MenoMedic TOP

Medical Insurance for Foreign Workers

Dear Policyholder!

Any time you need medical assistance, call the telephone number which appears in your Insurance Card, 24 hours a day, 365 days of the year

Our operators will respond quickly, by referring you to the relevant medical service providers.

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Whereas the policyholder whose name is stated hereunder has approached Menora Mivtachim Insurance Ltd. with a request to arrange the insurance whose details are stated hereon and has undertaken to pay the premium as agreed with him which is stated in the schedule of this policy.

This policy therefore witnesses that subject to its covers, extensions, conditions, exclusions and directives detailed herein and/or which may be added and/or endorsed thereto by agreement between the parties, the insurer agrees to indemnify the insured on the occurrence of an insurance event which occurs during the insurance period stated herein, in accordance with the covers as detailed in the sections of this policy.

It is emphasized that the schedule attached to the policy and the health declarations attached thereto are the basis of the insurance and constitute an integral part of the policy.

For the avoidance of doubt, this policy has been especially tailored to the directives of the Foreign Workers Ordinance (Prohibition against Unlawful Employment and Assurance of Fair Conditions) (Basket of Health Services for Worker), 5751 – 2001 (hereinafter: the "Ordinance"). For the avoidance of doubt it is clarified that in any event of discrepancy between the Ordinance and the policy, the wording of the Ordinance will prevail.

General conditions

Preamble

1. **Definitions**

   In this policy –

   1.1 **The policyholder:** The individual, group of individuals or corporation which is an employer entering into an agreement with the insurer by way of an insurance contract being the policy and whose name is stated in the schedule and/or in the proposal form as the policyholder.

   The insured: Any individual who works in Israel and whose name or names are stated in the schedule **and provided that they are foreign citizens whose permanent domicile is outside of Israel** and who joined the insurance in accordance with the directives of this policy.

   1.2 **The insurer:** Menora Mivtachim Insurance Ltd.

   1.3 **The insurance proposal or the proposal:** The proposal form constituting a request to join the insurance in accordance with this policy, being fully completed and signed by the insured and/or by the insured's spouse for themselves and on behalf of each of their family members. The proposal form also contains the health declaration which has been completed and signed by

the insured.

1.4 **The policy:** The contract of insurance between the policyholder and the insurer to cover the policyholder's employees including the proposal form, the health declaration and any appendix or endorsement attached thereto.

1.5 **The schedule/ insurance information page:** The policy schedule attached to the policy, which constitutes an integral part of the same, containing, inter alia, the policy number, personal details of the policyholder, personal details of the insured, the inception date of the insurance, the insurance period, the premium, the name of the insurance agent if there is one, limitations to the scope of the insurance coverage of a specific insured including exclusions due to a medical condition if any, underwriting additions if any exist, etc. **This insurance information page constitutes the insurer's consent in writing to insure the insured whose details are noted therein under the insurance coverages listed in their name, all under the qualifications listed on the insurance information page and subject to the terms of the policy**.

1.6 **Insurance event:** An event as defined in each of the policy sections, as applicable, in respect of which the insured is entitled to receive indemnity payments from the insurer, all subject to the conditions, exclusions and limitations in the policy.

1.7 **Inception date of the insurance:** The date stated in the schedule as the inception date of the insurance or the date on which the insured commences his stay in Israel – the later of the two.

1.8 **The insurance period:** The period commencing on the inception date of the insurance and continuing for the entire period of the insured's work in Israel, however in any event the insurance period will not exceed 60 months from the inception date of the insurance policy. Notwithstanding the aforementioned, in the event that an additional stay permit is provided by the Ministry of Interior in excess of a period of 60 months; the insurance period will be extended, however it will terminate in any event, at the very latest, on the date on which the validity of the visa expires. The insurance period will be extended sequentially upon the end of the insurance period at the request of the employer or the employee received by the insurer and provided the insurance premiums in respect of the interim period between the end of the original insurance period and the insurance extension have been paid.

In the event of a transition between employers the insured or policyholder shall be entitled to renew the insurance without underwriting, within a period of 90 days.

1.9 **Israel:** The State of Israel including the Israeli occupied territories, Judea, Samaria and the Gaza Strip, other than the territories occupied by the Palestinian Authority.

1.10 **Overseas:** Any country outside of the State of Israel other than enemy countries.

1.11 **Insurance Contract Law:** The Insurance Contract Law, 5741 – 1981.

1.12 **Health Insurance Law:** The National Health Insurance Law, 5754 – 1994.

1.13 **The second amendment:** The second amendment to the Health Insurance Law, which contains and details the basket of health services provided under the Health Insurance Law.

1.14 **The Ordinance:** The Foreign Workers Ordinance (Prohibition against Unlawful Employment and Assurance of Fair Conditions) (Basket of Health Services for Worker), 5751 – 2001.

1.15 **The National Insurance Law:** The National Insurance Law [Consolidated Version], 5755 – 1995.

1.16 **The Commissioner**: the Capital Markets, Insurance and Savings Commissioner at the Ministry of Finance.

1.17 **Legislative arrangement**: the Supervision of Financial Services Law (Insurance), 5741 - 1981, the Insurance Contract Law, 5741 - 1981, and the regulations and orders promulgated and/or that will be promulgated under these laws and instructions and Commissioner Circulars, which will regulate the conditions applicable to a policyholder, the insured and the insurer in connection with this policy.

1.18 **Call center:** A call center which is operated by the insurer or on behalf of the insurer, operational 24 hours per day, year-around, for the purpose of obtaining and providing information including with regard to the options available under the policy for obtaining medical treatment required in accordance with the policy – including the places and times, hospitalization authorization, dealing with the return of injured parties and the deceased to their home countries and the provision of any other assistance required in accordance with the insurance in accordance with this policy.

1.19 **Dollar:** The US Dollar.

