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SAFE STAY +

Foreign Worker's Extended Health Policy

In consideration of the payment of premiums as specified hereafter, the insurer shall indemnify the insured in respect of expenses for medical services and/or shall make payment directly to the providers of the service and/or to the medical institution having supplied the health services in respect of the insured contingency, and/or shall indemnify the insured, all as set forth and defined in the policy proper, in the appendix and in the schedule page, for the duration of the insurance term, within the insurer's liability limits, on the conditions, and subject to the exclusions and exceptions as set forth in this policy.

Chapter I: Definitions and general conditions

1. Definitions

1.1 **Insurance Event:** An event for which the Insured requires, within the Insurance Period, medical treatment in Israel that is included under the coverage of this Policy, for which the medical treatment is provided within the Insurance Period and/or within 90 days from the date of Termination of the Insurance Period, at the latest, all subject to the terms, qualifications, and exclusions set forth in this Policy.

1.2 **Medical certificate:** a medical certificate as per Section 1B of the Foreign Workers Law, within the following definition thereof and/or a medical certificate attesting that the worker has undergone a medical examination in Israel, at the insurer's demand.

1.3 **General hospital:** an institution in Israel that is recognized by the competent authorities as a general hospital and serves as a hospital only, excepting an institution being a sanatorium and/or a rehabilitation facility.

1.4 **Policyholder:** an employer, whether being a person, a group of persons or a corporation, contracting with the insurer under the insurance contract, and being named in the policy as the policyholder, wishing to insure the foreign worker pursuant to this policy.

1.5 **Premiums:** The amounts payable by the policyholder to the insurer in respect of the insurance coverage pursuant to this policy, in accordance with the policy conditions.

1.6 **The insurer:** Harel Insurance Company Ltd.

1.7 **The Insured:** An individual who lives, or intends to live, in Israel as a foreign worker, employed by the Policyholder.

1.8 **The Policy:** An Insurance Contract, between the Insurer, the Policyholder and the Insured, who is an employee of the Policyholder, including the Insurance Proposal, the Insurance Details Page, the Appendices, the Effective Date of the Insurance, the Date of Termination of the Insurance Period, the Insurance Premium, the Date of Payment, and so forth.

1.9 **The insurance proposal:** a proposal form in a wording to be determined by the insurer, duly filled out in all particulars thereof, including a declaration of health, a declaration of date of entry into Israel and a written waiver of medical confidentiality, signed by the insured named in the proposal as the insured and by the policyholder, wherever its signature is required.

1.10 **Customary payment:** a payment, including a guarantee or deposit, payable by the insured, as against the actual provision of the medical service, and which is specified in the Second or Third Schedule to the Health Insurance Law, as is on date of commencement of the insurance term, or in a notice concerning conditions and payments, served by the State upon an individual, on the determining date pursuant to the Health Insurance Law, or in a proposal by a health fund pursuant to Section 8 (A1) of the Health Insurance Law, approved in accordance with Section 8(A2) of that Law, and, if the various provisions contain different payments for such service – whichever is the higher.

1.11 **Abroad/outside Israel:** anywhere outside the State of Israel, including all means of transportation en route from or to Israel.

1.12 **Israel:** Israeli territories, excepting any means of transportation en route to or from Israel, including the territories under control of the IDF, but excepting the territories held by the Palestinian Authority.

1.13 **Health Insurance Law:** The National Health Insurance Law 1994.

1.14 **Foreign Workers Law:** The Foreign Workers Law (Unlawful Employment and Assurance of Fair Conditions), 1991.

1.15 **Insured's card:** a card to be issued by the insurer in addition to the policy, specifying the personal particulars of the insured, including his photograph for identification purposes, to be presented by the insured to any medical institution, in order to obtain medical service.

1.16 **Medical institution:** a hospital or a clinic.

1.17 **The service centre:** a call-in centre under the auspices of the insurer, providing a response to insured parties in all matters pertaining to the service providers, and operating twenty-four hours a day.

1.18 **Medical emergency:** circumstances in which an immediate threat is posed to an individual's life, or where there exists an immediate risk that an individual will sustain severe, irreversible disability unless urgent medical treatment is administered, and all subject to the definitions contained in the Patient's Rights Law, 1996 on date of commencement of the insurance term.

1.19 **Pre-existing condition:** a defect, a congenital disease including hereditary diseases, and/or a state of health and/or a medical phenomenon and/or disease, whether or not being treated, and/or the direct or indirect results thereof, having been occasioned and/or aggravated due to a health condition that was in existence prior to the date of commencement of the insurance, subject to the insured's declaration and/or to a doctor's certificate and all subject to sub-paragraph 5.1.4 hereafter.

1.20 **Service providers:** a public hospital and/or a private hospital, previously approved by the insurer, and also physicians and/or a medical institution that have contracted in an agreement with the insurer, that are named in the schedule annexed to the policy, and located within a spread conforming to the provisions of the Foreign Workers Order, and from which, exclusively, the insured shall be entitled to received the health services enumerated in this policy, all subject to the policy conditions.

