

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.

TRANSLATION

In the event of any discrepancy between this translation and the original issued in the Hebrew language, the latter will prevail.

MenoMedic^{TOP}

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 this policy, 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 insured event which occurs during the period of insurance stated herein, in accordance with the covers as detailed in the sections of this policy.

It is emphasised 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 sake of avoidance of doubt, this policy has been especially tailored to the directives of the Foreign Workers Ordinance (Prohibition of Illegal Employment and Assurance of Fair Conditions) (Employee's Health Services Basket) – 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.

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.
- 1.2 **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 adjoins the insurance in accordance with the directives of this policy.
- 1.3 **The insurer:** Menora Mivtachim Insurance Ltd.
- 1.4 **The proposal form or the proposal:** The proposal form constitutes a request to adjoin 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.

- 1.5 **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.
- 1.6 **The schedule:** The policy schedule attached to the policy, which constitutes an integral part of the same. The schedule contains the policy number, personal details of the policyholder and the insured/s, the period of insurance, the premium etc.
- 1.7 **Insured 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.
- 1.8 **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 latter of the two.
- 1.9 **The period of insurance:** 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 case the period of insurance 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 exceed of a period of 60 months; the period of insurance will be extended however will in any event terminate, at the very latest, on the date on which the validity of the visa expires.
For the avoidance of doubt it is clarified that the period of insurance will expire on the date stated in the schedule and no later than the dates stated above.
- 1.10 **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.
- 1.11 **Overseas:** Any country outside of the State of Israel other than enemy countries.
- 1.12 **Insurance Contract Law:** The Insurance Contract Law – 1981.

- 1.13 **Health Insurance Law:** The National Health Insurance Law – 1994.
- 1.14 **The second amendment:** The second amendment to the Health Insurance Law, which contains and details the basket of health services provided in the context of the Health Insurance Law.
- 1.15 **The Ordinance:** The Foreign Workers' Ordinance (Prohibition of Illegal Employment and Assurance of Fair Conditions) (Employee's Health Services Basket) – 2001.
- 1.16 **The National Insurance Law:** The National Insurance Law [Combined Version] – 1995.
- 1.17 **Call centre:** A call centre 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, hospitalisation authorisation, dealing with repatriating injured parties and corpses to their home countries and the provision of any other assistance required in accordance with the insurance in accordance with this policy.
- 1.18 **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 The policy becomes effective on the inception date of the insurance however not before the premium has been paid.
- 2.2 If funds are paid to the insurer on account of the premium before the insurer has agreed to cover the proposer to the insurance, the payment will not be considered to construe 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.

- 2.3 The rejection of the proposal form or an approach to the insured with a counter-offer for insurance cover 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 cover, 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 period of insurance, subject to the policy conditions.

3. Duty of disclosure

- 3.1 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.
- 3.2 If an incomplete and dishonest reply is provided to a question regarding a material fact 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 insured event has not occurred.
- 3.3 If the insurer cancels the policy by virtue of this clause, the policyholder is entitled to a refund of the premium paid to the insurer for the period following the cancellation of the insurance, less the insurer's expenses, unless if the insured acted with fraudulent intent.
- 3.4 If an insured 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:
- 3.4.1 The reply was provided with fraudulent intent.
- 3.4.2 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 insured event, less the insurer's expenses.

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

3.5.1 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.

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

3.6 **For the avoidance of doubt it is clarified that where the insured event arises from a previous medical condition (as defined in clause 6 of Section A hereunder), that stated in sub-clause 3.4 above will apply and the insurer will only be liable to make reduced indemnity payments or, in the cases stated above – will be entirely exempt from liability.**

4. The premium and the method of payment

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

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

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

4.4 The insurer will be entitled to alter the premium for this insurance for all parties covered by this insurance. Such an alteration will be effective on condition that the Commissioner of Insurance authorises the alteration and this 60 days after the date on which the insurer notifies the insured in writing of the same. If the premium is altered as aforementioned, the new premium will be calculated without reference to any changes which

have occurred to the health condition of the insured during the period which preceded the alteration as aforementioned.

