlement of your bills (where possible).

If it's an emergency

Get the emergency treatment you need and call us if you need any advice or support. If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (within 48 hours of the emergency) to inform us of the hospitalisation. We can take Pre-authorisation Form details over the phone when you call us.

We can also take Pre-authorisation Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if pre-authorisation is not obtained, where required.

Claiming for your out-patient, dental and other expenses

If your treatment does not require our pre-authorisation, you can simply pay the bill and claim the expenses from us. In this case, follow these steps:

In Lebanon

1. Receive your treatment and pay the medical provider.
2. Get an invoice from your medical provider.
   This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.
3. Claim back your eligible costs via our Lumi app (www.nextcarehealth.com/mobileapp/).
   Simply enter a few key details, add your invoice(s) and press 'submit'.

Outside Lebanon

Receive your medical treatment and pay the medical provider.

Get an invoice from your medical provider. This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Claim back your eligible costs via our MyHealth app or online portal (www.allianzcare.com/en/myhealth.html).
Simply enter a few key details, add your invoice(s) and press 'submit'.

Quick claim processing

Once we have all the information required, we can process and pay a claim. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

We will email or write to you to let you know when the claim has been processed.

Evacuations and repatriations

At the first indication that you need medical evacuation or repatriation, please call our 24 hour Helpline and we will take care of it. Given the urgency, we would advise you to phone if possible. However, you can also contact us by email. If emailing, please write 'Urgent – Evacuation/Repatriation' in the subject line.

Please contact us before talking to any providers, even if they approach you directly, to avoid excessive charges or unnecessary delays in the evacuation. In the event that evacuation/repatriation services are not organised by us, we reserve the right to decline the costs.

+353 1 630 1301
medical.services@e.allianz.com

Seeking treatment in the USA

If you have worldwide cover, we offer you simple access to medical care in the USA, through our local third-party partner, supporting your access to medical providers in the country.

To access treatment in the USA, simply show your membership card: your medical provider will then contact our third-party partner to sort any paperwork related to your treatment. We will pay the cost of your eligible treatment directly to your medical provider, if applicable; if you are responsible for any part of the costs, your provider will let you know.

For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

Additional information about claiming for your expenses

Medical claims
Before submitting a claim to us, please pay attention to the following points:

- **Claiming deadline:** You must submit all claims (via app or online portal) no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.

- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.

- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:

  - collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
  - send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

  Attach all supporting receipts and/or invoices with your claim.

- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one

currency to another, we will use the exchange rate that applied on the date the invoices were issued.

- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-authorisation requirements, deductibles or co-payments outlined in the Table of Benefits.

- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.

- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.

- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Treatment needed as a result of someone else's fault
If you are claiming for treatment that you need when somebody else is at fault, you must write and tell us as soon as possible. For example, if you need treatment following a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault. We can then recover from the other insurer the cost of the treatment paid for by us. If you are able to recover directly the cost of any treatment that we have paid for, you will need to repay that amount (and any interest) to us.

Terms and conditions of your cover

Terms and conditions

This section describes the benefits and rules of your health insurance policy. Please read it together with your Insurance Certificate and Table of Benefits.

Your health insurance policy is an annual contract between us and the insured person(s) named on the Insurance Certificate. The contract is made up of:

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your health insurance policy. It should be read together with your Insurance Certificate and Table of Benefits.

- The **Insurance Certificate**. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added), and the geographical area of cover. If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions Form which we send you before you're placed on cover. We'll send you an updated Insurance Certificate if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.

- The **Table of Benefits**. This shows the plan(s) selected, the benefits available to you, and states which benefits/treatments require submission of a Pre-authorisation Form. It also confirms any benefits where specific benefit limits, waiting periods, deductibles and/or co-payments apply.

- Information provided to us by (or on behalf of) the insured person(s) in the signed Application Form, Confirmation of Health Status Form or

others (we'll refer to all of these collectively as the 'relevant application form') or other supporting medical information.

Administration of your policy

When cover starts

When you receive your Insurance Certificate, this is our confirmation that you've been accepted onto the policy. It will confirm the start date of your cover. Please note that no benefit will be payable under your policy until the initial premium has been paid, with subsequent premiums being paid when due.

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you are the policyholder and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 25th birthday if they are in full-time education. At that time, they may apply for cover in their own right under one of our Healthcare Plans for Individuals and Families.

