FLAME

MUTUAL HEALTH PLAN

DEFINITIONS

1. SOCIO-MEDICAL MUTUAL FUND

The Socio Medical Mutual Fund (French appellation: **C**aisse **M**utuelle **S**ocio-**M**édicale) (Denoted as **CMSM**) recognized by the General Directorate of the Mutual Funds under N°. 20/AT dated on 30/10/1992, and registered as such under N°. 23/1, to practice its activities on the Lebanese territory, aims to support and serve its adherents, through mutuality, solidarity and sharing in the medical care and hospitalization expenses as defined in this Mutual Health Plan.

2. ADMINISTRATOR

Administrator s.a.l. (Denoted as **Administrator)** is a company acting persistently in the name and on behalf of the **CMSM** to administering, partly, this Mutual Health Plan, monitoring and supporting its appropriate implementation. The Administrator administers the Adherents medical files using regional offices and professionals (e.g. physicians, nurses and delegates).

In Particular, the Administrator continuously verifies the Adherents healthcare services eligibility required, and makes the adequate recommendation for approval or rejection of a coverage requested. To that effect, the Administrator manages the Adherent's medical claim and financial file, and, if needed, coordinates with the pertinent attending physicians.

3. ADHERENT

A person who applies for membership to the CMSM, acting in his/her own capacity, and/or in the name and on behalf of the beneficiaries and/or legal dependents whose membership application is legally endorsed by **CMSM**.

4. ADHERENT/BENEFICIARY

The adherent's family member(s) and/or any other person listed in the membership form or added subsequently whose application is legally endorsed by CMSM.

5. DEPENDENTS

The dependents of the principal Adherent: (Spouse, unmarried children aged between 14 days and 18 years or 25 years if still full time university students) whose application is legally endorsed by CMSM.

6. ACCESS CARD

A personalized Card issued in the name of each Adherent, enabling his/her access to the healthcare services offered by the CMSM Mutual Health Plan. This card remains the property of CMSM. If the card is stolen or lost, the Adherent has the obligation to notify CMSM. Until such notice is received, the Adherent/Beneficiary is accountable for all illegal transactions.

7. MUTUAL HEALTH PLAN

The set of healthcare coverages and benefits provided in the Mutual Health Plan (FLAME), along with their limitations and exclusions specifically identified as approved for coverage, for each Adherent/Beneficiary, in the document attached to the Membership Schedule and forming an integral part thereof and referred to as the **Membership Schedule**.

8. ENROLLMENT DATE

At 00:00 hours of the day, month and year appearing on the Membership Schedule, on which the Adherent has been, for the first time, enrolled with the CMSM under this Membership.

9. RENEWAL EFFECTIVE DATE

At 00:00 hours of the day, month, and year appearing in the Membership Schedule, at which CMSM is deemed to have formally accepted in writing to renew this Membership (as such term is defined in article (1) here below) having been in force and effect without interruption, following the due signature, by the **Adherent** (as such term is defined in article (1) here below), documents and the payment of the due premium on time.

10. GUARANTEED RENEWABILITY EFFECTIVE DATE

At 00:00 hours of the day, month and year appearing in the Membership Schedule, at which the CMSM is deemed to have formally accepted the application in writing, and officially granted in writing the Guaranteed Renewability, as per the provisions of Article 7 herein. Such effective date applies per Adherent/Beneficiary individually and not necessarily for the whole Mutual Health Plan or for all other Adherents/Beneficiaries.

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

A special form, available at request from the Administrator must be completed by the attending physician of the Adherent/Beneficiary and submitted to the Administrator prior to hospitalization. It is a mandatory prerequisite to benefiting from the In-Hospital coverage.

12. AMBULATORY/PRESCRIPTION MEDICINE TRANSACTION

A virtual electronic form, processed through the personalized Access Card of the Adherent/Beneficiary, allowing him/her to benefit, when applicable, from the **Ambulatory Benefit Plan** and/or the **Prescription Medicine Benefit Plan**. The financial limitation(s), excess deductible, number of transactions, Fees Installments, or any other specific limitations, if any, are shown in the Membership Schedule. In order to benefit from this cover, the Adherent must complete the prescribed transaction within a delay of fifteen (15) days as from the date of prescription by the attending physician.

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

13. HEALTHCARE PROVIDERS

The providers of specific healthcare services (including notably and for illustrative purposes hospitals, medical centers, integrated clinics, pharmacies, laboratories, physiotherapy centers…), located throughout Lebanon and Syria, adopted by the Administrator as participating in its network of providers to cover the whole or part of the available healthcare services.

A list of the Administrator's **Providers Network** is available with the CMSM and handed to every Adherent. These Healthcare Providers or parts of their services or sections may be modified during the Membership Period (added or reduced) without the need to the prior notification of the Adherent or his approval.

The list of providers that shall be in force and effect shall be the list that is held by the CMSM or the Administrator at a given date.

GENERAL TERMS AND CONDITIONS

Article 1: MUTUAL HEALTH PLAN MEMBERSHIP

a. The **Membership Form** and **Medical Questionnaire(s)**, of the Adherent/Beneficiary, the Preamble, the Membership Schedule, (including but not limited to the accepted census list, and the special Limitations and/or Exclusions, if any), the Definitions, the General Terms and Conditions, the various Applicable Healthcare Plans including their relative Scope of Healthcare Benefits covered along with their Limitations and Exclusions, as well as any attachment(s) and endorsement(s) to any of the aforementioned, shall constitute the entire agreement of the parties hereto (herein referred to as the **"Mutual Health Plan"**.

b. Any amendment or addition to the Mutual Health Plan shall be void, unless it is in writing, signed and sealed by CMSM. No person including a CMSM **Delegate** has the authority to amend this Plan or waive any of its provisions.

c. If special Exclusions and/or Limitations are applied by CMSM, the Principal Adherent is deemed to have approved them, in his name as well as in the name and on behalf of his/her legal dependent(s) listed in the Membership Application, by receiving the Mutual Health Plan documents and/or Access Cards relating thereto.

Article 2: COTISATIONS (Premiums)

a. Premiums are annual, payable by the Adherent per the Terms and Conditions specified in the Membership Schedule. They include Net Premiums and other charges. CMSM shall not be held liable of any over charged amount that does not figure on the Membership Schedule. This is to prevent any recourse against the CMSM when a Delegate, illegally over charges the premium to the Adherent.
b. The payment of the premium in whole or in part (Down Payment) at the time of first application or renewal application does not bind CMSM and does not constitute acceptance of the submitted membership. The CMSM's acceptance can only take effect by the formal issuing of the signed and stamped Membership Schedule or Renewal Report, and Access Card.
c. A Down Payment of **25%** of the total amount of the premium calculated is paid at the first/renewed Membership Application. The rest of the total premium amount is installed on (**1-9**) payments paid by the Adherent in one of the banks adopted by CMSM.
d. If the Adherent fails to effect the payment of two consecutive due installments as indicated in the Membership Schedule, then the CMSM shall have the right to cancel the Membership from its inception or from its renewal date, as applicable, without any premium refund. In all cases, and until the payment is effected, the CMSM may freeze all benefits under the Membership Mutual Health Plan and therefore may deny coverage of the Adherent/Beneficiary healthcare benefits.