5. Claims and indemnity payments

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

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

5.2 The receipt of the insurer's authorisation in the event of any insured event in which the insurer's authorisation is required is a fundamental condition to the liability of the insurer in accordance with this insurance.

5.3 If the insured is hospitalised 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 direct approach to the hospital is provided immediately to the insurer's call centre.

5.4 The insured is obliged to submit a waiver of medical confidentiality form to the insurer, permitting any doctor and/or 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.

5.5 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.

5.6 Medical confidentiality

5.6.1 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 clause 62 of the Employment Service Law – 1959 (hereinafter: "the party connected to the transaction"), unless the insured provides his informed consent. The insurer will take appropriate measures to ensure compliance with this directive.

5.6.2 The insurer will not accept a waiver of medical confidentiality form from the insured which contains an agreement to submit the said information to the employer of the insured or to the party connected to the transaction. 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.

5.6.3 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 transaction with a request to obtain the said medical information for the insurer, other than in the event of a medical emergency condition.

5.7 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.

5.8 The insurer will be entitled at its sole discretion to make indemnity payments or part thereof directly to the service provider or to pay them to the insured after having received **original** receipts. 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.

5.9 If the insured dies, the insurer will pay the balance of the indemnity payments to the service provided to whom the insurer provided a financial undertaking. In the absence of an undertaking to the service provider or if there is an outstanding balance after payment has been

made in accordance with the said undertaking, the insurer will pay this balance.

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

5.10.1 If the insured is also entitled to indemnity from a third party due to an insured 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 directives of this clause will not apply to an insured 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.

5.10.2 If 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 clause 59 of the Insurance Contract Law will apply.

6. Cancellation of the insurance policy

6.1 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.

- 6.2 If the premium has not been paid on time as stated in clause 4 above, the insurer will be entitled to cancel the insurance subject to the directives of the Insurance Contract Law.
- 6.3 The insurer is entitled to cancel the policy in any situation in which it is entitled to do so in accordance with the Insurance Contract Law.
- 6.4 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.
- 6.5 Subject to that stated in clause 7.2 hereunder, if the insurance is cancelled due to the termination of employment relations between the insured and the policyholder as stated in clause 6.4 above, the insurer will be under no obligation to cover the aforementioned individual as an employee of another employer and/or to cover the aforementioned insured under any other policy.
- 6.6 If an insured event occurs prior to the cancellation of the policy, the insurer will indemnify the insured for the insured event for a period of up to 90 days from the date on which the policy is cancelled.

7. Extension of the insurance and continuity of insurance

- 7.1 The insurer will extend the period of insurance 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 period of insurance, however in no event will the extended period of insurance exceed the period of insurance as defined in clause 1.9 above.
- 7.2 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 period of insurance for the insured will in no case extend past the period of insurance as defined in clause 1.9 above.

8. 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 insured event occurs, as conventional in Israel.

9. 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 centre.

10. Call centre

The insurer undertakes to establish and operate a call centre 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 centre" in the preamble.

11. Obtaining medical treatment

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

11.2 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 centre as soon as possible.

12. 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 fact in respect of which the duty of disclosure applies as stated in clause 3 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 directives of clause 3 above will apply.

13. 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.

14. Proscription

The proscription period of a claim for indemnity payments is 3 years from the date of the occurrence of the insured event.

15. Application of the Insurance Contract Law

The directives of the Insurance Contract Law – 1981 will apply to all matters connected to this policy insofar as stipulated in accordance with the subject matter unless otherwise stipulated to the benefit of the policyholder and the insured under this policy.

16. Notifications between the parties

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

16.2 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.

Section A – Cover for medical services provided in accordance with the Health Insurance Law

1. Preamble

1.1 This section provides cover to the insured for all medical services contained in the ordinance at the scope of entitlement and excluding defined services as detailed hereunder:

1.1.1 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.