Anything stated in this policy in the singular also applies in the plural and vice versa. Anything stated in the masculine applies equally in the feminine and vice versa.

2. Validity of the policy

2.1 Manner of joining the insurance

2.1.1 The insured's joining the insurance shall be after the insured's consent in writing to accept him in the insurance.

2.1.2 The insured shall give its consent to accept the insured after receiving a request to join form, signed by the candidate for insurance, and the completion of a health declaration and an underwriting process that shall determine the terms of acceptance to the insurance, to the insured's satisfaction and with its consent. It shall be clarified that failure to meet any of the terms specified above shall not derogate from the insured's right to insurance coverage after being accepted in the insurance policy.

2.2 The policy becomes effective on the inception date of the insurance after arranging for the payment of the premium.

2.3 If funds are paid to the insurer on account of the premium before the insurer has agreed to cover the candidate to the insurance, the payment will not be considered as the agreement of the insurer to execute the insurance contract. If the insurance is not effected the insurer will refund these funds paid plus indexation and interest according to legal provisions within not more than one month.

2.4 The rejection of the proposal form or an approach to the insured with a counter-offer for insurance coverage will be made within three months of the date on which the first deposit is made with the insurer, or if the insurer contacts the insured with a request to provide supplementary information, within six months of the date on which the first deposit is made with the insurer. If the insurer does not reject the proposal form and does not make a counter-offer for the insurance coverage, or if the insurer notifies the insured that he has been accepted to the insurance according to the conditions of the proposal form within the aforementioned dates, the insurer will not be entitled to alter the conditions stated in the proposal form until the expiry of the insurance period, subject to the policy conditions. In the event that an insurance event occurred before the insurer responded with a counter-offer or rejected the insurance proposal, the insured will be entitled to insurance coverage in the event that under the provisions of the insurer's existing medical underwriting in respect of policyholders with similar characteristics, the insurer would have notified the insured on his acceptance to the insurance were it not for the occurrence of the insurance event.

3. The term of the agreement and the insurance period

3.1 The insurance period will begin on the day specified on the insurance.

3.2 The maximum age for joining the policy is 65. **It should be clarified that the foregoing does not derogate from the rights of an insured whom the insurer approved his acceptance to the insurance even if he was added to the insurance when older than the maximum age set forth above**.

3.3 The insurance coverage for each policyholder would and upon his death, or the end of the insurance period, or at the time of termination of employment - whichever comes first, subject to the provisions of section 8.2 below.

4. Duty of disclosure

4.1 **The insurance in accordance with this policy has been arranged relying on the written information, the replies to the questions and the written declarations submitted to the insurer by the insured and/or by the policyholder**.

4.2 If the insurer presented to the policyholder before the execution of the policy, in the insurance proposal form or otherwise in writing, a question on a matter which may affect the willingness of the insurer to enter into the policy at all or enter into it under its terms (hereinafter – "material matter"), the insured person must provide a complete and honest answer in writing. A sweeping question, which covers various matters without differentiating between them, does not require such an answer unless it is reasonable at the time of entry onto the agreement and the intentional concealing with fraudulent intent by the insured of a matter he knows is a material matter, is tantamount to giving an answer that is not complete and honest.

4.2.1 In the event that an incomplete and dishonest reply is provided to a question regarding such a material matter, the insurer is entitled to cancel the policy by written notification to the policyholder within 30 days of becoming aware of the same and this as long as an insurance event has not occurred. The insurance premiums paid for the period

after the cancellation, minus the insurer's expenses, shall be refunded to the entity that paid them unless the insured acted with fraudulent intent.

4.2.2 **If an insurance event occurred prior to the cancellation of the insurance by virtue of this clause, the insurer is liable solely to make reduced indemnity payments at the ratio between the premium that would have been normally paid to the insurer in accordance with the actual situation and the agreed premium. Notwithstanding the aforementioned the insurer will be entirely exempt from liability in any of the following situations**:

4.2.2.1 **The reply was provided with fraudulent intent**.

4.2.2.2 **A reasonable insurer would not have entered into such an insurance contract even at a much higher premium if it would have been aware of the actual situation. In such a case the policyholder is entitled to a refund of the premium paid for the period following the occurrence of the insurance event, less the insurer's expenses**.

4.3 Sections 3.2 and 3.4 will not apply in the following cases, unless the incomplete and dishonest reply was provided with fraudulent intent:

4.3.1 If the insurer was aware or should have been aware of the actual situation at the time of executing the contract, or caused the incomplete and dishonest reply to be provided.

4.3.2 If the fact regarding which the incomplete and dishonest reply was provided ceased to exist prior to the occurrence of the insurance event, or did not influence the insurance event or the liability of the insurer or the scope of the liability.

4.4 **The premium and the method of payment**

The premium will be paid to the insurer in advance by the policyholder and/or the insured who makes such an undertaking prior to the inception of the insurance period and during the entire insurance period, unless the insurer agrees in writing in advance to the payment being made by any other method.

4.5 If the premium is paid by bank standing order or by credit card provided by the policyholder and/or the insured to the insurer at the inception of the insurance period, the act of crediting the insurer's bank account or the credit card company will constitute the sole method of paying the premium.

4.6 The premium will be paid in NIS, adjusted to the representative rate of the US Dollar on the payment date.

4.7 **Claims and indemnity payments**

On the occurrence of an insurance event, the insured or the policyholder is obliged to notify the insurer's call center as soon as possible.

In cases where the prior authorization of the insurer is required, the insured and/or the policyholder are required to obtain such authorization in writing.

4.8 **If the insured is hospitalized due to an emergency medical condition**

which prevents the insured and/or the policyholder from providing advance notification to the insurer as required in accordance with the policy conditions, the insured and/or the policyholder will ensure that notification of his turning directly to the hospital is provided immediately to the insurer's call center.