Article 3: CONTRACTUAL PERIOD AND RENEWABILITY

a. The contractual period of this Membership is identified in the Membership Schedule, starting as from the effective date till the expiry date. No termination notice is required and no grace period allowed for.
b. Although the Renewal notices are delivered at least one month in advance, there is no obligation on the CMSM to issue any renewal notice. Also terms of the renewal conditions may ultimately change between the date the Renewal notice was issued and the effective date of the renewal. Contractually, there is no binding in the renewal notice however; there is a

Mutual/ethical consideration to be taken. Any renewal that is filed after expiry date may be conditional to "subject to no claim", additional observation, probation period, and other constraining clauses that the CMSM may find suitable to apply.

c. In the instance where the first/renewed Membership Application is rejected by CMSM, the full amount of the down payment will be refunded to the applicant.
It is important that the applicant/Adherent gets an answer within the shortest delay possible. If more information is requested prior to accept the Membership Application, such request of information must be done in writing, and most importantly must be done in a comprehensive way, this to speed up the decision process.

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

Article 4: HOSPITALISATION AND HEALTH COVERAGE

1- Age:

a. CMSM membership is limited to the applicants aged between 14 days and 85 years inclusive. The CMSM may, at its discretion and in writing increase the age limit to over 85 years.

b. Age is computed based on the year per the effective Membership date minus the year of birth.

c. In this case all Adherents over **65** have to fulfill the following requirements:
   i. One or more of his/her younger **Legal Independents**, simultaneously, has to apply for Membership.
   ii. Submit the Special Medical Report (available at CMSM) duly completed and signed by the family or the attending Physician.

d. The age limitation is automatically waived for Adherent benefiting from the **Guaranteed Renewability Feature**.

e. The applicant/adherent chooses upon enrollment/renewal of membership one hospitalization class for all the family members with no distinction, regardless the kin relationship**.**

2- Hospitalization Class

The hospitalization class per membership period corresponds to the class of In-Hospital Healthcare Benefits to which the Adherent/Beneficiary is entitled to as identified in the Membership Schedule, unless otherwise stipulated in the special Terms and Conditions,

3- Financial limitation

For the implementation of its Mutual Health Plan CMSM covers all Adherents/Beneficiaries during a Membership Contractual Period (one year), with a total amount of:

- Mutual Class **-K- //100,000US$//.**
- **1st** Class -**A**- //**125,000US$**//.

4- Territoriality:

The CMSM Mutual Health Plan coverage applies to medical expenses incurred in Lebanon, Syria and worldwide, subject to the Terms, Conditions, Limitations and Exclusions provided herein.

5- Duplicate and/or Supplementary Coverage

In the case of a Supplementary Coverage to the one provided by the National Social Security Fund (**CO-NSSF)** specified in the Adherent/Beneficiary Membership Schedule Class (A)/ (MUT), CMSM shall only cover the portion that is supplementary to the coverage provided by NSSF scheme, even if the healthcare provider is not contracting with NSSF, and irrespective of whether or not the Adherent/Beneficiary has been successful in receiving such coverage of benefits.

6- Coverage General Scope

In return for the premium paid by the Adherent/Beneficiary, CMSM shall cover all usual, customary and reasonable healthcare services and their related expenses incurred by the Adherent/Beneficiary under an Applicable Healthcare Plan while this Plan is in force, subject to its Terms, Conditions, Limitations and Exclusions.

Article 5: PAYMENT OF CLAIMS

I. Direct Payment

1. The Approval of Coverage is a decision taken by the Administrator in the name and on behalf of CMSM, to cover a healthcare service sought by an Adherent/Beneficiary; this decision may also determine the conditions and extent of the approved coverage.

2. The Approval of Coverage for direct payment provided for hereinafter is only applicable when the healthcare services are sought at one of Administrator's Providers Network and when the Adherent/Beneficiary complies with the procedures of the following applicable cases:

    (a) In the cases of non-emergency admission to one of the Providers Network, whether requiring an overnight stay at the hospital or not, a prior approval must be acquired by the concerned Adherent/Beneficiary from the Administrator by submitting the Medical Report for Admission (M.R.A.) duly completed and signed by the attending Physician.
    (b) In the cases of emergency admission for at least an overnight stay, as defined in the Membership Schedule, Approval of coverage must be requested by the Adherent/Beneficiary from the Administrator, immediately upon admission but not later than the next working day if admission falls within a holiday.
    (c) In the cases of admission to an Emergency Room not requiring an overnight stay, the Adherent/Beneficiary must present his/her Access Card and Personal ID to the hospital, awaiting the Administrator's decision.

3. The Administrator may, upon the evaluation of each case, grant or reject the approval of coverage based on the Terms, Conditions, Limitations and Exclusions of the Membership Schedule. This decision is relayed to the Adherent/Beneficiary through the concerned Regional Office, or an Administrator delegate, providing that the final decision to grant or to reject the approval of coverage is to be authorized by CMSM.

II. Reimbursement

As an exceptional procedure, the Adherent/Beneficiary may be reimbursed for the total or partial incurred fees and expenses of covered healthcare services under this Membership Mutual Health Plan, subject to complying with a special reimbursement procedures provided for hereinafter:

1. A written request for reimbursement must be addressed directly to CMSM, together with all the requested supporting documents (e.g. detailed original bill and receipt, discharge report, medical and examination reports, and results).

2. The reimbursement procedure may be applicable exclusively in the following cases:
   (i) As appeal, by an Adherent/Beneficiary, to a previously declined approval of coverage at a Administrator Providers Network.
   (ii) In instances of emergency treatments (as defined in the Scope of In-Hospital benefits) at a non-Administrator Providers Network.
   (iii) When the Adherent/Beneficia**ry** has secured the prior approval of coverage from the Administrator, for In-Hospital healthcare services to be delivered at a non-Administrator Providers Network.
   (iv) In case of medical necessity, and the treatment requested is not available within the Administrator Providers Network, provided that the Adherent/Beneficiary has obtained a prior approval of coverage from the Administrator, for In-Hospital healthcare services to be delivered at a non-Bankers Assistance Participating Provider

3. In the above instances provided for in sub-sections 2 (i) and 2 (ii), the reimbursement of the incurred fees and expenses will be effected based on the preferential tariffs applicable to CMSM at an equivalent Administrator Providers Network at the time of the incurred expenses. In the instance provided for in sub-section 2 (iii), the reimbursement of the incurred fees and expenses will be effected at the rate of 75% (seventy five percent) of the preferential tariffs referred to above unless CMSM makes different decision.

   In the instance provided for in section 2 (iv), the reimbursement of the incurred fees and expenses will be effected based on the average daily cost per the number of hospitalization days, approved by the Administrator, which is calculated as follows:

   The daily average of fees and expenses incurred for usual and/or intensive care hospitalization at an equivalent Administrator Providers Network is retained for all kinds of surgical procedures (if the bill, subject of the claim is a surgical procedure) or for all kinds of medical procedures (if the bill, subject of the claim is a medical procedure). It is based on the hospitalization class, which the Adherent/Beneficiary benefits from, the preferential tariff and the related statistics available at the Administrator for the year under consideration.

   In all the above instances, identified under section II (3), the total approved fees and expenses cannot exceed the amount of the invoice subject of the claim.

4. In all the instances provided for in sections II (2) and II (3) above, payment is effected on the condition that the Adherent/Beneficiary has filed a claim with the CMSM within:
   - Fifteen (15) days from hospital discharge if the healthcare services were rendered in Lebanon, or
   - Thirty (30) days from hospital discharge if the healthcare services were rendered abroad.

5. In all emergency cases, reimbursement may be effected on the additional condition that the CMSM or the Administrator is informed in writing of the hospitalization within 24 (twenty four) hours from admission.

6. In all non-emergency cases when a healthcare service is sought at non-Administrator Providers Network, reimbursement will be effected on the condition that the Adherent/Beneficiary has sought, prior to admission, a special approval of coverage from the Administrator.