Adding dependants

Are you getting married or having a baby? Congratulations!

You may apply to include any member of your family as a dependant by completing the relevant application form.

How do I add a newborn to my policy?
Please send an email to awc@sna.com.lb within four weeks from birth and attach the birth certificate. With the exception of multiple birth babies, we will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of eight continuous months. Cover will start at birth.

However, if the baby is less than four weeks old when you contact us, but we have not covered either of their parents for a continuous period of at least

eight months then we will (based on a completed application form for the dependant):

- either cover the baby from the date on which you accept any terms we offer, or
- decline to add the baby to your plan. If we decline to add the baby, we'll explain the reason for this in writing.

What happens if I don't notify you within four weeks?
The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

What if I am adding multiple birth babies, babies born by surrogacy, adopted and fostered children?
Multiple birth babies will be underwritten and if accepted, cover will start from the date of acceptance.
There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy.
- is adopted.
- is fostered.
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is US$ 40,500 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder (if not already insured under Allianz) will need to complete an application form and full medical underwriting will apply. Please refer to the section on 'Death of the policyholder or a dependant' if the requested change is due to the death of the policyholder.

Death of the policyholder or a dependant

We hope you will never need to refer to this section; however, if a policyholder or a dependant dies, please inform us in writing within 28 days.

If the policyholder dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed. We may request a death certificate before a refund is issued. Alternatively, if they wish to, the next named dependant on the Insurance Certificate can apply to become the policyholder and keep the other dependants on their policy. If they apply to do this within 28 days, we will not add any further special restrictions or exclusions that didn't already apply at the time of the policyholder's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that person will be made, if no claims have been filed. We may request a death certificate before a refund is issued.

Changing your level of cover

If you want to change your level of cover, please get in touch with us before your policy renewal date to discuss your options. Changes to cover can only be made at policy renewal. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire and/or to agree to certain exclusions or restrictions to any additional cover before we accept your application. If an increase in cover is accepted, an additional premium amount will be payable and waiting periods may apply.

Changing country of residence

Cover is offered to individuals residing in Lebanon who travel abroad or to Lebanese individuals residing abroad.

Also, in general, it is important to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there.

Contact us to check if your cover is valid in the country you are moving to: individual.admin@e.allianz.com

Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewing your cover

Subject to 'Reasons your membership would end', your policy will automatically renew at the end of every Insurance Year, if:

- the plan or plan combination selected is still available. If it is not available anymore, we will offer you the most suitable SNA plan.
- we can still provide cover in your country of residence.
- all premiums due to us have been paid.
- the payment details we have for you are still valid on the policy renewal date. Please update us if your bank account details have changed.

As part of this automatic process, one month before the renewal date, you will receive a new Insurance Certificate along with details of any policy changes. If you don't receive your Insurance Certificate one month before your renewal date, please notify us.

In accordance with ministerial decree number 186 issued by the Ministry of Economy and Trade, this policy is subject to an Observation Period of six months commencing on the effective date of enrolment (i.e. the start date shown on your first insurance certificate). During this observation period we reserve the right to re-underwrite the policy and amend any condition including the table of benefits (including any limits), exclusions and/or the class of risk.

Changes that we may apply at renewal

At any renewal date, the company reserves the right to amend the whole or part of the contract thereof (e.g. General Conditions, plans, benefits, premiums of the plan selected by the contract owner and covered under this contract), provided such amendments, apply on equal terms to all its Insured pertaining to the same class of risk.

It is agreed and understood that any sub-standard terms applied at the initial underwriting process prior to the enrolment date, when applicable, shall be enforced at each renewal date.

These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover. Please note that any sub-standard terms, restrictions or exclusions or special terms agreed for your policy when you joined will continue to apply at each renewal.

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Conversion Option: Is the option given to any member who has been insured for at least one year in the policy to convert his policy from Allianz worldwide plan to any other SNA local individual plan. The conversion option is only valid for one month from the offer date presented to the client.

The conversion to a local individual plan will be as per the terms and conditions offered by the Company at the time of conversion, if available and with same exclusions and class of risk applied to the member at the initial underwriting process prior to the enrolment date and/or at any re-underwriting process during the observation period.

In case of conversion, the dependent members will also jointly follow the principal member.

Guaranteed renewal: As per decree number 186, we will renew your policy automatically for the following insurance year if you have paid all premiums due.