4.9 **In the event the insured did not turn to the insurer to receive advance authorization, the indemnity payments shall be reduced to the amount the insurer would have paid, had it been given advance notice.**

4.10 The insured is obliged to submit a waiver of medical confidentiality form to the insurer, permitting all of its doctor and/or any entity or medical institution or other institution in Israel or overseas to submit all medical information in their possession relating to the insured to the insurer.

4.11 The insured or the policyholder, as applicable, is obliged to submit details to the insurer relating to the claim together with medical documents or other documents requested by the insurer for the purpose of clarifying its liability.

4.12 **Medical confidentiality**

4.12.1 **Any medical information relating to the physical or mental health condition of the insured or treatment provided to the insured as well as all medical records, including the insured's medical file (hereinafter: "the medical information") must be submitted to the insurer by the insured. The insurer will not submit such medical information to the employer of the insured or to any other party connected directly or indirectly to the employment of the insured with the employer such as a Private Bureau as defined in Article 62 of the Employment Service Law, 5719 – 1959 (hereinafter: "the party connected to the employment"), unless the insured provides his informed consent. The insurer will take appropriate measures to ensure compliance with this directive.**

4.12.2 **The insurer will not accept a waiver of medical confidentiality form from the insured which contains an agreement to submit said information to the employer of the insured or to the party connected to the employment. The insurer is entitled to obtain the informed consent as aforementioned solely if it is provided in another manner which confirms that in each and every case such agreement was not made in a general manner.**

4.12.3 **If the insurer requests medical information from a foreign worker, it will not approach the employer of the same employee or the party connected to the employment with a request to obtain the said medical information for the insurer, other than in the event of a medical emergency condition.**

4.13 The insured will make himself available, if requested by the insurer, for a medical examination by a doctor or doctors appointed by the insurer and at the insurer's expense.

4.14 The insurer shall pay the indemnity payments directly to the service provider.

4.15 The insured will be entitled to receive a financial undertaking from the insurer

to the service provider which will enable him to obtain medical treatment as detailed in the policy sections, provided that his entitlement in accordance with the policy is not under dispute.

4.16 **An insurance event covered by virtue of legal provisions and/or by an insurance company and/or by a third party**

4.16.1 If the insured is also entitled to indemnity from a third party due to an insurance event other than by virtue of an insurance contract, this right is assigned to the insurer from the moment that the insurer makes indemnity payments and this up to the amount paid and without prejudice to the rights of the insured in the first instance to collect indemnity from the third party in excess of the indemnity payments he receives in accordance with this policy.

If the insured receives indemnity from a third party and/or in accordance with legal provisions which the insurer would have been entitled to receive, the insured is obliged to transfer it to the insurer. If the insured makes a compromise agreement, provides a waiver or performs any other action which prejudices the right assigned to the insurer, the insured is obliged to compensate the insurer for the same.

The provisions of this section will not apply to an insurance event which was caused unintentionally by an individual whom a reasonable insured would not claim indemnity from due to family or employment relations between them.

4.16.2 In the event the insured is entitled to the coverage of expenses by indemnity payments payable in accordance with this insurance from another insurer or in accordance with another insurance policy, the insurer will be liable to the insured jointly and severally with the other insurer for the overlapping sum insured and in such a case the directives of Article 59 of the Insurance Contract Law will apply.

4.17 **Cancellation of the insurance policy**

The policyholder is entitled to cancel the policy at any time by written notification to the insurer and the cancellation will become effective on receipt of the notification by the insurer.

4.18 **If the premium has not been paid on time as stated in section 4 above, the insurer will be entitled to cancel the insurance subject to the directives of the Insurance Contract Law**.

4.19 **The insurer is entitled to cancel the policy under any circumstances in which it is entitled to do so pursuant the Insurance Contract Law**.

4.20 To the insurance premiums not paid on time, upon their day of payment in addition to linkage differential, interest under the Adjudication of Interest and Linkage Law, 5721-1961 shall also be added, from the time of the creation of the arrears until their actual payment by the policyholder.

4.21 **If employment relations between the policyholder and the insured terminate, the policyholder is obliged to notify the insurer immediately and in such a case the insurance will be cancelled from the date on which these relations terminate, subject to the provisions of section 8.2 below**.

4.22 **Notwithstanding the provisions in this section, in the event an**

insurance event which is the actual receipt of treatment, pursuant to the provisions of Chapter A, occurs prior to the cancellation of the policy, the insurer will indemnify the insured for the insurance event for a period of up to 90 days from the date on which the policy is cancelled.

5. **Extension of the insurance and continuity of insurance**

5.1 The insurer will extend the insurance period beyond the period stated in the schedule without any new underwriting if the policyholder and/or the insured requests the same prior to the expiry of the current insurance period, however in no event will the extended insurance period exceed the insurance period as defined in section 1.9 above.

5.2 If employment relations between the policyholder and the insured terminate, the insured will be entitled, either personally or via another policyholder, to renew the insurance without any new underwriting, provided that he provides notification of the same within 60 days of the date on which such relations terminate and provided that he pays the outstanding premium for this period.

The insurance period for the insured will in no case extend past the insurance period as defined in section 1.9 above.

6. **Level of medical service**

The insurer undertakes to provide the medical services to the insured in respect of which the insured is entitled to receive in accordance with this policy for the coverage of his expenses in accordance with medical discretion, at a reasonable quality, within a reasonable period of time and at a reasonable distance from his home or the place in which the insurance event occurs, as customary in Israel.

7. **Insured's card**

The insurer will issue an insurance card to the policyholder for each employee covered which will contain identification details of the insured and the policyholder as well as the telephone number of the insured's call center.

This card, together with a passport or an official certificate bearing the insured's photo, shall serve as means of identification of the insured and the examination of his eligibility when receiving service.

8. **Call center**

The insurer undertakes to establish and operate a call center that will be operational 24 hours per day, year-round, that will provide all of the necessary information and assistance to the insured parties and policyholders relating to the covers in accordance with this policy and in accordance with the definition of the "call center" in the preamble.