1.1.2 Psychiatric hospitalisation services.

1.1.3 Additional medical examinations and health services.

1.1.4 The basket of medications.

- 1.1.5 The basket of services at work – all of the services enumerated in amendments 2 and 5 of the Parallel Tax Regulations (Basket of Services at Work) – 1973 however in any place in which the terminology "health fund" is stated, it is replaced with the words "the medical insurer".
- 1.2 **For the avoidance of doubt it is emphasised that in addition to that stated in the general exclusions in the preamble section, the provision of the medical services detailed hereunder in this section will be subject to the restrictive conditions relating to previous 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, such 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.**
- 1.3 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 authorisation in cases in which authorisation is required is a fundamental condition to the liability of the insurer in accordance with this policy.**
- 1.4 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 recognised 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 **Hospitalisation expenses:** All expenses for hospitalisation in a scheme hospital for a period exceeding 24 hours, for the medical treatment provided at the time of and during hospitalisation including surgeon's fees, anaesthetist's fees, emergency medical treatment expenses as well as expenses for examinations and medications performed and provided during the hospitalisation.
- 2.5 **Expenses other than during hospitalisation:** All expenses for the medical treatment provided to the insured other than during hospitalisation 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 a 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 gynaecology, 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 recognised 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 gynaecologist), 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 period of insurance other than an illness or accident which is excluded and/or limited in this policy. In the event of a previous medical condition, that stated in clause 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 hospitalisation:** Hospitalisation whose need is foreseen in advance and where the hospitalisation of the insured for the purpose of performing surgery is not performed via a referral from an emergency room in an urgent condition.
- 2.13 **Diagnostic clinic:** A clinic performing EG, EMG and audiology 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 **Basket of medications:** All of the medications included in the National Health Insurance Ordinance (Medications in the Health Service Basket) – 1995, as periodically amended, which is in effect at the time of the occurrence of a medical event defined as an insured event in accordance with the policy.
- 2.16 **Pharmacy:** An institution authorised 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.
- 2.17 **The conventional 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 clause 8(1A) of the Health Insurance Law which has been ratified in accordance with clause 8(2A) of the same law, and if there are different payments in the said directives – the higher of them.

3. Directives for obtaining 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 gynaecology, 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 authorisation 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 centre.

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 centre in order to receive authorisation 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 authorisation or notification of the declinature to provide such authorisation 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 authorisation will not endanger the insured.

3.4 **Elective hospitalisation**

Determining the need for elective hospitalisation will be made by a primary doctor and/or specialist doctor treating the insured. The insured is obliged to obtain prior written authorisation from the insurer via the call centre for performing the aforementioned elective hospitalisation.

The authorisation or notification of the declinature 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 authorisation will not endanger the insured.

3.5 **Emergency room**

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

If the insured approaches an emergency room in any other situation, the insured will be obliged to provide a prior authorisation 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 subject the provision of the services in accordance with this policy to the payment of the deductible by the insured in the conventional amount as defined in clause 2.17 above. The amount of the deductible will be equivalent to the conventionally 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 obtaining such service.

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

4.1 **Hospitalisation expenses in a scheme hospital in Israel** as defined above.

4.2 **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 unified by stitches or alternative unification means; breathing a foreign matter into the respiratory system; the penetration of a foreign matter into an eye; treatment of cancer; treatment of haemophilia; 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 hospitalisation; an emergency medical condition.

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

4.4 **Hospitalisation in a psychiatric hospital** or in a psychiatric department of a general hospital.

4.5 **Expenses other than during hospitalisation**

4.6 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 hospitalisation, including the other services contained in the Ordinance, via service providers having an agreement with the insurer in accordance with its directives.

4.7 **Additional medical services**

4.7.1 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 clause 4.9 hereunder.