Provider network in Lebanon: The comprehensive provider network, approved by us, includes at least one of the five university hospitals listed under article 5 of the ministerial decision number 186.

Your right to cancel

You can cancel the contract in relation to all insured persons, or only in relation to one or more dependants, within 30 days of receiving the full terms and conditions of your policy or from the start/renewal date of your policy, whichever is later. Please note that you cannot backdate the cancellation of your membership.

If you wish to cancel, please complete the 'Right to change your mind' form which was included in your welcome/renewal pack. You can send us this form via email: awc@sna.com.lb.

Alternatively, you can post this form to the Client Services Team, using the address provided at the back of this guide.

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s) premiums paid for the new Insurance Year, provided that no claims have been made. If you choose not to cancel (or amend) your policy within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment, according to the payment frequency that you selected.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Insurance Certificate) will end:

- if you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.
- if you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- upon the death of the policyholder. Please see the section on 'Death of the policyholder or a dependant' for further details.
- if there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information – either intentionally or carelessly – which may influence us when deciding:
  - whether we accept the application for cover.
  - the applicable premium to pay.
  - whether we have to pay a claim.

  Please see the section on 'The following terms also apply to your cover' for further details.

- if you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on 'Your right to cancel' for further details.

If your membership ends for reasons other than for fraud/non-disclosure, we will refund any premiums you have paid which relate to a period after your membership has ended, subject to the deduction of any money which you owe us.

Please note that if your membership ceases, your dependants' cover under this policy will also end. However, your dependants (spouse and children)

can apply for continuation of their cover under a new policy without medical underwriting and without interruption of the period of cover.

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. For up to six months after the expiry date, we will reimburse any eligible expenses incurred during the period of cover. If your policy is not renewed and your cover ends while you are undergoing in-patient treatment, we will cover you up to a maximum and uninterrupted period of 20 additional days. In this additional period we will cover your in-patient treatment only.

Paying premiums

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You need to pay us in advance for the duration of your cover. You need to pay the initial premium or first premium instalment immediately after we accept your application. Subsequent premiums are due on the first day of the chosen payment period. You may choose between quarterly, half-yearly or annual payments depending on the payment method you choose. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties.

You should pay your premium in US$. If you are unable to pay your premium for any reason, please contact us on: **+961 5 422000.**

Failure to pay the premium on time may result in loss of insurance cover. We will have no liability to pay claims for any Insurance Year for which the full premium has not been received.

If the premium due is not paid, we shall suspend your cover 10 days after we have provided you with written notice by registered letter. Your policy shall then be deemed cancelled if the premium due has not been paid, twenty days after expiry of the ten day notice period.

However, if the outstanding premium (i.e. all premium payments or instalments subject to the formal notice issued by registered letter, together with any premium instalments falling due during the suspension period as well as any costs of recovery) is received by us prior to cancellation taking effect, cover shall resume from midday on the day after we receive the full outstanding amount.

After cancellation we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days of the date of cancellation.

Paying other charges

If applicable, you may also need to pay the following taxes in addition to your premium:

- Insurance Premium Tax (IPT)
- VAT
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these. If they change or if new taxes are introduced, we will write to inform you.

In some countries you may also be required to apply withholding tax. If that is the case, it is your responsibility to calculate and pay this amount to the relevant authorities in addition to payment of your full premium to us.

The following terms also apply to your cover

Applicable law:
Your membership is governed by the laws of Lebanon unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in Lebanon.

Sanctions suspension clause:
Any benefits, cover and claims payments are suspended if any element of the cover, benefit, activity, business, or underlying business exposes us to:

- any applicable sanction, prohibition or restriction under the United Nations' resolutions, or
- the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or United States of America.

The above suspension will continue until such time as we are no longer exposed to any such sanction, prohibition, or restriction.

The amounts we will pay:
Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

Who can make changes to your policy:
No one, except an appointed representative is allowed to make changes to your policy on your behalf. Changes are only valid when confirmed in writing by us.