8.1 **Receiving medical care**

If an insured is in need of medical treatment, he may contact the call center which will refer the insured to the service provider nearest to the place in which he is located.

8.2 In the event of a medical emergency, the insured is entitled to approach a hospital directly and in such a case must ensure that notification of the same is submitted to the call center as soon as possible.

9. Proof of age

The insured is obliged to provide documentary proof of his date of birth to the satisfaction of the insurer. The insured's date of birth is a material matter subject to the duty of disclosure applies as stated in section 4 above and in the event of the provision of an incomplete or dishonest reply or in the event of the withholding of facts in connection with the same the provisions of section 4 above will apply.

10. The irrevocable designation of a beneficiary

The irrevocable designation of a beneficiary to the rights under this policy is subject to the prior, express and written agreement of the insurer.

11. Proscription

The proscription period of a claim for indemnity payments is 3 years from the date of the occurrence of the insurance event. Cause of action that is disability due to an accident, shall be counted from the date the insured' right to make a claim for insurance benefits under this policy has arisen.

12. Application of the Insurance Contract Law

The provisions of this policy are subject to the provisions of the Insurance Contract Law, 5741 – 1981. In any event of discrepancy between the provisions of this policy and the provisions of the Insurance Contract Law, the provisions of the Insurance Contract Law shall prevail, except as otherwise provided in favor of the policyholder and the insured by this policy.

12.1 Double insurance

12.1.1 The insurer will be responsible, individually, for the insured for the full amount of insurance benefits up to the limit fixed in the insurance information page, even if the insured was entitled to coverage of the costs paid for the insurance event under another health insurance policy as well, whether with the same insurer or with another insurer.

12.1.2 In policies whereby the indemnity payments are paid to the extent of the damage caused, the insurers will bear the burden of costs among themselves, based on the ratio of indemnity payments limits relating to the insurance event as set in the insurance policies.

12.1.3 In the event that in respect of the insurance event the insured had a right of indemnity against a third party, not by virtue of an insurance contract, this right shall pass to the insurer from the time it paid the insured the indemnity payments and at the rate of the payments made by a third party in this section, including HMOs.

12.1.4 The insurer is not entitled to use the right transferred to it under this chapter, in a manner impairing the right of the insured to collect from the third party indemnity in excess of the insurance proceeds received from the insurer.

12.1.5 In the event the insured arrived at a settlement, made a concession or any other act impairing the right transferred to the insurer, he must compensate it for it.

12.1.6 **In the event the insured received from a third party indemnity for expenses covered by this policy, whether by virtue of an insurance contract or not under an insurance contract, the insurer shall be entitled to deduct the amount of the indemnity from the total indemnification type payments the insured is entitled to under this policy**.

12.1.7 **The insured shall not be entitled to any other additional indemnity type insurance benefits for other policies, similar or identical, with the insurer, due to the same insurance event**. In the event the insurer took out such additional policies for the insured, it will refund the premiums for the additional policies as of the date on which the double insurance was discovered.

13. Notifications between the parties

13.1 Notifications from the insurer to the insured and/or the policyholder will be submitted to their last address known to the insurer.

13.2 Notifications from the policyholder and/or the insured to the insurer will be submitted to the insurer's offices as stated in the insurance documents or to any other address to which the insurer requests the policyholder and/or the insured submit notifications.

Chapter A – Coverage for health services provided in accordance with the Health Insurance Law

1. **Preamble**

This chapter provides coverage to the insured for all health services contained in the Ordinance at the scope of entitlement and excluding defined services as detailed hereunder:

All of the services included in the basket of treatments detailed hereunder, whose scope is stated in the second amendment to the Health Insurance Law as periodically amended.

Psychiatric hospitalization services.

Additional medical examinations and health services.

The basket of medications.

The basket of services at work – all of the services enumerated in Regulations 2 and 5 of the Parallel Tax Regulations (Health Services at Work), 5733 – 1973 however any reference to "HMO" is to be replaced by "the medical insurer".

For the avoidance of doubt it is emphasized that in addition to that stated in the general exclusions in the preamble chapter, the provision of the medical services detailed hereunder in this chapter will be subject to the restrictive conditions relating to pre-existing medical conditions, work accidents, the incapacity of the insured to perform the work for which he was employed by his employer - the policyholder, as well as to the additional conditions and procedures detailed hereunder, so that the policyholder and the insured will be aware of the scope of the insurer's liability and the insured's rights in accordance with this policy.

The insurer will indemnify the insured for expenses incurred in obtaining the medical services detailed hereunder in this policy **from the service providers with whom the insurer has an agreement and solely from them other than if otherwise expressly stated.**

For the avoidance of doubt it is clarified that obtaining the insurer's authorization in cases in which authorization is required is a fundamental condition to the liability of the insurer in accordance with this policy.

The insurer will be entitled at its discretion to make full or partial indemnity payments directly to the party that supplies the medical service to the insured or to make payment to the insured after having received original receipts.

2. **Definitions for this section**

2.1 **Hospital:** A medical institution which is recognized as such by the competent authorities in Israel and which operates solely as a general hospital.

2.2 **Scheme hospital:** A hospital having an agreement with the insurer for the provision of services in accordance with this policy.

2.3 **Emergency room:** A wing forming an integral part of a general hospital in which the insured stays prior to being admitted to the hospital and/or being released.

2.4 **Hospitalization expenses:** All expenses for hospitalization in a scheme hospital

for a period exceeding 24 hours, for the medical treatment provided at the time of and during hospitalization including surgeon's fees, anesthetist's fees, emergency medical treatment expenses as well as expenses for examinations and medications performed and provided during the hospitalization.

2.5 **Expenses other than during hospitalization:** All expenses for the medical treatment provided to the insured other than during hospitalization by service providers having an agreement with the insurer for the provision of services in accordance with this policy and which are stated in the second amendment to the Health Law, other than any expenses excluded by decree or in accordance with this policy.