1.21 **Health services basket:** within the definition thereof in the Health Insurance Law.

1.22 **Foreign worker:** a person working in Israel who is neither an Israeli citizen nor an Israeli resident.

1.23 **Foreign Workers Order:** The Foreign Workers Order (Prohibition of Unlawful Employment and Assurance of Fair Conditions) (Worker's Health Services basket), 2001.

1.24 **Physician:** the holder of a medical qualification being duly authorized to work as a physician in Israel.

1.25 **Attending physician:** a general practitioner not being a specialist, and also a specialist in family medicine and/or in internal medicine and/or in gynaecology.

1.26 **Health/medical services:** all the medical services to which the foreign worker is entitled under the conditions of this policy.

1.27 **Primary medical services:** the services of a general practitioner, not being a specialist, and also the services of a specialist in family medicine and/or in internal medicine and/or in gynaecology.

1.28 **Insurance Period:** The Insurance Period as defined in the Policy and the Insurance Details Page, or a period shorter than that as a result of shortening the period according to the instructions and terms of the Policy.

1.29 **Single employment period:** the insured's entire period of employment, even if non-continuous, in which employee-employer relations existed between a particular employer and a particular foreign worker.

1.30 **The Health Services at Work Regulations:** Parallel Tax Regulations (Health Services at Work)**,** 1973.

2. General conditions

2.1 **Duty of disclosure: the insurance pursuant to this policy is made on the basis of the information and written declarations given to the insurer by the policyholder and the insured and that are annexed to the policy. The correctness thereof constitutes a fundamental condition for the insurance. If the insured and the policyholder have given other than a complete and honest answer/s or declaration/s to questions relating to the insured's state of health, then the insurer shall be entitled to cancel the insurance policy or to reject the insured's claim, all subject to Section 7 of the Insurance Contract Law, 1981.**

2.2 **Age: the insured's age is a material matter for the purpose of Clause 2.1 of this policy. Nothing contained in this clause is such as to derogate from the insured's duty to disclose any other material detail as per sub-paragraph 2.1 aforesaid.**

2.3 **Validity of the policy: this policy shall take effect from date of commencement of the insurance term as specified in the policy, but not before the date on which all the preconditions set forth in the policy and in the schedule annexed to the policy are fulfilled, including payment of the first premiums as specified in the schedule annexed to the policy. Wherever the date of commencement of the insurance, as specified in the policy, occurs before the requisite documents listed in the schedule annexed to the policy have been issued to the insurer, the policyholder and the insured must produce such documents within 14 days of the date of commencement of the insurance term. If such documents are not produced within the said interval, the policy shall automatically become null and void. If the policy is voided as aforesaid, the policyholder and/or the insured shall restore the insured's card to the insurer, and in such case, there shall be refunded to the policyholder the insurance premiums paid for the period subsequent to the date of return of the insured's card to the insurer, in accordance with the principles governing the refund of insurance premiums in case of the abbreviation of the insurance term by the policyholder as detailed in this policy.**

2.4 **Duty of producing doctor's certificate:** the policyholder shall warrant in writing that it has obtained a doctor's certificate in respect of each of the insured pursuant to this policy, and shall issue the certificate to the insurer forthwith on demand.

2.5 **Waiver of medical confidentiality:**

2.5.1 The policyholder shall deliver to the insurer a waiver of medical confidentiality signed by the insured, directing his physicians and/or any medical body or institute, whether in Israel or abroad, and/or the National Insurance Institute and/or any other government ministry and/or insurance company and/or health fund to forward to the insurer any reasonable medical information relating to the insured and which is in their possession (hereafter: **"waiver of confidentiality form")**.

2.5.2 The policyholder shall cause the insured to sign a waiver of confidentiality form provided by the insurer in a language understood by the insured and shall forward the form to the insurer in a language understood by the insured and signed by the insured, together with the policyholder's declaration that the waiver of confidentiality form was signed by the insured after the tenor thereof was explained to him in a language understood by him and/or that the insured signed a waiver of confidentiality form after having read the content thereof in a language understood by him.

2.5.3 **The production of a confidentiality waiver form as aforesaid in this clause is a precondition for the insurer's liability pursuant to this policy.**

2.6 **Health declaration form** – sub-paragraphs 2.5.1 – 2.5.3 shall apply to the insured's declaration of health, mutatis mutandis.

2.7 **An insured contingency** that is covered by more than one insurance company and/or by a third party:

2.7.1 If, in connection with an insured contingency covered under this policy, the insured also has a right to indemnity from a third party, other than by virtue of the Insurance Contract Law, then such right shall pass to the insurer as from its having paid insurance benefits, and at the rate of the benefits paid, and without prejudice to the insured's right to first collect from the third party indemnity over and above the insurance benefits pursuant to this policy. If the insured receives from the third party an indemnity amount that was due to the insurer in accordance with this clause, then he must transfer it to the insurer. If he reached a compromise, waiver or other act being prejudicial to the right having passed to the insurer, he must compensate the insurer in respect thereof. The insured undertakes to cooperate to such extent as may be required of him to enable the insurer to realise its right aforesaid.