Circumstances outside of our control (force majeure):
We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things that are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

Fraud:

a) The information you and your dependants give us, e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the Application Form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that.

b) If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

c) We will not pay any benefits for a claim if:
   - The claim is false, fraudulent or intentionally exaggerated.
   - You or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

Cancellation:

We will cancel the policy where you have not paid the full premium due and owing. We will notify you of this cancellation and the contract will be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

Making contact with dependants:
In order to administer your policy, we may need to request further information. If we need to ask about one of your dependants (e.g. when we need to collect an email address for an adult dependant), we may contact you as the person acting on behalf of the dependant, and ask you for the relevant information, provided it is not sensitive information. Similarly, for the purposes of administering claims, we may send you non-sensitive information that relates to a family member.

Data protection

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit:
www.allianzcare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy:
+ 961 5 422000 (when calling from inside Lebanon), and
+ 353 1 630 1301 (when calling from outside Lebanon)

If you have any queries about how we use your personal data, please email us at: AP.EU1DataPrivacyOfficer@allianz.com

Complaints and dispute resolution procedure

SNA is totally committed to provide you with the best service and to listen to your opinion and concerns. Therefore, we appreciate your feedback on our products and services, as it gives us the opportunity to improve and consequently increase your satisfaction.

If you have any comments or complaints, please call us on:

Telephone:	**+961 5 422000**
Email:	awc@sna.com.lb
Address:	PO BOX 16-6528 Beirut, Lebanon; SNA s.a.l.; SNA s.a.l. Building; Hazmieh, Lebanon
Fax:	+961 5 956 624

Legal action
You will not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.

Definitions

The following definitions apply to our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not defined below, the definition will appear in the 'Notes' section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

Accident

Sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accommodation costs for one parent staying in hospital with an insured child

Hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute

Sudden onset of symptoms or a medical condition.

Chronic condition

Sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

- Is recurrent in nature.
- Is without a known, generally recognised cure.
- Is not generally deemed to respond well to treatment.
- Requires palliative treatment.
- Leads to permanent disability.

Please refer to the 'Notes' section of your Table of Benefits to confirm whether chronic conditions are covered.

Complementary treatment
Therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practised by approved therapists.

Complications of childbirth
Post-partum haemorrhage and retained placental membrane only. Where your plan also includes the benefits 'Routine maternity' or 'Routine delivery and newborn care', 'Complications of childbirth' includes medically necessary caesarean sections.

Complications of pregnancy
It relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Co-payment
The percentage of the costs which you must pay. E.g. if a benefit has an 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per Insurance Year.

CPME/CTT previously FMU
The continuation of your full medical underwriting terms that you had with a previous insurer. Cover will still be governed by the benefits, terms and conditions of the plan with us.

Day-care treatment
Planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible
Also referred to as 'excess' in health insurance. It is the part of the cost that is payable by you and that we deduct from the amount we will pay.

Where deductibles apply, they are payable per person per Insurance Year (or per visit, for the out-patient treatments only), unless your Table of Benefits states otherwise.

Dental prescription drugs
Drugs prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental prostheses
Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery
Surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.

Dental treatment
An annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dependant
Your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 25th birthday if they are in full-time education.

Diagnostic tests
Investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

Dietician fees
Charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practise in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

Digital health app
It provides a contribution towards one digital health app of your choice per Insurance Year. The app should assist with the prevention, detection or management of a disease or condition such as back pain, diabetes or mental health issues. Cover is provided when the insured member is the subscriber to the app, covered under a valid policy at the time of purchase. When submitting a claim, please attach a dated receipt.

Direct family history
It exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

Doctor
A person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Emergency
The onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment
Acute emergency dental treatment for the relief of pain that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency event. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency out-patient dental treatment
Treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on 'Emergency out-patient dental treatment' benefit. In that case, the Dental Plan terms will apply.

Emergency out-patient treatment
Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an Out-patient Plan, it will cover you for out-patient treatment in excess of the limit on 'Emergency out-patient treatment' benefit. In that case, the Out-patient Plan terms will apply.

Emergency treatment outside area of cover
Treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You must tell us if you are going to be outside your area of cover for more than six weeks.

Epidemic/pandemic diseases
In-patient treatment in an event of epidemic or pandemic disease. An epidemic/pandemic is a general and widespread sudden outbreak of an acute infectious disease caused by a virus, bacteria, parasites, etc. that affects simultaneously numerous individuals and that is officially

declared as epidemic/pandemic disease by competent authorities such as the Ministry of Health (MoH) and/or the World Health Organization (WHO).