4. The reimbursement of all claims incurred in a foreign currency (i.e. other than Lebanese Pounds) will be effected in USD converted at the exchange rate applicable at the date of discharge from the healthcare provider; as such date is evidenced by the bill.
   The Adherent/Beneficiary must clearly know and understand that in case of a Reimbursement claim, the evaluation basis of the cost is the average of similar cases at a similar provider, and not the cost at the highest provider cost.

Article 6: WAIVER OF MEDICAL CONFIDENTIALITY

a. CMSM shall have the right and opportunity to inquire about the Adherent/Beneficiary past and actual state of health and its evolution, examine him/her and investigate the circumstances of any and all claims (e.g. review the medical and administrative files), whenever and as often as it may reasonably require prior to, during and after the delivery of any healthcare service. To that effect, the Adherent and the Beneficiary hereby waive their right of Medical Confidentiality to the benefit of CMSM, the Administrator and the Administrator delegates, and grant the aforementioned full authority to access all medical and administrative information, related to the Adherent/Beneficiary, from any healthcare provider (e.g. hospital, physician, and laboratory) and/or any other insurance company or guarantor or other, receive copies of the aforementioned medical and administrative documents and use them as need be. The Adherent and the Beneficiary also hereby authorize CMSM, the Administrator and the Administrator delegates to provide their attending physicians, within their capabilities and without any obligation to that effect, of the information available at their end about their state of health.

b. The Adherent and or the Beneficiary may be requested by the Administrator, upon any admission to a healthcare provider, to sign a waiver of medical confidentiality consistent with the aforementioned; such document must be signed by the Adherent and or the Beneficiary as a condition for benefiting from the Mutual Health Plan coverage.

Article 7: TERMS AND CONDITIONS TO BENEFIT FROM THE [GR] GUARANTEED RENEWABILITY FEATURE

I. The Guaranteed Renewability <u>is NOT automatically</u> granted, regardless of the Product/Covers features. CMSM must clearly stipulate, in the Membership schedule wording, that the Guaranteed Renewability is granted for one, some or all the listed Adherents/Beneficiaries. To be noted also the waiver of the one year waiting period. The benefit of the Guaranteed Renewability can therefore be granted immediately upon accepting the application, or after a non-binding observation period, at the sole discretion of CMSM.

1) The benefit of the Guaranteed Renewability Feature cannot be implied by the acceptance of the application. It can only be decided explicitly and in writing by CMSM, each Adherent/Beneficiary being considered separately, and such decision being evidenced by the following:

(i) The Membership Schedule will identify, by an appropriate symbol, the Adherent/Beneficiary who benefits from this feature and the Plan under which the feature is covered; it will also identify the maximum number of covered

hospitalization days per Adherent/Beneficiary, per lifetime as stipulated in article 3 (b) and,

(ii) The Adherent/Beneficiary benefiting from the lifetime Guaranteed Renewability will also receive an Access Card bearing the "**GR**" flag, confirming that he/she is entitled for the Guaranteed Renewability Feature, according to the Terms and Conditions of the Medical Program. All other Adherents/Beneficiaries listed in the Membership Schedule that do not benefit from the Guaranteed Renewability Feature will remain subject to the yearly underwriting rules and provisions as applicable.

2) The benefit of the Guaranteed Renewability does not have any effect and does not imply any waiver of any waiting period that is applicable to any condition listed in the General Terms of this Mutual Health Plan, and consequently all applicable waiting periods will still be in force as per Terms of this Plan.

3) Having the Guaranteed Renewability solely bind CMSM to renew the contract does not constitute or imply that some or all probation periods for some impairment are waived. If any, the waiver of these waiting periods must be done on the Membership Schedule if he/she is a new Adherent/Beneficiary; otherwise, the waiver of the waiting periods is done on an ongoing basis, as per General Terms of this Mutual Health Plan.

4) The Adherent/Beneficiary will still have to apply annually for the renewal of the Medical Program prior to its expiry, failing which CMSM has the right to consider any late application as ground for withdrawing the benefits of the Guaranteed Renewability provisions identified in this article. The Membership Renewal application and the Mutual Health Plan remain subject to all current legal and contractual provisions, except that the CMSM shall no more-throughout the lifetime of the Adherent/Beneficiary benefiting under the Mutual Health Plan from the Guaranteed Renewability Feature - take into consideration his/her attained health in its decision to amend, renew or not renew the cover.

However, if the In-Hospital lifetime limitation of the Guaranteed Renewability Feature is totally consumed, the Policy will then become null and void for the concerned Adherent/Beneficiary without any premium refund.
The lifetime limitation is defined in the Membership Schedule that also shows the number of days used, and the remaining balance. Currently, the lifetime limitation is set at 720 days per Adherent/Beneficiary.

5. CMSM reserves the right to reconsider the Terms and Conditions of the Mutual Health Plan at each renewal date, in the event the Adherent requests a change in the Scope of Benefits (e.g. class upgrading, additional plans and/or benefits) or decides to renew for some Adherents while deleting a number of others, with no justification consistent with the Terms and Conditions of the Membership Mutual Health Plan or with the standard practice in the healthcare coverage. CMSM has also, at its discretion, the right to reject the request of the change without the need of any justification.

6. Any change in the coverage structure, except the Adherent/Beneficiary's age and health condition, gives CMSM the right to reconsider its obligation to renew the contract. This is most important so that CMSM avoids the anti-selection that can be initiated by the Adherent. Also, any consideration of change by CMSM shall and must be done through a Medical Questionnaire Application duly filled and signed by the Adherent. Request for changes cannot be accepted if sent by letter, fax, e-mail, etc.…This restriction applies only in case the request of change is considered an upgrade in the Mutual Health Plan,

i.e. that this changes implies an increased exposure in risks. The fact that adequate premium is being charged does not give an automatic right to upgrade.

7. CMSM reserves the right not to renew the Guaranteed Renewability Plan without any further written notice and/or grace period if the premium due is not settled according to the Terms and Conditions of this Mutual Health Plan.

8. Any false declaration or non-disclosure, made by the Adherent/Beneficiary during the initial Membership prior to the Enrollment Date or during any of the following renewal applications, will render the Mutual Health Plan null and void from inception, without the need for a written notice. CMSM will have the further right not to renew the Plan.

9. Any grace benefit allowed by CMSM while knowing the false declaration or non-disclosure, does not waive its right later on to reject the Renewal Membership or to amend the Terms and Conditions of the Mutual Health Plan.

10. CMSM reserves the right to introduce any amendment to the whole Mutual Health Plan or to any portion thereof at any renewal date (e.g. General Conditions, Premiums, Plans and Scope of Benefits), provided such amendments apply in equal terms to all the Adherent/Beneficiary falling under the same Class of Risk.

II. Any Adherent/Beneficiary who is subject to the Membership's deletion clause (article-12 below), has the privilege to convert his/her coverage to a new Membership, i.e. the Adherent/Beneficiary may apply for a new Mutual Health Plan without any proof of insurability, while retaining the privilege to benefit from the Guaranteed Renewability conditions taking into account his/her Enrollment Date under the Mutual Health Plan from which he/she was deleted. This conversion privilege is made conditional upon the following:

(i) The conversion application is received by the CMSM within 30 (thirty) days from receipt of the deletion written notice;
(ii) The application is made for the same Scope of Benefits, Terms and Conditions as the ones stipulated in the Mutual Health Plan from which he/she was deleted.

Article 8: TERMINATION OF PROGRAM BY THE MEMBER

1. This Program is subject to termination by the Adherent upon the receipt by the CMSM of a written notice accompanied with the Access Card (s).

   No cancellation can be done unless the request of cancellation is signed by the Adherent. No Delegate or third party is entitled to request cancellation.