2.7.2 If all or part of the insured events were insured with more than one insurer for overlapping periods, then the policyholder must so notify the insurer in writing forthwith after the making of the double insurance, or on becoming aware of it. The insurer shall be entitled to render payment of the insurance benefits contingent on assignation of the insured's rights under the other policies to the insurer, in respect of insurance benefits exceeding the insurer's proportionate share in the insured expenses actually expended.

2.7.3 The policyholder and the insured must cooperate with the insurer and do any act necessary in order to enable the insurer to obtain the amounts paid by the insurer and that were on the responsibility of the third party.

2.8 **Claims:**

2.8.1 Notice of any insured event shall be served on the insurer within a reasonable space of time, as quickly and as soon as possible, either by mailing a letter or by transmitting a facsimile message. Annexed to such notice shall be all the details of the insured event, which shall be sent to the insurer in order to make available all the facts necessary to the insurer.

2.8.2 The policy-holder and/or the insured shall annexe to the form of notice of the insured event all medical papers relevant to the insured event including diagnoses, anamnesis, and, if the policyholder and/or the insured made any payments – original receipts only, attesting to the making of payment.

2.8.3 The policyholder and the insured shall cooperate with the insurer both before and after the filing of the claim, and shall do all the necessary to enable the insurer to clarify its liability for payment pursuant to this policy and the scope thereof.

2.8.4 **Compliance with clause 2.8 and all sub-paragraphs thereof by the policyholder and/or the insured is a precondition for the insurer's liability pursuant to this policy.**

2.9 **Medical examination**: the insured shall be obliged, at the insurer's demand, to undergo a medical examination by a physician under the insurer's auspices, and at the insurer's expense, and shall furnish the insurer with any medical detail and/or document that may reasonably be required. **Compliance with this clause is a precondition for the insurer's liability pursuant to this policy**.

2.10 **Extension of insurance term**

2.10 **Extension of the Insurance Period**

2.10.1 The Insurer undertakes to extend the Policy of the Insured, consecutively only, if the Policyholder or the Insured requests such extension, as long as the Insured continues to work as a foreign worker in Israel for a period that does not exceed 5 (five) years from the Effective Date of Insurance with the Insurer, without renewed underwriting (hereinafter: **"Extension Without Underwriting"**).

The transfer of the Insured to a different Policyholder (hereinafter: "Interim Period") shall not prejudice the right of the Insured to extend the Policy, as long as the Insurance Premium continues to be paid in the Interim Period according to the terms of the Policy and the Insured was employed by the new Policyholder within 30 days of the day on which he/she ceased being employed by the former Policyholder.

The abovesaid in section 2.10.1 above notwithstanding, the Insurer undertakes to extend the Insurance Period of the Insured for a period exceeding the period set forth in section 2.10.1 above, consecutively only, if the permit of the Insured to stay in Israel as a foreign worker is extended, and this for the period of the extended permit only.

In this section, "consecutive" means the extension and/or renewal of the Policy no later than 30 days prior to the end of the former Insurance Period. An Insured who applies to the Insurer at a date later than this shall not be entitled to Extension Without Underwriting and this Insured shall be subject to all the instructions that apply to a new Insured.

To eliminate any doubt, extension and/or renewal of the Policy in accordance with the instructions of this section shall not change the Effective Date of Insurance of the Insured.

2.10.2 An Insured who is not entitled to Extension Without Underwriting as set forth in section 2.10.1 shall be subject to the instructions of sections 2.10.3-2.10.6 below. Any extension of any type is subject to the instructions of sections 2.10.7-2.10.8 below.

2.10.3 The Policyholder of a Policy for which the Insured is not entitled to Extension Without Underwriting is entitled to apply to the Insurer to extend the Insurance Period. Extension of the Insurance Period according to this Policy is subject to the written agreement of the Insurer, which will be given expressly for this purpose.

It is hereby clarified that upon Termination of the Insurance Period, as defined in the Policy, the Insurance will not be automatically extended and that the Insurance will not be extended by virtue of silence or any other act of the Insurer, except by its agreement as set forth in this section, even if the Policyholder and Insured proposed that the Insurer extend the policy at any time.

2.10.4 The policyholder is entitled to seek an extension of the insurance term (hereafter: "**extension application").** The extension application shall be mailed to the insurer by registered mail at least 30 days before the end of the insurance term.

2.10.5 If the insurer consents to extend the insurance term – the insurer shall notify the policyholder of its consent in writing. The letter shall be mailed to the policyholder within 10 days of receipt of the extension application. If the insurer consents to extend the insurance, then the insured's continuity of coverage shall be preserved, including the first date within the definition thereof hereafter, in the framework of a pre-existing condition.

2.10.6 Failure by the insurer to serve notice, within the interval specified in sub-paragraph 2.10.5 of its consent to extend the insurance, shall be deemed a refusal to extend.