2.6 **Doctor:** An individual qualified by the competent authorities in Israel or overseas to engage in medicine in Israel, whether as a primary doctor or as secondary treatment (specialist doctor).

2.7 **Primary doctor:** A general practitioner who is not a specialist in a specific field or a specialist in family medicine, internal medicine or gynecology, who has an agreement with the insurer for the provision of services in accordance with this policy.

2.8 **Specialist doctor:** A doctor who is recognized as a specialist by the health authorities in the State of Israel and provided that his field of expertise is in the field required for the medical treatment (other than a family doctor, specialist in internal medicine or a gynecologist), who has an agreement with the insurer for the provision of services in accordance with this policy.

2.9 **Scheme doctor:** A doctor who has an agreement with the insurer for the provision of services in accordance with this policy.

2.10 **Medical event:** An illness or accident which the insured sustains during the insurance period other than an illness or accident which is excluded and/or limited in this policy. In the event of a pre-existing medical condition, that stated in section 6 hereunder will apply.

2.11 **Medical emergency:** Circumstances in which the insured's life is in immediate danger or if there is an immediate risk that the insured will be rendered severely and irrevocably disabled if he is not provided with urgent medical treatment.

2.12 **Elective hospitalization:** Hospitalization whose need is foreseen in advance and where the hospitalization of the insured for the purpose of performing surgery is not performed via a referral from an emergency room in an urgent condition but rather the insured was referred to hospitalization by a specialist doctor from a clinic (including a hospital's outpatient clinic).

2.13 **Diagnostic clinic:** A clinic performing EG, EMG, audiology and ergometry tests, which has an agreement with the insurer for the provision of services in accordance with this policy.

2.14 **Imaging clinic:** An x-ray, ultrasound, nuclear medicine, computerized tomography (CT) and echocardiography clinic, which has an agreement with the insurer for the provision of services in accordance with this policy.

2.15 **Insurance event: an event or medical condition resulting in the insured being in need of the services included in section 4 of this Chapter A**.

2.16 **Basket of medications:** All of the medications included in the National Health Insurance Ordinance (Medications in the Health Service Basket), 5755 – 1995,

as periodically amended, which is in effect at the time of the occurrence of a medical event defined as an insurance event in accordance with the policy.

2.17 **Pharmacy:** An institution authorized in accordance with legal provisions to sell and market medication to the general public, which has an agreement with the insurer for the provision of services in accordance with this policy.

2.18 **The customary payment:** The payment, including guarantees or deposits, which the insured is required to pay for obtaining medical services as detailed in this policy and which is stated in the second amendment or the third amendment to the Health Insurance Law, or in a notification regarding conditions and payments provided by the government to individuals on the determining date in accordance with the Health Insurance Law or in the Health Fund Proposal in accordance with Article 8(1A) of the Health Insurance Law which has been ratified in accordance with Article 8(2A) of the same law, and if there are different payments in the said directives – the higher of them.

3. Instructions for receiving services in accordance with the policy

3.1 Primary healthcare

If the insured requires treatment by a general practitioner, who is not a specialist or a specialist in family medicine, internal medicine or gynecology, he may approach any doctor who has an agreement with the insurer for the provision of services in accordance with this policy without the need for prior authorization from the insurer.

3.2 Non-primary healthcare

If the insured requires treatment by a specialist, he may approach any doctor who has an agreement with the insurer for the provision of services in accordance with this policy provided that he has obtained a written referral from a primary doctor or a referral from the call center.

3.3 Medical clinics

If the insured requires examinations in an imaging clinic and/or in a diagnostic clinic as defined above and/or in a gastroenterology clinic and/or laboratory examinations, he must contact the call center in order to receive authorization to perform the aforementioned action or actions in the clinics which have an agreement with the insurer for the provision of services in accordance with this policy, this after having received a written referral from a primary doctor or a specialist doctor.

The authorization or notification of the declinature to provide such authorization will be provided within a reasonable period and within not more than 7 days of the request of the attending doctor (primary or specialist) and in any case the time it takes to issue the authorization will not endanger the insured.

3.4 Elective hospitalization

Determining the need for elective hospitalization will be made by a primary doctor and/or specialist doctor treating the insured.

The authorization or notification of the decline to provide it will be provided within a reasonable period and within not more than 7 days of the request of the attending doctor (primary or specialist) and in any case the time it takes to issue the authorization will not endanger the insured.

3.5 Emergency room

If the insured requires emergency room services in a general hospital in Israel as detailed section 4.2 hereunder, he will be entitled to approach any emergency room without the need for any type of prior authorization.

If the insured approaches an emergency room in any other situation, the insured will be obliged to provide a prior authorization from his attending doctor (either primary or specialist).

3.6 **Pharmacies**

If the insured requires medication covered in accordance with this policy, he may obtain the medication with a medical prescription provided to him by a primary and/or specialist doctor who has an agreement with the insurer for the provision of services in accordance with this policy from a pharmacy that has an agreement with the insurer.

3.7 **Deductible**

The insurer is entitled to stipulate the provision of the services in accordance with this policy to the payment of the deductible by the insured in the customary amount as defined in section 2.17 above. The amount of the deductible will be equivalent to the customary applicable deductible amount on the date of obtaining the relevant service.

The deductible will be stated on the insured's card and if circumstances permit will be paid prior to obtaining the service and will constitute a pre-condition for receiving such service.

4. **The insurer undertakes to pay the expenses connected to a medical event which is defined as an insurance event, as follows:**

Hospitalization expenses in a scheme hospital in Israel as defined above.