Expenses for one person accompanying an evacuated/repatriated person
Travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

Family history
It exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

Full medical underwriting
The assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

General advice
Any medical opinion or medical recommendation from a relevant accredited professional body in relation to a medical condition or treatment that confirms, in our reasonable opinion, an established medical practice or opinion.

Health and wellbeing checks including screening for the early detection of illness or disease
Health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present.

Home country
A country for which you hold a current passport or which is your principal country of residence.

Hospital
Any establishment that is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation
Standard private or semi-private accommodation as shown in the Table of Benefits – deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are: 'Psychiatry and psychotherapy', 'Organ transplant', 'Oncology', 'Routine maternity', 'Palliative care' and 'Long-term care'.

Infertility treatment
All invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilisation (IVF), for diagnosed cases of infertility. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

All non-invasive investigative procedures undertaken to establish the cause of infertility are covered within the relevant benefit limits of the Out-patient Plan (if you have one). Examples of benefits that cover non-invasive investigations procedures are 'Diagnostic tests', 'Medical practitioner fees' and 'Specialist fees'.

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to US$40,500 per child for the first three months following birth. Out-patient treatment is paid under the terms of the Out-patient Plan.

In-patient cash benefit
It is payable when you receive in-patient treatment for a medical condition that is covered by us but is free of charge for you, i.e. when the full cost of your treatment is funded by your national health service and no claim is made or paid by us under any section of this policy. In-patient cash benefit is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

In-patient treatment
Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate
A document we issue that outlines the details of your cover. It confirms that an insurance relationship exists between you and us.

Insurance Year
It applies from the effective date of your policy, as shown on the Insurance Certificate and ends exactly one year later.

Insured person
You and your dependants as stated on your Insurance Certificate.

Laser eye treatment
The surgical improvement of the refractive quality of the cornea using laser technology, including the necessary pre-operative investigations.

Local ambulance
Ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Long-term care
Care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

Medical advice
Any medical opinion, medical recommendation or information given by a medical professional.

Medical evacuation
It applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally
- If adequately screened blood is unavailable in an emergency

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Medical necessity

Medical treatment, services or supplies that fulfil all of the following:

- Essential to identify or treat your condition, illness or injury.
- Consistent with your symptoms, diagnosis or treatment of the underlying condition.
- In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover).
- Required for reasons other than the comfort or convenience of you or your doctor.
- Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover).
- Considered to be the most appropriate type and level of service or supply.
- Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition.
- Provided only for an appropriate duration of time.

In this definition, the term 'appropriate' means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, 'medically necessary' also means that diagnosis can't be made or treatment can't be safely and effectively provided on an out-patient basis.

Medical practitioner fees

Fees charged for non-surgical treatment performed or administered by a medical practitioner.

Medical practitioners

Doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical repatriation

An optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

You must contact us at the first indication that repatriation is required. From this point onwards we will organise and coordinate all stages of the repatriation until you arrive safely at your destination of care. If the repatriation is not organised by us, we reserve the right to decline all costs incurred.

Midwife fees
Fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

Newborn care
Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant).

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to US$40,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Non-prescribed physiotherapy
Treatment provided by a registered physiotherapist without being referred by a doctor in advance. Cover is limited to the number of sessions indicated in your Table of Benefits. A doctor must prescribe any additional sessions over this limit, which will be covered under the Prescribed physiotherapy benefit. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta.

Nursing at home or in a convalescent home
Nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long-term care.

Obesity
It is diagnosed when a person has a body mass index (BMI) of over 30.

Occupational therapy
Treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).

- Coordination, balance and other skills such as dressing, eating and grooming.

We will need to see a progress report after every 20 sessions.

Oculomotor therapy

A specific type of occupational therapy that aims to synchronise eye movement when there is a lack of coordination between eye muscles.

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Oral and maxillofacial surgical procedures

Surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth
- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

Organ transplant

The following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics

The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria are very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

- Increased overjet > 6mm but <= 9 mm
- Reverse overjet > 3.5 mm with no masticatory or speech difficulties
- Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
- Severe displacements of teeth > 4

- Extreme lateral or anterior open bites > 4 mm
- Increased and complete overbite with gingival or palatal trauma
- Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
- Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
- Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
- Partially erupted teeth, tipped and impacted against adjacent teeth
- Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the 'Orthodontic treatment' benefit limit.

Orthomolecular treatment
Alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery
Surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment
Treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

Palliative care
Ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Partner
A person you have lived with in a conjugal relationship for a continuous period of 12 months.