2.10.7 The premiums for the additional period shall be computed in accordance with the number of extension days, at the insurance premium tariff in effect with the insurer on commencement of the extension.

2.10.8 The insurer shall be entitled to modify the premiums on commencement of any extension of this policy.

2.11 **Cancellation of the insurance**

2.11.1 If the insurance premiums have not been regularly paid as provided in this policy, and are also not paid within 15 days of the insurer presenting the policyholder with a written demand to pay, then the insurer shall be entitled to notify the policyholder in writing that the policy is due to be cancelled after the lapse of a further 21 days unless the amount in arrears is cleared before that time.

2.11.2 If the policyholder cancels the policy before the end of the insurance term due to expiry of the insured's term of employment with the policyholder, then the insurer shall refund to the policyholder a proportion of the premiums as per sub-paragraph 2.11.3 hereafter, subject to its obligation under the Insurance Contract Law 1981.

2.11.3 For the purpose of sub-paragraph 2.11.2: the proportionate premiums shall be refunded to the policyholder for the period subsequent to the return of the insured's card to the insurer, net of handling fees. For the purpose of this sub-paragraph, "handling fees" means the insurer's expenses involved in issuing the insurance policy and the insured's card, stamp duty and any other expense attendant on the process of issuing the policy, and that shall be not less than the insurance premiums for two months in respect of this policy.

2.11.4 The instructions of the section above shall not be construed to prejudice the right of the Insurer to cancel the Policy according to the instructions of the chapter on the Duty of Disclosure above and/or according to any other essential term mentioned in the Policy and/or according to the instructions of the Insurance Contract Law.

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2.12 **Insurer's non-liability for acts and/or omissions of service providers – the insurer shall bear no liability whatsoever for any acts and/or omissions on the part of the service providers in connection with the health services and/or the results thereof, whether chosen by the insurer or whether chosen by the insured.**

2.13 **Prescription – the prescription term of a claim for payment of insurance benefits in respect of an event insured pursuant to this policy is three years from the day of occurrence of the insured event.**

2.14 **The Insurance Contract Law –** the provisions of the Insurance Contract Law 1981 shall apply to this policy in respect of all matters not regulated in this policy itself, and which may be excluded.

2.15 **Modifications in the health services -**

2.15.1 **The insured shall be entitled to the services included in the health services basket, the drugs basket and the services-at-work basket, within the following definitions thereof, and as modified from time to time.**

2.15.2 **If any changes occur in the health services basket, and/or the drugs basket and/or the services-at-work basket, and/or in the Health Law and/or in any order and/or provision after commencement of the insurance term (hereafter: "the new health basket"), then the insurer shall notify the policyholder of the changes having taken place and/or that are due to take place in the health services basket, the drugs basket and the services-at-work basket, and/or in any order and/or provision after commencement of the insurance term and shall demand such increment to the insurance premiums as is required consequent on the said modification and (shall specify) the time for the payment thereof (hereafter: "increment to premiums").**

2.15.3 **An increment to premiums is tantamount to premiums and the provisions of clause 2.11 governing the premiums shall also apply to the increment to premiums.**

2.16 **Notices:** the policyholder must notify the insurer of any change in its address by registered mail. Any notice sent by the insurer to the policyholder at its last known address shall be deemed duly delivered.

2.17 **Payment of premiums, taxes and levies:** the policyholder must pay the insurer the insurance premiums and the governmental and other taxes applicable to this policy or that are levied on the premiums, and all other such payments as the insurer is required to pay pursuant to this policy, whether such taxes exist on the day of making the policy or whether they are imposed at a later date.

2.18 **Venue of jurisdiction:** the sole and exclusive venue of jurisdiction in all matters pertaining to and arising from this policy shall be the competent courts in Israel.

Chapter 2: The Health Services

3. The health services to be provided to the insured

3.1 Subject to the tenor of this policy, the insured shall be entitled to health services in Israel, all as set forth hereafter:

3.1.1 Basket of treatments -

3.1.1.1 All the services enumerated in the Second Schedule to the Health Insurance Law on commencement of the insurance term, and as modified from time to time.

3.1.1.2 Hospitalisation services in a psychiatric hospital or in a psychiatric ward of a general hospital, in a state of medical emergency, for a period not exceeding 60 days per term of employment.

3.1.1.3 The following services -

3.1.1.3.1 Examination of amniotic fluid for women aged 35 and over on commencement of the pregnancy.

3.1.1.3.2 Immunisation against tetanus, rabies and diphtheria.

3.1.1.3.3 Mantoux examinations and lung X-rays.

3.1.1.3.4 Wheelchairs and walkers.

3.1.2 The drugs basket – all the services enumerated in the National Health Insurance Order (Drugs in the Health Services Basket), 1995, on date of commencement of the insurance term.

3.1.3 Services-at-work basket – all the services enumerated in Regulations 2 and 5 of the Health Services at Work Regulations, in the manner prescribed in those Regulations, mutatis mutandis on date of commencement of the insurance term.