4.1 **Emergency room services in any general hospital in Israel (and not solely in a scheme hospital) in any of the following cases:** Any new fracture, severe dislodgement of a shoulder or elbow; an injury which needs to be treated with stitches or alterative measures of closing; breathing in a foreign matter into the respiratory system; the penetration of a foreign matter into an eye; treatment of cancer; treatment of hemophilia; treatment of cystic fibrosis; transfer in an ambulance to an emergency room from the street or other public place, due to a sudden event; referral concluding in non-elective hospitalization; an emergency medical condition.

4.2 **Hospitalization services** which are provided to the insured in a hospital as detailed in section 4.2 above following arrival at the emergency room of the same hospital, if performed in the cases detailed in section 4.2 above.

4.3 **Hospitalization in a psychiatric hospital** or in a psychiatric department of a general hospital.

4.4 **Expenses other than during hospitalization**

Such services will be provided to the insured solely in a medical emergency as defined above, for a period not exceeding 60 days per single period of employment.

In this regard, "**single period of employment**" means the entire period, even if not consecutive, in which employment relations exist between a specific employer and the insured. Medical expenses for a medical examination or examinations by a scheme doctor as defined above, laboratory examinations, x-

rays performed in a diagnostic clinic as defined and/or in an imaging clinic, including the Basket of Services at Work and medication as defined which are provided to the insured other than during hospitalization, including the other services contained in the Ordinance, via service providers having an agreement with the insurer in accordance with its directives.

4.5 **Additional medical services**

4.5.1 Amniotic fluid examinations for women over the age of 35 from the onset of pregnancy, subject to the directives stated regarding the issue of pregnancy in section 4.8 hereunder.

4.5.2 Vaccinations against tetanus, rabies and diphtheria.

4.5.3 Mantoux tests and lung x-rays.

4.5.4 Wheelchairs and walking frames.

4.6 **Medication**

Medication basket – all of the services listed in the National Health Insurance Ordinance (Medications in the Health Service Basket), 5755 – 1995 as may be from time to time; medication purchased in accordance with the orders of a doctor and in accordance with a medical prescription, **other than medication which is excluded in this policy and on condition they are purchased in a pharmacy that has an agreement with the insurer as defined above**.

4.7 **Medical services for pregnant women**

If the insured is in need of the services stated above during pregnancy, she will be entitled to receive them **solely** if the one of the following conditions are met and/or have been met:

4.7.1 If the insured has been employed by the policyholder and/or another employer for an accumulative period exceeding 9 months.

4.7.2 If she is in need of medical services covered by the policy due to a medical emergency as defined above.

5. **Exclusions to this section:**

The insurer will not be liable to make indemnity payments in accordance with any of the policy sections if the insurance event is a direct consequence of and/or if the insurance event arises from the following:

5.1 If the insurance event occurs after the expiry of the insurance period. This exclusion will apply in respect of each insured once in consecutive insurance periods (at the time when the insurance coverage for the insured has lastly expired) and will reapply each time in which an insured re-joins the insurance in inconsecutive periods of insurance.

5.1.1 Road accidents as defined in the Road Accident Victims Compensation Law, 5735 – 1975.

5.1.2 A hostile act and/or acts, as defined in the Compensation for Victims of Hostile Acts Law, 5730 – 1970, if the insured was "injured" as defined in the same law.

5.1.3 The provision of services of any type outside of Israel (regardless as to whether the event occurs in Israel or overseas).

5.1.4 Incapacity to work for the purpose of which the insured came to work in Israel, subject to that stated in section 7 of this chapter.

5.1.5 Work accidents as defined in section 8 of this chapter.

5.2 The insurer will not be liable to make indemnity payments in accordance with any of the policy sections if the insurance event is as follows:

5.2.1 In the framework of the basket of treatments -

5.2.1.1 Psychological treatments.

5.2.1.2 Dead Sea treatments provided to psoriasis patients.

5.2.1.3 Genetic examinations.

5.2.1.4 Nursing hospitalization or other nursing treatments.

5.2.1.5 Services for treating impotence or sterility problems, sexual functioning disruption, male or female fertility as well as artificial insemination or artificial fertilization.

5.2.1.6 Embryo or premature birth treatment.

5.2.2 In the framework of the basket of medications -

5.2.2.1 Medication for the treatment of Alzheimer's disease.

5.2.2.2 Medication designated to treat impotence or sterility problems, sexual functioning disruption, male or female fertility or which is provided in the context of artificial insemination or artificial fertilization treatment.

6. **Pre-existing medical conditions**

6.1 The insured will not be entitled to medical treatment as defined in this policy if the medical event constituting an insurance event in respect of which the insured is in need of medical treatment arises from a medical condition which precedes the inception date of the insurance period in accordance with this policy (hereinafter: "pre-existing medical condition") and/or which precedes the first date on which any employer in Israel arranged medical insurance for him (hereinafter: "the first date") and if any one of the following two conditions exist:

a. The insured confirms that the insurance event constituting the medical problem in respect of which he is in need of the service arises from a pre-existing medical condition.

b. A doctor confirms, in accordance with his findings, that the medical condition in respect of which the insured is in need of the service arises from a pre-existing medical condition.

If the insured spends time outside of Israel after the first date (hereinafter "the stay") for a period or periods exceeding 90 consecutive days, or exceeding 120 consecutive days if the stay separated between periods of employment with the same employer – the first date will be considered to be the first day following the stay in which the employee was covered by medical insurance.

6.2 Notwithstanding the provisions in section 6.1 above, if 3 years have elapsed from the date of the Ordinance's entry into effect or the first date, the latter of the two, the aforementioned limitations will not apply to him.

6.3 Notwithstanding the aforementioned, the entitlement of an insured to receive medical services as stated in this section, which he requires in a situation of a medical emergency arising from a pre-existing medical condition in order to stabilize his medical condition to a condition which allows his ongoing treatment outside of Israel will not be restricted, or to restrict other medical services which he requires due to a pre-existing medical condition for the 30 day period after the doctor's certification as aforementioned or the determination of the stabilization of his medical condition as aforementioned.