4.7.2 Vaccinations against tetanus, rabies and diphtheria.

4.7.3 Mantoux tests and lung x-rays.

4.7.4 Wheelchairs and walking frames.

4.8 **Medication**

Medication which is purchase in accordance with the directives of a doctor and in accordance with a medical prescription, other than medication which is excluded in this policy and on condition that it are purchased in a pharmacy that has an agreement with the insurer as defined above.

4.9 **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 complied with and/or have been complied with:

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

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:**

5.1 **The insurer will not be liable to make indemnity payments in accordance with any of the policy sections if the**

insured event is a direct consequence of and/or if the insured event arises from the following:

- 5.1.1** If the insured event occurs after the expiry of the period of insurance. This exclusion will apply in respect of each insured once in consecutive periods of insurance (at the time when the insurance cover for the insured most recently expired) and will reapply each time in which an insured re-adjoins the insurance in inconsecutive periods of insurance.
 - 5.1.2** Road accidents as defined in the Road Accident Victims Compensation Law – 1975.
 - 5.1.3** A hostile act and/or acts, as defined in the Compensation for Victims of Hostile Acts – 1970, if the insured was "injured" as defined in the same law.
 - 5.1.4** The provision of services of any type outside of Israel (regardless as to whether the event occurs in Israel or overseas).
 - 5.1.5** Incapacity to work for the purpose of which the insured came to work in Israel, subject to that stated in clause 7 of this section.
 - 5.1.6** Work accidents as defined in clause 8 of this section.
- 5.2** The insurer will not be liable to make indemnity payments in accordance with any of the policy sections if the insured event is as follows:
- 5.2.1** In the framework of the basket of treatments -
 - A.** Psychological treatments.
 - B.** Dead Sea treatments provided to psoriasis patients.
 - C.** Genetic examinations.
 - D.** Nursing hospitalisation or other nursing treatments.

- E. Services for treating impotence or sterility problems, sexual functioning disruption, male or female fertility as well as artificial insemination or artificial fertilisation.**
- F. Embryo or premature birth treatment.**

5.2.2 In the framework of the basket of medications -

- A. Medication for the treatment of Alzheimer's disease.**
- B. 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 fertilisation treatment.**

6. Previous medical conditions

6.1 The insured will not be entitled to medical treatment as defined in this policy if the medical event constituting an insured 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 period of insurance in accordance with this policy (hereinafter: "previous 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 insured event constituting the medical problem in respect of which he is in need of the service arises from a previous 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 previous 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 that stated in clause 6.1 above, if 3 years have elapsed from the date of the ordinance 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 obtain medical services as stated in this section will not be restricted which he requires in a medical emergency arising from a previous medical condition in order to stabilise his medical condition to a situation which will facilitate his ongoing treatment outside of Israel will not be restricted, or to restrict other medical services which he requires due to a previous medical condition for the 30 day period after the doctor's certification as aforementioned or the determination of the stabilisation of his medical condition as aforementioned.**

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 stabilising his medical condition to a situation which will facilitate 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 stabilisation of his medical condition as aforementioned.**
- 7.2 In the event that the entitlement of the insured to medical services due to a previous medical condition or incapacity to work as aforementioned in clauses 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 insured event that constitutes a work accident as defined in the National Insurance Law [Combined Version] – 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 If the medical event constituting an insured event is a work accident as defined in the National Insurance Law and such injury is confirmed by the employer (policyholder) in the designated injury form, the insurer will be released and exempt from any liability for the provision of the services detailed in this policy.**
- 8.3 If the work injury form is submitted to the National Insurance Institute and this 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 directives of clauses 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 previous medical condition and a doctor's confirmation that the insured's medical condition has stabilised will be issued by a specialist doctor.**
- 9.2 The determination of a doctor regarding the incapacity of the insured to work, including if medical treatment has been provided will be performed 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 clause**

9.4 hereunder and attaching details of the entities or organisations 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 Commissioner of the Capital Markets, Insurance and Savings in the Ministry of Finance (hereinafter – the determining fee);**
- 9.6 If 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) who is involve 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 Health Ministry 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 hospitalised, or in the absence of the manager – the deputy department manager – determines that his medical condition has not yet stabilised on the date on which the entitlement of the insured to medical treatment due to the previous medical condition as stated in clause 6 above or due the incapacity to work as stated in clause 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 clause.**

- 9.8** The entitlement to the services in accordance with clauses 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 clause 9.6 above however such decision regarding the stabilisation of the medical condition of the insured will not be considered to be final in the event of decision as aforementioned in clause 9.7.