4. Insurer's further undertakings

4.1 Subject to the tenor of this policy, the insurer shall bear the following expenses, all subject to the conditions, the exclusions and the exceptions set forth in this policy and hereafter -

4.1.1 Customary payment: in respect of medical services covered under this policy, and for which the insurer is obliged to pay as against their being provided for the customary payment, the insurer shall bear the customary payment. **The insurer shall not bear the customary payment where the medical service in respect of which the customary payment was made is not covered pursuant to this policy.**

4.1.2 The full amount of the expenses related to the insured's air travel from Israel back to his country of origin in any event in which his condition necessitates medical accompaniment or other special arrangements during the flight.

4.1.3 Removal expenses of insured's body -

4.1.3.1 In case of the death of the insured, under circumstances entitling him to medical service pursuant to this policy, the insurer shall bear the removal expenses of the body from Israel to the insured's country of origin.

4.1.3.2 Notwithstanding sub-paragraph 4.1.3.1 aforesaid, and sub-paragraph 5.1.6 hereafter, if the insured dies as a result of a work injury, within the definition thereof in sub-paragraph 5.1.6 hereafter, then the insurer shall bear the expenses of the removal of the insured's body from Israel to the insured's country of origin.

4.1.3.3 **The insurer's liability under sub-paragraphs 4.1.3.1 and 4.1.3.2 is contingent on prior approval being obtained from the insurer and that the aforesaid air-freighting of the body to another country be made through the good offices of the insurer only.**

4.1.4 Emergency air passage for a near relative to Israel

4.1.4.1 In this clause, "**near relative"** means – wife, husband, son, daughter, brother or sister.

4.1.4.2 If the insured is hospitalised under circumstances entitling him to health services pursuant to this policy for the purpose of an invasive surgical procedure involving hospitalisation and exceeding 10 days, or if the attending physician has determined that the insured's life is at risk, then the insurer shall pay a near relative the cost of purchasing a flight ticket and travel to the place where the insured is hospitalised in Israel up to a sum of $1,500 and the cost of a stay of up to ten days in a hotel up to a maximum of $40 per diem.

The insurer's undertaking pursuant to this clause is contingent on the flight ticket and the hotel stay arrangements being purchased through the insurer's good offices, and the insurer having given its prior written consent thereto.

4.1.5 Air travel expenses in case of incapacitation for work: if a specialist in occupational medicine has determined that the insured is unfit to perform the work for which he was hired by the policyholder, and that he will not be fit to perform it within a period of 90 days from the day on which he was examined by such physician, even if given the medical treatment he requires (hereafter: "**incapacitation")**, and all within the insurance term, then the insurer shall bear the cost of a flight ticket to the insured's country of origin up to a maximum amount of $2,000.

The insurer shall not bear flight ticket expenses as per sub-paragraph 4.1.5 aforesaid, where the incapacitation derived from circumstances not entitling the insured to medical services pursuant to this policy, except for circumstances as per sub-paragraph 4.1.5 aforesaid and 5.1.5 hereafter.

4.1.6 Dental first aid services-

4.1.6.1 The insured shall be entitled to receive the following dental emergency services and dental first aid services, and such services only, all through dental clinics in all parts of Israel, as may be designated from time to time by the insured, and the particulars of which may be obtained from the insurer's service centre -

4.1.6.1.1 Extensive caries, temporary filling.

4.1.6.1.2 Open tooth cavity, temporary filling.

4.1.6.1.3 Exposed neck of tooth, desensitising substance.

4.1.6.1.4 Severe inflammation, extraction of nerve, embalming substance.

4.1.6.1.5 Dental source abscess, drainage of abscess and/or treatment of occlusion.

4.1.6.1.6 Compaction of foodstuff, gingival treatment.

4.1.6.1.7 Perio-coronal inflammation, lavage and/or drug therapy.

4.1.6.1.8 Post-extraction pain, pain alleviation.

4.1.6.1.9 Ulcers beneath existing prosthesis, release of ulcers.

4.1.6.1.10 Any additional treatment deriving from toothache - treatment will be provided for the alleviation or cessation of the pain.

4.1.6.1.11 Examination and X-ray of painful teeth.

4.1.6.1.12 Issue of appropriate prescription for alleviation of pain where tooth cannot be treated at the time.

4.1.6.2 Notwithstanding sub-paragraph 5.1.4 hereafter, the insured shall be entitled to the emergency services and the first aid detailed in sub-paragraph 4.1.6.1 aforesaid, even if required due to pre-existing condition.

5. Exceptions to Chapter 2

5.1 Notwithstanding Clauses 3 and 4 aforesaid, the insurer shall not bear medical expenses in respect of the services enumerated hereafter, and the insured shall not be entitled to such expenses and/or services in the framework of this policy -

5.1.1 Under the basket of treatments -

5.1.1.1 Psychological services.

5.1.1.2 Treatments at the Dead Sea for psoriasis patients.

5.1.1.3 Genetic examinations

5.1.1.4 Hospitalisation for nursing care or other nursing services.

5.1.1.5 Services for the treatment of impotency, disorders in sexual function, male or female fertility, and also artificial fertilisation or artificial insemination treatments.