6.4 In the event that the insured's entitlement to health services was restricted because of a pre-existing medical condition, the insurer will pay the insured the full payment of all the expenses related to his flight from Israel in any case in which the medical condition requires accompaniment or other special arrangements during the flight.

7. The insured's capability to work

7.1 If a doctor determines that the insured is incapable of performing the work for which his employer accepted him and determines that he will be incapable of doing so for a period of 90 days from the date on which he was examined by the doctor, even if he undergoes the medical treatment which he requires, the insured will only be entitled to the medical services which he needs in an emergency medical condition for the purpose of stabilizing his medical condition to a situation which will enable his ongoing treatment outside of Israel as well as other medical services which he needs in the 30 day period following the determination of the doctor as aforementioned regarding the stabilization of his medical condition as aforementioned.

7.2 In the event that the entitlement of the insured to medical services due to a pre-existing medical condition or incapacity to work as aforementioned in sections 6.1 and 7.1 above is restricted, the insurer will pay the insured all of the expenses involved in transporting the insured from Israel by plane in any situation in which his medical condition requires accompaniment or other special arrangements during the flight.

8. Work accidents

8.1 If the insured suffers an insurance event that constitutes a work accident as defined in the National Insurance Law [Consolidated Version], 5755 – 1995, the policyholder being the employer of the insured will be required to complete form NI 250 designated for this purpose and to submit it to the National Insurance Institute without delay.

If the policyholder does not complete the aforementioned form and if he incurs fees for medical services due to a work accident, the insurer will be entitled to subrogate against the policyholder any amount paid due to the non-completion of the aforementioned form and its submission to the National Insurance Institute.

8.2 The services included in the basket of health services under this Ordinance will not be given to the employee in the event he needed them due to a work accident, within its meaning of the National Insurance Law [Consolidated Version], 5755 – 1995, provided that the employer confirmed, in the form prescribed by the National Insurance Institute and intended for this purpose (hereinafter - injury form) that said that the injury is work accident.

8.3 In the event the employer submitted the work injury form to the National Insurance Institute and the Institute does not determine, within 90 days of the date of the injury, that it is a work accident, the insurer will bear the expenses for the services provided to the insured due to the aforementioned injury, within the 90 days, even if provided by service providers who do not have an agreement with the insurer and will thereafter pay the expenses for the services provided solely by service providers who do have an agreement with the insurer, subject to the provisions of sections 4.2 and 4.3 above and this until a decision is provided by the National Insurance Institute.

9. **Claims handling procedure and payment of indemnity**

9.1 A doctor's certification that the medical problem in respect of which the insured is in need of the service arises from a pre-existing medical condition and a doctor's confirmation that the insured's medical condition has stabilized must be obtained.

9.2 The determination of a doctor regarding the incapacity of the insured to work, including if medical treatment has been provided – will be made by a specialist doctor in occupational medicine.

9.3 If the insurer requests that the insured undergoes a medical examination by a specialist doctor appointed by the insurer, the examination will be paid for by the insurer. The insurer will submit the specialist medical opinion to the insured, attaching a notification regarding the insured's entitlement to obtain a counter - opinion from a doctor selected by the insured as stated in section 9.4 hereunder and attaching details of the entities or organizations which may assist him in performing the same who have provided their agreement to the same.

9.4 The insured is entitled to a counter-opinion from a specialist doctor whom he selects and this must be submitted to the insurer within 21 days of the date on which the insured received the specialist medical opinion from the insurer's doctor.

9.5 The fee of the specialist doctor appointed by the insured will be paid by the insurer, at the rate determined by the General Manager of the Ministry of Health and the Capital Markets, Insurance and Savings Commissioner at the Ministry of Finance (hereinafter – the determining fee);

9.6 In the event that the two specialist doctors as aforementioned disagree, the parties will appoint a doctor agreed upon by them; this will be paid for by the insurer and his opinion will prevail; if the parties do not reach an agreement on the doctor as aforementioned, an arbitrating doctor will be appointed by the Head of the Israeli Medical Federation (hereinafter – the Federation) engaged in the medical field related to the insured's illness and in respect of determining incapacity to work including the provision of medical treatment – by the Head of the Occupational Medicine Association of the Federation (hereinafter – arbitrating doctor) and his opinion will prevail; if the Head of the Association does not appoint an arbitrating doctor within 15 days of the date on which the insurer approaches him, the arbitrating doctor will be appointed by the General Manager of the Ministry of Health or by a party agreed upon; the fees of the arbitrating doctor will be the determining fee and will be paid by the insurer.

9.7 Notwithstanding the aforementioned, if the department manager in the hospital

in which the insured is hospitalized, or in the absence of the manager – the deputy department manager – determines that his medical condition has not yet stabilized on the date on which the entitlement of the insured to medical treatment due to the pre-existing medical condition as stated in section 6 above or due the incapacity to work as stated in section 7 above is due to terminate, his decision will be binding as long as no other decision has been issued either by the department manager or his deputy as aforementioned, or in accordance with the directives of this section.

9.8 The entitlement to the services in accordance with sections 6 and 7 above will only terminate and the 30 days stated in the same clauses will only be counted from the date of the final certification or the final decision provided in accordance with section 9.6 above however such decision regarding the stabilization of the medical condition of the insured will not be considered to be final in the event of decision as aforementioned in section 9.7.

Chapter B – Special expenses

The coverage in this chapter applies in addition to the coverage under Chapter A.

1. The insurer will pay special expenses incurred following a medical event defined as an insurance event in Chapter A, as follows:

   1.1 **Repatriation of body:** In the event of the death of the insured - expenses for the transfer of the corpse from Israel to the insured's home country will be paid up to a maximum sum of US$ 5,000.

   1.2 **Emergency dental treatment:** Emergency dental treatment performed in a dental clinic which has an agreement with the insurer, solely in the event that the insured is in need of such treatment as first aid, up to a maximum sum of US$ 200 per annual insurance period.