2. If the termination by the Adherent is done during the first month of his/her membership application or renewal he/she will be entitled of the total Cotisation (Premium) reimbursement.

   The Cotisation (premium) refund will exclude all Administration Fees, and all premiums related to the Mutual Health Plan under which the Adherent/Beneficiary would have benefited from a covered claim, regardless of the amount of the paid claim.

3. The Adherent/Beneficiary is only entitled to a premium refund computed on the Gross Cotisation (Premium) based on the **Prorata Temporis** scale applied by the CMSM if the termination is done after the first month of his/her membership application or renewal.

The Cotisation (Premium) refund will exclude all Administration Fees, and all premiums related to the plan under which the Adherent would have benefited from a covered claim, **regardless of the paid claim's amount.**

Article 9: TERMINATION OF MEMBERSHIP BY CMSM

This Membership is subject to termination by CMSM in case of breach by the Adherent/Beneficiary of its obligations under this Mutual Health Plan, including for non-payment by the Adherent of the premium due and in case of false declaration, as stipulated in articles 2 (d) and 10 below.

Article 10: FALSE DECLARATION AND NON-DISCLOSURE

Any false declaration or non-disclosure made by the Adherent/Beneficiary will render this Mutual Health Plan null and void from inception, without the need for a written notice, and without any cotisation (premium) refund.

False declaration is defined as ANY information, that was asked for by CMSM in the Membership Application's Medical Questionnaire, or subsequent Renewal Applications, and which was concealed or partially or wrongly answered. The validity of the pertinence and importance of the missing information is at the sole discretion of CMSM, and is non-negotiable.

Without prejudice to the rights of the CMSM to terminate the Mutual Health Plan or consider it null and void on any legal grounds whatsoever, CMSM may deny any benefit under the Mutual Health Plan in case of any false declaration or non-disclosure of a health condition by any of the Adherent/Beneficiary until the Mutual Health Plan is modified in order to exclude the health conditions and/or medical systems object of the false declaration or disclosure, which will thus constitute and be considered as a special exclusion to the Mutual Health Plan.

Article 11: ADDITION OF NEW INSURED

1. Newlywed spouse and newborn children of the Adherent/Beneficiary in the case when the Adherent/Beneficiary is not himself/herself a Principal Adherent, are eligible for addition to the Mutual Health Plan during its contractual period, as per the procedure set by CMSM, provided that the Membership Application for addition is made to the latter within thirty (30) days following the wedding or the birth accompanied with the appropriate premium deposit.

2. Newborn children medically eligible, and whose maternity has been covered by CMSM, will be added to the Mutual Health Plan, free of charge, once they attain the age of 14 days and for the remaining contractual period of the mother's Membership; they will benefit from the same Mutual Health Plan terms and conditions including the applicable Mutual Health Plan benefiting to the mother.

Article 12: DELETION OF ADHERENT/ADHERENT/BENAFICIARY

1. The deceased Adherent, **Newlywed,** or any individual Adherent/Beneficiary no longer meeting the requirements of a **Legal Dependent** should be deleted from the Mutual Health Plan as per the procedure set by CMSM, upon the receipt by the latter of a written notice accompanied with the Access Card (s).
2. If no claim was paid or is payable by CMSM under the Mutual Health Plan for a deleted Adherent/Beneficiary, he/she will be entitled to a Cotisation (premium) refund computed on pro-rata basis.

   However, if the deletion is related to a deceased Adherent/Beneficiary, whose payment of Cotisation (premium) was based on installments as identified in the Membership Schedule,

his/her legal heirs will still be entitled to a Cotisation (premium) refund when applicable as identified above, even if a claim was paid during the contract period, provided that the heirs submit an official death certificate within two months from the death of the Adherent/Beneficiary.

3. No Cotisation (premium) will be refunded, and no Cotisation (premium) readjustment will be effected on **Outpatient Cotisation (premiums)**, in case of deletion of one or more family members, regardless of the reason of deletion, when the family has enrolled under a comprehensive **Out-Patient** cover.

Article 13: REIMBURSEMENT OBLIGATION OF THE ADHERENT

The Adherent shall be liable to reimburse CMSM all claim amounts paid by the latter in the following cases:

1. Any undue payment (e.g. **Deductible**).
2. If CMSM pays in excess of the limits of benefits provided in the Mutual Health Plan.
3. Abuse or misuse usage of the benefits provided for under the Mutual Health Plan.
4. Abuse or misuse usage of the Access Card(s), or any other document delivered with the Mutual Health Plan document.

Article 14: LOSS OF THE ACCESS CARD

In case of loss of the Access Card, the Adherent must immediately notify CMSM in writing, failing which any expenses incurred based on the usage of the non-reported lost Access Card, shall be borne by him/her.

Article 15: NON-WAIVER OF RIGHTS

Without prejudice to the rights of CMSM under the applicable law or under the Mutual Health Plan (particularly, provisions of Articles 1 (b) and 13), any coverage granted by CMSM**,** in some instances, to the Adherent/Beneficiary beyond or contrary to what is strictly provided for herein in terms of Scope of Coverage, Exclusions, Limitations or Procedures may neither be interpreted as an implied waiver of the latter, nor constitute an acquired right for the Adherent/Beneficiary.

Article 16: SUBROGATION

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

Article 17: NOTICES

All notices and notifications must be sent by registered mail, Electronic Mail or Courier Service; they are considered valid and lawful if sent to the addresses of the parties hereto appearing in the Mutual Health Plan Preamble and in the Membership Application. Any change of address is ineffective, unless notified in writing to the other party.

Article 18: LEGAL RECOURSE

All disputes relating to the implementation, interpretation or cancellation of this Mutual Health Plan between the parties hereto (i.e. CMSM and Adherent and or Adherent/Beneficiary) shall be resolved by the CMSM's Board Administration and/or the competent courts, according to the applicable Lebanese Law.

IN-HOSPITAL HEALTH CARE PLAN

A. HOSPITALISATION CLASS

The Adherent/Beneficiary will be covered under the hospitalization class identified in the Membership Schedule, except as otherwise stipulated in item (2) of In-Hospital Healthcare Benefits Scope.

B. SCOPE OF BENEFITS

CMSM covers, subject to payment of premium, exclusively the following as In-Hospital healthcare benefits:

1. The treatment (medical, surgical or endoscopic) of covered healthcare conditions, providing that such treatment cannot be undergone on an Ambulatory basis, as defined hereinafter, and requires an uninterrupted hospital confinement occurring during the Mutual Health Plan contractual period.
2. All diagnosed surgical and endoscopic procedures (conventional or endoscopic) and all other treatments covered by Mutual Health Plan, that do not require an overnight stay at the hospital, provided in a "one day room unit", as defined by the Provider's boarding policy, irrespective of the Adherent/Beneficiary class of hospitalization, such as gastroscopy, chemotherapy, radiotherapy, excision of lymph node, etc.

   Some Providers classify the "one day room unit" as 1st, 2nd, 3rd and "MUT" class. Others don't adopt such classification. In this case the Adherent/Beneficiary will be boarded in a particular service room, in most cases shared by other patient.