5.1.1.6 Services administered outside Israel.

5.1.1.7 The Insurance Event occurred after Termination of the Insurance Period and/or consecutive Insurance Periods as set forth in section 2.10 above.

5.1.2 <u>Under the drugs basket</u>

5.1.2.1 Drugs for the treatment of Alzheimer's.

5.1.2.2 Drugs for the treatment of impotency, disorders in sexual function, male or female fertility, and also drugs administered in the course of treatment in artificial fertilisation or artificial insemination.

5.1.3 <u>Pregnancy</u> – Health services in connection with pregnancy during the first nine months, cumulatively, in which employee-employer relations existed between the employee and one or more employers in Israel, except in case of medical emergency.

5.1.4 <u>Pre-existing condition</u> – medical services needed by the insured by reason of a medical problem arising from a medical condition precedent to the first date on which any employer in Israel arranged for medical insurance, all for the first three years as from the date of coming into force of the Foreign Workers Order or from the first date on which medical insurance was arranged for the insured, whichever may be later (hereafter: "the first date"), if one of the following two conditions is fulfilled:

5.1.4.1.1 The insured himself has confirmed that the medical problem respecting which he resorted to the service derived from a pre-existing condition.

5.1.4.1.2 A physician has confirmed, based on the findings before him, that the medical problem respecting which the worker resorted to the service derived from a pre-existing condition.

5.1.4.2 If the insured sojourned outside Israel, after the first date, for a period or periods exceeding 90 successive days with a number of employers, or for a period exceeding 120 successive days if the sojourn intervened between discrete terms of employment with the same employer – then the first date, for the purpose of sub-paragraph 5.1.4, shall be deemed to be the first date after the sojourn in which the employee is insured under medical insurance.

5.1.4.3 <u>Health services in a state of medical emergency due to a pre-existing condition:</u> notwithstanding sub-paragraph 5.1.4 aforesaid, the insurer shall bear the medical costs in respect of health services needed by the insured during a state of medical emergency deriving from a pre-existing condition, in order to stabilise his medical condition, until he reaches a condition enabling the continuation of treatment outside Israel, and also expenses in respect of other medical services required by the insured due to that same pre-existing condition, and to which the insured resorted in the 30 day period following determination by the physician as aforesaid, or the determination as regards the stabilisation of his medical condition as aforesaid.

5.1.5 <u>Incapacitation for work</u> -

5.1.5.1 Medical services needed by the insured after a specialist in occupational medicine has determined that the insured is unfit to perform the work for which he was hired by the policyholder, and that he will not be fit to perform it within a period of 90 days from the day on which he was examined by such physician, even if given the medical treatment he requires.

5.1.5.2 Notwithstanding sub-paragraph 5.1.5.1 aforesaid, the insured shall be entitled to the medical services he requires in a state of medical emergency for stabilising his medical condition, until his condition enables him to be treated outside of Israel, and also to other medical services he may require during the 30-day a period after the physician's determination as aforesaid, or a

determination regarding the stabilisation of his medical condition as aforesaid.

5.1.6 <u>Road accidents and hostilities</u> – medical services needed by the insured due to:

5.1.6.1 Road accidents, within the definition thereof in the Compensation to Road Accident Victims Law, 1975.

5.1.6.2 Hostilities, within the definition thereof in the Benefits to Victims of Hostilities Law, 1970.

5.1.7 <u>Health services consequent on occupational injury</u>

5.1.7.1 The insurer shall not bear the insured's health services expenses if the insured has need of them due to a work accident within the meaning thereof in the National Insurance Law [Combined Wording] 1995 (hereafter: "work injury"), provided that the employer has confirmed, on a form prescribed by the National Insurance Institute, and designated for the purpose (hereafter: "the injury form") that such injury is a work injury.

5.1.7.2 If the employer has furnished an injury form and the National Insurance Institute has not determined, within three months of the date of the work injury, that it was a work injury, then the insurer shall bear the expenses of the health services administered to the insured consequent on such work injury, during the three months, even if they were rendered other than by the service providers, and, after the lapse of three months, if they were rendered by the insurer's service providers.

5.1.7.3 Where the injury derived from a work injury, the policyholder undertakes to confirm the injury as per sub-paragraph 5.1 aforesaid, on the injury form, to the National Insurance, with a copy to the insurer, within 7 days of the date of the work injury. If a policyholder does not provide confirmation as aforesaid, and the injury is found to have been a work injury, within the aforesaid definition thereof, then the policyholder shall bear all the expenses covered by the insurer and shall pay them together with indexation differences and lawful compound interest within 7 days of the date of the insurer's demand.