2. **Exclusions to Chapter B**:

   The insurer will not be liable in accordance with this chapter if the death or disability is caused directly or indirectly by or due to:

   2.1 Intentional self-injury or attempted suicide, regardless as to whether the insured is sane or not.

   2.2 Alcoholism, drunkenness or use of drugs by the insured, unless if supplied in accordance with a doctor's prescription.

   2.3 The insured's participation in criminal activity.

   2.4 War or belligerent acts of regular or irregular hostile forces.

   2.5 Acts of sabotage or terrorism of any type, if the insured is entitled to compensation from a governmental entity.

   2.6 The insured flying in any type of aircraft other than if the insured flies in a civil aircraft authorized to carry passengers.

   2.7 The active participation of the insured in underwater diving, skydiving or hunting.

   2.8 The use of explosives.

   2.9 Intentional self-endangerment, other than self-defense and lifesaving.

   2.10 An accident as a consequence of surgery including minor surgery.

   2.11 Road accidents as defined in the Road Accident Victims Compensation Law, 5735 – 1975 or any other law replacing the same.

   2.12 Work accidents as defined in the National Insurance Law [Consolidated Version], 5755 – 1995 or any other law replacing the same.

Chapter C – Accidental death insurance and disability due to an accident

This Chapter shall enter into effect only if purchased and noted explicitly in the schedule.

If the insured suffers an insurance event as detailed hereunder during the insurance period, the insurer will make indemnity payments as follows:

1. **Death due to an accident:**

1.1 **Definitions for this section**

Accident: Bodily injury which is sustained exclusive of any other causes due to an external, violent and accidental cause.

1.2 **Insurance event:** The death of the insured as a direct and decisive consequence of an accident, on condition that the death occurs within the insurance period stated in the policy schedule and whilst the policy is fully valid.

If the insured dies not as a direct, immediate and sole result of the accident itself (hereinafter: "the external causes"), the insurer will be liable solely if these external causes were not the decisive cause of the death of the insured

1.3 **Indemnity payments:** The insurer will pay compensation of US$ 10,000 on the occurrence of an insurance event to the beneficiary or, in the absence of a beneficiary, to the legal heirs of the insured.

1.4 If indemnity payments have been made to the insured due to the same insurance event in respect of disability due to an accident, in the event of the death of the insured the insurer will pay solely the difference, if applicable, between the amount in accordance with this section and the amount paid as aforementioned in respect of disability.

2. **Disability due to an accident:**

2.1 **Definitions for this section**

Accident: as defined in section 1.1 of Chapter C above, provided it did not result in the death of the insured.

Insurance event: Permanent disability of the insured due to an accident which is a direct and decisive consequence of the same accident during the insurance period stated in the policy schedule, on condition that the insured is still alive 90 days after the occurrence of the accident and on condition that at the time of the accident the premiums for the policy have been fully paid.

2.2 If the disability was not a direct, immediate and exclusive result of the accident itself, the insurer shall be responsible only if this effect was not the deciding cause for the insured's disability.

2.3 **Indemnity payments:**

2.3.1 The insurer will pay the sum insured of US$ 10,000 (hereinafter: "**the sum insured**" or "**the capital amount**") or part thereof, in accordance with the rate of medical disability which is determined for the insured by a specialist doctor in the relevant field in accordance with the provisions of the National Insurance Law and its regulations (excluding regulation 15), as a work injury, as defined in the National

Insurance Law and subject to the exclusion stated in section 6.11 hereunder. In the event of medical disability which is not stated in the National Insurance tests, the level of disability will be determined by a specialist doctor in the relevant field, and the payment will be made as a percentage of the disability rate determined by the specialist doctor out of the full sum insured.

2.3.2 **Cumulative disability percentages:** A total cumulative level of disability will be determined for an insured who suffers from several disabilities each of which in respect of he is entitled to a disability percentage in accordance with this appendix.

2.3.3 For the avoidance of doubt, the insured will not be entitled to a total amount exceeding 100% of the disability sum insured due to an insurance event, regardless as to whether a lump-sum is paid due to the total disability of the insured or whether it is paid in instalments due to a number of claims for partial or cumulative disability. The amount payable will be calculated as a percentage of the full sum insured in respect of this appendix. As soon as the total amounts payable by the company in accordance with this appendix equals the full sum insured, the validity of this appendix will expire.

3. **Under no circumstances will the total amount payable in respect of the coverage in accordance with this section exceed US$ 10,000.**

4. **The coverage in accordance with this section will apply solely from the moment that the insured leaves the aircraft when he arrives in Israel until he leaves Israel and this is subject to the definition of the insurance period in the definitions section in the preamble section.**

5. **Exclusions to Chapter C**:

The insurer will not be liable in accordance with this chapter if the death or disability is caused directly or indirectly by or due to:

5.1 Intentional self-injury or attempted suicide, regardless as to whether the insured is sane or not.

5.2 Alcoholism, drunkenness or use of drugs by the insured, unless if supplied in accordance with a doctor's prescription.

5.3 The insured's participation in criminal activity.

5.4 War or belligerent acts of regular or irregular hostile forces.

5.5 Acts of sabotage or terrorism of any type, if the insured is entitled to compensation from a governmental entity.

5.6 The insured flying in any type of aircraft other than if the insured flies in a civil aircraft authorized to carry passengers.

5.7 The active participation of the insured in underwater diving, skydiving or hunting.

5.8 The use of explosives.

5.9 Intentional self-endangerment, other than self-defense and lifesaving.

5.10 An accident as a consequence of surgery including minor surgery.

5.11 Road accidents as defined in the Road Accident Victims Compensation Law, 5735 – 1975 or any other law replacing the same.

5.12 Work accidents as defined in the National Insurance Law [Consolidated Version], 5755 – 1995 or any other law replacing the same.