Periodontics
Dental treatment related to gum disease.

Podiatry
Medically necessary treatment carried out by a State Registered podiatrist.

Post-hospitalisation treatment
Out-patient treatment required in the 90 days following discharge from an in-patient or day-care treatment for the same acute medical condition. This benefit covers medical practitioners' fees, specialists' fees, out-patient surgery, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other diagnostic tests and procedures.

Post-natal care
Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions
Medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it.

Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- the date we issued your Insurance Certificate, or
- the start date of your policy.

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the 'Notes' section of your Table of Benefits to confirm if pre-existing conditions are covered.

Pregnancy
The period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care
Common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Pre-hospitalisation tests
Out-patient pre-hospitalisation tests carried out in the 72 hours before in-patient or day-care treatment covered under your plan.

Prescribed drugs
Over the counter drugs when prescribed by a doctor to:

- Treat a confirmed diagnosis or medical condition
- Compensate a lack of vital bodily substances

Examples are aspirins, vitamins and hypodermic needles. Prescribed drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered.

Prescribed glasses and contact lenses including eye examination
Cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses and glasses to correct vision.

Prescribed medical aids
Any device that is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses
- Hearing and speaking aids such as an electronic larynx
- Medically graduated compression stockings
- Long-term wound aids such as dressings and stoma supplies

We do not cover costs for medical aids that form part of palliative care or long-term care.

Prescribed physiotherapy
Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription drugs
Products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines. You can claim for a supply of up to a 3 months from the prescription date, subject to length of time remaining on the policy.

Preventive surgery
Prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventive surgery when:

- you have a direct family history of a disease that is part of a hereditary cancer syndrome (for example, breast cancer or ovarian cancer), and
- genetic testing has established the presence of a hereditary cancer syndrome.

Preventive treatment
Treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the 'Preventive treatment' benefit is listed in your Table of Benefits.

Principal country of residence
The country where you and your dependants (if applicable) live for more than six months of the year.

Psychiatry and psychotherapy
Treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited to 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review

the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Counselling is available through our Expat Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness. For more information see the 'Expat Assistance Programme (EAP)' section of this guide.

Reasonable and customary
Treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Rehabilitation
Treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

Repatriation of mortal remains
The transportation of the insured deceased remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine maternity
Medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine maternity' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

Specialist
A licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees
Non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

Speech therapy
Treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Surgical appliances and materials
Those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

Therapist
A chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs of insured family members in the event of an evacuation/repatriation
The reasonable transportation costs of all insured family members of the evacuated or repatriated person, including minors who might otherwise be left unattended. If all family members can’t travel in the same vehicle with the evacuated/repatriated person, we will pay for their round-trip transport at economy rates.

The 'Travel costs of insured family members in the event of a repatriation' benefit is covered if you have a repatriation plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains
The reasonable transportation costs of any insured family members who had been living abroad with the insured person who died, to travel to the country of burial of the deceased. Reasonable transportation costs are considered to be round trip transport costs at economy rates. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured members to be with a family member who is at peril of death or who has died

The reasonable transportation costs of insured family members to be with a first-degree relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). In the case of a deceased relative, travel must commence within 6 weeks of their date of death. Reasonable transportation costs are considered to be round trip transport costs at economy rates. A first-degree relative is a spouse or partner, parent, brother, sister or child, including adopted children, fostered children or step-children. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment

Medical procedure needed to cure or relieve illness or injury.

Vaccinations

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Vaccination against COVID-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

*We cover any COVID-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) that demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the COVID-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

Video consultation services

They provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local

country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

Waiting period

A period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods. Waiting periods do not apply to you if you have a non-underwritten policy.

We/Our/Us

SNA (when related to the provision of insurance cover), **Nextcare** (in relation to the administration of the insurance cover inside Lebanon) and **Allianz** (in relation to the administration of the insurance cover outside Lebanon.

You/Your

The policyholder and any dependants named on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

ACQUISITION OF AN ORGAN
Expenses for the acquisition of an organ such as, but not limited to donor search, typing, harvesting, transport and administration costs.

CHEMICAL CONTAMINATION AND RADIOACTIVITY
Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

COMPLEMENTARY TREATMENT
Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER
Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

DENTAL VENEERS
Dental veneers and related procedures.