6. **Principles for confirmation or determination by a specialist physician – pre-existing condition and incapacitation for work**

6.1.1 A medical certificate attesting that the medical problem respecting which the insured resorted to medical service derived from a pre-existing condition, and a physician's determination that the medical condition of an employee has been stabilised - shall be given to a specialist. A physician's determination as to the insured's incapacity to work even if given medical treatment – shall be given to a specialist in occupational medicine.

6.1.2 The 30 days referred to in sub-paragraphs 5.1.4 and 5.1.5 shall only start to be counted from the date of final confirmation or the final determination given as per sub-paragraph 6.1.3 aforesaid, but such determination regarding the stabilisation of an employee's medical condition shall not be deemed a final determination. If the head of the hospital department to which the insured was admitted, or the deputy head of the department – in absence of the head – have determined that at the date on which the insured's entitlement to medical services is due to expire as provided by this policy, his medical condition has not yet been stabilised, such determination shall prevail unless and until determined otherwise, either by the head of the department or by his deputy as aforesaid.

6.1.3 The principles for confirmation or determination as per sub-paragraph 6.1.2 shall be as follows:

6.1.3.1 The insurer shall be entitled to demand that the insured undergo examination by a specialist under its auspices, at the insurer's expense. The physician's opinion shall be delivered to the insured together with notice of the insured's entitlement to a countervailing opinion as per sub-paragraph 6.1.3.2 hereafter, and together with details of bodies or organisations able to help him realise such entitlement, and that have consented to do so.

6.1.3.2 The insured is entitled to a countervailing opinion from a specialist of his choice, to be delivered to the insurer within 21 days of the date the insured received the opinion issued on behalf of the insurer. The insurer shall bear the expenses of the countervailing opinion up to a ceiling of the amount determined by the Director General of the Ministry of Health and the Superintendent of Insurance and Capital Markets at the Ministry of Finance (hereafter: "the fixed fee").

6.1.3.3 If the specialists aforesaid hold different opinions, the parties shall appoint a mutually agreed physician, to be financed by the insurer, and his opinion shall prevail. If the parties fail to reach agreement

on such physician, an adjudicating specialist shall be appointed by the Head of Union of the Israel Medical Association (hereafter: "IMA"), engaging in the branch of medicine relevant to the insured's disease, and for the purpose of determining incapacity even where medical treatment is provided - by the Head of the Union of Occupational Medicine of the IMA (hereafter: "the adjudicating physician"), and his opinion shall prevail. If the Head of Union as aforesaid has not appoint an adjudicating physician within 15 days of the date he was approached by the insurer, then the adjudicating physician shall be appointed by the Director General of the Ministry of Health or by whomsoever he shall empower thereto. The fee of the adjudicating physician shall be the fixed fee and shall be paid by the insurer.

CHAPTER 3: Service providers and medical services contingent on confirmation

7. Service providers

7.1 Subject to any modification of which the insurer shall serve written notice on the policyholder, the medical services included in this policy shall be provided by the service providers only. If a service provider ceases to work with the insurer, the insured shall apply to the insurer's call-in centre in order to obtain a referral to another service provider.

7.2 The medical services included in this policy shall be administered to the insured based upon medical discretion, shall be of reasonable quality, and shall be given within a reasonable space of time and at a reasonable distance from the insured's place of residence.

7.3 Notwithstanding sub-paragraph 7.1 aforesaid, the insured shall be entitled to the following medical services, under the following conditions, at the insurer's expense:

7.3.1 Emergency room services at every general hospital in Israel, in each of the following instances:

7.3.1.1 Any new fracture.

7.3.1.2 Severe dislocation of shoulder or elbow.

7.3.1.3 An injury requiring stitches or alternative means of fusion.

7.3.1.4 Inhalation of a foreign body into the respiratory tract.

7.3.1.5 Penetration of foreign body into eye.

7.3.1.6 Treatment of cancer.

7.3.1.7 Treatment of haemophilia.

7.3.1.8 Treatment of cystic fibrosis.

7.3.1.9 Removal by ambulance to emergency room, from the street or other public place, due to a sudden event.

7.3.1.10 The application concludes by the insured being admitted for non-elective hospitalisation.

7.3.1.11 Medical emergency condition.

7.3.2 Hospitalisation services provided to the insured immediately after applying to the emergency room, if occurring in the instances set forth in sub-paragraph 7.3.1 aforesaid.

8. **Provision of medical service contingent on prior approval**

8.1 The medical services enumerated hereafter shall be provided by the service providers only.

8.2 Access to the various medical services shall be conditional on prior approval by the insurer and/or confirmation by the attending physician and/or shall be free of charge, all as follows:

8.2.1 Access to the primary medical services included in this policy shall be free, and the insured shall not be required to obtain prior approval from the insurer before obtaining such medical service.

8.2.2 Access to non-primary medical services, except in the instances enumerated in sub-paragraph 7.3 aforesaid, shall be contingent on obtaining the prior approval of the attending physician in the primary medical services.

8.2.3 Access to examinations in imaging institutes, diagnostic institutes, a gastroenterologic institute, laboratories and elective hospitalisation services, shall be contingent on the insurer's prior written consent.