3. The Laparoscopic surgical procedures covered by CMSM Mutual Health Plan are the following:
   - a- Cholecystectomy
   - b- Inguinal hernia
   - c- Ovarian cystectomy
   - d- Ectopic pregnancy
   - e- Diagnostic laparoscopy
   - f- Fundoplication of Nissen
4. Based on medical indication, Hysteroscopy is covered for all ages as of the 2nd year of membership enrolment.
5. Providing a legitimate professional concern of a significant medical problem, Emergency treatments is defined as follows: a treatment (medical or surgical) of all accidents or incidents of sudden sickness that can't be delayed and is delivered in a hospital Emergency Room (**ER**)
   Specific exclusions are covered in the ER room up to **250 USD** only.
6. Pre-Operative Tests (PT, PTT, and CBC), exclusively limited to the following: anesthesia pre-requisite basic medical tests conducted at the hospital prior to surgery.
   Cardiac diagnostic tests (CXR, cardio CS, EKG), will be covered based on medical indication.
7. Physiotherapy treatments related to a covered hospitalization, if delivered at the hospital.
8. Out of hospital physiotherapy treatments are covered by the Ambulatory (AM) Plan.
9. Homecare services, medically indicated and approved by the treating physician, are covered.
10. Clinical procedures are only covered on reimbursement basis whether done in hospital or at the physician's clinic.
11. In the event of an Adherent/Beneficiary death following admission and during hospitalization, CMSM shall compensate a sum of 1,000 USD (one thousand) as morgue and burial expenses upon presentation of evidences of costs and expenses, death certificate and

any other related document (if required), in a delay not exceeding two (2) months of the date of death.

12. Work related accidents are covered up to 1,000 USD per accident per Adherent/Beneficiary.

C. MATERNITY

1. CMSM Mutual Health Plan covers Adherent/Beneficiary's normal delivery or cesarean section in Mutual Class -MUT- up to the fourth month of the pregnancy at the date of membership, as well as abortion medically justified, abnormal pregnancy, Epidural (in Normal delivery) and complications related to pregnancy and its results supported by all requested documents.
2. To benefit from the above mentioned coverage **new** Adherent/Beneficiary has to apply for Membership **as a couple** (Husband and Wife). In the case of Wife solely applying for Membership, a waiting period of twelve (12) months is applied, as well as same waiting period is applied on Adherent/Beneficiary in **Class -A-**.
3. If maternity (normal/cesarean sections) is covered under this Mutual Health Plan, CMSM takes in charge the expenses of newborn baby's nursery as of birth for a maximum period of ten (10) days only, regardless of the stay period of the mother, as well as one consultation of the attending pediatrician fees.
4. In case the new born baby needs an Intensive Care Neonatal or Incubator stay (ICN), CMSM will covers **only** the difference of NSSF/ MOH share on reimbursement basis.
5. Once, after 14 days of birth, the baby is joined to CMSM Health Plan, any ICN required stay will fall under the coverage of congenital cases.
6. Screening tests are covered for new born CMSM babies up to 50 USD only.
7. In all cases, if performed during hospital confinement CMSM covers the professional fees and expenses of a baby male circumcision.

D. CARDIO VASCULAR TREATMENTS

After three (3) months waiting period, Open Heart Surgery, Coronarography, and Cardio-Vascular Sections are totally covered, if medically indicated and are not pre-existing cases, otherwise stipulated in the Mutual Health Plan.

E. PRE EXISTING CASES

Preexisting Case is a health condition or impairment that medically exists prior to the membership enrollment date of Adherent whether it is known to him/her or not.

1. Any preexisting case is covered as of the second (2^{nd}) year of the initial Membership, unless it is otherwise stipulated in the Membership Schedule.
2. Specific underwriting conditions (Exclusions or Limitations) do not fall under preexisting cases. Therefore, any specific condition can be applied as of the second (2^{nd}) year.
3. Adherent should declare any medical information related to him/her and his/her family. In case of non-declared information, false declaration is applied as stated in the Mutual Health Plan (Article (10).
4. For an Adherent/Beneficiary whom his/her Mutual Health Plan contractual period expires while confined in hospital and did not proceed to renew his/her Membership, coverage will continue up to 10 (ten) uninterrupted confinement days following the expiry date.

F. CONGENITAL CASES

Congenital cases are defined as follows: Diseases, anomalies, birth defects and deficiencies revealed at birth, either in an evident manner or in a potential manner diagnosed at a later stage.

CMSM Health Plan covers totally (25) Congenital Cases for a new born baby medically eligible at birth until (12) twelve years of age.

The following (25) congenital cases are:

1- Tongue tie
2- Hernia
3- Thyrioglossal cyst
4- Pyloric stenosis
5- Urinary reflux
6- Gastroesophageal reflux
7- Cataract
8- Laparoschisis and Omphalocele
9- Epispadias
10- Hypospadias
11- Hydro nephrosis u-p Junction
12- Ectopic testis
13- Biliary atresia
14- Bronchogenic cyst
15- Cystic adenomatoid malformation
16- Congenital megacolon
17- Imperforate anus
18- Esophageal atresia
19- Duodenal atresia
20- Intestinal atresia
21- Posterior urethral valve
22- Extrophy of bladder
23- Extrophy of lower abdomen
24- Mega ureter
25- Diaphragmatic hernia

For CMSM babies all other Congenital Cases are covered only up to 3,000USD/case.

For all other babies enrolled in CMSM Health Plan, all congenital cases (including the (25) cases mentioned above) are covered only up to 3,000USD/case.

G. PROSTHESIS

1. If medically indicated, unless otherwise specified in the Special Conditions of the Mutual Health Plan, Cardio-Vascular, Prosthesis and other Restorable Prosthesis are 100% covered, per organ per case per surgery, up to **4,000USD** for Class **MUT** and **5,000USD** for Class **A.**
2. For adherents under Co-NSSF Plan, CMSM covers the difference of NSSF Prosthesis value, providing not to exceed the limits as stated in (1) above.

H. INFERTILITY

As of the second (2^{nd}) year of membership enrollment, Infertility and all related treatments, procedures (including Hysteroscopy, Coelioscopy, Varicocele) and ambulatory tests are covered up to **2,000USD** per year.

I. DIALYSIS

CMSM Health Plan takes in charge Dialysis Sessions for Acute Renal Failure only during initial admission till discharge.

J. DENTAL AND GUM

Following an accidental injury covered by CMSM Health Plan, occurring during the Membership's contractual period, and subject to a prior written approval from the Administrator**,** dental and gum, medical or surgical treatments if medically indicated are covered, providing that the treatment takes place within a maximum of 6 (six) months of the accident and before the Membership expiry date.

K. CORNEA TRANSPLANT

Cornea Transplant surgery expenses are covered, excluding the cornea cost.

L. NOSE RELATED SURGERIES

Subject to a prior written approval from the Administrator**,** and due to an accident occurring during the contractual period, any nose related surgery is covered as of the first (1^{st}) year.

M. COSMETIC AND PLASTIC SURGERIES

Following an accidental injury covered by CMSM Health Plan, occurring during the Membership's contractual period, and subject to a prior written approval from the Administrator**,** Cosmetic and/or

plastic surgeries if medically indicated are covered, providing that the treatment takes place within a maximum of 6 (six) months of the accident and before the Membership expiry date.

N. SLEEP APNEA PROCEDURES

If medically indicated, Polysomnography procedures required for sleep apnea are covered as of the second (2^{nd}) year of enrollment, excluding related surgery treatments and complications.