DEVELOPMENTAL DELAY
Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified

medical professionals and documented as a delay in development of at least 12 months.

DRUG ADDICTION OR ALCOHOLISM
Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY
Any form of treatment or drug therapy that in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE
Treatment required as a result of failure to seek or follow medical advice.

FAMILY THERAPY AND COUNSELLING
Costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

FEES FOR THE COMPLETION OF A CLAIM FORM
Doctor's fees for the completion of a Claim Form or other administration charges.

GENETIC TESTING
Genetic testing, except:

- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- where testing for genetic receptor of tumours is covered.

HOME VISITS
Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

INFERTILITY TREATMENT
Infertility treatment including medically assisted reproduction or any treatment for any medical problems arising from it, unless you have a specific benefit for

infertility treatment or have an Out-patient Plan. If you have an Out-patient plan we will only cover non-invasive investigations into the cause of infertility (within the limits of your Out-patient Plan). These exceptions do not apply to members of the Channel Islands Plan, for whom investigation into infertility is excluded.

INJURIES CAUSED BY PROFESSIONAL SPORTS

- Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR

Treatment required as a result of medical error.

OBESITY TREATMENT

Investigations into and treatment for obesity.

ORTHOMOLECULAR TREATMENT

Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

PLASTIC SURGERY
Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

PRE- AND POST-NATAL
Pre- and post-natal classes.

PRE-EXISTING CONDITIONS (APPLICABLE TO POLICIES WITH FULL MEDICAL UNDERWRITING OR CPME/CTT PREVIOUSLY FMU)
Pre-existing conditions (including pre-existing chronic conditions) when:

- indicated on a Special Conditions Form that we issue before your policy starts.
- conditions were not disclosed on the application form.
- conditions arise between completing the application form and the later of the following:
  - the date we issue your Insurance Certificate, or
  - the start date of your policy.

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

PRODUCTS SOLD WITHOUT PRESCRIPTIONS
Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

SEX CHANGE
Sex change operations and related treatments.

SLEEP DISORDERS
Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

SPEECH THERAPY
Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

STAYS IN A CURE CENTRE
Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION
Investigations into, treatment of and complications arising from:

- **Sterilisation**
- **Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery)**
- **Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.**

SURROGACY
Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

TERMINATION OF PREGNANCY
Termination of pregnancy, except where the life of the pregnant woman is in danger.

TRAVEL COSTS
Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

TREATMENT IN THE USA IN THE FOLLOWING CASES
Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- **before being insured with us.**

- before having the USA in your region of cover.

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER
Treatment outside the geographical area of cover unless for emergencies or authorised by us.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS
Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

TUMOUR MARKER TESTING
Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the 'Oncology' benefit.

VESSEL AT SEA
Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

VITAMINS OR MINERALS
Products classified as:

- vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes).
- supplements such as, infant formula and cosmetic products.

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS
The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Complications of pregnancy.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Home delivery.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Laser eye treatment.
- Medical repatriation.
- Organ transplant.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity, Routine delivery and newborn care and Complications of childbirth.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:

Nextcare (for information and assistance with treatments inside Lebanon):

Telephone: **+961 1 504000**
Email: Nc_Claims.lb@nextcarehealth.com
Fax: **+961 1 498323**
Address: Nextcare Lebanon S.A.L. Essor Building, Father Naamtallah Kahale Street, PO Box 55-630, Sin el Fil, Lebanon. Nextcare Lebanon S.A.L is a limited company incorporated in Lebanon. Commercial Registration Number: 76719 Beirut.

Allianz (for information and assistance with treatments outside Lebanon, evacuations and repatriations):

24/7 Helpline: **+353 1 630 1301**
Email: client.services@e.allianz.com
Address: Allianz, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes. Please note that only the policyholder (or an appointed representative) can make changes to the policy. Security questions will be asked of all callers to verify their identity.

The insurer of this policy is SNA s.a.l., registered in Lebanon in the Insurance Companies Register under No. 104, dated 23.3.1963 (as per decree No. 177/1 and subject to Legislative decree No. 9812 dated 4.5.1968 MOF 4698). Address: SNA Building Hazmieh, P.O. Box 16-6528, Beirut, Lebanon.

The policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. The Irish Branch is registered in the Irish Companies Registration Office with No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA acts as the reinsurer and provides administration services and technical support for the policy.