The insured must submit to the insurer a written application for approval of the services enumerated in this clause, together with the confirmation of the attending physician that the insured is in need of such medical service.

The desired approval or notice of refusal shall be served within 7 days of the determination by the attending physician as to the need for examination or hospitalisation all according, and/or from the day the insurer received the insured's application, whichever is the later, and, in any event, shall not be postponed in such a way as to endanger the insured or to prejudice the reasonable chance of success of the treatment to which he is entitled pursuant to this policy.

8.2.4 Apart from the instances enumerated in sub-paragraph 7.3 aforesaid, the insurer shall not bear expenses of the insured's medical services in an emergency room, unless the insured has obtained the prior confirmation of his attending physician.

CHAPTER 4: COMPENSATION IN RESPECT OF DEATH AND DISABILITY RESULTING FROM ACCIDENT

Insured persons not yet having attained 18 years of age and/or who have attained 65 years of age, shall not have insurance cover under this chapter.
The insurer's liability according to this chapter will not exceed a total sum of 10,000 usd per insured.
This benefit is limited to a single occurrence only.

9.

9.1 In this chapter -

9.1.1 "**The insured"**: one sojourning in the State of Israel as a foreign worker provided that he is aged over 18 years and less than 65 years.

9.1.2 "**Accident"**: unanticipated bodily harm caused during the insurance term by a visible violent external means being the sole, direct and immediate cause of the death or disability of the insured, excepting damage caused as a result of verbal violence, and except if such damage were occasioned as the result of hostilities within the definition thereof in the Benefits to Victims of Hostilities Law, 1970.

9.1.3 "**Permanent disability":** total anatomical or functional loss of an organ or limb or parts thereof, due to an accident having occurred, and being occasioned with 6 months of its occurrence.

9.1.4 **"Death of the insured"**: the death of the insured consequent on the accident, occasioned within 6 months of its occurrence.

9.2 If, within the insurance term, the insured sustains bodily harm directly caused by an accident, then insurance benefits shall be paid as follows:

9.2.1 In case of the death of the insured, whose age at the time of death was 18 years and less than 65 years, there shall be paid to the beneficiary named in the proposal, or, in absence of a beneficiary, to the insured's legal heirs or the administrators of his estate or the executors of his will, the sum of $10,000.

9.2.2 In case of permanent disability: there shall be paid to the insured certain percentages of the amount specified in sub-paragraph 9.2.1 aforesaid.

Body part	Percentage	Body part	Right	Left
One eye	30%	Arm	75%	65%
Both eyes	100%	Middle finger	65%	55%
One ear	20%	Hand	60%	50%
Both ears	50%	Thumb	25%	20%
Leg (above knee)	60%	Index finger	15%	12%
Thigh	70%	Middle finger	12%	10%
Foot	50%	Fourth finger	10%	8%
Big toe	5%	Little finger	12%	10%
One toe	3%	Joint of digit	1/3 of above percentage	

9.2.3 The percentages denoted in this table relate to 100% permanent disability of such body part. Any other permanent disability shall be calculated by comparison with the aforesaid table. Any disability existing prior to the accident shall be taken into account for the purpose of determining the disability rating.

9.2.4 In a left-handed person, a left body part shall be deemed a body part in accordance with the aforesaid table.

CHAPTER 5: EXCEPTIONS TO CHAPTER 4:

ACCIDENTAL DEATH AND DISABILITY COMPENSATION

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10. The Insurer shall not pay insurance benefits pursuant to this Policy if the death or disability was caused, directly or indirectly, by or as a consequence of:

10.1 An earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive contamination.

10.2 The Insured's active participation in a military, police, underground act, a revolution, rebellion, pogroms, riots, sabotage, terror, strike, or illegal act.

10.3 **The Insured's passive participation in any act of sabotage or terror of any kind whatsoever and/or in a war and/or in a warlike action of hostile, regular or irregular forces.**

10.4 **The Insured's flying in any aircraft whatsoever, except for the Insured flying as a passenger in a civil aircraft qualified as a passenger carrier, subject to the Insurer's liability in Israel only.**

10.5 **Intentional self-inflicted injury or suicide or an attempt thereof, whether the Insured is sane or insane.**

10.6 **Mountain-climbing with ropes, cliff-climbing or cliff-snappling, diving, bungee-jumping, sports activity within the framework of a sports association and/or competitive sports activity, boxing, wrestling and all types of full-contact fighting, parachuting, floating/gliding by means of parachutes and/or any other instrument used for floating/gliding, winter sports, hunting.**

10.7 **Use of explosives.**

10.8 **Intentional self-endangerment, except for self-defense and life-saving.**

10.9 **The Insured being inebriated, intoxicated or using drugs.**

10.10 **Death or disability resulting from surgery, including minor surgery.**

10.11 **A work accident, as defined in the National Insurance Institute Act.**

10.12 **A road accident, as defined in the Compensation for Road Accident Victims Act, 1975.**