EXCLUSIONS TO IN-HOSPITAL HEALTHCARE BENEFITS

The following medical conditions and cases, their complications and related consequences are not covered, unless otherwise specified in the Membership Schedule:

1. All Ambulatory benefits not specifically covered by the Mutual Health Plan, such as:
    a) Medical services that are medically justified but do not necessitate hospital confinement, such as services delivered at a physician's office, clinics, medical centers or out-patient hospital facilities.
    b) Medical Investigations, check-up tests, treatments and others).
2. Any Adherent/Beneficiary particular exclusion applied and stated in the Mutual Health Plan schedule or its endorsements.
3. Any Adherent/Beneficiary hospitalization not medically indicated (e.g. sight correction surgery and organ donation), including any experimental treatment or procedure, as well as any treatment not "usual, reasonable and customary".
4. All adults' congenital cases: diseases, anomalies, birth defects and deficiencies revealed at birth, either in an evident manner or in a potential manner diagnosed at a later stage and related complications.
5. Orthesis.
6. Kidney transplant surgeries.
7. Peritoneal dialysis, hemodialysis, chronic dialysis and Arterio Venostomy.
8. Mental or psychiatric disorders, nervous breakdowns, and psychological tests or evaluation.
9. Rest cures, sanatorium, custodial care and periods of quarantine, special diets and weight control procedures and surgeries, costs related to convalescence even when initial hospitalization was covered under the CMSM Health Plan.
10. Suicide, self-destruction or intentional self-inflicted injury or any attempt thereat, while sane or insane.
11. Alcoholism drugs and like substances addiction to, and abuse of medicines under no medical supervision, and all consequences arising there from.
12. Claims arising from the Adherent/Beneficiary taking active part in any of the following events: war, warlike activities, civil strife and commotion, crimes and misdemeanors; any claim arising from an illegal act of the Adherent/Beneficiary during his/her stay in prison.
13. Treatment of injuries and sickness consequent to the participation of the Adherent/Beneficiary, either as an amateur or professional, in hazardous sports (e.g. ATV, motor or motorcycling race, deep sea diving, scuba-diving, snorkeling, parachuting, hang gliding, delta-plane, etc.).
14. Claims arising from confirmed Epidemic or Pandemic Outbreak, Ionization, Polluting Chemicals or Nuclear Contamination.
15. Dental and gum medical or surgical treatment of any condition including abscess prosthesis and disorders of the temporomandibular joints.
16. Cosmetic and/or plastic surgeries unless medically indicated, following an accidental injury covered by CMSM Health Plan, occurring during the Membership's contractual period, as mentioned previously.
17. The surgery and cost of all kinds of organ transfer and transplantation, including bone marrow.

18. Abortion not medically indicated, Anti-conception procedures, and all related consequences, and Amniosynthesis.
19. Artificial Insemination Procedures, as well as all procedures related to the change of sex. All sexual fortifying products medicines (e.g. Viagra, Calis and L Vitra…), and the treatment of all consequences related thereto.
20. Sexually Transmitted Diseases (S.T.D.), Human Immune Deficiency Virus (H.I.V.), AIDS, and all screening tests, medications and treatments related thereto.
21. Epidemic diseases: HINI, Ebola Virus and other.
22. All procedures relating to the treatment (medical or surgical) of the falling of hair and all consequences related thereto.
23. All kinds of Parkinson disease treatments including all related surgical interventions.
24. Dynamic Laser therapy procedures Verteporfine, Orthphony sessions, Speech therapy.
25. All kinds of genetic tests and procedures (whether medical or surgical) including genetic engineering and cloning.
26. Land and Air Ambulance and Home-Nursing care expenses.

AMBULATORY HEALTH PLAN

A. SCOPE OF BENEFITS

1. All Ambulatory Benefits are limited to the healthcare services provided exclusively through the Administrator Providers Network in Lebanon.
2. CMSM covers Ambulatory expenses up to **85%,** excluding doctor fees, and this is up to (10) Ten claims per Adherent/Beneficiary per year, and **(5) five** claims per **new** Adherent/Beneficiary per year, as stated in the Membership Schedule.
3. Same In-hospital "Specific Exclusions, Limitations and Preexisting Cases" are covered as well.
4. All "Non-Declared" cases are excluded.

B. SCOPE OF COVRAGE

CMSM covers, the diagnostic tests and treatments listed hereunder, not requiring In-Hospital confinement.

1. Diagnostic Tests

Radiology, C.T. scan, MRI, Ultrasonography, laboratory tests, nuclear medicine tests, Electroencephalogram, Electrocardiogram, Electromyogram, Audiogram, Stress test, Evoqued response, Ocular Angiography, Thallium myocardial Scintigraphy, Echocardiography, Holter monitoring, Laser therapy, Physiotherapy, Kinesitherapy, Tuberculin test, Testicular Pelvic Echo Doppler.

2. MRI

a) The use of MRI is covered based on medical indication; the use of dental panoramic X-ray is limited to post-traumatic cases; both are subject to the prior approval of the Administrator.
b) Thallium Myocardial Scintigraphy and Abdominal-Pelvic Ultrasound are subject to the Administrator's control for medical necessity.

3. Osteodensitometry is covered for all Adherents/Beneficiaries aged **50 years and above** once per contractual year. The test will be covered exclusively in Private Diagnostic Centers (Not Hospitals), unless otherwise decided by CMSM.

4. **Toxoplasmosis tests** are covered 4 times per pregnancy if results are showing lack of immunity.
5. **Physicians' fees** relating to the necessary interpretation of technically specialized tests are covered, provided they are conducted at the same facilities where tests were performed.
6. **Pre-Marital tests** are covered on reimbursement basis with a proof of marriage.

EXCLUSIONS TO AMBULATORY HEALTHCARE BENEFITS

All general exclusions applicable to the In-Hospital Plan are applicable to the **Ambulatory** Plan, including routine checkups, Doctors' fees, Thalassemia, H.I.V, Syphilis tests, except when required for pre-marital tests on reimbursement procedures basis.

PRESCRIPTION MEDECINES BENEFIT PLAN

CMSM covers under the Prescription Medicine Benefit Plan the medicines duly registered and approved by the Lebanese Ministry of Health (**MoH**), and as per the tariffs set by the latter, prescribed by the Adherent/Beneficiary's attending physician.

SCOPE OF BENEFIT

1. All benefits of the Prescription Medicine Benefit Plan are limited to products dispensed exclusively through the Administrator Providers Network in Lebanon.
2. Covered products and medicines are included in a formulary list kept with the Administrator; it can be made available to the Adherent/Beneficiary upon request. The list may change from time to time by decision of CMSM or the Administrator.
   CMSM covers Prescription Medicine expenses in an average of **85%** of the prescribed medicines bill excluding the physician fees, and this is up to 10 (Ten) claims for every Adherent/Beneficiary in a contractual period, as stated in the Membership Schedule.
3. The quantity of covered prescribed medicines per transaction is limited to the normal, usual and customary need for a maximum of one month of treatment per transaction.
4. Covered compulsory vaccines to prevent the following diseases:
   Polio, Diphtheria, Pertussis, Tetanus, Hepatitis (B), Haemophilus Influenza Type B, Measles, Mumps, Rubella, as per the age of the Adherent and the quantity and immunity schedule suggested by the "United States Advisory Committee On Immunization Practices (ACIP)", which is a related department to the "Centres for Diseases Control and Prevention (CDC)" in Atlanta, Georgia.
5. In all instances, medicines & drugs, even if prescribed according to the followed rules and conditions, will not be covered if they don't match the sex or age of the Adherent/Beneficiary or if they have any contradiction to any other prescribed medicine or any other medical contra-indication that is known internationally and that is captured by the expert system used by the Administrator. Such medicine & drugs will be subject to the Administrator prior approval needed to specify whether these drugs are totally or partially covered, or rejected according to the applicable rules and regulations related to prior approval.