Section B – Special expenses

The cover in this section applies in addition to the cover under Section A.

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

Repatriation of corpse: 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.

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 period of insurance.

Section C – Accidental death insurance, death other than as a result of an accident and disability due to an accident

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

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

1.1 Definitions for this clause

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

If the insured dies due to the affect of an illness or due to the deterioration of an illness which is not connected to the accident itself, the insurer will be liable solely if this affect was not the decisive cause of the death of the insured.

- 1.2 **Insured event:** The death of the insured as a direct and decisive consequence of an accident, on condition that the death occurs within 90 days of the date of the accident, during the period of insurance stated in the policy schedule and whilst the policy is fully valid.
- 1.3 **Indemnity payments:** The insurer will pay compensation of US\$ 10,000 on the occurrence of an insured 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 insured 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 clause and the amount paid as aforementioned in respect of disability.

2. **Death other than due to an accident:**

- 2.1 **Insured event:** The death of the insured other than as a consequence of an accident as defined in clause 1.1 above, on condition that the death occurs within the period of insurance stated in the policy schedule and whilst the policy is fully valid.
- 2.2 **Indemnity payments:** The insurer will pay compensation of US\$ 4,000 on the occurrence of an insured event to the beneficiary or, in the absence of a beneficiary - to the legal heirs of the insured.

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

3.1 **Definitions for this clause**

Accident: Bodily injury which is sustained exclusive of any other causes due to an external, violent and accidental cause, provided that the insured does not die.

If the disability is aggravated by the affect of an illness or due to the deterioration of an illness which is not connected to the accident itself, the insurer will be liable solely if this affect was not the decisive cause of the insured's disability.

- 3.2 **Insured event:** Permanent disability of the insured due to an accident which is a direct and decisive consequence of the same accident during the period of insurance 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.

3.3 **Indemnity payments:**

3.3.1 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 directives 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 clause 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.

3.3.2 **Accumulative disability percentages:** A total accumulative 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.

3.3.3 For the sake of avoidance of doubt, the insured will not be entitled to a total amount exceeding 100% of the disability sum insured due to an insured 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 accumulative 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.

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

5. **The cover 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 period of insurance in the definitions clause in the preamble section.**

6. **Exclusions to Sections B and C:**

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

- 6.1 Intentional self-injury or attempted suicide, regardless as to whether the insured is sane or not.**
- 6.2 Intoxication, drunkenness or use of drugs by the insured, unless if supplied in accordance with a doctor's prescription.**
- 6.3 The insured's participation in criminal activity.**
- 6.4 War or belligerent acts of regular or irregular hostile forces.**
- 6.5 Acts of sabotage or terrorism of any type, if the insured is entitled to compensation from a governmental entity.**
- 6.6 The insured flying in any type of aircraft other than if the insured flies in a civil aircraft authorised to carry passengers.**
- 6.7 The active participation of the insured in underwater diving, skydiving or hunting.**
- 6.8 The use of weapons.**
- 6.9 Intentional self-endangerment, other than self-defence and lifesaving.**
- 6.10 An accident as a consequence of surgery including minor surgery.**
- 6.11 Road accidents as defined in the Compensation of Road Accident Victims Law – 1975 or any other law replacing the same.**
- 6.12 Work accidents as defined in the National Insurance Law (combined version) – 1968 or any other law replacing the same.**