EXCLUSIONS TO THE PRESCRIPTION MEDICINE BENEFIT PLAN

1. All over-the-counter products that can be dispensed without a medical prescription (e.g. beauty and cosmetic items, vitamins and mineral products, personal and household hygiene products), all homeopathy and phytotherapy products.
2. Antiseptic products (e.g. Dettol, Mercryl, soaps).
3. All hair treatment products.
4. All products for dental care or for the gum (e.g. hygienic or treatment products).
5. All sexual fortifying products. All products and medicines for contraception and the treatment of sterility, impotence and infertility.
6. All products related to the treatment of mental disorders, (such as psychosis, anxiety, depression, mania, etc.). In addition to amphetaminic, hypnotic and sedative products.
7. Dietetic products for all ages (e.g. milk, nutritional and diet products).
8. Dermatological products except those used for the treatment of infectious diseases (e.g. chicken pox), allergic reactions, or consequences of accidents (e.g. burns).
9. All medicines used for the treatment of chronic diseases (e.g. diabetes, hypertension, cholesterol, epilepsy, Parkinson, cardiovascular, cancer). This exclusion will be waived:

    a) for the Adherent/ Beneficiary who is benefiting from the Guaranteed Renewability Feature, under the Prescription Medicine's Plan, as per the limitations identified in the Membership Schedule, and
    b) For the Adherent/Beneficiary having the specific Prescription Medicine's Plan that covers Chronic Medicines. This plan will be stated in the Membership Schedule, with its relevant Financial Limitation and Excess deductibles **40%**, directly paid by the Adherent/Beneficiary.
10. All Hearing and Optical apparatuses (e.g. lenses, glasses) and the products used for their cleaning and up keeping.
11. All products for the treatment of Sexually Transmitted Diseases and AIDS.
12. All general exclusions applicable to the In-Hospital plan are applicable to the Prescription Medicine Benefit Plan.

ADHERENT PERSONAL ACCIDENT PLAN

A. SPECIAL DEFINITIONS

1. Accident

Accident means an unforeseen and unexpected event arising out of violent, external and visible causing bodily injury.

2. Death

Death means the loss of life, directly and independently of all other causes, resulting from an Accident as defined above and occurring within 12 (twelve) months of the date of that Accident. This coverage applies for the Adherent/Beneficiary age is **over 18 years and less than 85 years inclusive,**

3. Permanent Total Disablement

Means that the Adherent/Beneficiary is recognized as totally and permanently disabled if as a result of an Accident as defined above and at the expiration of 12 (twelve) calendar months from the date of occurrence of the Accident he/she is totally and permanently prevented from carrying out his/her occupation or attending to business of any kind.

4. **Permanent Partial Disablement**
   Means the loss of limb(s) or organs(s) or other permanent disability(ies) as described in the Scale of Disabilities attached herewith, directly and independently of all other causes, resulting from an accident as defined above and occurring within 12 (twelve) calendar months from the date of the Accident.

B. SCOPE OF PERSONAL ACCIDENT BENEFITS

Subject to the terms and conditions of the Mutual Health Plan it is hereby agreed and understood to extend the coverage provided therein to include the following additional benefits:

- Death following accident.
- Permanent disablement (total or partial) following accident.

C. LIMITATIONS TO PERSONAL ACCIDENT BENEFITS

- Death and Permanent Total Disablement (PTD): Sum of **5,000USD** as specified in the Membership Schedule.
- Permanent Partial Disablement (PPD): A percentage of the sum of (PTD) as per scale of permanent disabilities attached hereto.
- Anchylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall only entitle to 50% of the benefits, which would be due for the loss of the said members.
- Permanent disabilities not mentioned above shall be compensated in accordance with their seriousness as compared to those listed.
- The term "TOTAL LOSS" of a limb or organ as used above shall mean the "TOTAL LOSS BY PHYSICAL SEVERANCE" or the "TOTAL FUNCTIONAL LOSS" of such limb or organ.
- The total Benefits payable in respect of several disablements due to the same accident is arrived at by adding together the various sums, but shall not exceed the principal sum set out in the first Schedule.
- If the loss of a limb or organ is only partial, the indemnity provided for total loss will be decreased proportionally.
- The total loss of a limb or organ, which is already out of use before the accident, shall not give rise to an indemnity under this plan.
- Injury to a limb or organ already disabled will be compensated only for the difference between its condition before and after the accident.

SCALE OF DISABILITIES

PERMANENT TOTAL DISABLEMENT	
Total incurable insanity	100%
Total loss of sight of both eyes	100%
Complete deafness of both ears, of traumatic origin	100%
Removal of the lower jaw	100%
Total loss of speech	100%
Total loss of both arms or both hands	100%
Total loss of one arm and one leg	100%
Total loss of one arm and one foot	100%
Total loss of one hand and one leg	100%
Total loss of one hand and one foot	100%
Total loss of both legs	100%
Total loss of both feet	100%

PERMANENT PARTIAL DISABLEMENT	
HEAD	
Loss of osseous substance of skull in all its thickness	40%
Loss of one eye	40%
Complete deafness of one ear	30%
Partial removal of the lower jaw	40%
UPPER LIMBS	
Loss of one arm or one hand	60%
Considerable loss of osseous substance of the arm (definite & incurable lesion)	45%
Total loss of thumb	20%
Partial loss of thumb	10%
Total amputation of any finger	8%
Amputation of four fingers including thumb	50%
Amputation of a phalanx of any finger	3%
LOWER LIMBS	
Anchylosis of the hip	3%
Total loss of one leg	60%
Anchylosis of the knee	60%
Total loss of one foot	45%
Shortening of the lower limb by at least 5 cm	30%
Shortening of the lower limbs of 1 to 5 cm	10%
Total amputation of all the toes	25%
Amputation of four toes including the big toe	20%
Amputation of the big toe	10%
Amputation of one toe other than the big toe	3%

D. EXCLUSIONS TO PERSONAL ACCIDENT BENEFITS

1. All exclusions applicable to the In-Hospital Plan are applicable to the **Personal Accident Plan**.
2. Accident caused by a willful or unlawful act of the Adherent/Beneficiary (except in attempt to save human life) by self-injury, suicide or attempted suicide (whether felonious or not) by provoked assault, intoxication, drugs or insanity.
3. Accident caused by a willful or unlawful act of Adherent/Beneficiary (except in attempt to save human life) resulting in the death of the Adherent/Beneficiary.
4. Any accident consequent upon pregnancy or childbirth, pre-existing physical defect or infirmity or disease or illness, malaria or infections of any kind including bacterial infections, infertility.
5. Accidents occurring as a direct or indirect consequence of the Adherent/Beneficiary being a member of the armed forces or being engaged in the ambulance service, in professional or non-professional aviation as a pilot or crew member, in cave exploration (speleology), in chimney sweeping, in a circus performance, in demolition and/or clearing of high explosives, in diving of any kind, in fire-fighting (professional), in mountaineering necessitating use of ropes/guides, in nuclear energy activities, in all exploration / drilling / production, in police and security activities, in polo, in racing of any kind, in hang gliding, in professional sports activities, in stevedoring, in taming of wild animals, in tunneling or underground mining, or in shipping.
6. Accidents occurring as a direct or indirect consequence of the Adherent/Beneficiary being in any type of aircraft other than as a passenger.

SECOND MEDICAL OPINION (SMO)

A. SCOPE OF BENEFITS:

Second Medical Opinion and/or **Disease** and **Medical File Consultation (SMO)** is available for all Adherents/Beneficiaries for a specific and determined medical cases covered by the Mutual Health Plan, and in case of its implementation, it will be considered under the In-Hospital Plan based on the related medical results done (Consultations and Diagnostics).

1. **SMO** and/or Medical **Consultation**'s objective is to support the Adherent/Beneficiary and/or the **Treating Physician** in further and advanced diagnostic and/or consultation for the following medical cases:
    a. Circulatory and Nervous Systems.
    b. Cancer.
    c. Immune, not contagious, System.
    d. Any other medical case subject to a threat of life.
2. The above **SMO** coverage is offered by Medical Specialists with a highly standard related experience and registered in both Beirut and Tripoli "Doctors Syndicates".

B. LIMITATIONS TO SECOND MEDICAL OPINION BENEFITS:

Second Medical Opinion and/or Consultation maximum coverage is limited per Adherent/Beneficiary as follows:

1. One (1) "Second Medical Opinion" or Consultation for every covered case.
2. Two (2) "Second Medical Opinion" or Consultations in any contractual period.
3. Six (6) "Second Medical Opinion" or Consultations in life time of an Adherent/Beneficiary benefiting from the Guaranteed Renewability.

BUILT-IN TRAVEL INSURANCE PLAN

This plan covers the Adherents and/Beneficiaries worldwide when travelling for **personal** or for **leisure reasons** not exceeding **a period of 31 consecutive days.** This plan does not cover any **trip for professional or therapeutic reason.**

PLAN SPECIFICATIONS

A. DEFINITIONS

The words and phrases defined below shall have the following meanings wherever they appear in this document:

1. **Assistance Company**
   Assistance Company means Euro Cross Assistance or any of its appointed assistance providers worldwide.
2. **Mutual Fund**
   The insurer of this travel insurance coverage under this agreement is CMSM Caisse Mutuelle Socio Médicale.
3. **Adherent and/Beneficiary**
   Any of the covered persons whose name is stated in the Mutual Health Plan
4. **Country of Permanent Residence**
   The country in which, normally, the Adherent and/Beneficiary resides, whether or not he/she holds its citizenship.
5. **Deductible**

The first amount of claim payable by the Adherent and/Beneficiary, where applicable.

6. **Accident**
   A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place and independently of all other causes, resulting directly, immediately and solely in physical bodily injury or trauma and requiring immediate medical intervention treatment. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an Accident.
7. **Medical Emergency**
   Means unforeseen and non-recurrent sudden pathology that requires an emergency treatment to prevent or alleviate existing danger to health / life. An emergency no longer exists when medical evidence indicates that the Adherent and/Beneficiary is able to return to his/her country of permanent residence to seek and/or continue treatment. A pathology related to a pre-existing medical condition does not fall under the definition of a sudden pathology. Each time the patient is able to visit the doctor's office in person; such case shall not be considered an emergency.
8. **Pre-existing Medical Condition**
   Physical Pre-Existing defect, infirmity, injury, sickness, pathology, disease, affliction, anomaly, major risk factor, or any other medical condition, whether known or unknown to the Adherent/Beneficiary, which he/she was suffering from at the time of subscription to this plan.
9. **Scope of coverage:**
   - Period of Coverage: Up to 31 consecutive days.
   - Scope of Coverage: Worldwide excluding Lebanon
   - Conditions: This plan covers the beneficiaries worldwide when travelling for personal or for leisure reasons not exceeding a period of 31 consecutive days outside Lebanon.

B. BENEFITS

Coverage Limit:

1. Travel Information Service	Free of charge
2. Referral to Medical Correspondents Abroad	Free of charge
3. Long Distance Medical Advice	Free of charge
4. Delivery of Urgent Messages	Free of charge
5. Evacuation & Repatriation	Up to 50,000 $
6. Repatriation of Mortal Remains	Up to 50,000 $
7. Medical Expenses and Hospitalization Abroad	Up to 50,000 $
8. Transportation to Join Member	Round Trip Ticket
9. Return of Dependent Children	One-Way ticket

1. **Travel Information Service**
   The Adherent and/Beneficiary may, prior to his/her departure, call the appropriate alarm center Assistance Alarm Center on the Assistance number mentioned on his card, in order to obtain important administrative or medical advice regarding passport and visa processes, vaccination requirements, taxes, customs duties, currencies, and other various requirements.
2. **Referral to Medical Correspondents Abroad**
   The Adherent and/Beneficiary may call the appropriate Alarm Center in order to obtain referral to a medical correspondent in the area where he/she is located abroad. The majority of the appointed physicians speak English.

3. **Long Distance Medical Advice**
   Should the Adherent and/Beneficiary, during his/her journey abroad, need medical advice which is not available at their location, he/she may call the appropriate Alarm Center and get medical advice

from a qualified physician. A telephone conversation does not permit the establishment of a diagnosis and must therefore be considered as mere advice.

4. **Delivery of Urgent Messages**

In the event of an emergency calling for assistance, the Assistance Company shall transmit any urgent messages of the Adherent and/Beneficiary to his/her family or employer and keep them informed of any arrangements made to provide the required assistance.

5. Evacuation and Repatriation

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

(ii) The Assistance Company reserves the right, at its sole discretion, to determine the location to which the Adherent and/Beneficiary will be evacuated and the means or method by which such evacuation or repatriation will be carried out. In making such arrangements, the Assistance Company may consider all relevant circumstances including, but not limited to the Adherent/Beneficiary's medical condition, the degree of urgency, the Adherent and/Beneficiary's fitness to travel, airport availability, weather conditions and travel distance in determining whether transportation will be provided by private medically equipped aircraft, helicopter, regular scheduled flight, rail or land vehicle. Transportation shall be carried out under constant medical supervision, unless otherwise approved by an Assistance Company physician. Expenses incurred during the Adherent/Beneficiary's medical evacuation and repatriation shall be covered by the Insurance Company up to USD 50,000 per person.

7. **Repatriation of Mortal Remains**

In the event of the death of the Adherent and/Beneficiary as a result of a sudden pathology, the Assistance Company shall assist with the necessary procedures and shall cover only the expenses of transportation for repatriation of the mortal remains to such a location as may be selected by the legal representative of the deceased, up to a limit of USD 50,000. If requested by a family member or legal representative, the Assistance Company will pay for a local burial at the place of death, subject to any governmental regulations.

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

8. **Cover of Medical Expenses and Hospitalization Abroad**.

The Mutual Fund shall cover only reasonable medical emergency expenses (see definitions section), as well as hospitalization costs resulting from it, up to the limit of 50,000 USD, per person per claim according to the minimal and standard conditions of hospitalization of the country where the Adherent and Beneficiary is being treated. The cover of medical and hospitalization expenses is subject to the following deductibles per person per claim: USD 100 if the Adherent and/Beneficiary is under 71 years old and USD 250 if the Adherent and/Beneficiary is 71 years old or older.

The Mutual Fund shall cover emergency expenses following an accident or sudden illness (as defined above) as well as hospitalization costs resulting from it.

9. **Transportation to Join Adherent and/ Beneficiary**

In the event that the Adherent/Beneficiary, provided that he/she is traveling alone, is admitted to hospital for more than 10 days, the Assistance Company shall provide the person appointed by the

Adherent and/Beneficiary and having the same country of residence as the latter with an economy class round-trip air transport ticket or a regular class train ticket to allow him/her to join the Adherent/Beneficiary. The appointed person shall also receive an allowance of 80$ per day to cover for his/her basic stay expenses for a maximum period of 10 days.

10. **Return of Dependent Children**

In the case that dependent children are left unattended following an accident or a sudden illness of which the Adherent and/Beneficiary is victim; the Assistance Company shall arrange for and cover the expenses of one-way economy transportation for those dependent children to their place of residence. A qualified attendant shall also be appointed at no charge, whenever needed.

C. OBLIGATIONS of the ADHERENT/BENEFICIARY

In the event of an accident or a sudden illness, the Adherent and/Beneficiary releases from professional secrecy all doctors and paramedical staff who might examine him/her both before and after the accident.

Any reluctance or failure to declare a fact or circumstance limiting the benefits under this plan gives the Assistance Company the right not to intervene as soon as it acquires knowledge of such fact or circumstance.